GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 20, 2024

Karen Harris
Integrated Living, Inc.
43133 Schoenherr Road
Sterling Heights, MI 48313

RE: License #: AS500392831
Investigation #: 2024A0990009
Chapman

Dear Mrs. Harris:

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 (248) 975-5053.

Sincerely,

L. Reed

LaShonda Reed, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(586) 676-2877

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500392831
Investigation #:	2024A0990009
Complaint Receipt Date:	01/04/2024
Investigation Initiation Date:	01/04/2024
Report Due Date:	03/04/2024
Licensee Name:	Integrated Living, Inc.
Licensee Address:	43133 Schoenherr Road Sterling Heights, MI 48313
Licensee Telephone #:	(586) 731-9800
Administrator:	Karen Harris
Licensee Designee:	Michele Johnson
Name of Facility:	Chapman
Facility Address:	40290 Ryan Sterling Heights, MI 48310
Facility Telephone #:	(586) 731-9800
Original Issuance Date:	10/19/2018
License Status:	REGULAR
Effective Date:	04/18/2023
Expiration Date:	04/17/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A has been to the hospital several times since admission to the home for falls.	No

III. METHODOLOGY

01/04/2024	Special Investigation Intake 2024A0990009
01/04/2024	APS Referral Adult Protective Services (APS) complaint initiated at intake.
01/04/2024	Special Investigation Initiated - Letter I emailed the assigned APS worker Jasmaine Martin-Morris.
01/04/2024	Contact - Document Received I received an email from Jasmaine Martin-Morris, APS investigator.
01/09/2024	Contact - Face to Face I conducted an unannounced onsite investigation. I interviewed, Michele Johnson-home manager, Ruth Anderson-direct care staff and Resident A.
01/09/2024	Contact - Document Sent I requested Resident A's resident record and other documents pertinent to the investigation.
02/12/2024	Contact - Document Received I reviewed Resident A’s resident record.
02/12/2024	Contact - Telephone call made I conducted a phone interview with Jessica Dumas, supports coordinator.

02/20/2024	Contact - Telephone call made I left a detailed message with Relative A. Relative A returned phone call.
02/20/2024	Exit conference I conducted an exit conference with Karen Harris and Sarah Harris.

ALLEGATION:

Resident A has been to the hospital several times since admission to the home for falls.

INVESTIGATION:

On 01/04/2024, I received the complaint via email. In addition to the above allegation, it was reported that Resident A has been to the hospital several times since arriving at the home for falls. At one point, Resident A was doing physical therapy; however, this is no longer happening. When speaking with the house, they stated that Resident A keeps falling, and he is doing it intentionally. When asked how they knew he was doing it on purpose, staff said, "He knows that he cannot walk, so why would he fall out of bed." There is concern Resident A continues to fall out of bed. Resident A was at the ER last week for a fall; however, he checked out to be okay. Resident A's doctor is setting up physical therapy to return to the home to work with Resident A. A wheelchair was also ordered to assist in transferring.

On 01/04/2024, I received an email from Jasmine Martin-Morris, the APS investigator. Ms. Martin-Morris said that she interviewed the home manager, Michelle Johnson, and attempted to interview Resident A; however, he needs help understanding. Ms. Martin-Morris said they are closing their case after interviewing Relative A and the other service providers who had no concerns about his treatment.

On 01/09/2024, I conducted an unannounced onsite investigation. I interviewed Michele Johnson-home manager. Ms. Johnson began by stating that Resident A has had a few falls since his admission to the home on May 26, 2023. Ms. Johnson said that Resident A's first ER visit was on July 9, 2024, because he could not walk and was shaking. He was admitted to Troy Beaumont Hospital and was diagnosed with a urinary tract infection (UTI). Resident A was discharged from the hospital on July 11, 2023. At that time, Ms. Johnson requested in-home nursing services for Resident A, which included occupation therapy (OT) and physical therapy (PT). Resident A began in-home nursing services through Bay Nursing on July 13, 2023, and saw his primary care physician (PCP) on July 17, 2023. At that time, he was also having

shallow breathing and vomiting; therefore, he was taken back to Troy Beaumont Hospital and was admitted there until July 20, 2023. He was diagnosed with dehydration and low potassium. Resident A was also given a catheter on July 21, 2023, because of his UTIs and decreased mobility; Ms. Johnson said that the PT that came out on July 26, 2023, recommended that he be taken to the hospital because his urine was yellow. He was admitted and discharged on 07/31/2023. Ms. Johnson said his hospital visits were mainly due to health issues from having repeated UTI; however, he has had one or two falls since his admission date. Resident A was sitting in his wheelchair, leaning forward, attempting to stand, and falling. Resident A also fell out of bed because he attempted to get out of bed alone. As a result, the hospital ordered a hospital bed and a wheelchair. Resident A received OT and PT from Bay Nursing but was discharged on December 8, 2023. Resident A still has a nurse who comes out to check his catheter. Ms. Johnson said that Resident A was in a nursing home at his previous placement, in which he was moved from there due to having repeated falls. There are five current residents, and only Resident A was present. One of the residents was present and was non-verbal.

On 01/09/2024, I conducted an unannounced onsite investigation of Ruth Anderson's direct care staff. Ms. Anderson said Resident A has had several hospital visits but not for falls. Ms. Anderson recalled one fall Resident A had when he attempted to get out of bed on his own. Ms. Anderson was in the process of taking Resident A to a routine doctor's appointment.

On 01/09/2024, I conducted an unannounced onsite investigation. I attempted to interview Resident A, but he needed help understanding. I observed Resident A sitting in his wheelchair belted. He was dressed appropriately and appeared contented.

On 02/12/2024, I reviewed Resident A's resident record. Resident A's admission date was May 25, 2024. He has a legal guardian and receives services through Macomb County Community Mental Health. I reviewed his *Assessment Plan*, and Resident A needs assistance with ADLs, uses a wheelchair walker, and received OT and PT to strengthen his legs. I reviewed Resident A's Individual Plan of Service (IPOS) dated 01/03/2024. The first goal on the IPOS is that Resident A agrees to utilize his wheelchair and walker for short distances with supervision from staff. Resident A requires assistance with transferring due to a history of falling; Resident A uses a manual wheelchair capable of propelling himself. Resident A requires partial assistance maneuvering the wheelchair within the home and community. Resident A is prescribed a hospital bed to ensure safety due to the recurrent history of falls and being deemed a fall risk. Resident A will utilize a hospital bed when sleeping. Staff will ensure that Resident A is monitored while using his wheelchair for mobility. Per Resident A's Crisis Plan, it was documented that he has an unsteady gait.

On 02/12/2024, I reviewed Resident A's health care chronology note (HCC). Resident A began OT and PT on 07/13/2023 until 08/24/2023 twice a week through

Bay Nursing. OT and PT began again on 11/11/2023. Resident A's emergency hospital room visits, falls, and UTI's as follows:

- On 06/21/2023, Resident A had a seizure and was hospitalized and discharged on 06/23/2023.
- 7/9/2023 Resident A was taken to Troy Beaumont Hospital because he was shaking and could barely walk. Resident A was admitted for a UTI. At discharge on 07/11/2023, the doctor ordered OT/PT and skilled nursing care.
- 7/17/2023 Resident A was vomiting and unresponsive to staff. He was taken to Troy Beaumont Hospital and admitted for dehydration and low potassium. Resident A was diagnosed with gastroesophageal reflux (GERD), hypokalemia, and hypomagnesemia. Resident A was discharged on 07/20/2023 and instructed to follow up with skilled nursing through Bay Nursing.
- On 07/29/2023, Resident A was taken to Troy Beaumont Hospital because he was nauseous and coughing. Resident A was discharged from the hospital on 07/31/2023 with continuation of services and an antibiotic.
- 08/01/2023: The Bay Ridge nurse inserted a Foley catheter in Resident A. Resident A was also re-evaluated by OT for increased assistance with ADLs and functional mobility due to being a fall risk.
- 08/4/2023 The Bay Ridge nurse visited Resident A. Foley's catheter, and it was checked.
- On 08/10/2023, a urologist saw Resident A and the catheter was removed. Resident A was prescribed antibiotics.
- On 08/23/2023, Resident A was seen by a Bay Ridge nurse and discharged.
- On 08/25/2023, Resident A had a follow-up appointment with a urologist. A CT scan was ordered.
- 09/08/2023 Resident A fell in his bedroom while watching TV. Staff heard a loud thump and found Resident A on the floor with his head against the wall. Resident A was taken to Troy Beaumont Hospital. Resident A was discharged the same day with no changes to medication or care.
- 09/18/2023, Resident A was to be seen by PCP but refused to go. Ms. Johnson called PCP to cancel the appointment. An order was put in for skilled nursing and medication refills. The PCP ordered a hospital bed and wheelchair.
- 09/19/2023, Resident A was hospitalized for UTI.
- 09/25/2023 Resident A received a hospital bed and wheelchair after being discharged from the hospital. Resident A was ordered OT, PT, and antibiotics.
- 09/26/2023, Bay Nursing services began in the home.
- On 10/02/2023, Resident A was not responding to staff and was having difficulty breathing. Resident /A was admitted to /Troy Beaumont Hospital via ambulance.
- 11/11/2023 Resident A returned to Chapman Home after being in PriMedica Nursing Facility since hospital admission on 10/02/2023. Resident A was

ordered skilled nursing OT and PT. Resident A has a catheter. Resident A continues to receive professional nursing services, OT, and PT.

On 02/12/2024, I conducted a phone interview with Jessica Dumas, support coordinator. Ms. Dumas said that neither Relative A has any concerns regarding the care Resident A is receiving at the Chapman Home. Ms. Duas said that Resident A had not fallen in months and that most of his falls occurred at this placement before the Chapman Home. Resident A is receiving skilled nursing services and is primarily using a wheelchair. Ms. Dumas said the hospital bed is making a difference in preventing falls. Resident A has a long history of recurring UTI, which contributes to his falls and timed defiant behaviors (refusing to go to doctor's appointments). Ms. Dumas visits Resident A once a month.

On 02/20/2024, I conducted a phone interview with Relative A. Relative A said that Resident A has only had one fall at the Chapman Home. There were concerns about his repeated falls when he lived at a place called Washington House. Relative A said that she has no worries about the care Resident A is receiving.

On 02/20/2024, I conducted an exit conference via phone with Karen Harris and Sarah Harris. They were informed of the tentative finding before supervisory approval. Karen Haris said that most of Resident A's falls were at his prior placement in which there were stairs. Karen Harris noted that before Resident A's admission to the home, they were unaware of the reoccurring UTI, and it was not fair to them as providers to have to be subjected to multiple hospital visits.

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 investigation, there is insufficient evidence to support that The Chapman Home staff did not provide Resident A with adequate supervision and protection from repeated falls in the home. Resident A has an unsteady gait, outlined in his IPOS and Crisis Plan addressing falls. On May 26, 2023, Resident A moved into the home. Shortly after that, Resident A had multiple hospital visits due to various health conditions, primarily UTIs. Resident A had one fall on September 8, 2023, in which he fell out of his wheelchair in his bedroom. Resident A was not injured. Resident A received OT, PT, skilled nursing services, a wheelchair, and a hospital bed. Jessica Dumas, support coordinator, and Relative A said that Resident A's falls occurred at a different home, not the Chapman Home. They had no concerns regarding the care he was receiving.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

I recommend no change in the license status.

L. Reed 02/20/2024

LaShonda Reed Date
Licensing Consultant

Approved By:

Denise Y. Nunn Date
Area Manager