GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 30, 2024

Ashley Smith
South Torch Assisted Living LLC
5103 N. West Torch Lake
Kewadin, MI 49648

RE: License #: AM050394329
Investigation #: 2024A0870019
South Torch Assisted Living

Dear Ashley Smith:

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 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 (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 #:	AM050394329
Investigation #:	2024A0870019
Complaint Receipt Date:	03/26/2024
Investigation Initiation Date:	03/26/2024
Report Due Date:	05/25/2024
Licensee Name:	South Torch Assisted Living LLC
Licensee Address:	5103 N. West Torch Lake Kewadin, MI 49648
Licensee Telephone #:	(231) 340-0498
Administrator:	Ashley Smith
Licensee Designee:	Ashley Smith
Name of Facility:	South Torch Assisted Living
Facility Address:	12800 Cherry Ave Rapid City, MI 49676
Facility Telephone #:	(231) 322-4444
Original Issuance Date:	06/07/2019
License Status:	REGULAR
Effective Date:	12/07/2023
Expiration Date:	12/06/2025
Capacity:	12
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Residents are not being showered properly.	No
Residents fall, and staff are not allowed to call an ambulance. Last week a resident fell but the ambulance was not called, and the resident later ended up in the hospital.	Yes
Residents are not being fed properly.	No
Additional Findings	Yes

III. METHODOLOGY

03/26/2024	Special Investigation Intake 2024A0870019
03/26/2024	APS Referral This referral came from the Michigan Department of Health and Human Services, Adult Protective Services.
03/26/2024	Special Investigation Initiated - Telephone Case discussion with Antrim Co. APS worker Jackie Muzyl.
03/28/2024	Inspection Completed On-site Interviews conducted with staff and residents.
04/03/2024	Contact - Telephone call made. Case discussion with APS worker Jackie Muzyl.
04/05/2024	Contact - Telephone call made. Telephone call with Licensee Designee Ashley Smith.
04/08/2024	Contact - Telephone call made. Email with Licensee Designee Ashley Smith.
04/10/2024	Contact - Telephone call made. Case discussion with APS worker Jackie Muzyl.
04/12/2024	Contact - Telephone call made. Email with Licensee Designee Ashley Smith.
04/29/2024	Inspection Completed-BCAL Sub. Compliance

04/30/2024	Exit Conference Completed with Licensee Designee Ashley Smith.

ALLEGATION: Residents are not being showered properly.

INVESTIGATION: On March 26, 2024, I spoke with Michigan Department of Health and Human Services, Antrim County, Adult Protective Services worker Jackie Muzyl. Ms. Muzyl and I discussed the above stated allegations and coordinated for a joint on-site investigation.

On March 28, 2024, I met with Ms. Muzyl to discuss contacts she had made the previous two days. She informed me that she had interviewed staff members Lauren Krauth, Wendy Timmons, and Megan Zimmerman. Ms. Muzyl stated that each of these three staff informed her that most of the residents' bathe themselves with staff reminders or minimal assistance. None felt that residents were not being bathed adequately or needed assistance that was not being provided.

On March 28, 2024, I conducted an unannounced on-site special investigation at the South Torch Assisted Living AFC home. I was accompanied by Ms. Muzyl. We met with facility Administrator Stacie Wilson and informed her of the above stated allegations. Ms. Wilson stated that the facility currently has eight residents and five staff members. This includes Resident A, who is currently hospitalized and is expected to return to the facility upon discharge. She noted that four of eight residents require staff assistance with bathing, and they are showered twice weekly and more as necessary. Ms. Wilson noted that the other residents' bathe themselves and staff monitor to ensure all residents are clean. She further indicated that staff use "wet wipes" on the residents on days that they are not showered.

On March 28, 2024, I conducted an interview with Resident B. Resident B stated that she bathes herself "but staff help if I need it." She appeared clean and well-groomed during the interview and had clean clothing. Resident B stated, "this is a wonderful place, just the best." A review of Resident B's *Assessment Plan for AFC Residents (BCAL-3265)* states that she does require assistance with bathing.

On March 28, 2024, I conducted an interview with Resident C. Resident C stated that she does her own bathing. She noted that she gives herself "camp baths, sponge baths" noting that "I could get a shower if I want, but I don't like to take showers." Resident C appeared clean and well-groomed during this interview and was wearing clean clothing. A review of Resident C's *Assessment Plan for AFC Residents (BCAL-3265)* states that she does not require assistance with bathing.

On March 28, 2024, I conducted an interview with Resident D. Resident D stated that she "really doesn't need any help with bathing, she can clean herself." She did note that the facility staff will help her if she needs help. Resident D appeared clean and well-groomed during this interview and was wearing clean clothing. A review of

Resident D's *Assessment Plan for AFC Residents (BCAL-3265)* states that she does not require assistance with bathing.

On March 28, 2024, I conducted an interview with Resident E. Resident E stated that he gives himself his showers and does not need help from the staff. Resident E appeared clean and well-groomed during this interview and was wearing clean clothing. A review of Resident E's *Assessment Plan for AFC Residents (BCAL-3265)* states that he does not require assistance with bathing.

On March 28, 2024, I conducted an interview with Resident F. Resident F stated that the staff members help her with her bath. She noted that she bathes at least twice per week. Resident F further noted that the staff help her with dressing and grooming. She appeared clean and well-groomed during this interview and was wearing clean clothing. A review of Resident F's *Assessment Plan for AFC Residents (BCAL-3265)* states that she does require assistance with bathing.

On March 28, 2024, I conducted an interview with Resident G. Resident G appeared to have dementia and seemed confused by my questions. I observed that Resident G appeared clean and well-groomed during this interview and was wearing clean clothing. A review of Resident G's *Assessment Plan for AFC Residents (BCAL-3265)* states that she does require assistance with bathing.

On March 28, 2024, I conducted an interview with Resident H. Resident H also appeared to have dementia and was unable to understand any of my questions. He appeared clean and well-groomed during this interview and was wearing clean clothing. A review of Resident H's *Assessment Plan for AFC Residents (BCAL-3265)* states that he does not require assistance with bathing. I was informed by staff that the assessment notes he does not require assistance with bathing, when to me it appeared he would need it, is because his wife comes regularly to the facility and bathes Resident H.

On March 28, 2024, I conducted an interview with staff member Tabitha Casey. Ms. Casey stated that that staff assist Residents A, B, F and H with bathing and "the rest bath themselves." She did note that Resident H's wife comes regularly and bathes him. Ms. Casey stated she feels that the residents who bath themselves do an adequate job and that the staff "monitor" to ensure that all residents are clean and groomed. She noted that if anyone "needs encouragement" to bathe, the staff will "encourage them."

On April 5, 2024, I spoke with Licensee Designee Ashley Smith and informed her of the above allegations. I informed her that I had spoken with facility residents and observed that they appeared to be adequately bathed. She noted that many residents bathe themselves with minimal staff assistance other than to monitor their cleanliness.

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:	A review of resident assessment plans note that Residents A, B, F and G require assistance with bathing. Staff interviews indicate that facility staff do provide assistance with bathing, or monitor cleanliness, to facility residents. Visual observations of Residents B, C, D, E, F, G and H all note these residents were clean, groomed and dressed in clean clothing during the March 28, 2024, unannounced on-site special investigation. The Licensee is providing personal care services i.e. bathing, as specified in the residents written assessment plans.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Residents fall, and staff are not allowed to call an ambulance. Last week a resident fell but the ambulance was not called, and the resident later ended up in the hospital.

INVESTIGATION: On March 26, 2024, Ms. Muzyl informed me that Resident A had been hospitalized due to a fall. She reported that staff did not seek medical attention for Resident A even after the staff were informed that he had fallen and had expressed to the staff that he was in pain. Ms. Muzyl noted that a family member of Resident A took him to the hospital for evaluation only after she was informed by Resident A himself that he had fallen days prior.

On March 28, 2024, I met with Ms. Muzyl to further discuss this investigation. She informed me that she had conducted interviews with staff members Lauren Krauth, Wendy Timmons and Megan Zimmerman during the past two days. Ms. Muzyl stated that all three of these staff members informed her that they were told “by management” to not call 911 if a resident falls and staff are to call facility manager Stacie Wison or staff member Vicki Bishop for instructions. Ms. Muzyl further informed me that staff member Wendy Timmons recounted a recent time when a resident fell, she called Ms. Wilson for assistance/guidance, and did not receive a return call. She noted that Ms. Timmons told her that she “struggled to get this resident up from the floor and back into bed.”

On March 28, 2024, I met with Administrator Stacie Wison at the facility. Ms. Wison denied that staff cannot call 911 if they feel it is necessary. She noted that the "protocol" if a resident falls, is for staff to call her or staff member Vicki Bishop, who will then respond to the facility and evaluate the resident and the need to call 911 for an ambulance. Ms. Wilson stated that if a staff member sees an obvious injury to a resident, then the staff is empowered to call 911 right away. She denied ever instructing staff that they cannot call 911.

Ms. Wilson stated that she is aware of Resident A's fall. She noted that staff member Megan Zimmerman worked the afternoon shift of March 15, 2024, and quit her job at the end of that shift without telling anyone that Resident A had fallen. It is noted that this investigation later determined that Resident A is suspected of falling on March 16, 2024, and that Ms. Zimmerman quit her job after her March 16, 2024, shift. Ms. Wilson stated Ms. Zimmerman did not complete an incident report or any shift notes which state Resident A had fallen. She further noted that the next morning, March 17, 2024, Resident A informed staff member Tabitha Casey that he had fallen. Ms. Wilson further explained that later that day, staff member Vicki Bishop observed blood on Resident A's arm from a skin tear. Ms. Wilson then stated Resident A was unable to stand up the morning of March 18, 2024. She noted that she evaluated Resident A that morning and "Resident A acted normal." Ms. Wilson stated she informed Resident A's guardian, Mellissa, on March 19, 2024, and Mellissa took Resident A to the hospital for evaluation. It was determined at the hospital that Resident A had three broken ribs and a skin laceration. He was admitted to the hospital that day.

On March 28, 2024, Ms. Wison provided me with a copy of an *AFC Licensing Division – Incident/accident report (BCAL-4607)*. This report was written by staff member Tabitha Casey and is dated March 16, 2024. Of note, this investigation later determined that Ms. Casey wrote this report on March 17, 2024, and erroneously dated the form March 16, 2024. Ms. Casey documented that Resident A "wrang around 9 am, told me he needed help up. Asked if he was ok. Resident A told me he had fallen the night before. Had a laceration on his arm and said his back hurt.: (sic) Ms. Casey noted that the action she took was "gave him a gauze with healing lotion over the laceration." She further noted that she "notifying Stacie of situation" and "filling an incident report." (sic)

On March 28, 2024, I conducted an in-person interview with staff member Tabitha Casey. Ms. Casey stated that after she arrived for work the morning of March 16, 2024 (later determined to be March 17, 2024) Resident A told her he needed help up from his bed. Resident A informed her that he had fallen the day before. Ms. Casey stated she asked Resident A if he was "ok" and she stated he responded that "his back hurt" and she noted a laceration on his arm. She explained that she noted the laceration due to blood seeping through his shirt. Ms. Casey stated she took off Resident A's shirt, cleaned up the laceration and put gauze on it. She noted she informed Administrator Stacie Wilson of the situation, as she was present in the facility that morning. Ms. Casey noted that staff member Vicki Bishop had worked

the overnight shift the night prior and staff member Megan Zimmerman had worked the afternoon shift the day prior, “when the fall apparently happened.”

Ms. Casey explained that she has been instructed that “if a resident falls, we are to “look them over for injury” and then “we are to call Stacie (Wilson).” She further noted that if a resident has an “obvious injury” staff are to “evaluate the injury, talk to the residents’ family, and then call Stacie (Wilson).” Ms. Casey emphasized that “this is what we are instructed to do” and that if staff cannot get ahold of Stacie Wilson, then they are to contact Vicki Bishop.

On April 3, 2024, I spoke by telephone with APS worker Jackie Muzyl. She informed me that she had spoken with Resident A, who is still hospitalized. She stated Resident A “has no memory of anything related to his fall or hospitalization.” Ms. Muzyl noted she had also spoken with Resident A’s Power of Attorney, Melanie Dean-Dellatte. Ms. Dean-Dellatte stated that Resident A has been diagnosed with three broken ribs and an injury to his arm which are “consistent with a fall” per Resident A’s treating physicians. Ms. Dean-Dellatte further informed Ms. Muzyl that upon her arrival to the AFC home on March 19, 2024, to visit with Resident A, he told her “you better take me to the hospital, I fell.” Ms. Dean-Dellatte stated she first learned of the fall from Resident A and then afterwards, from an unknown facility staff member. She stated did not hear from Administrator Stacie Wilson until March 25, 2024.

On April 5, 2024, I spoke with Licensee Designee Ashley Smith concerning this allegation. Ms. Smith noted that the staff member, working the shift when Resident A fell, quit her job at the end of her shift and did not communicate to anyone that Resident A had fallen or was injured. Ms. Smith noted that staff are instructed that when a resident falls, they are to “communicate with family” and “if the staff thinks its an emergency, such as pain or obvious injury, they are to call 911.” She also noted that if the staff do not see an “obvious injury” they are to call Administrator Stacie Wilson.” Following this interview, Ms. Smith provided me with further documentation and video which clarifies that staff member Zimmerman worked the afternoon of March 16, 2024, and that she did not document a fall prior to her leaving her shift that evening.

On April 10, 2024, I spoke with APS worker Jackie Muzyl. Ms. Muzyl stated that she had conducted an interview with staff member Vicki Bishop. Ms. Bishop stated she had worked the overnight shift, relieving staff member Megan Zimmerman. Ms. Bishop stated that Ms. Zimmerman was “yelling and cussing” and told her “I’m outta here, don’t call me.” Ms. Bishop stated she was unaware that Resident A had fallen or that he might have been injured. Ms. Bishop informed Ms. Muzyl that the “protocol” for a resident fall is to “look the resident over for injury and then call Stacie (Wilson) for her evaluation and guidance, to make sure its ok to call 911.”

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 is suspected of falling sometime during the afternoon shift of March 16, 2024. Resident A informed staff Tabitha Casey the morning shift of March 17, 2024, that he had fallen, that his back hurt and she noted had a bleeding laceration on his arm. Ms. Casey stated she informed Administrator Stacie Wilson of Resident A's fall and injury on March 17, 2024. Resident A's Power of Attorney, Melanie Dean-Dellatte, stated she learned of Resident A's fall from Resident A on March 19, 2024. She took Resident A to the hospital that day. Resident A was diagnosed with three broken ribs and an arm injury "consistent with that of a fall." Facility staff members Lauren Krauth, Wendy Timmons, Megan Zimmerman, Tabitha Casey and Vicki Bishop all state the facility protocol if a resident is involved in a fall, is to call Administrator Stacie Wilson first. The group home failed to obtain needed medical care immediately upon discovering that Resident A had fallen, had complained of pain in his back and had a bleeding laceration on his arm. Resident A was taken to the hospital by his Power of Attorney Melanie Dean-Dellatte, after Ms. Dean-Dellatte was informed by Resident A that he had fallen, and he requested that she take him to the hospital.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Residents are not being fed properly.

INVESTIGATION: Staff members Stacie Wilson, Lauren Krauth and Tabitha Casey all stated that residents are provided with three full meals per day. Ms. Wilson stated that none of the residents, or any of their family members, have ever expressed dissatisfaction with the food served at the facility.

During my March 28, 2024, on-site special investigation I observed the written menu posted in the facility kitchen area. I observed that this menu indicates that a well-balanced nutritious diet is provided to the facility residents. I also observed that a variety of food items were on hand in the refrigerator and kitchen pantry.

Individual interviews with Residents B, C, D, E and F noted that they all were satisfied with the food being served at this facility. They noted that they receive a variety of foods which include fruits and vegetables. Many stated they are provided with "too much" food. They all felt they always have enough food to meet their dietary needs. They all noted they receive a full hot breakfast, a lunch, and a dinner daily.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	The licensee is providing three nutritious meals daily to the facility residents.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

During this special investigation, I received, from Ms. Wilson, an *AFC Licensing Division- Incident/Accident Report (BCAL-4607)* describing an incident involving Resident A informing a staff member that he had fallen. This report was written by staff member Tabitha Casey on March 17, 2024, at 9:00 a.m. although she dated the form March 16, 2024. Ms. Casey wrote: "He (Resident A) wrang around 9 a.m. Told me he needed help up. Asked if he was ok. (Resident A) told me he had fallen the night before. Had a laceration on his arm and said his back hurt (sic)." The report states that the action taken by Ms. Casey as: "gave him a gauze with healing lotion over the laceration." The report notes Ms. Casey documented in the section titled Corrective measures taken to remedy and/or prevent reoccurrence as "Notifying Stacie of incident" and "filling (sic) an incident report." The section titled Persons Notified is blank, indicating no one was notified. This report is signed by Ms. Casey and was not signed by either the facility administrator, Ms. Wilson, or the Licensee Designee Ms. Smith.

Ms. Muzyl had conducted an interview with Resident A's Power of Attorney, Melanie Dean-Dellatte on April 4, 2024. Ms. Muzyl stated that Ms. Dean-Dellatte informed her that she was unaware that Resident A had fallen and that he had received any

type of injury. Ms. Dean-Dellatte stated she was informed of this incident from Resident A himself on March 19, 2024, and later that same day from an unnamed facility staff member. Ms. Dean-Dellatte informed Ms. Muzyl that she took Resident A to the hospital that same day, March 19, 2024, that he was diagnosed with broken ribs in addition to an injury to his arm. Ms. Dean-Dellatte stated the doctors informed her that these injuries are consistent with that of a fall. Resident A was admitted into the hospital for treatment.

During this investigation, Ms. Wilson provided Resident A's *Assessment Plan for AFC Residents (BCAL-3265)* and his *AFC – Resident Care Agreement (BCAL-3266)* for my observation. It is noted that Ms. Dean -Dellatte signed both forms as Resident A's Designated Representative.

APPLICABLE RULE	
R 400.14311	**Incident notification, incident records.**
	(1) If a resident has a representative identified in writing on the resident's care agreement, a licensee shall report to the resident's representative within 48 hours after any of the following: **(b) Unexpected and preventable inpatient hospital admission.**
ANALYSIS:	Resident A received an injury which resulted in his hospital admission. Resident A's Power of Attorney, Melanie Dean-Dellatte, who is listed as his Designated Representative on his *AFC – Resident Care Agreement (BCAL-3266)*, was not notified in writing within 48 hours of receiving an unexpected and preventable injury which required inpatient hospital admission.
CONCLUSION:	**VIOLATION ESTABLISHED**

On April 30, 2024, I provided Licensee Designee Ashley Smith with an exit conference. I informed Ms. Smith of my findings as noted above. She stated she understood the findings and has already implemented procedural changes within the organization. Ms. Smith stated she would develop a written corrective action plan which addresses the above cited rules.

IV. RECOMMENDATION

I recommend, contingent upon the submission of an acceptable corrective action plan, that the status of the license remain unchanged.

April 30, 2024

Bruce A. Messer — Date
Licensing Consultant

Approved By:

April 30, 2024

Jerry Hendrick — Date
Area Manager