GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 5, 2023

Paula Danville
1383 E. Pine River Rd.
Midland, MI 48640

RE: License #: AL730398402
Investigation #: 2023A0580007
Pine Haven Assisted Living LLC, AFC

Dear Ms. Danville:

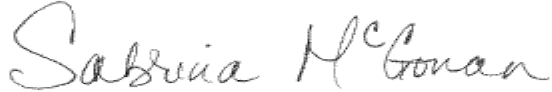
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

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 (517) 643-7960.

Sincerely,



Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 835-1019

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL730398402
Investigation #:	2023A0580007
Complaint Receipt Date:	11/09/2022
Investigation Initiation Date:	11/10/2022
Report Due Date:	01/08/2023
Licensee Name:	Paula Danville
Licensee Address:	1383 E. Pine River Rd. Midland, MI 48640
Licensee Telephone #:	(989) 295-6632
Administrator:	Paula Danville
Licensee Designee:	Paula Danville
Name of Facility:	Pine Haven Assisted Living LLC, AFC
Facility Address:	515 N Brennan Hemlock, MI 48626
Facility Telephone #:	(989) 642-5761
Original Issuance Date:	03/04/2020
License Status:	REGULAR
Effective Date:	09/04/2022
Expiration Date:	09/03/2024
Capacity:	18
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
On 11/02/22, Resident A was left unattended on the floor for two hours by a manager, Ms. Shelly Strong.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/09/2022	Special Investigation Intake 2023A0580007
11/09/2022	APS Referral This complaint was denied by APS for investigation.
11/10/2022	Special Investigation Initiated - Letter A review of the Incident Report received on 11/04/2022 was conducted.
11/15/2022	Contact - Telephone call made A call was made to the licensee requesting documentation and phone numbers.
11/21/2022	Inspection Completed On-site An onsite inspection was conducted. Contact was made with the licensee.
11/21/2022	Contact - Face to Face Interviews with staff on duty, Ms. Sherri Forrest, and Ms. Kim Fuller.
12/20/2022	Contact - Telephone call made A call was made to Ms. Deana Stewart, Direct Staff.
12/20/2022	Contact - Telephone call made I placed a call to former direct staff, Ms. Shelly Strong.
12/22/2022	Contact - Telephone call made I placed a call to Relative Guardian A.
01/03/2023	Contact - Telephone call made Call placed to Ms. Shelly Strong, Staff.

01/03/2023	Contact - Document Received Faxed copy of the Heart-to-Heart Hospice Plan of Care for Resident A received.
01/03/2023	Contact - Telephone call made Call to Ms. Meghan Nguyen, RN, Heart to Heart Hospice.
01/03/2023	Exit Conference An exit conference was held with the licensee designee, Ms. Paula Danville.

ALLEGATION:

On 11/02/22, Resident A was left unattended on the floor for two hours by a manager, Ms. Shelly Strong.

INVESTIGATION:

On 11/09/2022, I received a complaint via BCAL Online complaints. This complaint was denied by APS for investigation.

On 11/10/2022, I reviewed the incident report previously submitted by the licensee designee, Ms. Paula Danville. The Incident Report (IR) dated 11/02/2022 states that at 7:45am, Ms. Deana Stewart was working as the med passer when a resident informed her that Resident A had fallen out of bed. Ms. Stewart then went and asked floor staff, Ms. Shelly strong if she needed any assistance with picking Resident A up off the floor. Ms. Strong replied, "yes, she needed assistance as Resident A had been on the floor since 7:30am". Ms. Strong then indicated, "Resident A will be fine until Ms. Danville arrives. At least she can only crawl and not walk fall again". Staff, Ms. Stewart then contacted Ms. Danville to inform her what occurred. Upon her arrival Resident A was lying on her left side on the floor with her eyes closed. Ms. Danville inquired if Ms. Strong had called hospice or 911 for help. Ms. Strong replied that she texted the licensee. Ms. Danville then reminded Ms. Strong of the facilities policy for residents that have fallen and that her response was not appropriate. Resident A was assisted back in bed using a Gait Belt. No obvious injuries were noted. Corrective measures included contacting the assigned AFC licensing consultant, her attorney, and part owner, Mr. Richard Danville. Upon preparing to suspend Ms. Strong pending further investigation, she quit. Staff will be reminded of the fall policy of the facility. Resident A's physician, guardian, A & D Waiver case manager and Heart to Heart Hospice were all contacted.

On 11/15/2022, I spoke with Ms. Paula Danville, licensee designee, regarding the allegations. Ms. Danville stated that Ms. Strong was assigned to assist with the residents getting dressed, while Ms. Stewart was passing their medication. She adds

that staff, Ms. Strong is aware of the policy which requires staff to assist the resident, call 911 or hospice (if applicable) when a resident falls, however, she chose not to do so and quit before she could address the issue. Ms. Danville indicated that she will be retraining all staff and updating the policy for employees. A copy of the AFC Assessment and Hospice Plan for Resident A was requested.

The AFC Assessment plan for Resident A states that staff are to assist with all transfers due to increased confusion, unsteadiness, weakness and forgetting walker. Staff to assist with ambulation. Use gait belt. Assistive devices are listed as a walker and a wheelchair. This plan is signed and dated by the licensee designee, Ms. Paula Danville, and Relative Guardian A, effective 09/21/2022. Resident A was 87 years old

On 11/21/2022, I conducted an onsite inspection at Pine Haven AFC. While onsite I observed residents through the facility. Two residents were in the living room watching television. Other residents were observed in their rooms. There are currently 13 residents in the home. The residents appeared to be receiving adequate care and supervision.

Direct staff Ms. Sherri Forrest and Ms. Kim Fuller were the 2 staff there were on duty at the time of the visit. Both indicate that they were not working on the day Resident A was left on the floor. Both indicate that they are aware of what to do in case a resident has a fall.

On 12/20/2022, I placed a call to former direct staff, Ms. Shelly Strong. There was no answer. A voice mail message was left requesting a return call.

On 12/20/2022, I spoke with direct staff, Ms. Deana Stewart. She recalled that on the day in question she was preparing breakfast for the residents while staff, Ms. Strong was assisting residents when one of the residents that had already eaten came and informed her that Resident A was on the floor. When she found Ms. Strong and asked her if she knew Resident A was on the floor. She indicated that she was aware and had texted the licensee, Ms. Danville at 7:15am regarding the matter. Ms. Stewart noted that the current time was 8:30am. When she asked her if she wanted help, she stated no and indicated that she was waiting for the licensee to call her back. Ms. Stewart then placed a blanket over Resident A so she would not be cold. Due to the licensee residing on the premises, she saw one of her family members and asked if they would wake Ms. Danville up to inform her of the situation.

On 12/22/ 2022, I spoke with Relative Guardian A. She indicated that she was informed by the licensee when Resident A was found on the floor. She has no concerns that the fall contributed to Resident A’s death. She had no concerns with the care being provided at the facility. Resident A was diagnosed with Dementia, which was progressing. Resident A was a fall risk. To her knowledge, preventative measures put in place included a walker and a hospital bed and a bed alarm, however, she would continue to try and walk on her own. Resident A received services via Heart-to-Heart Hospice. Her official cause of death on her death certificate is listed as A Heart Disease

and Alzheimer and Atherosclerotic Heart Disease. Her date of death is 11/07/2022. The incident report received from Pine Haven Assisted Living dated 11/07/2022 indicates that 11:50am on this date, Resident A took her last breath in the presence of family. Hospice was contacted while the family was comforted.

On 01/03/2022, I placed a call to staff, Ms. Shelly Strong. There was no answer.

On 01/03/2023, I received a faxed copy of the Heart-to-Heart Hospice Plan of Care for Resident A. The plan, dated 09/20/2022, states that fall precautions have been put in place. It does not indicate that those precautions are.

On 01/03/2022, I spoke with Ms. Meghan Nguyen, RN, Heart to Heart Hospice. She shared that she began working with Resident A in September of 2022. Initially she started seeing Resident A twice a week. However, as she rapidly declined, her visits changed from two times a week to three times a week. In the end Resident A was receiving daily visits from hospice. Ms. Nguyen identified Resident A's fall-risks put in place in accordance to her hospice care plan consisted of a hospital bed, a bed alarm, and a wheelchair. She also encouraged the use of the Gait Belt for assistance with transferring the resident. No prescription for the use of the Gait Belt was written. She does not believe that the fall contributed to Resident A's death. She has no concerns with the care received at the AFC. She adds that Pine Haven is a very loving home that looked after Resident A to the best of their ability.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	It was alleged that Resident A was left unattended on the floor for two hours by a manager, Ms. Shelly Strong. The incident report dated 11/02/2022 indicates that Resident A was left on the floor for two hours. Licensee designee, Ms. Paula Danville stated that staff, Ms. Shelly Strong quit before she could inquire why she did not follow the fall policy for the facility. Staff Ms. Deana Stewart observed Resident A on the floor and attempted to assist staff Ms. Shelly Strong with picking her up, which Ms. Strong denied.

	Relative Guardian A stated that she does not believe the fall contributed to Resident A's death. Her official cause of death on her death certificate is listed as A Heart Disease and Alzheimer and Atherosclerotic Heart Disease. The AFC Assessment plan for Resident A states that staff are to assist with all transfers due to increased confusion, unsteadiness, weakness and forgetting walker. Staff to assist with ambulation. Use gait belt. Assistive devices are listed as a walker and a wheelchair. Hospice RN, Ms. Meghan Nguyen, indicated that Resident A was identified as a fall risk. Fall precaution measures were put in place in the hospice assessment plan. She does not believe the fall contributed to Resident A's death. Based on the information gathered in the course of this investigation, there is sufficient evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

The incident report dated 11/02/2022 indicates that Resident A was assisted back in bed using a Gait Belt.

The AFC Assessment plan for Resident A states that staff are to use a Gait Belt for assistance with all transfers due to increased confusion, unsteadiness, weakness and forgetting walker. Staff to assist with ambulation. Use Gait Belt.

On 01/03/2023, the licensee designee, Ms. Paula Danville stated that she does not have a prescription for the use of the Gait Belt and accepts responsibility for not knowing one was needed for a Gait Belt.

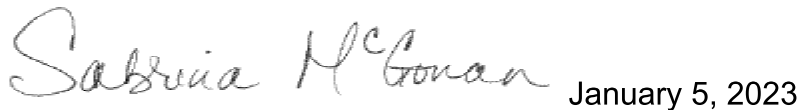
On 01/03/2023, I conducted an exit conference was held with the licensee designee, Ma. Paula Danville. Ms. Danville was informed of the findings of this investigation. She stated that she accepts responsibility for the use of the Gait Belt as she was not aware that a prescription was needed.

APPLICABLE RULE	
R 400.15306	**Use of assistive devices.**
	(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization.
ANALYSIS:	Based on the information written in the incident report indicating staff are to assist Resident A with the use of a Gait Belt and the licensee admission that she does not have a prescription, there is sufficient evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 01/03/2023, I conducted an exit conference was held with the licensee designee, Ma. Paula Danville. Ms. Danville was informed of the findings of this investigation.

IV. RECOMMENDATION

Upon the receipt of an approved corrective action plan, no change to the status of the license is recommended.


January 5, 2023

Sabrina McGowan Date
Licensing Consultant

Approved By:

January 5, 2023

Mary E. Holton Date
Area Manager