GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 31, 2023

Catherine Reese
Sodalis Temperance
667 W. Sterns Road
Temperance, MI 48182

RE: License #: AH580353904
Investigation #: 2023A0784055
Sodalis Temperance

Dear Ms. Reese:

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.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH580353904
Investigation #:	2023A0784055
Complaint Receipt Date:	04/19/2023
Investigation Initiation Date:	04/20/2023
Report Due Date:	06/18/2023
Licensee Name:	Vibrant Life Senior Living, OC Temperance LLC
Licensee Address:	5720 Williams Lake Road Waterford, MI 48329
Licensee Telephone #:	(734) 847-3217
Administrator:	Rebecca Molina
Authorized Representative:	Catherine Reese
Name of Facility:	Sodalis Temperance
Facility Address:	667 W. Sterns Road Temperance, MI 48182
Facility Telephone #:	(734) 847-3217
Original Issuance Date:	02/20/2014
License Status:	REGULAR
Effective Date:	02/20/2023
Expiration Date:	02/19/2024
Capacity:	46
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Inadequate medical attention for Resident A	Yes
Additional Findings	No

III. METHODOLOGY

04/19/2023	Special Investigation Intake 2023A0784055
04/20/2023	Special Investigation Initiated - On Site
04/20/2023	Inspection Completed On-site
04/20/2023	Exit Conference Conducted with administrator Rebecca Molina

ALLEGATION:

Inadequate medical attention for Resident A

INVESTIGATION:

On 4/19/2023, the department received this complaint from adult protective services.

According to the complaint, Resident B pushed his wheelchair back into Resident A and was kicking and yelling at him. Resident A went to his room and came back out. Resident B then punched Resident A in the face a number of times, pushed him to the ground, and kicked him in the stomach. Resident A hit his head and he passed out. It is unknown if Resident B has any injuries. Resident A was supposed to be sent out due to falling on the ground, per facility policy, and was not sent out. Resident A sustained a cut to his head above his right eye from the fall. Associate 1 an Associate 2 were working at the time.

On 4/20/2023, I interviewed administrator Rebecca Molina at the facility. Ms. Molina stated that an incident involving Resident A and Resident B did happen on the morning of 4/16/2023, but that the details as described in the complaint were not accurate. Ms. Molina stated Residents A and B were both in the dining area at the time and that Resident A was on the opposite side of the same table as Resident B. Ms. Molina stated that in order to get to his room, Resident A had to move from

where he was at, around the table and past where Resident B was sitting at the table. Ms. Molina stated Resident B was sitting in his wheelchair and then when he noticed Resident A walking in his direction, he moved his wheelchair back, apparently to get in Resident A's way. Ms. Molina stated Resident A then appeared to try and walk faster to get around Resident B and fell forward hitting the floor, subsequently hitting his head and sustaining a cut above his right eye. Ms. Molina stated Associate 1 immediately helped Resident A up off the floor, took his vitals and cleaned the but on his eye. Ms. Molina stated Resident A did not pass out. Ms. Molina stated it is unclear if Resident B hit or kicked Resident A as seen on the facilities video footage. Ms. Molina stated Resident A also had another fall in the hallway in the middle of the night the same night when he was walking out of his room into the hallway. Ms. Molina stated staff assisted Resident A off the floor at that time and assisted him back to bed. Ms. Molina stated that on the next morning, 4/17/2023, Resident A was evaluated by the nurse practitioner who requested he be sent to the hospital for evaluation due to having bruising on his eyebrow, blood on his sheets, from apparent skins tears on his arm and leg and having fallen and hit his head. Ms. Molina stated that Resident A is on blood thinners. Ms. Molina stated it is facility policy that if a resident falls and hits their head and is on blood thinners, they should be sent out. Ms. Molina stated that this is also true if a resident is on blood thinners and has an unwitnessed fall and staff are unable to determine if the resident hit their head. Ms. Molina stated Resident A should have been sent out after the first fall, let alone the second fall.

I reviewed the video footage, provided by Ms. Molina, of both the initial incident between Resident A and Resident B, and Resident A's subsequent fall later in the night on 4/16/2023. The footage was consistent with Ms. Molina's statements.

I reviewed a facility *Incident Report*, provided by Ms. Molina, pertaining to Resident A's incident with Resident B and subsequent fall which read consistently with her statements.

I reviewed the facilities *Training Manua*l policies which specified that "if a resident hits their head and is on blood thinner medication, they must be sent to the hospital for further observation".

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(c) Assure the availability of emergency medical care required by a resident.**

ANALYSIS:	The complaint alleged the facility did not seek adequate medical attention after Resident A was allegedly attacked by Resident B and injured. While the details provided in the complaint, of the incident between Resident A and B, were discovered to be inconsistent with the video evidence, Resident A did have at least two falls which Ms. Molina admitted would have, in each case, warranted that staff emergency medical attention, which they did not do. Based on the findings the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

5/25/2023

Aaron Clum Date
Licensing Staff

Approved By:

05/30/2023

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section