STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

June 13, 2023

Stephanie Riley
Valley Residential Serv Inc.
P O Box 186
St Charles, MI 486550186

RE: License #: AS670012827
Investigation #: 2023A0870030
Reed City Home

Dear Ms. Riley:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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 (231) 922-5309.

Sincerely,

Bruce A. Messer, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 342-4939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS670012827
Investigation #:	2023A0870030
Complaint Receipt Date:	05/25/2023
Investigation Initiation Date:	05/31/2023
Report Due Date:	07/24/2023
Licensee Name:	Valley Residential Serv Inc.
Licensee Address:	300 S Saginaw St. Charles, MI 48655
Licensee Telephone #:	(231) 580-5204
Administrator:	Sara Vallette
Licensee Designee:	Stephanie Riley
Name of Facility:	Reed City Home
Facility Address:	731 Stoney Creek Dr Reed City, MI 49677
Facility Telephone #:	(231) 832-4642
Original Issuance Date:	05/30/1991
License Status:	REGULAR
Effective Date:	06/27/2021
Expiration Date:	06/26/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On May 19, 2023, Resident A fell while walking into the dining room. After falling, Resident A could not stand up. Resident A's right leg is extremely swollen, and she has been requesting to go to the hospital. The staff refuse to take her to the hospital, and she is suffering.	Yes

III. METHODOLOGY

05/23/2023	Special Investigation Initiated - On Site On-site investigation initiated, along with MDHHS, APS worker Sam Talaske. Interview with Administrator Sara Vallette.
05/25/2023	Special Investigation Intake 2023A0870030
05/31/2023	APS Referral This referral was received from the Michigan Department of Health and Human Services, Protective Services Centralized Intake unit.
06/07/2023	Contact - Telephone call made Case discussion with APS worker Sam Talaske.
06/07/2023	Contact - Telephone call made Follow-up interview with Administrator Sara Vallette.
06/07/2023	Contact - Telephone call made Telephone interview with staff member Angel Moof.
06/07/2023	Contact - Telephone call made Telephone interview with staff member Cassie Meeves.
06/07/2023	Contact - Telephone call made Telephone interview with staff member Casey Maxwell.
06/07/2023	Contact - Telephone call made Telephone interview with staff member Karen Cutright.
06/07/2023	Contact - Document Received E-mail from Sam Talaske with interview notes of Resident A.
06/08/2023	Contact - Telephone call made Telephone interview with staff member Tricia Tate.

06/08/2023	Referral - Recipient Rights
06/08/2023	Contact - Telephone call made Case discussion with Jane Gilmore, Office of Recipient Rights, Community Mental Health for Central Michigan.
06/08/2023	Contact - Telephone call made Case discussion with APS worker Sam Talaske.
06/13/2023	Exit Conference Completed with Licensee Designee Stephanie Riley.

ALLEGATION: On May 19, 2023, Resident A fell while walking into the dining room. After falling, Resident A could not stand up. Resident A's right leg is extremely swollen, and she has been requesting to go to the hospital. The staff refuse to take her to the hospital, and she is suffering.

INVESTIGATION: On May 23, 2023, while on-site conducting a scheduled license renewal inspection, I was informed by Michigan Department of Health and Human Services, Adult Protective Services (APS) worker Sam Talaske, that his department had received an APS referral with the above stated allegation. Mr. Talaske and I discussed the allegation with Administrator Sara Vallette. Ms. Vallette noted that she had completed an *AFC Licensing Division – Incident/Accident Report (BCAL-4607)* and had emailed me a copy. Ms. Vallette explained that Resident A had fallen on May 19, 2023, staff had evaluated her, elevated her leg, and placed ice on the leg. She further explained that the next day, staff noticed her leg was swollen and Resident A was taken to the hospital where it was noted she had a broken femur.

On May 23, 2023, I reviewed my emails and noted I had received an email from Ms. Vallette, dated Saturday May 20, 2023, at 9:21 p.m.. Attached was an *AFC Licensing Division – Incident/Accident Report (BCAL-4607)* describing the accident involving Resident A. The report, completed by staff member Karen Cutright on May 19, 2023, at 7:35 a.m. states: *'(Resident A) came out of the bathroom to go to the table and lost her balance go to the floor (sic). She told staff that her right knee hurt. She fell on left side.'* Ms. Cutright notes staff action to this accident was: *'Staff assisted her up to wheelchair because she would not stand. Staff took (Resident A) to the bathroom and looked for redness and swelling and found no results.'* The report appears to have Ms. Vallette's handwritten notes added which state: *'Home manager talked to staff at 8:30 a.m. (Resident A) chose not to go to work. Was relaxing in her bed with ice pack and elevated her leg. Home manager called on May 20, 2023, to check on her and have staff look at her leg. Staff said her knee looked a little swollen. Home manager called guardian and she said to take her to the ER. At ER they checked her vitals and did X-Ray. Radiologist said she broke her femur in three spots, and they are transferring her to Butterworth. Home manager notified*

guardian and area manager.' The report notes that Resident A was sent to Spectrum Health ER on May 20, 2023, at 4:30 p.m.

On June 7, 2023, I spoke with APS worker Sam Talaske. We discussed the allegation and investigation. Mr. Talaske noted that the complaint to MDHHS APS intake was anonymous. He further noted that he had another APS worker from Kent County conduct a courtesy interview with Resident A, as she was still in the hospital in Grand Rapids. Mr. Talaske provided me with a copy of those interview notes. An excerpt read as follows:

Client Contact Date: 05/23/2023 01:26 PM
A face to face was completed at Butterworth hospital. Upon arrival to the hospital (Resident A) was located and she was agreeable to an interview. She reported that she did fall in the home and reported that her knee swelled up and was in pain. She reported that she told staff about the issues with her knee from the fall and they reportedly did nothing to help her. She was asked if they put ice on it or anything and she denied this. She reported that staff would not take her to the hospital or have it looked at. She reported that she was told by the hospital that it was broken. She stated that she has concerns that she did not receive proper care by the AFC home staff.

On June 7, 2023, I conducted a follow-up interview with Administrator/home manager Sara Vallette. She informed me that Resident A is no longer hospitalized but is in a rehab facility and has not yet returned to the AFC home. Ms. Vallette provided me with the names of the staff who worked at the home on May 19 and 20, 2023, along with the shifts they worked and their telephone numbers.

On June 7, 2023, I conducted a telephone interview with staff member Angel Moof. Ms. Moof stated she was working the morning shift on May 19, 2023, along with staff member Karen Cutright. She stated she did not see Resident A fall and believes Ms. Cutright was walking with Resident A. Ms. Moof stated she was called by Ms. Cutright who asked her to help, as Resident A had fallen. Ms. Moof noted that she and Ms. Cutright sat Resident A upright and Resident A stated that her leg hurt. Ms. Moof stated they took Resident A into the bathroom and pulled her pants down. She stated they did not see any swelling or redness at that moment. Ms. Moof also noted that Resident A stated her ankle was bothering her. Ms. Moof noted that Resident A did not want to go to work that day. She stated that later that shift Ms. Cutright noted some swelling of Resident A's leg, and put ice on it. Ms. Moof noted her shift ended at 3:00 p.m. She further stated that the next morning, upon her arrival to work at 7:00 a.m. on May 20, 203, she went to check on Resident A and saw that Resident A's leg "was more swollen" by the knee and thigh. Ms. Moof stated that she called Administrator Sara Vallette to update her on Resident A's condition. She stated the staff kept Resident A's leg elevated with ice during the rest of her shift, which ended at 3:00 p.m.

On June 7, 2023, I conducted a telephone interview with staff member Cassie Meeves. Ms. Meeves stated she did not work at the facility on May 19, 2023, but did work on May 20, 2023, from 7:00 a.m. to 3:00 p.m. Ms. Meeves stated that upon her arrival she looked in on Resident A and observed that Resident A's leg was "double its size" and that Resident A "screamed from just moving her legs." Ms. Meeves stated she feels that Resident A needed to go to the hospital "way earlier than she did." Ms. Meeves stated she sent a text to Ms. Vallette at 10:49 a.m. on May 20, 2023, and informed her that Resident A's leg is double its size. She stated that at 2:30 p.m. she called Ms. Vallette to further discuss Resident A's condition and Ms. Vallette told her that Resident A is "just being dramatic." Ms. Meeves stated that her shift ended at 3:00 p.m. and Resident A was still at the home when she departed.

On June 7, 2023, I conducted a telephone interview with staff member Casey Maxwell. Ms. Maxwell stated she worked a 12-hour shift from 7:00 p.m. on May 19, 2023, to 7:00 a.m. on May 20, 2023. She stated that upon her arrival she was briefed on Resident A's condition, and noted that Resident A was in her room, asleep. Ms. Maxwell stated she was working with staff member Tricia Tate at the time and that at approximately 8:00 p.m. Ms. Tate called Administrator Sara Vallette, telling Ms. Vallette that Resident A should go to the hospital. Ms. Maxwell stated that the instructions given to Ms. Tate, by Ms. Vallette, was "don't take her to the hospital, elevate her leg and give her Tylenol". She stated that Ms. Vallette further instructed Ms. Tate to "don't call EMS." Ms. Maxwell stated that Ms. Tate told her that Ms. Vallette said that she was 'not coming in tonight." Ms. Maxwell stated that at approximately 2:30 a.m. on May 20, 2023, Resident A called out saying her leg hurts. She stated that she gave Resident A Tylenol, put ice on her leg and Resident A fell back asleep. Ms. Maxwell stated she gave Resident A more ice around 5:00 a.m., per Resident A's request. She stated that at 7:00 a. m. shift change she briefed the oncoming staff, noted that Resident A was still in bed, as she was the entire shift, and that Resident A had not gotten up or been moved during that time.

On June 7, 2023, I conducted a telephone interview with staff member Karen Cutright. She stated she worked from 7:00 a.m. to 7:00 p.m. on May 19, 2023. Ms. Cutright stated she was walking Resident A out of the bathroom that morning when Resident A "went down." She stated that she checked Resident A over for injuries while she was still on the floor and the only complaint that Resident A expressed was that "her knee hurt." She stated she heard Resident A's knee crack when she tried to straighten out her leg. Ms. Cutright stated she lifted Resident A into her wheelchair, looked her over again and did not note any swelling or sign of injury. Ms. Cutright stated that her coworker, Angel Moof, called Administrator Sara Vallette to inform her of Resident A's fall and that Resident A was saying her leg hurt. She stated that she again "looked (Resident A) over" about two hours later and "still did not see any sign of injury" although Resident A did complain that her knee hurt. Ms. Cutright stated that Resident A did not want to go to work and "had a meltdown." She stated that she put Resident A in her bedroom to rest. Ms. Cutright stated that "about three hours after her fall" she put Resident A in her wheelchair to go to the

bathroom and Resident A “wouldn’t lift her leg” saying that her leg hurt her. Ms. Cutright noted that Ms. Moof again called Ms. Vallette at approximately 11:30 a.m. to get instructions for Resident A but does not know what was said or what instructions were given. Ms. Cutright stated she continued to check on Resident A during the shift and that Resident A would not let staff look at or touch her leg. She also stated that Resident A did not want to eat or drink anything at dinnertime. Ms. Cutright stated that she noticed swelling for the first time when she went to get Resident A up to toilet her at approximately 7:00 p.m. She also stated that Resident A would not lift her leg when she tried to move her.

On June 8, 2023, I conducted a telephone interview with staff member Tricia Tate. Ms. Tate stated she worked from 3:00 p.m. to 11:00 p.m. on May 19, 2023. She stated that Resident A was in bed when she arrived at the home. Ms. Tate stated she spoke with Resident A who told her that “her leg hurts and she wanted to go to the hospital.” Ms. Tate stated that to that point, no ice had been provided to Resident A. She stated that at approximately 8:00 p.m. she noticed that Resident A’s leg had “swollen to about double its size” from her thigh to down past her knee, and when she attempted to get her up, to take to the toilet, Resident A was “in a lot of pain” and “you could hear bone cracking, it was not normal sounds.” Ms. Tate said that Resident A “could not bare weight at all.” Ms. Tate stated she called Administrator Sara Vallette to discuss Resident A’s condition, telling her that Resident A cannot stand, her leg is swollen double size and she is screaming in pain. Ms. Tate stated that Ms. Vallette told her that she “had already worked 57 hours this week and was not coming in” to the facility to take Resident A to the hospital. Ms. Tate further stated that Ms. Vallette told her to “keep an eye on her” and that Resident A is “just being dramatic.” Ms. Tate stated that she assisted Resident A back into her bed where she remained until the end of her shift at 11:00 p.m. At the conclusion of this interview Ms. Tate stated, “what Sara (Vallette) did was completely wrong.”

On June 8, 2023, I made a telephone call/referral to Jane Gilmore, Recipient Rights Officer for Community Mental Health for Central Michigan. I informed her of the above allegation and discussed my investigation to that point. Ms. Gilmore stated that her office would be initiating an investigation into these allegations within the coming days.

On June 8, 2023, I spoke with MDHHS APS worker Sam Talaske to discuss the investigation. Mr. Talaske stated his investigation is still incomplete and ongoing.

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:	Resident A fell to the floor on the morning of May 19, 2023 and staff member Angle Moof stated Resident A stated her leg hurt and complained of ankle pain immediately after her fall. Staff member Karen Cutright stated Resident A complained that "her knee hurt" immediately after her fall and that when she straightening her leg out, Ms. Cutright heard Resident A's knee crack. Staff members Angle Moof, Cassie Meeves, Casey Maxwell, Tricia Tate, and Karen Cutright all state that Resident A complained of pain in her leg, had swelling of her leg, could not bare weight on her leg, and that she made requests to be taken to the hospital throughout the day on May 19 and 20, 2023. All staff noted that facility Administrator Sara Vallette was briefed on the incident and regularly updated on Resident A's condition as noted above. Staff stated that Ms. Vallette commented that Resident A was being "dramatic" and they should not take Resident A to the hospital, should not call EMS and that she was "not coming in as she had already worked 57 hours this week." Staff stated Ms. Vallette directed them to elevate Resident A's leg, provide ice packs and Tylenol for pain. Resident A was diagnosed with a fractured femur after being taken to the hospital emergency department at approximately 4:30 p.m. on May 20, 2023. Resident A stated to the MDHHS APS worker that she had informed facility staff that she was in pain and her knee was swollen. Resident A expressed her concern that facility staff "did nothing to help her." The Licensee failed to obtain needed care for Resident A immediately after her injury. They did not have her taken for care/evaluation for approximately 33 hours after the injury occurred.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14305	**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:	The facility failed to obtain an evaluation or needed care for Resident A's broken leg for approximately 33 hours after the injury occurred, even though it was evident that she was in pain, unable to bare weight and expressed a desire to be taken to the hospital. Staff member Cassie Meeves stated that when she was briefing home administrator Sara Vallette on Resident A's condition, but Ms. Vallette stated that Resident A was "just being dramatic." Staff member Tricia Tate stated that when she was briefing Ms. Vallette on Resident A's condition, Ms. Vallette stated "she already worked 57 hours this week and was not coming in" in order that Resident A could go to the hospital. Resident A was not treated with dignity and her personal needs, protection and safety were not attended to when staff failed to seek immediate medical attention for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

On June 13, 2023, I conducted an exit conference with Licensee Designee Stephanie Riley and informed her of my findings. Ms. Riley stated she understands the findings and recommendation that the facility's license be modified to Provisional status. She commented that the findings were different from her understanding of this incident based on her previous conversations with Ms. Vallette. Ms. Riley stated she will submit a corrective action plan addressing the above cited rules.

IV. RECOMMENDATION

Contingent upon the submission of an acceptable corrective action plan, I recommend that the license be modified to a six month Provisional License for the above-cited quality of care violation.

June 13, 2023

Bruce A. Messer   Date
Licensing Consultant

Approved By:

June 13, 2023

Jerry Hendrick Area Manager	Date