GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 12, 2025

Sally Londry
S & D Senior Living Home
1359 S. Colling Rd.
Caro, MI 48723

RE: License #: AM790388202
Investigation #: 2025A0580013
S&D Senior Living Home

Dear Sally Londry:

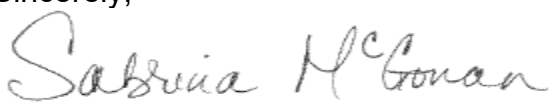
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 (517) 643-7960.

Sincerely,



Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 835-1019

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM790388202
Investigation #:	2025A0580013
Complaint Receipt Date:	12/18/2024
Investigation Initiation Date:	12/20/2024
Report Due Date:	02/16/2025
Licensee Name:	S & D Senior Living Home
Licensee Address:	1359 S. Colling Rd. Caro, MI 48723
Licensee Telephone #:	(989) 286-3711
Administrator:	Brooke Londry
Licensee Designee:	Sally Londry
Name of Facility:	S&D Senior Living Home
Facility Address:	1359 S. Colling Rd. Caro, MI 48723
Facility Telephone #:	(989) 286-3711
Original Issuance Date:	10/18/2018
License Status:	REGULAR
Effective Date:	04/18/2023
Expiration Date:	04/17/2025
Capacity:	10
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was not provided with timely medical care after having a fall.	Yes

III. METHODOLOGY

12/18/2024	Special Investigation Intake 2025A0580013
12/20/2024	Special Investigation Initiated - Telephone Call to the complainant.
12/20/2024	APS Referral Referred to APS.
12/20/2024	Contact - Telephone call received Spoke with Amy Ewald, Case Manager for Resident A.
01/08/2025	Inspection Completed On-site Unannounced onsite. Interview with Sally Londry.
01/09/2025	Contact - Telephone call received Call from Brooke Landy, Admin.
01/09/2025	Contact - Document Received Documents received.
01/13/2025	Contact - Document Received Documents received.
02/06/2025	Contact - Telephone call made Call to Steve Holman, NP.
02/10/2025	Contact - Telephone call made Call to CM Amy Ewald.
02/11/2025	Exit Conference Exit with Sally Londry.

ALLEGATION:

Resident A was not provided with timely medical care after having a fall.

INVESTIGATION:

On 12/18/2024, I received a complaint via LARA-BCHS-Complaints. On 12/20/2024, I made a referral to Adult Protective Services (APS) sharing the allegations.

On 12/20/2024, I spoke with the complainant. The complainant stated that there is concern that Resident A was not provided with timely medical care after having a fall.

On 12/20/2023, I spoke with Amy Ewald, Guardian/Case Manager (CM) at Connections Human Services assigned to Resident A. Amy Ewald stated that Resident A was initially at Caro Community Hospital, however Resident A was transferred to Bay City McLaren Hospital. Amy Ewald shared that Resident A's hip was not broken as initially thought, and did not require any surgery; however, Resident A will be released to a skilled nursing facility. Amy Ewald shared that AFC homes' administrator, Brooke Londry called and left a voice mail message on 12/17/2024 requesting medical advice regarding Resident A's fall, which occurred on 12/15/2024. Amy Ewald expressed concern that the home did not seek immediate medical care for Resident A.

On 01/08/2025, I conducted an unannounced onsite inspection. Contact was made with Sally Londry who explained that on the day in question, 12/15/2024, staff prompted Resident A to go the bathroom, however, he went outside instead and fell. Resident A got up and came back inside and appeared to be fine. The following day Resident A had an eye exam; however, Resident A could barely walk. Afterwards Resident A was taken to Caro Community Hospital and has not returned.

While onsite, I obtained a copy of the AFC Assessment Plan for Resident A. The plan indicates that Resident A does not require assistance with walking or mobility. Resident A requires prompts for toileting. As he will wet himself. Resident A does not move independently while in the community as he is easily confused, wanders off and gets lost in crowds. Resident A is diagnosed with Schizophrenia and has no history of falls.

While onsite, 4 residents were observed in the living room watching television, while 2 residents were sitting at the dining room table enjoying coffee. The residents were adequately dressed and groomed. No concerns were noted. They appeared to be receiving proper care.

On 01/09/2025, I spoke with administrator (Admin) Brooke Londry, who recalled that on 12/15/2024. Admin Londry sent Resident A to the bathroom, Resident A instead went outside and fell. Resident A got up on his own and walked back inside to the kitchen table. Resident A then walked to the bathroom. Admin Londry state that she contacted Nurse Practitioner (NP), Steve Holman, who told her to watch for bruising and to take

Resident A to the ER (Emergency Room) if things got worse. A day went by, and while preparing to attend a scheduled eye appointment, Resident A did not want to get up. Admin Londry thought Resident A was being stubborn; however Resident A was unbalanced. After Resident A's eye appointment, Resident A was taken to the ER and as not returned.

On 01/09/2025, I received a copy of the documents requested. The incident report dated 12/15/2024 states that Resident A was prompted to go to the bathroom to use the toilet and to get changed for bed. Resident A went outside in inclement weather and fell on the porch. Resident A stood up on own and walked in the house alone with staff offering help. Resident A did not show any different signs of walking. Resident A said, “yes”, he was ok. Resident A’s walking has been poor due to failing health. Has been voiced to Resident A’s doctor, guardian and case manager. Doctor was sent a text message Monday morning following the fall. Doctor stated to watch for bruising. As a corrective measure, next time staff will walk Resident A to the bathroom instead of sending and checking on him.

Admin Landy provided a copy of the test message exchange between she and NP Steve Holman. The text message, sent on Monday 12/16/2024 states, “Hello Steve just letting you know that Resident A fell on the ice when he went outside on his own”. The remainder of this message could not be seen because it was blurred out. NP Holman, then responded, “keep watch for bruising, thank you”.

The incident report dated 12/17/2024 states that Admin Londry called NP Holman to report that they believe Resident A is hurt from his fall. Resident A could not walk or stand-alone by 12/17/2024, from the fall on 12/15/2024. NP Holman stated that it would be a good idea to take him to ER for evaluation. Guardian was left a message stating Resident A would be going to Caro McLaren. Resident A was transferred to Bay McLaren for further treatment.

On 01/13/2025, I received a copy of the Bay City McLaren discharge instructions for Resident A. The records indicate that Resident A is a 64-year-old male who presented at the Caro emergency department on 12/17/2024, after sustaining a fall. Resident A is a resident of a local AFC home and is mostly nonverbal. Upon arrival at the emergency department an x-ray conducted showed minimally displaced right greater trochanter fracture and UTI. Resident A was admitted.

On 02/06/2025, I spoke with NP Steve Holman’s office. The medical case notes for Resident A indicate that NP Holman did receive contact from Brooke Londry on 12/16/2024, indicating that Resident A had fallen and was limping as a result. NP Holman suggested that staff monitor him for bruising or complaints of pain. Brooke Londry called back on 12/17/2024 to report that Resident A could not walk or support weight. NP Holman suggested that he be taken to the ER.

On 02/10/2025, I spoke with Resident A’s Guardian/CM, Amy Ewald. Amy Ewald shared that Resident A continues to be placed at a skilled nursing facility in Bay City

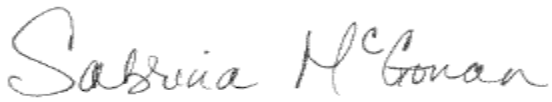
where he is doing well with his healing, receiving physical therapy and able to get around without the assistance of a walker. Resident A is having some wandering issues while adjusting to the new placement.

On 02/1/2025, I conducted an exit conference with the licensee designee, Sally Londry, explaining the license rule violation. For future reference, Licensee Londry agreed to seek immediate medical treatment for residents if needed.

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:	It was alleged Resident A was not provided with timely medical care after having a fall. Based upon my investigation, which consisted of interviews with facility staff members, Sally and Brooke Londry, Amy Ewald, Guardian/Case Manager for Resident A and Nurse Practitioner Holman's office staff, as well as a review of AFC Assessment Plan, Incident Reports, and medical records, there is enough evidence to substantiate the allegation the facility did not seek needed care immediately. Resident A fell outside on 12/15/2024. The home did not obtain medical care for Resident until 12/17/2024.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

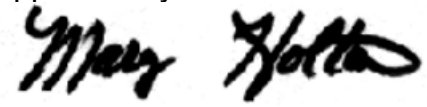
Upon the receipt of an approved corrective action plan, no change to the status of the license is recommended.



February 11, 2025

Sabrina McGowan — Date
Licensing Consultant

Approved By:



February 12, 2025

Mary E. Holton — Date
Area Manager