STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

September 27, 2021

David Benjamin
A&D Charitable Foundation Inc
3150 Enterprise Dr
Saginaw, MI 48603

RE: License #: AH730401359
Investigation #: 2021A0585049
Community Village

Dear Mr. Benjamin:

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 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 (248) 975-5053.

Sincerely,

Brender L. Howard

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
4th Floor, Suite 4B, 51111 Woodward Avenue
Pontiac, MI 48342
(313) 268-1788
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH730401359
Investigation #:	2021A0585049
Complaint Receipt Date:	08/30/2021
Investigation Initiation Date:	08/30/2021
Report Due Date:	10/29/2021
Licensee Name:	A&D Charitable Foundation Inc
Licensee Address:	3150 Enterprise Dr Saginaw, MI 48603
Licensee Telephone #:	(989) 792-5442
Administrator:	Rebecca Miller
Authorized Representative:	David Benjamin
Name of Facility:	Community Village
Facility Address:	3200 Hospital Rd Saginaw, MI 48603
Facility Telephone #:	(989) 792-5442
Original Issuance Date:	03/18/2020
License Status:	REGULAR
Effective Date:	09/18/2021
Expiration Date:	09/17/2022
Capacity:	90
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident C slid or fell out of a wheelchair onto the floor.	No
Additional Findings	Yes

III. METHODOLOGY

08/30/2021	Special Investigation Intake 2021A0585049
08/30/2021	Special Investigation Initiated - Telephone Interviewed the complaint regarding the allegations.
09/07/2021	Inspection Completed On-site Completed with observation, interview and record review.
09/27/2021	Exit conference. Conducted with authorized representative David Benjamin.

ALLEGATION:

Resident C slid or fell out of a wheelchair onto the floor.

INVESTIGATION:

On 8/29/21, the department received the allegations from a complainant via the BCAL Online Complainant website. The complainant alleges that Resident C slid or fell out of her wheelchair while being pushed by a staff member.

On 8/30/21, I interviewed the complainant by telephone. She stated that the facility doesn’t know what happened. She stated that she was told Resident C was leaning forward and fell out of the wheelchair and was also told that staff pushed her in the wheelchair, and she fell.

During an onsite on 9/7/21, I interviewed the administrator, Rebecca Miller. She stated that Resident C did not have a fall but was lowered to the floor by staff. She stated that Resident C was at the dining room table when she began scooting in her chair. She stated that Resident C continued to scoot in her chair as staff moved her

and she slid out of the chair. She stated that staff was able to catch Resident C and lowered her to the floor. She stated that there were no injuries. She stated that Resident C was sent to the hospital.

During the onsite, Ms. Miller submitted additional documentation including Resident C's service plan, Resident C's hospital discharge papers, and an incident/accident report.

The incident/accident report read on 8/29/21, "Resident C was in wheelchair. Staff [Alexis Poklmel pulled away from dining room table. She began to slip; my arms went under hers and she was lowered to ground on right side. No injury found, complaints of pain. Physician notified; resident authorized representative notified. Transported by EMT to hospital."

On 9/13/21, I interviewed resident care giver Alexis Pokhrel. She stated that she was feeding Resident C in the dining room. She stated that once they were done, she pulled Resident C away from the dining room and she began to slide. She stated that she put her arms under Resident C's arm and lowered her to the floor. She stated that there were no injuries, but Resident C complained of pain. She stated that Resident C's vitals were checked, and they called it in. She stated that Resident C went to the hospital.

The hospital discharge notice read, [Resident C] was admitted to the hospital on 8/29/21 and was diagnoses of contusion of right hip, fall, and hip pain.

Resident C's 2/9/21 service plan read, "[Resident C] needs cuing and encouraging for eating, and at times staff will need to feed her.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	Resident C slipped from her wheelchair onto the floor. This appears to be an isolated incident. Therefore, this claim could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION

The incident report section on additional comments and/or steps taken to prevent recurrence was left blank.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(1) The home shall complete a report of all reportable incidents, accidents, and elopements. The incident/accident report shall contain all of the following information: **(e) The corrective measures taken to prevent future incident/accident, along with the time and date.**
For reference R325.1901	**Definition.**
	(17) “Reportable incident/accident” means an intentional or unintentional event in which a resident suffers harm or is at risk of more than minimal harm, such as, but not limited to, abuse, neglect, exploitation, or unnatural death.
ANALYSIS:	The incident report did not include any corrective measures to prevent it from reoccurrence.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION

Ms. Miller stated that although she completed an incident report, she did not send a copy of the report to the department because resident didn’t have any injuries. She stated that Resident C went to the hospital after the incident.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in

	writing to the resident's authorized representative, if any, and the resident's physician.
ANALYSIS:	The incident was not reported to the department; therefore, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/27/21, I conducted an exit conference with licensee authorized representative David Benjamin by telephone.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

Brender L. Howard 9/27/21

Brender Howard Date
Licensing Staff

Approved By:

Russell Misiak 9/27/21

Russell B. Misiak Date
Area Manager