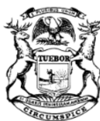


STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 25, 2023

Ian Coleman
Coleman Foundation
313 S Church St
Hudson, MI 492471353

RE: License #: AL460007203
Investigation #: 2023A1032048
Coleman Foundation Unit B

Dear Ian Coleman:

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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Dwight Forde, 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 #:	AL460007203
Investigation #:	2023A1032048
Complaint Receipt Date:	07/31/2023
Investigation Initiation Date:	08/01/2023
Report Due Date:	09/29/2023
Licensee Name:	Coleman Foundation
Licensee Address:	313 S Church St Hudson, MI 492471353
Licensee Telephone #:	(517) 448-3101
Administrator:	Suzanne Zito
Licensee Designee:	Ian Coleman
Name of Facility:	Coleman Foundation Unit B
Facility Address:	313 S. Church Street Hudson, MI 49247
Facility Telephone #:	(517) 448-3101
Original Issuance Date:	05/24/1983
License Status:	REGULAR
Effective Date:	12/04/2021
Expiration Date:	12/03/2023
Capacity:	15
Program Type:	PHYSICALLY HANDICAPPED, DEVELOPMENTALLY DISABLED, AGED

ALLEGATION(S)

	Violation Established?
Staff members did not properly account for Resident A's severe injury.	No
The home did not properly document Resident A's fall.	No
Additional Findings	No

II. METHODOLOGY

07/31/2023	Special Investigation Intake 2023A1032048
08/01/2023	Special Investigation Initiated - On Site
08/29/2023	Contact – Telephone call made
09/14/2023	Contact - Document Received Incident Report for Resident A
09/20/2023	Exit Conference

ALLEGATION:

Staff members did not properly account for Resident A's severe injury.

INVESTIGATION:

On 8/1/23, I interviewed administrator Suzanne Zito in the home. I advised Ms. Zito that there was a concern that the home had not properly assessed Resident A, and had used an explanation of Resident A crawling around, when Resident A had not been exhibiting that behavior. Ms. Zito stated that Resident A fell on Mother's Day. Ms. Zito advised that during that event, when they were waiting for the ambulance to arrive, Resident A stood up on more than one occasion. Ms. Zito stated that the staff members tried to direct Resident A to remain where she was and not try to walk.

I interviewed staff member Cathy Kalnbach, in the home. Ms. Kalnbach stated that Resident A tried to stand and move around after falling and breaking her hip. Ms. Kalnbach advised that Resident A would often crawl on all-fours. Ms. Kalnbach denied being aware of any prior incident reports where Resident A had fallen, and denied being aware of any conditions that would have made Resident A's fracture more intense. She advised that Resident A was on the couch watching television prior to the fall.

I reviewed Resident A's *Resident Assessment Plan*. The plan reflected that prior to Resident A's admission to the home, she had been observed crawling around on all fours.

I reviewed Resident A's health care appraisal, dated 9/3/22. The document reflected standard procedures of care.

I interviewed Resident B in the home. Resident B did not provide any information about Resident A's fall but expressed that he likes the care he receives in general.

I observed lunch being served and residents were observed eating their meal and socializing with one another.

On 8/29/23, I interviewed the complainant, who did not provide any additional information. I advised that the investigation was still ongoing.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(a) Medications.** **(b) Special diets.** **(c) Susceptibility to hyperthermia and hypothermia and related limitations for physical activity, as appropriate.** **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**

ANALYSIS:	Based on staff interviews and a review of documents, it does not appear that the home had not properly assessed Resident A, resulting in an extensive injury, nor does it appear that the explanation provided did not align with the extent of the injury.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The home did not properly document Resident A's fall.

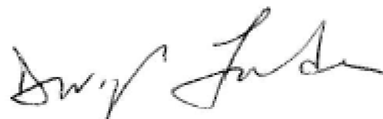
INVESTIGATION:

On 9/14/23, I reviewed an incident report dated 5/13/23, which details Resident A's fall from the couch and her attempts to get up, then fall again. The staff member was documented telling Resident A to stay in place until the ambulance arrives. The IR was transmitted to Resident A's responsible parties.

APPLICABLE RULE	
R 400.15311	**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: **b) Any accident or illness that requires hospitalization.**
ANALYSIS:	The incident report was sent to the relevant authorities and reflects that Resident A stood up and fell twice after the initial fall.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

III. RECOMMENDATION

I recommend no change to the status of this license.



9/25/23

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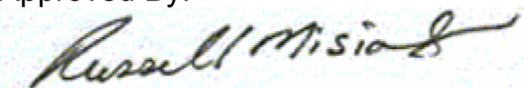
Dwight Forde Date
Licensing Consultant

Approved By:



9/27/23

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Russell B. Misiak Date
Area Manager