GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 22, 2023

Carol DelRaso
Senior Living Forest Glen, LLC
7927 Nemco Way, Ste 200
Brighton, MI 48116

RE: License #: AL140412989
Investigation #: 2023A1030050
Forest Glen Assisted Living

Dear Mrs. DelRaso:

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 (616) 356-0183.

Sincerely,

Nile Khabeiry, LMSW

Nile Khabeiry, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL140412989
Investigation #:	2023A1030050
Complaint Receipt Date:	08/15/2023
Investigation Initiation Date:	08/16/2023
Report Due Date:	10/14/2023
Licensee Name:	Senior Living Forest Glen, LLC
Licensee Address:	7927 Nemco Way, Ste 200 Brighton, MI 48116
Licensee Telephone #:	(810) 220-0200
Administrator:	Kelsey Kline
Licensee Designee:	Carol DelRaso
Name of Facility:	Forest Glen Assisted Living
Facility Address:	29601 Amerihost Drive Dowagiac, MI 49047
Facility Telephone #:	(269) 782-5300
Original Issuance Date:	03/10/2023
License Status:	REGULAR
Effective Date:	09/10/2023
Expiration Date:	09/09/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
The home did not provide for the care and safety of Resident A.	No
Additional Findings	Yes

III. METHODOLOGY

08/15/2023	Special Investigation Intake 2023A1030050
08/16/2023	Special Investigation Initiated - Telephone Interview with complainant
08/21/2023	Contact - Face to Face Interview with Kelsey Kline
08/21/2023	Contact - Document Received Received and reviewed documents for Resident A
08/21/2023	Contact - Face to Face Interview with Resident A
08/21/2023	Contact - Telephone call made Interview with Robin Moser
08/22/2023	Contact – Documents received Received and reviewed training records
08/28/2023	Contact - Telephone call made Interview with Keshia Martinez
08/29/2023	APS Referral
09/06/2023	Contact - Telephone call made Interview with Kayla Lyons
09/06/2023	Contact - Telephone call made Interview with Kara Harnish
09/08/2023	APS Referral Interview with Kristin Veans

09/22/2023	Exit Conference Exit conference by phone

ALLEGATION:

The home did not provide for the care and safety of Resident A.

INVESTIGATION:

On 8/17/23, I interviewed the complainant by phone. The complainant reported Resident A moved into the home on 6/2/22 and had her first fall on 6/22/22. The complainant also reported Resident was dropped on 7/7/22, 3/5/23 and 5/26/23. The complainant reported he is upset the home did not train their staff very well and that Resident A was a two person assist which is why she was dropped several times when only one staff was assisting her. The complaint was asked if Resident A was a one or two person assist. The complainant indicated she was a two person assist and the home raised her personal care rate based on her needing a two person assist. The complainant reported Resident A is receiving skilled nursing care at Cartel Inn in St. Joseph, MI. The complainant reported Resident A will be at the facility for a couple more weeks but will not be returning to the home due to several incidents of being dropped resulting in several injuries.

On 8/21/23, I interviewed Kelsey Kline at the home. Ms. Kline reported she was not working at the home during the time when Resident A moved into the home or had the first two falls. Ms. Kline reported Resident A did have falls but was not "dropped" by any of the staff. Ms. Kline reported Resident A was taken to the hospital by her son at the request of her doctor. Ms. Kline reported Resident A will not be returning to the home.

I reviewed Resident A's file and received the following documents; *Assessment Plan for AFC Residents* (AP) dated 6/2/22, and unsigned AP dated 6/1/23, *Resident Care Agreement* (RCA) dated 10/26/22, *Progress Note* (PN) from Hollie Nate PA-C dated 6/2/22, *Resident Care Conference Summary* (RCCS) dated 6/5/23, list of injuries while residing in the home, Incident Reports (IR) dated 6/22/22, 7/18/22, 7/22/22,3/5/23, 3/23/23, 3/31/23, 5/25/23 and 6/7/23, *Resident Ledger* (RL) detailing an accounting of monies paid to the home for rent and personal care and two *General and Supplemental Fee Policy* (GSFP) documents dated 6/2/22 and 10/25/22.

Based on the documents reviewed I noted there should be a RCA for Resident A dated in June 2022 as she was admitted to the home on June 2, 2022. The RCA indicated she was assessed at Care Level 2 and was changed $1,650.00 per month and a monthly rent of $5,030.00. The AP and PN indicated Resident A was a one person assist with a gait belt. The GSFP dated 6/2/23 indicated Resident A was charged $4.765.00 and $1,650.00 for personal care. The GSFP dated 10/25/22 indicated Resident A's rent increased to $5,030.00 while her personal care (Level 2) did not change.

On 8/21/23, I interviewed Resident A at her skilled nursing facility. Resident A she liked living at the home but did not like being “dropped.” Resident A reported she has difficulty ambulating and uses a walker or wheelchair when ambulating. Resident A reported she did need staff assistance but never had two staff members assist her when transferring or receiving personal care. Resident A reported she suffered injuries to her right leg and left hip.

On 8/22/2023, I received and reviewed training records emailed to me by Ms. Kline. The records included training for all direct care staff members (DCSM) to safely use a gait belt.

On 8/28/23, I interviewed Activities Director, Robin Moser by phone. Ms. Moser reported she was asked to call regarding an investigation concerning Resident A. Ms. Moser was provided with the dates of incidents in question. Ms. Moser reported she was working on 6/22/22 when Resident A had her first fall. Ms. Moser reported she does not remember the incident but did review an incident reported dated 6/22/22 that she authored indicating Resident A was transferring from her recliner to her wheelchair and “missed the handle” which caused her to fall on her right side. Ms. Moser again denied having a clear memory of the event but reported Resident A was never a resident that they would encourage to ambulate without a wheelchair or walker. Ms. Moser reported she always used a gait belt while assisting Resident A.

On 8/28/23, I interviewed DCSM Keshia Martinez by phone. Ms. Martinez reported she has worked at the home for eight years and usually works first shift. Ms. Martinez reported she was working on 6/22/22 and on 3/5/23 when Resident A fell at the home. Ms. Martinez reported she was not directly working with Resident A when the falls occurred but did provide support to her after the incidents occurred. Ms. Martinez acknowledged Ms. Moser was working with Resident A on 6/22/22 and thinks Ms. Moser used her gait belt while trying to transfer her Resident A “leaned forward” and lost her balance. Ms. Martinez reported Resident A was “very unstable” and no one would transfer her without using a gait belt. Ms. Martinez reported Resident A’s family thought she would be ok using her walker but thinks Resident A should have only used her wheelchair due to her unsteady gait.

Ms. Martinez reported on 3/5/23 Resident A was in bed and a DCSM tried to help her transfer out of bed using a gait belt, but she fell on the floor in her bedroom. Ms. Martinez reported Resident A went to the hospital after her falls but does not believe the injury on her hip or leg were caused by the falls as Resident A always would lay on her side causing “pressure points.” Ms. Martinez reported there would be no way to assist Resident A without using a gait belt and Resident A herself always made sure the DCSM had their gait belt before they would help her transfer. Ms. Martinez reported Resident A was always a one person assist.

On 9/6/23. I interviewed DCSM Kalya Lyons by phone. My Lyons reported she has worked at the home for ten years and worked with Resident A when she lived in the home. Ms. Lyons reported she remembers Resident A falling three times. My Lyons

reported Resident A needed assistance with transferring and walking so the DCSM would use a gait belt. Ms. Lyons reported Resident A's family "insisted" a gait belt be used anytime they worked with her. Ms. Lyons reported Resident A used a wheelchair if she went any "long distance" and her walker with gait belt when she was in her bedroom. Ms. Lyons reported Resident A was one person assist and denied she was ever a two person assist.

On 9/6/23, I interviewed DCSM Kara Harnish. Ms. Harnish reported she has worked in the home for two years and is a lead staff and usually works third shift. Ms. Harnish reported she works third shift and knows that Resident A has fallen several times but was never working when she fell. Ms. Harnish reported Resident A was always "unsteady on her feet" and the staff needed to use a gait belt when she transferred of ambulated. Ms. Harnish reported a gait belt was always used and it was in her "care plan." Ms. Harnish reported Resident A was a one person assist when she first entered the home but became a two person assist after she broke her arm in the shower. Ms. Harnish reported they had to use a Hoyer lift and you need two people to use the Hoyer. Ms. Harnish reported she believe the change form a one person assist to a two-person assist would be documented in her file but is unsure if it was officially documented. Ms. Harnish reported Resident A went to a Rehab center two days after she broke her arm and when she returned, she only needed a one person assist as she was doing very well when she came back.

On 9/8/23, I interviewed DCSM Kristen Veans by phone. Ms. Veans has worked at the home for six years and generally works first shift. Ms. Veans reported she has never witnessed Resident A falling but is aware she had fallen several times. Ms. Veans was unsure of the dates of the falls but does remember her falling in the shower some time last year. Ms. Veans reported she thinks Resident A was able to ambulate without assistance prior to her first fall in June 2022 but always had assistance after she fell due to being unsteady on her feet. Ms. Veans reported the staff used a gait belt when transferring or walking short distances and a wheelchair when traveling longer distances within the home. Ms. Veans reported Resident A was a one person assist and was never a two person assist even after she was injured in the shower.

APPLICABLE RULE	
R 400.15303	**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:	It was alleged the home did not provide for the care and safety of Resident A which led to several falls and injuries. Based on interviews with staff members, Resident A, Resident A's family and review of Resident A's file, the home's training records this violation will not be established. Although Resident A had

	several falls while living at the home it could not be established the staff did not provide appropriate care based on her Resident A's Assessment Plan. Resident A was assessed as needing a one person assist with the use of a gait belt which was used by the staff members. It should be noted that three of the reported falls occurred at the home while under a different license number and several of the staff members who were working during that time frame no longer work at the home and could not be interviewed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

I reviewed Resident A's file and was unable to locate a Resident Care Agreement (RCA) when she was admitted on 6/2/22 which would have established, in part her care needs and fee for rent and care services needed. I also reviewed Resident A's fee ledger which documents the fees for care services and noted the fee and care level changed twice without a corresponding RCA completed.

APPLICABLE RULE	
R 400.15301	**Resident care agreement;**
	(6) At the time of a resident's admission, a licensee shall complete a written care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative and the licensee, and which specifies the responsibilities of each party.
ANALYSIS:	The home did not have Resident A's initial RCA completed at admission.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15301	**resident care agreement.**
	(9) A licensee shall review the written care agreement with the resident or the resident's designated representative, if applicable at least annually or more often if necessary.
ANALYSIS:	In addition to having the initial RCA at admission for Resident A, I was unable to locate any subsequent RCA that documented change in her level of care.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/22/23, I shared the findings of my investigation with administrator, Kelsey Kline. Ms. Kline acknowledged and agreed with the findings and will complete a corrective action plan.

IV. RECOMMENDATION

Contingent upon submission of an acceptable corrective action plan, I recommend no change in the current license status.

Nile Khabeiry, LMSW

9/25/23

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Nile Khabeiry Date
Licensing Consultant

Approved By:

Russell Misiak

9/25/23

_____

Russell B. Misiak Date
Area Manager