GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 2, 2025

Erin Griffiths
CHT Curry House MI Tenant Corp.
450 S. Orange Ave
Orlando, FL 32801

RE: License #: AL830337616
Investigation #: 2025A0870019
Curry House

Dear Erin Griffiths:

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 #:	AL830337616
Investigation #:	2025A0870019
Complaint Receipt Date:	04/15/2025
Investigation Initiation Date:	04/16/2025
Report Due Date:	05/15/2025
Licensee Name:	CHT Curry House MI Tenant Corp.
Licensee Address:	450 S. Orange Ave Orlando, FL 32801
Licensee Telephone #:	(949) 878-1324
Administrator:	Erin Griffiths
Licensee Designee:	Erin Griffiths
Name of Facility:	Curry House
Facility Address:	5858 S. 47 Mile Road Cadillac, MI 49601
Facility Telephone #:	(231) 227-4849
Original Issuance Date:	10/15/2014
License Status:	REGULAR
Effective Date:	04/15/2025
Expiration Date:	04/14/2027
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
The facility staff dropped Resident A which resulted in a fractured femur.	Yes

III. METHODOLOGY

04/15/2025	Special Investigation Intake 2025A0870019
04/16/2025	Special Investigation Initiated - Telephone Telephone interview with Complainant -1.
04/16/2025	Contact - Telephone call made Telephone interview with Licensee Designee Erin Griffiths.
04/18/2025	Inspection Completed On-site Interviews conducted with facility staff.
04/25/2025	Contact - Telephone call made Telephone interview with facility staff.
04/28/2025	Contact - Telephone call made Telephone interview with Resident A.
04/28/2025	APS Referral Referral made to MDHHS APS intake.
04/28/2025	Inspection Completed-BCAL Sub. Compliance
05/02/2025	Exit Conference Completed with Licensee Designee Erin Griffiths.

ALLEGATION: The facility staff dropped Resident A which resulted in a fractured femur.

INVESTIGATION: On April 16, 2025, I conducted a telephone interview with Complainant -1 to clarify her concerns related to this complaint. Complainant -1 stated her complaint is regarding the facility staff dropping Resident A during a transfer from her bed to her wheelchair. Complainant -1 stated this “drop” resulted in a fracture to Resident A’s femur. She noted she feels facility staff did not use due caution or follow proper transfer protocol for Resident A which led to Resident A

being “dropped and injured.” Complainant -1 further noted that upon Resident A’s return from the hospital, the facility issued a discharge notice, stating that the facility could no longer provide care to Resident A.

On April 16, 2025, I spoke with Licensee Designee Erin Griffiths and informed her of the above stated allegation. Ms. Griffiths noted that the accident involving Resident A occurred on March 4, 2025, prior to her assuming her role as Licensee Designee/Administrator, and she would need to review Resident A’s record to further discuss this issue. Ms. Griffiths noted that Resident A moved out of the facility at the end of March following the issuance of a 30-day discharge notice. She stated the discharge notice was issued after the facility reevaluated Resident A’s care needs upon her return from the hospital, and it was determined the facility was no longer able to provide for Resident A, due to her increased care needs. I informed Ms. Griffiths that I would be conducting an on-site investigation on April 18, 2025, and will meet with her to further discuss this complaint. I requested that she make available Resident A’s records for my review.

On April 18, 2025, I conducted an on-site special investigation at the Curry House AFC home. I met with Ms. Griffiths at the facility. She provided for my review copies of Resident A’s Assessment Plan/functional needs assessment dated December 31, 2024, Incident Report related to Resident A’s March 4, 2025, incident/accident dated March 4, 2025, 30-Day notice of intent to discharge dated March 12, 2025, and Munson Hospital Cadillac Emergency Department report from March 4, 2025. Ms. Griffiths provided, for my review, the staff shift work schedule for March 4, 2025. I noted that two staff members, Jessica Wilson and Faith Amista, were assigned to work the 7:00 a.m. to 3 p.m. shift on March 4, 2025. Additionally, Resident Care Coordinator (RCC) Tasha Edwards, was also on staff that shift/day. It is noted that the RCC is jointly assigned to both the Adult Foster Care home and to the adjoining Home for the Aged. Ms. Griffiths noted the AFC was providing care to 16 residents on March 4, 2025.

My review of the Incident Report notes that this document was completed by staff member Jessica Wison on March 4, 2025. In this report, Ms. Wilson states Resident A’s, *“legs buckled under her when staff was transferring her from the bed to her power chair. She was not able to help bear weight at all. She landed on her knees and laid over to her left side. Her legs were bent behind her. Staff got her legs straightened out in front of her and assisted (Resident A) up and into power chair. The resident then complained of pain in her left knee/leg. She stated she could not move it, but was lifting her heal up and wiggling her toes. (Resident A) was asked if she wanted to go to ER for evaluation, and (Resident A) wanted to call her daughter first to come and see her before deciding to go. Daughter came and (Resident A) decided to go get checked out, (Resident A) left facility at 11:30 a.m.”*

My review of Resident A’s Resident Functional Needs Assessment notes that the most recent assessment completed by the facility prior to March 4, 2025, was conducted on December 31, 2024. This assessment documents under the category

of “fall potential” that Resident A is a “high fall risk” and requires “use of assistive mobility device.” The category of “transfer” notes “physical assist resident to transfer 1-2 times during 1st and 2nd shift.” It assesses that Resident A requires “physical assistance with Sliding Board.”

My review of Munson Hospital Cadillac Radiology report from March 4, 2025, shows that Patrick Gartland, MD, reviewed radiological images of Resident A, from her Emergency Department exam this same day. Dr. Gartland noted findings of “acute nondisplaced distal femoral fracture, which appears to extend through the medial and lateral femoral condyles.”

On April 18, 2025, I conducted an in-person interview with staff member Tasha Edwards. Ms. Edwards stated that she is a Resident Care Coordinator and was working the morning of March 4, 2025. She noted her responsibilities include both the AFC and the attached HFA. Ms. Edwards stated she received a call from staff member Courtney Leatherman that assistance was needed with Resident A, as she was injured and lying on the floor. Ms. Edwards stated that when she got to Resident A’s room, she asked Resident A if she was hurt, and Resident A replied “no.” She stated that staff member Jessica Wilson helped her lift Resident A into her wheelchair, at which time Resident A complained of pain. Ms. Edwards instructed Ms. Wilson to call EMS but Resident A stated she wanted staff to call her daughter first.

On April 18, 2025, I conducted an in-person interview with staff member Faith Amista. Ms. Amista stated she worked the morning shift of March 4, 2025, along with staff member Jessica Wilson. Ms. Amista stated she was “paged” by Resident A and went to Resident A’s bedroom shortly after. She stated Resident A needed assistance with transferring from her bed to her wheelchair. Ms. Amista noted she called for Ms. Wison, and Ms. Wison called for additional assistance from staff member Courney Leatherman, who was assigned to work in the attached Home for the Aged this shift. Ms. Amista stated that she had left Resident A’s bedroom while Ms. Wilson awaited Ms. Leatherman’s arrival, and did not see Ms. Wilson and Ms. Leatherman attempt to transfer Resident A or Resident A drop to the ground. Ms. Amista noted she heard on the walkie talkie that assistance was needed in Resident A’s bedroom. When she returned to Resident A’s bedroom, she observed Ms. Wilson and Ms. Leatherman were attending to Resident A, who was on the floor, and Ms. Edwards arrived shortly after. Ms. Amista noted the AFC had 16 residents in care that shift.

On April 25, 2025, I conducted a telephone interview with staff member Courtney Leatherman. Ms. Leatherman stated she was assigned to work in the attached Home for the Aged facility on March 4, 2025. She noted she was called on the walkie talkie radio by Ms. Wilson who stated she needed assistance with Resident A. She stated that upon her arrival to Resident A’s bedroom, Resident A was in her bed, and Ms. Wilson was present awaiting her arrival to assist in transferring Resident A from her bed to her wheelchair. Ms. Leatherman stated that she

assisted Ms. Wison in transferring Resident A and while doing so Resident A's "legs gave out" and Resident A "went to the ground with one leg going behind her." Ms. Leatherman stated that neither she, nor Ms. Wilson, used any assistive device, such as a Hoyer lift, a gait belt, or a "slide board." She noted that she is aware that Resident A does have a gait belt, which she stated was not used, and noted that she was later told that Resident A has a "slide board" which also was not used. Ms. Leatherman stated she was unaware of the "slide board" at the time of this incident/accident. Ms. Leatherman stated that after Resident A was on the floor she called Ms. Amista and Ms. Edwards for assistance. She noted Resident A was lifted into her wheelchair and complained of pain. Ms. Leatherman stated that Resident A's daughter was called and informed of the situation and Resident A was taken to the hospital by her daughter shortly thereafter.

On April 28, 2025, I conducted a telephone interview with staff member Jessica Wilson. Ms. Wilson recounted that she, along with Ms. Leatherman, were transferring Resident A from her bed to her wheelchair when Resident A's legs "buckled" and Resident A "was lowered to the floor." Ms. Wison stated that Resident A has no support from her legs, and she held Resident A under one arm while Ms. Leatherman held Resident A under the other arm. She noted that Resident A's wheelchair was at a 90-degree angle and about six inches from the bed. Ms. Wison stated that she and Ms. Leatherman "tried a two-person transfer" of Resident A. She stated that they did not use any type of assistive device while attempting this transfer. Ms. Wilson stated she is aware that Resident A has a "sliding board" but did not use it because Resident A "didn't like it." She noted that when Resident A first moved into the facility, staff did use the sliding board, but have not used it in a while. Ms. Wilson stated that while attempting this transfer, Resident A knees went out and she went over to her left side. She noted that she got Resident A to a sitting position on the floor and then was lifted into her wheelchair. Ms. Wilson stated Resident A complained of leg pain once in her wheelchair and Resident A's daughter was called and informed of the incident/accident. She noted Resident A was taken to the hospital shortly thereafter.

On April 28, 2025, I conducted a telephone interview with Resident A. Resident A noted that she no longer resides at Curry House AFC and now lives with her daughter. She stated that she uses a "scooter", which she later clarified is a powered wheelchair, and does need help to transfer from her bed to her scooter. Resident A stated that facility staff members assisted her with transferring when she lived at Curry House AFC. Resident A stated she has a "sliding board" which is used to transfer from her bed to her scooter and she "has two of them." She stated that on the day she "was dropped on the floor", March 4, 2025, the facility staff did not use her sliding board. Resident A denied telling the staff not to use her sliding board. She further commented she does not feel the staff are trained on how to use her sliding board. Resident A stated she was "dropped on the floor" while staff Jessica (Wilson) and "another small" staff were attempting to transfer her. She noted that neither staff member has the strength to "hold me."

On April 28, 2025, I contacted, via email, Ms. Griffiths requesting if the facility has any documentation of Resident A “fall/drops” during her residency at Curry House AFC. Ms. Griffiths replied back this same day noting that the facility does not have any records of Resident A falling during the time frame from her last assessment, December 31, 2024, and March 4, 2025.

APPLICABLE RULE	
R 400.15303	**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:	Resident A’s Resident Functional Needs Assessment, conducted on December 31, 2024, documents under the category of “fall potential” that Resident A is a “high fall risk” and requires “use of assistive mobility device.” It documents that Resident A requires “physical assistance with Sliding Board.” Resident A was dropped/fell to the floor when staff attempted to transfer her from her bed to her wheelchair. Resident A was injured and later diagnosed with a “acute nondisplaced distal femoral fracture.” Staff members Jessica Wilson and Courtney Leatherman both state they attempted to transfer Resident A from her bed to her wheelchair and acknowledged they did not use any type of assistive device such as a gait belt or “sliding board.” Resident A states that she has two siding boards and on the day she was “dropped”, the staff did not use a sliding board while attempting to transfer her from her bed to her wheelchair. The Licensee failed to provide Resident A with protection, as defined in the act, by not utilizing a “sliding board” or other “assistive mobility device,” while transferring Resident A, in accordance with her December 31, 2024, Functional Needs Assessment.
CONCLUSION:	**VIOLATION ESTABLISHED**

On May 2, 2025, I conducted an exit conference with Licensee Designee Erin Griffiths. I explained my finding as noted above. Ms. Griffiths stated she understood the findings of this investigation and had no further information to provide, nor any additional questions to ask, concerning this special investigation.

Ms. Griffiths stated she would develop and submit a corrective action plan addressing the established rule violation.

IV. RECOMMENDATION

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

May 2, 2025

Bruce A. Messer — Date
Licensing Consultant

Approved By:

May 2, 2025

Jerry Hendrick — Date
Area Manager