GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 23, 2024

Arielle Radick
Rosewood AFC Of Dewitt Inc
1070 West Webb Road
Dewitt, MI 48820

RE: License #: AM190087711
Investigation #: 2024A0790026
Rosewood AFC of Dewitt

Dear Arielle Radick:

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 (517) 284-9730.

Sincerely,

Rodney Gill

Rodney Gill, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM190087711
Investigation #:	2024A0790026
Complaint Receipt Date:	05/08/2024
Investigation Initiation Date:	05/09/2024
Report Due Date:	07/07/2024
Licensee Name:	Rosewood AFC Of Dewitt Inc
Licensee Address:	1070 West Webb Road Dewitt, MI 48820
Licensee Telephone #:	(517) 669-3688
Administrator:	Jillian Peters
Licensee Designee:	Arielle Radick
Name of Facility:	Rosewood AFC of Dewitt
Facility Address:	1070 West Webb Road Dewitt, MI 48820
Facility Telephone #:	(517) 669-3688
Original Issuance Date:	01/10/2001
License Status:	REGULAR
Effective Date:	11/07/2023
Expiration Date:	11/06/2025
Capacity:	12
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 05/06/2024 Resident A was either found on the floor or direct care staff members (DCSMs) attempted to transfer Resident A and she began to yell she was falling, so DCSMs lowered Resident A to the floor. After the incident Resident A was in her bed covered in dried feces. Feces was on both of her legs, feet, buttocks, covering her catheter, on her clothing, and the floor.	No

III. METHODOLOGY

05/08/2024	Special Investigation Intake 2024A0790026
05/08/2024	APS Referral is not necessary because Adult Protective Services (APS) is investigating the allegations.
05/09/2024	Special Investigation Initiated - Telephone Interviewed adult protective services (APS) worker Tom Hilla.
05/09/2024	Inspection Completed On-site Interviewed direct care staff member (DCSM) Jessica Heniser.
05/09/2024	Contact – Telephone call received. Interviewed licensee designee Arielle Radick.
05/23/2024	Exit Conference / Interview with licensee designee Arielle Radick.

ALLEGATION: On 05/06/2024 Resident A was either found on the floor or direct care staff members (DCSMs) attempted to transfer Resident A and she began to yell she was falling, so DCSMs lowered Resident A to the floor. After the incident Resident A was in her bed covered in dried feces. Feces was on both of her legs, feet, buttocks, covering her catheter, on her clothing, and the floor.

INVESTIGATION:

I reviewed a denied Adult Protective Services (APS) referral dated 05/06/2024.

The referral indicated Resident A resides at Rosewood AFC of Dewitt. Resident A has been diagnosed with acute kidney failure and is receiving hospice care. Resident A uses a wheelchair to ambulate. The referral indicated on 05/06/2024 there were a couple different accounts of an incident surrounding Resident A. The first account was direct care staff members (DCSMs) found Resident A on the floor but it was unknown how she got there. DCSMs called hospice and called for a lift assist.

A second account was DCSMs were attempting to transfer Resident A and Resident A began to yell that she was falling so DCSMs lowered her to the floor. After the incident, Resident A was in her bed covered in dried feces. There was feces on both of Resident A's legs, feet, on her buttocks, covering her catheter, clothing, as well as on the floor.

I interviewed adult protective services (APS) worker Tom Hilla via phone on 05/09/2024. Mr. Hilla stated he investigated the allegations and found no evidence of abuse or neglect. Mr. Hilla said he is not substantiating and will be closing his investigation. I reviewed APS worker Tom Hilla's APS report which documented he interviewed direct care staff member (DCSM) Jessica Heniser on 05/07/2024. Ms. Heniser informed Mr. Hilla she worked on 05/06/2024 when the incident happened but was not working at the time of the incident. Ms. Heniser stated to Mr. Hilla the incident happened at approximately 7:00 a.m. and an *AFC Licensing Division – Incident / Accident Report* has been completed. Ms. Heniser indicated Resident A fell and the two DCSMs working at the time attempted but were unable to get Resident A back up. Ms. Heniser said 911 was contacted to complete a lift assist. Ms. Heniser informed Mr. Hilla she was not sure if they contacted Mercy or Dewitt Township Emergency Medical Services (EMS). Ms. Heniser indicated she was informed Resident A was complaining she was in pain. Ms. Heniser said she was informed there was a meeting between hospice, family member(s), and administrator Arielle Radick from Rosewood AFC of Dewitt an hour after the fall occurred and it was decided Resident A should transfer to a hospice facility care setting. Ms. Heniser said DCSMs contacted hospice and hospice arranged for Resident A to be transported to this hospice facility to assist with pain management.

Mr. Hilla reported interviewing DCSM Dawn Randall on 05/07/2024. Ms. Randall reported it was a rough night for Resident A. Ms. Randall stated she lives downstairs at the facility and came up after Resident A fell. Ms. Randall said as she was walking down the hallway, she witnessed Resident A already on the floor with some skin tears and had fallen on her walker. Ms. Randall stated she and DCSM Jaleesa Long attempted to pick Resident A up off the floor but were unable. Ms. Randall said she then called 911 and requested a lift assist and hospice. She stated Resident A had been receiving additional care from Hospice of Lansing. Ms. Randall stated paramedics arrived shortly after calling 911 and lifted Resident A off the floor. She said she then left the facility and was replaced by DCSMs Jessica Heniser and Mindy Wirt while the paramedics were still at the facility. Ms. Randall stated she believes Resident A attempted to get up by herself because she had a toileting accident and defecated on herself. Ms. Randall said she did not witness Resident A attempting to get up because Resident A was already lying on the floor in the hallway and had fallen on her walker.

Ms. Randall was unsure if an *AFC Licensing Division – Incident / Accident Report* was completed.

Mr. Hilla reported interviewing administrator Jillian Peters on 05/07/2024. Ms. Peters reported Resident A rang her bell on 05/06/2024. She stated it is well known and documented Resident A has issues with bowel movements. Ms. Peters said Resident A is prescribed Imodium twice daily because of loose stool. Ms. Peters stated Resident A has a catheter, so she does not have to sit in urine. She said on 05/06/2024 Resident A did not have an adult brief on because she had a rash DCSMs were attempting to air out.

Ms. Peters said DCSMs went to get Resident A up to go to the bathroom the morning of 05/06/2024. She stated Resident A had already relieved herself and was walking with her walker toward the bathroom when DCSMs walked into her bedroom. Ms. Peters said Resident A's leg gave out and she fell in the hallway. She said DCSM Jaleesa Long caught Resident A as she was falling and helped ease her down to the floor. Ms. Peters stated Resident A sustained some skin tears after landing on her walker. Ms. Peters said Ms. Long and Ms. Randall attempted to assist Resident A off the floor but could not do so. She said 911 was called requesting EMS for a lift assist and Hospice of Lansing. Ms. Peters said her and the other DCSMs priority was to make Resident A as comfortable as possible before cleaning up Resident A, the floor, and/or Resident A's assistive device.

Ms. Peters confirmed there was a meeting held to determine next steps for Resident A. The meeting consisted of DCSMs, family member(s) of Resident A, and professionals from Hospice of Lansing. Ms. Peters said arrangements were made to transport Resident A to a hospice care facility because the AFC facility was limited regarding the level of comfort care they can provide. Ms. Peters informed Ms. Hilla Resident A had already been discharged and transported to this hospice care setting.

DCSM Jaleesa Long was interviewed by Mr. Hilla on 05/07/2024. Ms. Long stated she works third shift from 11:00 p.m. to 7:15 a.m. Ms. Log disclosed Resident A hit her call light because she needed to use the bathroom on the morning of 05/06/2024. Ms. Long stated when she responded to assist Resident A, she had already defecated, and Ms. Long could tell Resident A felt embarrassed. Ms. Long said she reassured Resident A and assisted her to the bathroom. She stated Resident A was using her walker as Ms. Long guided her toward the bathroom from behind. Ms. Long said all the sudden Resident A's leg gave out on her. Ms. Long stated Resident A was in a lot of pain so Ms. Long lowered her to the floor. Ms. Long stated she then went downstairs to get DCSM Dawn Randall for assistance. She said she and Ms. Randall attempted to lift Resident A but were unable to.

Ms. Long stated Ms. Randall called 911 and then hospice. She said EMS arrived and helped Resident A to her bed. Ms. Long said Resident A was in extreme pain and would not allow DCSMs to clean her up from the bowel accident. Ms. Long said DCSMs did everything they could to keep Resident A comfortable and hospice gave her

morphine for the pain. Ms. Long said there was a meeting held with family member(s), DCSMs, and hospice professionals. She stated immediate arrangements were made to transport Resident A to Stoneleigh Residence and Hospice of Lansing.

Ms. Long stated she provided a statement regarding what happened during the incident and Ms. Peters filled out an *AFC Licensing Division – Incident / Accident Report,* contacted, and spoke with family member(s).

Family Member A1 was interviewed by Mr. Hilla on 05/07/2024. Family Member A1 reported Resident A has resided at the facility for two years. Family Member A1 stated she has no issues with DCSMs working at the facility and believes they did everything they could for Resident A. Family Member A1 said Resident A has been treated kindly and well cared for by DCSMs. Family Member A1 stated Resident A has never been neglected at the facility. Family Member A1 stated Resident A will more than likely stay at the hospice care facility for the rest of her remaining days because Resident A is on a lot of pain medication.

Mr. Hilla reported he went to the hospice care facility on 05/08/2024 and observed Resident A. Mr. Hilla reported Resident A was sleeping and not able to conduct an interview.

I conducted an unannounced onsite investigation on 05/09/2024. I interviewed DCSM Jessica Heniser who stated she had no firsthand knowledge of what happened involving Resident A on 05/06/2024 because she was not working when the incident occurred. Ms. Heniser said she worked on 05/06/2024 but was not working when the incident happened. She stated the incident occurred at approximately 7:00 a.m. Ms. Heniser said Resident A was loved by all the DCSMs and residents and everyone is taking it hard. Ms. Heniser said she was informed Resident A did not fall. She stated Resident A had rung her bell and DCSM Jaleesa Long went to get Resident A up to go to the bathroom. She stated Resident A had already relieved herself and was walking with her walker toward the bathroom when Ms. Long walked into her bedroom. Ms. Heniser stated she was informed Resident A's leg gave out on her in the hallway and she began to fall. She said DCSM Ms. Long was walking behind Resident A, caught her as she began to fall and helped her down to the floor. Ms. Heniser said she was informed Resident A sustained some skin tears after landing on her walker and was in a lot of pain.

Ms. Heniser said Ms. Long went and got DCSM Dawn Randall who is the live in DCSM to assist her with getting Resident A up and back in bed. Ms. Heniser said she was told Ms. Long and Ms. Randall attempted to assist Resident A off the floor but could not do so. She said 911 was called requesting EMS for a lift assist and Hospice of Lansing. Ms. Heniser stated there was a meeting held to determine next steps for Resident A. The meeting consisted of DCSMs, family member(s) of Resident A, and professionals from Hospice of Lansing. Ms. Heniser said arrangements were made to transport Resident A to hospice care facility because the AFC facility was limited regarding the

level of comfort care they can provide. She stated Resident A was transported by EMS and is currently at Stoneleigh.

Ms. Heniser contacted licensee designee Arielle Radick via phone. I spoke with Ms. Radick, requested documentation, and asked her about the allegations. Ms. Radick provided similar information as Ms. Heniser.

I reviewed an *AFC Licensing Division – Incident / Accident Report* dated 05/06/2024. The report indicated at 6:30 a.m. on 05/06/2024 Resident A called for assistance to the bathroom. Resident A stood up, bowels released on the floor and bed. Upon walking to the bathroom Resident A had a sudden buckle of legs and DCSMs assisted her to the floor. Resident A reported 8 out of 10 pain level. Resident A's blood pressure was 90/68, heart rate of 90, oxygen saturation (Sat) of 97, and temperature of 97.1. The report indicated DCSMs contacted live-in DCSM Dawn Randall for assistance, law enforcement / on call, Hospice of Lansing to notify and obtain directives, consulted with administrator Jillian Peters, contacted EMS for a lift assist from the floor to Resident A's bed pending registered nurse (RN) evaluation and assessment. DCSMs then administered comfort medications as advised. DCSMs began performing activities of daily living (ADL). Resident A's pain level could not be managed, and she refused touch unless necessary until pain could be controlled as advised by the RN from Hospice of Lansing. The report indicated the RN's evaluation and assessment were completed at 8:42 a.m. and a second RN evaluated and assessed Resident A's condition shortly after. Resident A was evaluated and assessed by the Hospice of Lansing primary care physician (PCP).

The report indicated evaluation and monitoring of symptoms were performed after medication was administered and modifications were made by the Hospice of Lansing team at bedside with Family member A1 present. A full review was completed, x-rays taken, repositioning, catheter care, oral sponges with recommendation for EMS transfer to the hospice care facility for pain management.

I reviewed Resident A's *Assessment Plan for AFC Residents.* The plan indicated under Use of Assistive Devices: Resident A uses a walker, wheelchair, and pillow under legs at night. The report indicated under Walking/Mobility: Resident A uses walker for short distances and wheelchair for long distances. The report indicated under Other (explain): Resident A is under the care of Tri-County Office on Aging (TCOA) and Hospice of Lansing Inc.

I received notification from licensee designee (LD) Arielle Radick on 05/10/2024 Resident A passed away peacefully at 6:00 a.m. that morning with family members by her side while at the hospice care facility.

I conducted an exit conference with licensee designee Arielle Radick informing her there was no rule violation established because of this Special Investigation.

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 information gathered during this Special Investigation through review of documentation and interviews with APS worker Mr. Hilla, DCSMs Ms. Heniser, Ms. Randall, Ms. Long, administrator Ms. Peters, licensee designee Ms. Radick, and Family Member A1 there was no evidence found indicating the licensee failed to provide supervision, protection, and personal care as defined in the act and as specified in Resident A's *Assessment Plan for AFC Residents.* Prior to being lowered to the floor due to her legs buckling, Resident A experienced a bowel accident while was addressed as soon as Resident A allowed direct care staff members to assist her and after her pain level was under control.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

I recommend that the status of the license remains the same.

05/23/2024

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Rodney Gill Date
Licensing Consultant

Approved By:

05/31/2024

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Dawn N. Timm Date
Area Manager