GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 11, 2023

Connie Clauson
Leisure Living Mgt of Portage
Suite 203
3196 Kraft Ave SE
Grand Rapids, MI 49512

RE: License #: AL390016015
Investigation #: 2023A1024005
Fountain View Ret Vil of Port #2

Dear Mrs. Clauson:

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 #:	AL390016015
Investigation #:	2023A1024005
Complaint Receipt Date:	11/15/2022
Investigation Initiation Date:	11/17/2022
Report Due Date:	01/14/2023
Licensee Name:	Leisure Living Mgt of Portage
Licensee Address:	Suite 203 3196 Kraft Ave SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Connie Clauson
Licensee Designee:	Connie Clauson
Name of Facility:	Fountain View Ret Vil of Port #2
Facility Address:	7818 Kenmure Drive Portage, MI 49024
Facility Telephone #:	(269) 327-9595
Original Issuance Date:	08/01/1995
License Status:	REGULAR
Effective Date:	09/04/2022
Expiration Date:	09/03/2024
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A fell and hit her head due to staff not providing the required supervision.	No

III. METHODOLOGY

11/15/2022	Special Investigation Intake 2023A1024005
11/17/2022	Special Investigation Initiated – Telephone with direct care staff members Melvina Higgins and Precious Higgins
11/17/2022	Contact - Telephone call made left voicemail for complainant
11/17/2022	Contact - Telephone call made with Relative A1
12/02/2022	Inspection Completed On-site with direct care staff members Tasha Glover and Angela Jones
12/05/2022	Inspection Completed On-site with regional director Karen Hodge and activity director Taria James
12/05/2022	Contact-Document Received-*Resident Evaluation*, *Health Care Appraisal, After Visit Summary*
12/05/2022	Contact - Telephone call made with direct care staff member Clarissa Whitmore
01/04/2023	Contact-Document Received-*AFC Licensing Division-Incident/Accident Reports*
01/04/2023	Exit Conference with licensee designee Connie Clauson

ALLEGATION:

Resident A fell and hit her head due to staff not providing the required supervision.

INVESTIGATION:

On 11/15/2022, I received this complaint through the Bureau of Community and Health Systems (BCHS) online complaint system. This complaint alleged Resident A fell and hit her head due to staff not providing the required supervision. This complaint further

alleged Resident A fell on 9/16/2022 and later passed away on 9/28/2022 from complications of having a head injury from the fall.

On 11/17/2022, I conducted interviews with direct care staff members Melvina Higgins and Precious Higgins. Ms. M. Higgins stated on 9/16/2022 Resident A fell and hit her head while walking to an outdoor activity for residents facilitated by staff members. Ms. M. Higgins stated she has observed Resident A walk independently outdoors with the use of her walker in the past and has never witnessed Resident A have trouble walking using her walker. Ms. M. Higgins stated after the fall Resident A was taken to the hospital for evaluation and was diagnosed with a fractured rib. Ms. M. Higgins stated Resident A showed no unusual behaviors or symptoms after she returned from the hospital after hitting her head during the fall other than Resident A complained of having rib pain at times. Ms. M. Higgins stated about two weeks after Resident A returned from the hospital, she had a seizure and passed away while at the hospital. Ms. Higgins stated on the day Resident A had a seizure, she was sitting at the dining room table for church service and began seizing while sitting at the table. Ms. M. Higgins stated Resident A had never had a seizure before, therefore Ms. M. Higgins was very alarmed by this incident. Ms. M. Higgins stated regional director Karen Hodge assisted and sat with Resident A while waiting for emergency medical services (EMS) to arrive. Ms. M. Higgins stated Resident A never returned from the hospital after this incident. Ms. M. Higgins stated Resident A was social with other residents and staff members and seemed to enjoy living at the facility. Ms. M. Higgins stated Resident A did not require staff supervision while outdoors however a direct care staff member was present and in close proximity when Resident A walked outdoors.

Ms. P. Higgins stated she was working when Resident A fell and hit her head on the cement while walking to an outdoor activity for residents which was held in the patio area of the adjacently licensed AFC building which is where all outdoor activities are routinely held for residents. Ms. P. Higgins stated Resident A walked outdoors to the activity with other residents and staff member, Taria James and while walking Resident A chose to stop and sit down on her walker which rolled out in front of her causing Resident A to fall. Ms. P. Higgins stated she believed Resident A did not lock both wheels on her walker prior to sitting down, which caused the walker to move when Resident A tried to sit down. Ms. P. Higgins further stated when she arrived outside after hearing a loud noise, she observed Ms. James on the ground with Resident A while Resident A was holding her head yelling that she hit her head. Ms. P. Higgins stated she immediately called 911 and called Resident A's family member who was not able to be reached initially however Ms. P. Higgins was eventually able to contact Resident A's granddaughter later in the day. Ms. P. Higgins stated a few weeks after being discharged from the hospital, Resident A had a seizure while attending church service in the facility on 9/27/2022 and passed away while at the hospital on 9/28/2022. Ms. P. Higgins stated Resident A had a walker and/or wheelchair to assist with mobility however Resident A used her walker "99% of the time." Ms. P. Higgins stated Resident A often enjoyed going outside for fresh air and walking in front of the building. Ms. P. Higgins stated Resident A never had any issues walking with her walker in the past and attended outdoor activities on multiple occasions including for music activities. Ms. P.

Higgins also stated Resident A walked next door to get her hair washed and styled by a licensed hair stylist. Ms. P. Higgins stated Resident A was active most of the time and was very independent. Ms. P. Higgins further stated Resident A did not require any special supervision, including 1:1 direct care staff supervision, when walking outdoors however staff accompanied Resident A when she walked outdoors as a precaution.

On 11/17/2022, I conducted an interview with Relative A1. Relative A1 stated she is very upset Resident A fell and hit her head which Relative A1 believed resulted in Resident A having a seizure two weeks later and passing away from complications of having a head injury. Relative A1 stated Resident A required staff supervision when walking and Resident A should not have been walking outdoors without 1:1 staff supervision. Relative A1 stated Resident A lived in the facility for almost four years and Relative A1 believed Resident A should not have been able to give consent to do things on her own since Resident A was diagnosed with dementia. However Relative A1 stated Resident A was never legally deemed incompetent therefore had no legal restrictions in place. Relative A1 stated she was Resident A's patient advocate and believed direct care staff members were neglectful by allowing Resident A to walk outside without close staff supervision.

On 12/02/2022, I conducted an onsite investigation at the facility and interviewed direct care staff members Tasha Glover and Angela Jones. Ms. Glover and Ms. Jones both stated they worked regularly with Resident A and often observed Resident A independently walk with her walker indoors and outdoors without any issues. Ms. Glover stated Resident A never had any issues however Relative A1 often made complaints especially after Resident A returned from the hospital after hitting her head from a fall while walking from an outdoor activity. Ms. Glover stated there was one incident Relative A1 yelled at direct care staff members because Relative A1 believed Resident A was too cold while in her room and accused staff members of trying to "kill Resident A" due to the temperature in her room. Ms. Glover stated she tried to explain to Relative A1 that Resident A requested to have her air conditioner on in her room however Relative A1 stated that she did not want staff members to listen to Resident A because Relative A1 believed Resident A "did not know what she was talking about." Ms. Glover stated Resident A was very independent and could do most things on her own with minimal staff assistance. Ms. Glover further stated Resident A communicated her needs to staff members as needed and was a "great communicator." Ms. Glover stated Resident A was competent, alert and was a joy to be around. Ms. Glover stated Resident A enjoyed taking walks on the sidewalk in front of the building and sitting on the porch.

Ms. Jones stated Resident A was very independent and communicated to staff when she needed assistance. Ms. Jones stated Resident A often walked indoors and outdoors with the use of her walker and did not require staff supervision when outdoors however a staff member was always outdoors with Resident A to ensure her safety. Ms. Jones stated the facility offers enrichment activities for the residents that are held indoors and outside if the weather is appropriate. Ms. Jones stated Resident A attended many outdoor activities over the years and walked with her walker to these

activities without incident. Ms. Jones further stated direct care staff members walk with residents to and from activities to ensure the safety of all residents when there are outdoor activities. Ms. Jones stated Resident A interacted with staff and residents often in the common areas and regularly attended church service in the dining room area. Ms. Jones stated Resident A also routinely sat outside on the porch.

On 12/05/2022, I conducted an onsite investigation at the facility with regional director Karen Hodge and activity director Taria James. Ms. Hodge stated while walking to a life enrichment activity with direct care staff member Ms. James, Resident A fell and hit her head outside of the facility. Ms. Hodge stated according to Ms. James, Resident A stated she wanted to sit and rest on her walker however Resident A failed to lock both wheels on her walker which caused the walker to move when Resident A attempted to sit down. Ms. Hodge stated Ms. James attempted to catch Resident A before she fell however was not able to get to Resident A quickly enough before she fell. Ms. Hodge stated Resident A was sent to the hospital and diagnosed with having a broken rib. Ms. Hodge stated when Resident A returned to the facility after being hospitalized, Resident A did not require special care or supervision however did receive a hospital bed with rails for additional safety. Ms. Hodge stated a few days after Resident A's return from the hospital, Resident A had a seizure while in the dining room and was transported back to the hospital where Resident A eventually passed away the following day. Ms. Hodge stated Resident A routinely walked around with her walker indoors and outdoors and was beloved by all staff members.

Ms. James stated on 9/16/2022 she walked with three other residents, including Resident A, to the building next door to set up for the entertainment activity that was being held in the patio area outdoors. Ms. James stated while they were walking Resident A stated that she was tired and sat down on her walker. Ms. James stated Resident A's walker rolled and moved forward as Resident A sat down. Ms. James stated she immediately dropped the lawn chairs and bags that she was carrying and attempted to catch Resident A from falling however Resident A had already fell to the ground by the time Ms. James leaped over to catch her. Ms. James stated she landed on the ground next to Resident A and sat with Resident A until EMS arrived. Ms. James stated EMS was called by other direct care staff members. Ms. James stated Resident A was alert while waiting for EMS, stated her chest was hurting and requested direct care staff call her family members to notify them of her falling. Ms. James stated she observed Resident A regularly walk with her walker indoors and outdoors in the past without any issues and believed on this occasion Resident A did not lock one of her wheels when she sat down on the walker which caused the walker to move. Ms. James stated after Resident A returned from the hospital, Resident A utilized her wheelchair more often. Ms. James stated there was no mention from the hospital regarding Resident A having a head injury however she did return with a broken rib. Ms. James stated life enrichment activities are routinely held next door in the patio area and outdoor activities are only held outside when the weather is nice and appropriate. Ms. James stated Resident A was active and attended most life enrichment activities indoors and outdoors on a regular basis.

On 12/05/2022, I reviewed Resident A's *Resident Evaluation* dated 2/24/2022. According to this evaluation, Resident A was independent in life enrichment activities and socialization activities. The evaluation stated Resident A loves to walk outside weather permitting accompanied by an aide and loves to sit on the porch. The evaluation stated Resident A has minimal difficulty expressing ideas and needs and needs minimal prompting and assistance. The evaluation further stated Resident A is independent in her mobility and uses a walker and wheelchair.

I also reviewed Resident A's *Health Care Appraisal* dated 11/21/2021. According to this *Health Care Appraisal,* Resident A was diagnosed with Hyperlipidemia, CVD, Ataxia, Bradycardia, and Dementia. The *Health Care Appraisal* stated Resident A uses a walker and wheelchair for mobility.

I also reviewed Resident A's *After Visit Summary* dated 9/16/2022-9/21/2022. According to this *After Visit Summary* Resident A was admitted to Bronson Hospital on 9/16/2022 and discharged on 9/21/2022 for a fall. Resident A was diagnosed with having chest pain, upper back pain, closed fracture of multiple ribs of the right side and hypoxia. It should be noted the *After Visit Summary* did not order any specific supervision requirement for Resident A including 1:1 supervision at any time or additional assistance with mobility.

On 12/05/2022, I conducted an interview with direct care staff member Clarissa Whitmore. Ms. Whitmore stated she worked regularly with Resident A, and she was the staff member that observed Resident A having a seizure while attending church service in dining room of the facility. Ms. Whitmore stated Resident A was social and often walked with her walker indoors throughout the building. Ms. Whitmore stated she has observed Resident A also walk outdoors as Resident A enjoyed sitting on the porch. Ms. Whitmore stated Resident A required minimal assistance, such as prompting, with her personal care needs and was good at communicating what she required as needed.

On 01/04/2023, I reviewed the facility's *AFC Licensing Division-Incident/Accident Report* dated 9/16/2022. According to the *AFC Licensing Division-Incident/Accident Report*, Resident A was walking with staff member Taria James to the patio area and Resident A sat on her walker, which was not completely locked, causing the walker to move downhill and turn. The report stated Ms. James attempted to catch Resident A however Resident A fell and hit the back of her head. The paramedics were called and Resident A was sent to the hospital.

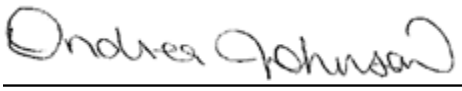
I also reviewed an *AFC Licensing Division-Incident/Accident Report* dated 9/27/2022. According to this report, direct care staff member Clarissa Whitmore observed Resident A having a seizure while in the dining room. Ms. Whitmore stated Resident A had no prior history of seizures. Ms. Whitmore stated paramedics were immediately called and staff members attended to Resident A while waiting for EMS.

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:	Based on my investigation which included interviews with regional director Karen Hodge, Relative A1, direct care staff members Melvina Higgins, Precious Higgins, Tasha Glover, Angela Jones, Taria James, and Clarissa Whitmore along with a review of *AFC Licensing Division-Incident/Accident Reports*, hospital discharge summary, Resident A's *Resident Evaluation* and *Health Care Appraisal* there is no evidence Resident A required additional assistance with mobility or special supervision while walking outside/inside the facility. This includes on 09/16/2022 when Resident A fell while walking to an activity. According to direct care staff member Ms. James while she was walking with Resident A to an outdoor activity, Resident A stopped and sat on her walker which rolled forward causing Resident A to fall and hit her head. Ms. James stated she attempted to catch Resident A before she fell and landed on the ground next to Resident A while doing so. EMS was immediately called to provide evaluation and treatment to Resident A. Direct care staff members Ms. P. Higgins, Ms. M. Higgins, Ms. Glover, Ms. Jones, Ms. James and Ms. Whitmore all stated Resident A routinely walked with her walker indoors and outdoors without incident and attended life enrichment activities regularly. The resident evaluation also stated Resident A enjoyed taking walks and was independent in life enrichment activities and socialization activities. Although Resident A did not require 1:1 staff supervision when outdoors Resident A was still accompanied by a direct care staff member when she was walking outside. Resident A was also provided with this assistance on 09/16/2022, therefore Resident A's protection and safety needs were attended to at all times.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 01/04/2023, I conducted an exit conference with licensee designee Connie Clauson. I informed Ms. Clauson of my findings and allowed her an opportunity to ask questions or make comments.

IV. RECOMMENDATION

I recommend the current license status remain unchanged.



1/4/2023

Ondrea Johnson — Date
Licensing Consultant

Approved By:

01/11/2023

Dawn N. Timm — Date
Area Manager