GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 22, 2022

Mike Dykstra
Golden Life AFC, LLC
4386 14 Mile Rd, NE
Rockford, MI 49341

RE: License #: AM590395969
Investigation #: 2022A1024041
Golden Life AFC #2

Dear Mr. Dykstra:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems
427 East Alcott
Kalamazoo, MI 49001

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AM590395969
Investigation #:	2022A1024041
Complaint Receipt Date:	06/30/2022
Investigation Initiation Date:	06/30/2022
Report Due Date:	08/29/2022
Licensee Name:	Golden Life AFC, LLC
Licensee Address:	4386 14 Mile Rd, NE Rockford, MI 49341
Licensee Telephone #:	(616) 307-7719
Administrator:	Mike Dykstra
Licensee Designee:	Mike Dykstra
Name of Facility:	Golden Life AFC #2
Facility Address:	503 W. Montcalm Greenville, MI 48838
Facility Telephone #:	(616) 232-2584
Original Issuance Date:	01/22/2019
License Status:	REGULAR
Effective Date:	07/22/2021
Expiration Date:	07/21/2023
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Staff failed to seek medical attention when Resident A was found on the floor in pain after a fall.	No

III. METHODOLOGY

06/30/2022	Special Investigation Intake 2022A1024041
06/30/2022	Special Investigation Initiated – Telephone with home manager Trysta Gorsuch
06/30/2022	Contact - Document Received *AFC Licensing Division-Incident/Accident Report*
07/05/2022	Contact - Document Received-Resident A's *After Visit Summary,* physician correspondence*,* and *Health Care Appraisal*
07/08/2022	Inspection Completed On-site with home manager Trysta Gorsuch
08/04/2022	Contact - Telephone call made with home manager Trysta Gorsuch, direct care staff Erica Behrenwald, and Kierra Strouse
08/04/2022	Contact - Telephone call made nurse case manager with Reliance Community Care Partners Dusty Elliot Young
08/05/2022	Contact - Telephone call made with direct care staff member Bonnie Southard
08/22/2022	Exit Conference with licensee designee Mike Dykstra

ALLEGATION:

Staff failed to seek medical attention when Resident A was found on the floor in pain after a fall.

INVESTIGATION:

On 6/30/2022, I received this complaint through the Bureau of Community and Health Systems (BCHS) online complaint system. This complaint alleged staff failed to seek medical attention when Resident A was found on the floor in pain after a fall.

This complaint further stated Resident A was on the floor for three hours and had multiple falls prior throughout the day.

On 6/30/2022, I conducted an interview with home manager Trysta Gorsuch regarding this allegation. Ms. Gorsuch stated Resident A had been having incidents of falls for the past week and his doctor had been working on trying to figure out the causes for these falls by making adjustments to his medications. Ms. Gorsuch stated she has been been in contact with Resident A's case manager regarding these falls and Resident A has been to the hospital for having falls on multiple occasions however the hospital had not been able to find any medical issues to keep Resident A for further evaluation and treatment. Ms. Gorsuch stated during the last incident of Resident A falling on 6/27/2022, Resident A refused to get up off the floor even though he reported he was not hurt or injured. Ms. Gorsuch stated direct care staff member Kierra Strouse talked with Resident A while he was on the floor and provided him with a blanket to make him more comfortable. Ms. Gorsuch stated eventually the staff members decided to called emergency medical services since Resident A eventually agreed to get up off the floor however was not able to get up independently on his own. Ms. Gorsuch further stated Resident A was not on the floor for three hours prior to calling 911 for assistance. Ms. Gorsuch stated Resident A had just returned back from the hospital on 6/27/2022 when he had multiple falls that same day. Ms. Gorsuch stated falls for Resident A was not a new issue and it was something they were dealing with by working with Resident A's case manager and primary care physician.

On 6/30/2022, I reviewed the facility's *AFC Licensing Division-Incident/Accident Report* dated 6/27/2022 at 6:18pm. This report stated Resident A came to the kitchen, talked with direct care staff members, stated he was tired and was going to go to bed. Staff walked behind Resident A to make sure he got to his bedroom safely but Resident A took off running. While running, Resident A tripped over his feet and fell to the floor. The report stated after assessing Resident A for safety, it was decided to call 911.

I also reviewed *AFC Licensing Division-Incident/Accident Report* dated 6/27/2022 at 1:50pm. This reported stated Resident A had been very off balance and has had several falls in the last few days. This report stated when Resident A was on the porch, he almost fell off the steps however direct care staff was able to reach out to catch him before he fell. Shortly after this Resident A walked away from the porch and again lost his balance and fell. Resident A then went to his bedroom to lay down and after staff left his room, Resident A got out of bed and attempted to walk and again fell down. Staff members assisted Resident A to his chair so he can watch television. The report stated within five minutes of staff leaving Resident A in his chair, Resident A got up again and fell in the hallway near his bedroom. Staff members contacted Dr. Gendich, guardian and nurse case manager regarding these multiple falls. Staff also then assisted Resident A with walking whenever he got up to move around.

On 7/5/2022, I reviewed Resident A's *After Visit Summary* dated 6/27/2022. According to this summary Resident A was admitted to Spectrum hospital on 6/26/2022 for having altered mental status and discharged on 6/27/2022.

I reviewed Resident A's *After Visit Summary (summary)* dated 6/26/2022. According to this summary, Resident A was evaluated on 6/26/2022 for a fall and discharged on 6/27/2022.

I reviewed Resident A's *After Visit Summary* dated 6/20/2022 with Dr. Sheila Gendich which recorded a routine office visit for Resident A with his primary care physician.

I reviewed physician correspondence from Dr. Sheila Gendich M.D to Interim Home Help Care. On 6/28/2022 Dr. Gendich sent a referral to Interim Home Help Care due to Resident A having recurrent falls, continued instability when walking, increased confusion, and dementia. This referral included a summary of the care Resident A has received at her doctor.

I also reviewed physician correspondence from Dr. Sheila Gendich with Golden Life AFC. On 6/27/2022, Dr. Gendich advised if allowed Resident A needs to have his bed on the floor temporarily until she can figure out why he continues to fall. Dr. Gendich also stated she is going to decrease Resident A's Gabapentin from three times a day to once in the morning and once in the evening for three days. Following this, begin to give him the dosage of 1 tablet at bedtime until July 11th until it is discontinued.

I reviewed Resident A's *Health Care Appraisal (appraisal)* dated 1/24/2022. According to this appraisal Resident A was diagnosed with Ischemic Brain Injury and was fully ambulatory.

On 7/8/2022, licensing consultant Eli Deleon conducted an onsite investigation at the facility with home manager Trysta Gorsuch. According to Ms. Gorsuch Resident A was still in the hospital and Ms. Gorsuch does not believe he will be returning back to the home.

On 8/4/2022, I conducted interviews with home manager Trysta Gorsuch, direct care staff Erica Behrenwald, and Kierra Strouse. Ms. Gorsuch stated Resident A was now relocated to a nursing home and is being treated for Delirium.

Ms. Behrenwald stated on 6/27/2022, she came into the home and noticed that Resident A was sitting on the floor therefore she kneeled down and asked if he was okay. Ms. Behrenwald stated Ms. Strouse informed her that Resident A did not want to get back up after falling and his vitals had been taken. Ms. Behrenwald stated she was aware that Resident A had fallen earlier in the day and had incidents of falling the day before at which time he was seen at the hospital however was returned home with no further evaluation. Ms. Behrenwald stated Resident A did not

have any history of falls and all of sudden he started having issues with repeated falls in a one-week time frame. Ms. Behrenwald stated staff always notified Resident A's guardian, case manager and physician whenever Resident A had a fall.

Ms. Strouse stated on 6/27/2022 she observed Resident A with poor balance throughout the day which was not uncommon as Resident A had been dealing with having falls for about a week and he had just returned from the hospital for a fall which occurred the day before. Ms. Strouse stated she checked on Resident A periodically and stayed in close proximity of Resident A whenever she saw him walking around the house to ensure his safety from falls. Ms. Strouse stated later in the day on 6/27/2022, Resident A fell after running and tripping over his feet. Ms. Strouse stated she tried to encourage Resident A to get up off the floor however he refused and chose to sit on the floor for about an hour. Ms. Strouse stated Resident A informed her that he was not injured or in any pain therefore she provided Resident A with a blanket and pillow to make him more comfortable while he sat on the floor. Ms. Strouse stated eventually two other direct care staff members tried to encourage Resident A to get up off the floor and when Resident A eventually agreed to get up off the floor, he was not able to physically get up on his own. Ms. Strouse stated staff then decided to call emergency medical services for assistance. Ms. Strouse stated Resident A was then transported to the hospital and has not returned back to the home since this incident.

On 8/4/2022, I conducted an interview with Resident A's nurse case manager Dusty Elliot Young who stated that the direct care staff members did a great job communicating concerns of falls involving Resident A to her, Resident A's guardian and Resident A's primary care physician. Ms. Young stated she believes Resident A was overly prescribed medications which caused him to have an altered mental status however this was not something direct care staff members had control over. Ms. Young stated direct care staff members sent Resident A to the hospital for falls however the hospital would immediately return him back to the home with no medical concerns. Ms. Young stated Resident A's health declined within a week and she was in constant communication with staff members and doctors regarding this issue. Ms. Young stated Resident A has now been relocated to a nursing home facility and his medications have been modified. Ms. Young further stated the staff members sought medical attention as required for Resident A while he resided in the adult foster care.

On 8/5/2022, I conducted an interview with direct care staff member Bonnie Southard who stated that on 6/27/2022 she went to the facility to conduct paperwork and saw Resident A on the floor talking with another staff member. Ms. Southard stated she noticed Resident A was not able to get up off the floor on his own therefore she called emergency medical services. Ms. Southard stated Resident A had been dealing with having repeated falls throughout the day and the day before on 6/26/2022. Ms. Southard further stated Resident A had also just returned from the hospital on 6/27/2022 for having the falls he had on 6/26/2022. Ms. Southard stated Resident A did not have a history of falls prior to the month of June 2022 and

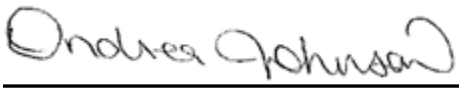
his primary care physician was working to figure out why Resident A had sudden issues with falls.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Based on my investigation which included interviews with home manager Trysta Gorsuch, direct care staff members Erica Behrenwald, Kierra Strouse, Bonnie Southard, case manager Dusty Elliot Young, and review of facility's physician correspondence, incident reports, Resident A's *Health Care Appraisal* and *After Visit Summary* there was no evidence direct care staff members failed to seek medical attention when Resident A was found on the floor in pain from a fall. Ms. Gorsuch, Ms. Behrenwald, Ms. Strouse and Ms. Southard all stated Resident A had a fall on 6/27/2022 and had been having issues with repeated falls for about a week. All also confirmed Resident A was evaluated at the hospital for these falls however discharged back to the facility. They also stated they reported these concerns to Resident A's primary care physician and case manager regularly. Ms. Young stated staff members did a great job communicating regularly with her, Resident A's guardian and primary care physician regarding Resident A having repeated falls and Ms. Young was working with Resident A's doctor to address this issue. Ms. Strouse stated on 6/27/2022, Resident A fell and chose to sit on the floor however stated he was not in any pain or injured. Ms. Strouse, Ms. Behrenwald and Ms. Southard all stated 911 was called when Resident A eventually agreed to get up off the floor however was not able to do so independently on his own. According to the facility's incident report Resident A went to the hospital on 6/27/2022 for having multiple falls throughout the day and Resident A's *After Visit Summary* states that Resident A was seen on 6/26/2022 for falls and 6/27/2022 for having a altered mental status. Medical care was obtained for Resident A as required.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 8/22/2022, I conducted an exit conference with licensee designee Mike Dykstra. I informed Mr. Dykstra of my findings and allowed him an opportunity to ask questions or make comments.

IV. RECOMMENDATION

I recommend the current license status remain unchanged.



Ondrea Johnson — 8/22/2022
Licensing Consultant — Date

Approved By:

Dawn N. Timm — 08/22/2022
Area Manager — Date