GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 15, 2023

Krishelle Wiley
The Coach Stop Manor, LLC
2003 W. Jefferson
Trenton, MI 48183

RE: License #: AS820410244
Investigation #: 2023A0116036
Island House

Dear Ms. Wiley:

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 (313) 456-0380.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820410244
Investigation #:	2023A0116036
Complaint Receipt Date:	05/09/2023
Investigation Initiation Date:	05/09/2023
Report Due Date:	07/08/2023
Licensee Name:	The Coach Stop Manor, LLC
Licensee Address:	2003 W. Jefferson Trenton, MI 48183
Licensee Telephone #:	(734) 692-9291
Administrator:	Krishelle Wiley
Licensee Designee:	Krishelle Wiley
Name of Facility:	Island House
Facility Address:	8504 Macomb Street Grosse Ile, MI 48138
Facility Telephone #:	(734) 692-0564
Original Issuance Date:	03/29/2022
License Status:	REGULAR
Effective Date:	09/29/2022
Expiration Date:	09/28/2024
Capacity:	6
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A fell out of the bed again on 05/08/23, because the staff are leaving the rails down. Resident A also fell out of bed in March 2023. A hospital bed with rails was ordered and provided.	No
Additional Findings	Yes

III. METHODOLOGY

05/09/2023	Special Investigation Intake 2023A0116036
05/09/2023	Special Investigation Initiated - Telephone Interviewed Relative A.
05/10/2023	Inspection Completed On-site Interviewed staff Kimberly Dale, staff Patricia Taylor, Relative A and visually observed Resident A. Reviewed Resident A's records and requested to review Ms. Taylor's employee record.
05/10/2023	Contact - Document Sent Email sent to licensee designee, Krishelle Wiley requesting that she send me Ms. Taylor's employee record for review.
05/11/2023	Contact - Telephone call received Spoke with licensee designee, Krishelle Wiley.
05/15/2023	Contact - Document Received Received Patricia Taylor's employee record and copies of Resident A's orders for her therapeutic supports.
05/17/2023	Contact - Telephone call made Interviewed Danielle Bober, Resident A's Hospice Nurse.
05/22/2023	Inspection Completed On-site Investigating allegations on SIR#2023A0116037. Visually observed Resident A and requested to review employee records.
05/22/2023	Inspection Completed-BCAL Sub. Compliance
05/26/2023	Exit Conference With licensee designee, Krishelle Wiley.

06/07/2023	Contact - Document Received Ms. Wiley emailed contents of three employee records that were not in the home during both onsite inspections on 05/10/23 and 05/23/23.

ALLEGATION:

Resident A fell out of the bed again on 05/08/23, because the staff are leaving the rails down. Resident A also fell out of bed in March 2023. A hospital bed with rails was ordered and provided.

INVESTIGATION:

On 05/09/23, I interviewed Relative A and she reported that there always seems to be an issue when the weekend staff, Patricia Taylor, is working. Relative A reported that it is her understanding that anytime Resident A is in her bed that the bed rails are supposed to be up to prevent her from falling out of bed. Relative A reported that Resident A fell out of bed on 05/08/23 for the second time, because the rails were down, and staff Patricia Taylor was asleep. Relative A reported that Resident B had to yell and wake Ms. Taylor up so that she could tend to Resident A. Relative A reported that Hospice was contacted, and Resident A did not require hospitalization. Relative A reported that Resident A likely sustained bruised ribs and is in some pain. Relative A reported that the hospice doctor/nurse prescribed some pain medication for Resident A and they are keeping a close watch on her. Relative A reported that Resident A is 102 years old and suffers with Dementia. Relative A reported that she will be moving Resident A to a new facility.

On 05/10/23, I conducted an unscheduled onsite inspection and interviewed staff, Kimberly Dale, Patricia Taylor and visually observed Resident A asleep in her wheelchair. Ms. Dale reported that she was not working when the incident occurred but reported hearing about it. Ms. Dale reported that when she works, and Resident A is in her bed for any length of time she makes sure the bedrails are up. Ms. Dale confirmed that after Resident A fell out of the bed in March of 2023, Elara Hospice ordered and had a hospital bed with rails delivered.

I interviewed staff, Patricia Taylor, and she reported that she is no longer working in the home. Ms. Taylor reported she had come by the home to grab something and was about to leave. Ms. Taylor agreed to be interviewed. Ms. Taylor reported that she has worked in the home for about five months and worked Fridays from 12:00 p.m. until Monday 12:00 p.m. Ms. Taylor reported that this was her regular shift and reported she worked alone. Ms. Taylor reported that she was told that it was up to Resident A whether or not she wanted her bed rails up while in bed. Ms. Taylor reported that before Resident A went to bed she asked her if she wanted her rails up

and she reported that she said she did not. Ms. Taylor reported that she left them down and told Resident A to call her if she needed assistance with using her bedside commode. Ms. Taylor reported that at around 6:00 a.m. on 05/08/23 Resident B was yelling her name as Resident A had fallen out of bed attempting to use her bedside commode. Ms. Taylor admitted that she was asleep and was awakened by Resident B calling for help for Resident A. Ms. Taylor reported that she contacted Ms. Wiley, Resident A's daughter, and the Hospice nurse, Ms. Bober, after getting Resident A off the floor. Ms. Taylor reported Ms. Bober came to the home and assessed Resident A, and because she complained of pain, she started her on Morphine and ordered Tylenol every six hours for pain. Ms. Taylor apologized and was very remorseful. She reported that she is overwhelmed with guilt and reported this was an accident. Ms. Taylor reported that this incident has taken a toll on her, and she has decided to terminate her employment.

I asked to review Ms. Taylor's employee record. Ms. Dale provided me with a folder with Ms. Taylor's name on it, however, it only contained a prescription order from her doctor stating she is eligible to work without restrictions. I asked Ms. Dale for the other employee records, and she reported they were not there, and that I needed to contact licensee designee, Ms. Wiley.

I reviewed Resident A's records to review and confirm that an order had been written and received for the hospital bed and bed rails. No order was in the records. Ms. Dale again recommended that I contact Ms. Wiley.

I spoke with Relative A briefly as she was onsite during the inspection. Relative A reported that Resident A is still in some pain, but the medication appears to be helping.

I interviewed licensee designee, Krishelle Wiley, on 05/11/23 and she reported that she is currently out of state. I informed her of the investigation and what I observed during the onsite inspection. Ms. Wiley reported that when she returned home, she would send me staff, Patricia Taylor's employee record as well as the orders for Resident A's therapeutic supports. Ms. Wiley reported that she was aware of what had occurred and reported that it was an accident.

On 05/15/23, I received and reviewed Ms. Taylor's employee record. I also received and reviewed the physician order for Resident A's hospital bed with rails and other therapeutic supports. The order did not state whether or not the bedrails needed to be up at all times when Resident A is in bed.

On 05/17/23, I interviewed Danielle Bober, Hospice Nurse, with Elara Caring. Ms. Bober reported that upon admission on Hospice a hospital bed with bedrails are ordered. Ms. Bober reported that they do not specify in the order for a resident that is alert and oriented, like Resident A, that the rails must stay up when the resident is in the bed. Ms. Bober reported that it is up to the resident and staff is instructed to ask them whether or not they would like the bedrails up while they are in bed and

that the staff should respect their wishes. I shared with Ms. Bober that normally when bedrails are ordered that the expectation is that they will be used any time the resident is in the bed to prevent them from rolling or falling out of the bed. I also shared with Ms. Bober that it would be extremely helpful if their orders were more specific in stating how/when the therapeutic supports are to be used so that the staff and licensing staff are clear. Ms. Bober reported that she understood, however, reported when a resident is on hospice it is their choice.

Ms. Bober further reported that she has not had any concerns regarding the care the staff at the home provided Resident A.

On 05/26/23, I conducted the exit conference with licensee designee, Krishelle Wiley. Ms. Wiley reported that the incident was an accident, and that prior to Resident A moving into another home, she was doing well. Ms. Wiley reported that she nor the staff were ever instructed to keep the bedrails up when Resident A was in her bed. Ms. Wiley reported that the hospice nurse, Ms. Bober, told them that it was Resident A's choice and that if she did not want the rails up, staff was to respect her wishes. I informed Ms. Wiley that in the future she should be reviewing the orders and if they are generic in nature, she should request that the order be updated to be more specific as it relates to how and when the therapeutic supports should be used so that everyone is clear. Ms. Wiley reported that she would.

I informed Ms. Wiley of the findings of the investigation. She agreed with the findings.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	Based on the findings of the investigation, which included interviews of staff Patricia Taylor, hospice nurse, Danielle Bober, licensee designee, Krishelle Wiley, and review of Resident A physicians order I am unable to corroborate the allegation. Resident A fell out of her bed on 05/08/23 after staff Patricia Taylor left her bed rails down. Ms. Taylor reported that she was instructed by the hospice nurse, Ms. Bober, to ask Resident A whether or not she wanted her bedrails up while she was in bed. Ms. Taylor reported that the night of 05/07/23, Resident A did not want her bed rails up and she reported respecting her wishes. Ms. Bober reported that because Resident A is alert and oriented, staff were instructed to ask her whether or not she wants her bed rails up or down when she gets in bed. Ms. Bober reported that she informed the staff that they are to respect her wishes as it relates to the bedrails. Ms. Wiley reported that she too was instructed by the hospice nurse, Ms. Bober, that it was Resident A's choice as to whether or not she wanted her bed rails up while she is in bed. Ms. Wiley reported although she was not happy that Resident A fell out of her bed, she knows that there was no ill-intent on the part of Ms. Taylor. Ms. Wiley reported that Ms. Taylor asked Resident A if she wanted her bedrails up on the night of 05/07/23, and she responded that she did not and Ms. Taylor respected her wishes. Although Resident A fell out of her bed on the morning of 05/08/23, due to her bed rails not being up, the staff, at the instruction of Resident A's hospice nurse, Ms. Bober, was following her recommendations. Those recommendations/instructions were for staff to ask Resident A whether she wanted the rails up while she was in bed and to respect her wishes.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 05/09/23, I interviewed Relative A and she reported that she had concerns that staff, Patricia Taylor, was working the entire weekend alone and that when Resident A fell out of her bed Ms. Taylor was asleep and had to be awakened by Resident B, who shares the room with Resident A. Relative A reported that the staff is also well aware that if they leave the bedside commode in the bedroom while the bedrails are down, Resident A will get out of bed and attempt to use the commode without assistance. Relative A reported that sometimes Relative A does fine and has no issues but at other times she may fall as she has a history of such.

On 05/10/23, I conducted an unscheduled onsite inspection and interviewed staff Patricia Taylor, Ms. Taylor reported that on the morning of 05/08/23, she was the staff person on shift and responsible for the care of the residents. Ms. Taylor admitted she was asleep and woke up to Resident B yelling for her as Resident A had fallen out of her bed, while attempting to use her bedside commode. Ms. Taylor reported it was around 6:00 a.m. when the incident occurred. Ms. Taylor reported that she was unable to lift Resident A by herself and had to call Grosse lle lift assist for help getting Resident A off the floor and back in bed. Ms. Taylor reported that Resident A is not a two person assist and is normally able to maneuver herself with assistance in her bed and wheelchair, however, when she fell, she was unable to lift herself up even with her assistance. I asked Ms. Taylor how long she was asleep, and she reported that she was not sure. Ms. Taylor reported that she thought it was okay to sleep while the residents were asleep at night. I informed Ms. Taylor, that if there is a resident in the home that requires assistance with toileting at times and/or has a history of falls, staff has to be alert and able to hear if and when the resident calls for assistance, additionally staff should be alert and available to residents at all times. Ms. Taylor reported understanding.

Ms. Taylor confirmed that she had been working alone in the home since Friday 05/05/23 at 12:00 p.m.

On 05/11/23, I interviewed licensee designee Krishelle Wiley. Ms. Wiley reported that she and Ms. Taylor are very sorry that Resident A fell and reported being glad that she is doing well and is in good spirits. Ms. Wiley reported that prior to the fall Resident A , who does require staff assistance with toileting, still desires to be independent and had been using her bedside commode without incident. I informed Ms. Wiley that Ms. Taylor was asleep on shift and therefore was not available to assist Resident A or hear her if she had called for help. Ms. Wiley understood my concerns and the rule requirement relating to staff being available at all times for the supervision, personal care and protection of the residents.

On 05/26/23, I conducted the exit conference with Ms, Wiley and informed of her the findings of the investigation. I also cautioned and referred Ms. Wiley to the Wage

and Hour Division and explained that staff are required to have an uninterrupted eight-hour rest period and that staff should not be working 72 straight hours as Ms. Taylor had done, which may have contributed to her falling asleep and not being available to the residents. Ms. Wiley reported understanding and stated that the this has already been addressed and she has different staff working day, afternoon and night shifts.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on the findings of the investigation, which included interviews of Relative A, Ms. Taylor, and Ms. Wiley this violation is established. Relative A reported her concerns that staff, Patricia Taylor was asleep and not alert when Resident A fell out of bed. Relative A also reported her concerns that Ms. Taylor was the only staff working in the home the entire weekend. Ms. Taylor admitted that she was asleep and that Resident B woke her up by yelling that Resident A had fallen out of her bed. Ms. Wiley was made aware that Ms. Taylor was asleep when the incident occurred and reported that she has addressed the issues. Ms. Wiley also reported that she has already changed how she is scheduling staff. This violation is established as the licensee designee did not have sufficient staff on duty at all times for the supervision, personal care, and protection of the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 05/10/23 and 05/22/23, I conducted unscheduled onsite inspections and requested to review employee records. On 05/10/23, there were no employee records available to review. On 05/22/23, the only staff file available for review was Shana Benson. The employee records for Suzanne Dobrzenski, Rachel Lion and Tonita Jones were not in the home or available for review on either date.

On 05/11/23, I interviewed licensee designee, Krishelle Wiley, and she reported that she was sorry and that she knows that employee files should be in the home and available for consultant review. Ms. Wiley reported that some of the files were in her office as some of the staff also work for her home health care business. Ms. Wiley reported that she would get the files to the home.

On 05/22/23, I conducted a unscheduled onsite inspection and spoke with staff Shana Benson. Ms. Benson was able to provide her employee record and reported to her knowledge no other files were in the home and that I needed to contact Ms. Wiley.

On 05/26/23, I conducted the exit conference with Ms. Wiley and she reported that she is getting the employee records together and will ensure that they all are taken to the home. I informed her of the rule violation cited and she reported understanding.

On 06/07/23, Ms. Wiley informed me that the employee records were complete and in the home. Ms. Wiley submitted an email to me with the three employee records attached.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(1) A licensee shall maintain a record for each employee. The record shall contain all of the following employee information: **(a) Name, address, telephone number, and social security number.** **(b) The professional or vocational license, certification, or registration number, if applicable.** **(c)A copy of the employee's driver license if a direct care staff member or employee provides transportation to residents.** **(d) Verification of the age requirement.** **(e) Verification of experience, education, and training.** **(f) Verification of reference checks.** **(g) Beginning and ending dates of employment.** **(h) Medical information, as required.**

	(i) Required verification of the receipt of personnel policies and job descriptions.
ANALYSIS:	This violation is established as the licensee designee, Krishelle Wiley, failed to create and maintain a record for each employee that contained all of the required information listed in this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 05/10/23, I conducted an unscheduled onsite inspection and visually observed Resident A asleep in her wheelchair. I interviewed Relative A who was in the home visiting at that time. Relative A reported that she is at the home three of four times per week and reported Resident A has been using the wheelchair since March of 2023 after falling. Relative A reported that Resident A has had to use it more since her most recent fall on 05/08/23 and hopes that she will be able to discontinue using it once she is no longer in pain. Relative A added that she will be moving Resident A to a new home as soon as he can get all the paperwork complete.

I interviewed staff Kimberly Dale and asked her if she was aware that the home was not licensed for wheelchair accessibility. Ms. Dale reported that she was aware but reported that the Hospice doctor ordered the wheelchair in March of 2023 after Resident A's first fall. Ms. Dale reported that Resident A has had to use the wheelchair because she has been weak and unable to ambulate as good since falling. Ms. Dale added that on some days Resident A is better then other days and is able to ambulate with her walker, but some days she requires the use of the wheelchair.

On 05/15/23, I received and reviewed the hospice orders for Resident A. A wheelchair was ordered for Resident A on 03/22/23.

On 05/22/23, I conducted an unscheduled onsite inspection in response to new allegations for SIR#2023A0116037. During the inspection, I observed Resident A in her wheelchair. Resident A's hospice aide was present in the home and was pushing Resident A in her wheelchair as she prepared to shower her. Staff, Shana Benson reported that Resident A was preparing to move to her new home today.

On 05/26/23, I conducted the exit conference with licensee designee, Krishelle Wiley. I informed Ms. Wiley that because she is not licensed as wheelchair accessible, and the home had not been determined to have the physical accommodations to meet the needs of Resident A. I informed Ms. Wiley that if the wheelchair use was temporary and Resident A did not require the regular use of it

then the diagnosis, and duration of use should have been documented on the physician order. I informed Ms. Wiley that that is the only way I would be able to determine whether Resident A only required temporary use of the wheelchair. I advised Ms. Wiley that in the future she should be reviewing all physician orders to ensure that they meet the intent of the rule. Ms. Wiley reported an understanding and reported that Resident A only used the wheelchair for a small amount of time. I informed Ms. Wiley that during both unscheduled onsite inspections, which were two weeks apart, I observed Resident A in her wheelchair both times. Ms. Wiley reported that Resident A is no longer in the home and reported that she would be submitting a modification request to add wheelchair accessibility to the license.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.**
ANALYSIS:	This violation is established as the licensee designee, Ms. Wiley, retained a resident in the home that required the regular use of a wheelchair, prior to the home being accessed and determined to have the physical accommodations to meet her needs.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 05/10/23, I conducted an unscheduled onsite inspection and requested to review Resident A’s record. During the review of the record, I observed that weights had not been recorded for Resident A since 08/01/22.

On 05/26/23, I conducted the exit conference with licensee designee, Krishelle Wiley and informed her of the findings of the investigation. Ms. Wiley reported that the weights were recorded somewhere else and had not been added to the record or on

the weight sheet. I informed Ms. Wiley of the rule cited and she reported an understanding.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.
ANALYSIS:	This violation is established as the licensee designee failed to record Resident A monthly weights since 08/01/22.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 05/10/23, I conducted an unscheduled onsite inspection and interviewed staff Kimberly Dale. While interviewing Ms. Dale and confirming who the current residents were living in the home Ms. Dale corrected herself and informed me that Resident C had passed away at the end of April of 2023. I asked Ms. Dale if an incident report had been completed. Ms. Dale reported that she did not know. I asked Ms. Dale if the home had an incident report binder or file. Ms. Dale reported that she was not aware of such.

On 05/26/23, I conducted the exit conference with licensee designee, Krishelle Wiley and informed her of the findings of the investigation. I also informed Ms. Wiley that the death of a resident requires that an incident report is completed and sent to me within 48 hours. Ms. Wiley reported an understanding.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(a) The death of a resident.**

ANALYSIS:	This violation is established as the licensee designee failed to complete and submit an incident report within 48 hours, following the death of Resident C.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 05/10/23, I conducted an unscheduled onsite inspection and asked to review Resident A's records. During the review I observed that Resident A's funds and valuables part II did not document her cost of care payments since 08/01/22.

On 05/26/23, I conducted the exit conference with licensee designee, Krishelle Wiley and informed her of the findings of the investigation. Ms. Wiley reported an understanding.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(3) A licensee shall have a resident's funds and valuables transaction form completed and on file for each resident. A department form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	This violation is established as the licensee designee failed to complete and document Resident A's cost of care since 08/01/22 on her funds transaction form as required by these rules.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

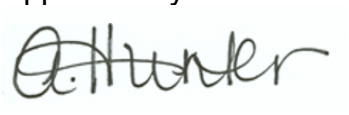
Contingent upon receipt of an acceptable corrective action plan, I request the status of the license remain unchanged.

06/14/23

Pandrea Robinson
Licensing Consultant

Date

Approved By:



06/15/23

_____

Ardra Hunter
Area Manager

Date