GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 15, 2022

Janet Mazzetti
Lake Orion Assisted Living, LLC
PO Box 564
Oxford, MI 48371

RE: License #: AS630294500
Investigation #: 2022A0611032
Pineview Manor

Dear Ms Mazzetti:

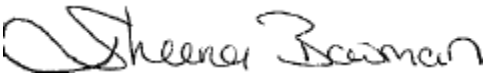
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Sheena Bowman, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd, Suite 9-100
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630294500
Investigation #:	2022A0611032
Complaint Receipt Date:	07/05/2022
Investigation Initiation Date:	07/12/2022
Report Due Date:	09/03/2022
Licensee Name:	Lake Orion Assisted Living, LLC
Licensee Address:	1814 S Lapeer Lake Orion, MI 48360
Licensee Telephone #:	(248) 814-6714
Administrator:	Janet Mazzetti
Licensee Designee:	Janet Mazzetti
Name of Facility:	Pineview Manor
Facility Address:	2888 S Baldwin Lake Orion, MI 48360
Facility Telephone #:	(248) 814-6714
Original Issuance Date:	04/11/2008
License Status:	REGULAR
Effective Date:	12/15/2020
Expiration Date:	12/14/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Resident B had a bad fall that resulted in extensive injuries.	Yes

III. METHODOLOGY

07/05/2022	Special Investigation Intake 2022A0611032
07/05/2022	APS Referral The assigned Adult Protective Services (APS) worker is Ra'Shawnda Robertson.
07/12/2022	Special Investigation Initiated - On Site I completed an unannounced onsite. I interviewed the Area Director Lori Lee, I received a copy of Resident B's discharge paperwork, I observed and attempted to interview Resident B.
07/13/2022	Contact - Document Received I received a copy of the Adult Protective Service worker, Ra'Shawnda Robertson narrative from her contact with the Area Director Lori Lee on 07/11/22.
07/14/2022	Contact - Telephone call made I left a voice message for staff member, Michelle Stoval requesting a call back.
07/14/2022	Contact - Telephone call made I left a voice message for staff member, Samantha Crews requesting a call back.
07/14/2022	Contact - Telephone call made I made a telephone call to the Area Director, Lori Lee. I explained to Ms. Lee that I left voice messages for Ms. Stoval and Ms. Crews requesting a call back. Ms. Lee stated Ms. Stoval is hard to get in contact with. Ms. Lee stated she will contact Ms. Stoval and Ms. Crews and have them return my phone call.
07/14/2022	Contact - Telephone call made I left a voice message for the reporting source requesting a call back.

07/14/2022	Contact - Telephone call received I received a return phone call from the reporting source. The allegations were discussed.
07/14/2022	Contact - Telephone call made I made a telephone call to Resident B's son-in-law. The allegations were discussed.
07/14/2022	Contact - Telephone call made I made a telephone call to staff member, Samantha Crews. The allegations were discussed.
07/14/2022	Exit Conference I completed an exit conference with the licensee designee, Janet Mazzetti via telephone.
07/15/2022	Contact- Telephone call made I made a telephone call to staff member, Michelle Stoval. The allegations were discussed.
07/15/2022	Contact- Telephone call made I made a telephone call to Area Director, Lori Lee. Ms. Lee provided additional information.
07/15/2022	Exit Conference I completed a second exit conference with the licensee designee, Janet Mazzetti via telephone.

ALLEGATION:

Resident B had a bad fall that resulted in extensive injuries.

INVESTIGATION:

On 07/05/22, I received the following allegations: Resident B suffers from dementia. On July 2, Resident B had a fall at the facility which caused her to have extensive injuries. Due to the fall, Resident B has a fractured arm and cuts on her face. She also has two black eyes which required stitching to her eyes and head. She also had to have injuries on her head stapled. She suffered a bruised finger which is swollen as well. When the Lakeview staff were asked about the injuries, staff members reported that they did not witness the fall but found her sitting underneath a counter with extensive injuries. The staff then contacted 911 to get Resident B medical attention. Resident B was transported to the hospital and is still there undergoing evaluations. There is a concern

if the staff members explanation of a fall is consistent with Resident B's injuries. The medical staff at the hospital have not made a determination as of yet.

On 07/12/22, I completed an unannounced onsite investigation. I interviewed the Area Director Lori Lee, I received a copy of Resident B's discharge paperwork, I observed and attempted to interview Resident B.

On 07/12/22, I interviewed the Area Director Lori Lee. Regarding the allegations, Ms. Lee stated Resident B has a broken arm, broken nose, two black eyes, and the right side of her forehead was stapled due to being injured. Ms. Lee was not present during the incident. The incident occurred on 07/02/22 around 7:30 am. Ms. Lee thinks when Resident B woke up, she started wandering around the AFC group home looking for a staff member. While Resident B was walking down the hallway towards the kitchen and dining area, she must of fell and hit the molding to the open window that leads to the kitchen. Ms. Lee stated there was blood splattered all over the molding, the wall, and the floor. During the incident, staff member, Michelle Stoval was the only staff on duty. Ms. Stoval found Resident B immediately after she fell. Ms. Stoval observed Resident B's injuries and then she called Ms. Lee. Ms. Lee instructed Ms. Stoval to call EMS and Ms. Lee contacted Resident B's son-in-law. Resident B's son-in-law arrived at the home while EMS was present. The son-in-law followed EMS to St. Joseph hospital in Pontiac. Resident B was discharged from the hospital on 07/06/22.

Ms. Lee stated Resident B's family did not have a problem with Resident B returning to the AFC group home. Per the discharge instructions, a nurse started visiting Resident B on 07/07/22 and Resident B started physical and occupational therapy on 07/11/22. Resident B will be seen by the nurse once a week and she will receive physical and occupational therapy twice a week.

On 07/12/22, I observed Resident B sitting in the living area. I took pictures of Resident B's face and left arm. Resident B's eyes were purplish and yellow underneath. Resident B's right cheek area was dark purple and yellowish. Resident B had a cut at the top right of her forehead which appeared to be stapled. Resident B's left arm was in a sling. Resident B was unable to be interviewed due to her dementia as she could not understand any of my questions. I asked Resident B what happened to her arm and she said she did not know and asked me if I knew.

On 07/12/22, I received a copy of Resident B's discharge paperwork. There was no diagnosis included on the discharge paperwork. The instructions were to receive home care from a nurse, physical and occupational therapy. The staff are to take out sutures on Resident B's forehead one week after discharge. Instructions were given on how to care for a broken arm and how to prevent from falling.

On 07/13/22, I received a copy of the Adult Protective Services worker, Ra'Shawnda Robertson narrative from her contact with the Area Director Lori Lee on 07/11/22. A copy of the narrative is below:

> “APS contacted Pineview Manor. APS spoke to Lori Lee regarding the incident with Resident B. Ms. Lee reported that the facility houses 6 residents but reported that they only have 4 ladies. She reported that Resident B has her own room. APS was advised that only one staff works per shift. One day shift worker and one midnight worker. Ms. Lee reported that Samantha Crews (248-977-8513) worked the midnight shift and Michelle Stoval (586-610-3802) came on to work the day shift at 7am. She denied that Ms. Crews saw Resident B before she left. Ms. Lee reported that she received the call from Ms. Stoval at 7:30a after finding her. She reported that she had last seen Resident B on 06/30/22. Ms. Lee denied that she had observed any visible injures. APS inquired as to whether Resident B had a history of falling. Ms. Lee reported that Resident B fell a year ago due to being dizzy from some medication she had been prescribed. She denied that Resident B sustained any injuries at that time. Ms. Lee denied that any of the residents in the home are known to be aggressive. APS asked Ms. Lee if there was another number where she can be reached and she reported 248-249-3925”.

On 07/14/22, I received a return phone call from the reporting source. Regarding the allegations, the reporting source does not believe anyone at the AFC group home has physically assaulted Resident B. The reporting source spoke to an ER nurse at the hospital and was told Resident B’s injuries are consistent with a fall. The reporting source denied any concerns regarding abuse or neglect at the AFC group home. The reporting source stated he likes the AFC group home and the area director that works there.

On 07/14/22, I made a telephone call to Resident B’s son-in-law. Regarding the allegations, the son-in-law stated initially there were concerns regarding Resident B’s injuries however, he now believes Resident B sustained her injuries from falling. The son-in-law arrived at the AFC group home about a half hour after Resident B fell. The son-in-law saw Resident B sitting on the floor near the open window ledge that leads to the kitchen. The son-in-law saw blood on the wall and the floor. The son-in-law stated it appeared that Resident B hit the molding around the open window. The son-in-law spoke to a doctor regarding Resident B’s injuries and he was told that falling was a common thing among the elderly with dementia. The doctor stated Resident B fell flat on her face because she could not catch herself. The son-in-law does not have any concerns regarding Resident B being physically abused or neglected at the AFC group home.

On 07/14/22, I made a telephone call to staff member, Samantha Crews. Regarding the allegations, Ms. Crews stated she works the midnight shift from 11:00pm to 7:00 am on Tuesday’s and every other Friday. Ms. Crews has worked at the AFC group home on and off for 12 years. Ms. Crews stated she worked the midnight shift on Friday 07/01/22. The residents were sleep including Resident B when Ms. Crews started her shift. Ms. Crews checked on all the residents every two hours in their bedrooms to ensure they were still breathing. Ms. Crews stated Resident B woke up the following morning (07/02/22) and she saw her sitting at the dining table. Ms. Crews did not

observe any injuries on Resident B. Ms. Crews stated Resident B was okay when she saw her. Ms. Crews was talking to staff member, Michelle Stoval and informed her that the midnight shift went well. Ms. Crews thinks Ms. Stoval was preparing breakfast for Resident B. Ms. Crews then left the AFC group home.

Ms. Crews stated she was informed by Ms. Lee that Resident B fell near the open window near the kitchen. Ms. Crews was also informed that Resident B hit her head and broke her arm. Ms. Crews denied ever seeing a staff member hit or abuse Resident B. Ms. Crews does not have any concerns with regards to any staff member abusing any of the residents. Ms. Crews stated there are no new staff members and she has worked with the current staff for several years. Ms. Crews does not have any concerns with any of the residents abusing another resident.

On 07/14/22, I completed an exit conference with the licensee designee, Janet Mazzetti via telephone. Mrs. Mazzetti was informed that the allegations will not be substantiated.

On 07/15/22, I made a telephone call to staff member, Michelle Stoval. Regarding the allegations, Ms. Stoval stated she was working by herself during the time Resident B fell. Ms. Stoval stated before Resident B fell, she was sitting in the dining area with Resident M. Ms. Stoval was also in the dining area cleaning up as she had just finished making breakfast. Resident B got up from the dining table and proceeded to walk towards the hallway. When Resident B turned the corner, she lost her balance and fell. Ms. Stoval saw Resident B's head on the floor and sat her up. Resident B was bleeding from a cut on her forehead, her nose, and from the corner of her eye.

Ms. Stoval could not tell if Resident B had hit anything but, she thinks she just hit the ground hard. Ms. Stoval stated there was nothing on the ground that would have made Resident B fall or lose her balance. Ms. Stoval contacted Ms. Lee and Ms. Lee advised her to call 911. Resident B's son-in-law arrived at the home while EMS was there. Ms. Stoval stated Resident M is verbal but she does not think she is capable of being interviewed. Ms. Stoval stated the other two residents were in their room when Resident B fell.

On 07/15/22, I made a telephone call to the Area Director, Lori Lee. Ms. Lee stated Resident M has dementia and she is not capable of being interviewed. Ms. Lee stated she will provide a copy of the staff schedule.

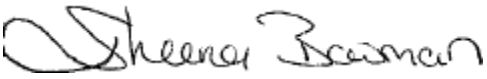
On 07/15/22, I received a copy of the staff schedule from Ms. Lee via text message. The staff schedule is dated 06/27/22 through 07/03/22. Ms. Crews worked on 07/01/22 from 11:00pm to 7:00 am. Ms. Stoval worked on 07/02/22 from 7:00 am to 3:00 pm.

On 07/15/22, I completed a second exit conference with the licensee designee, Janet Mazzetti via telephone. Mrs. Mazzetti was informed that the allegations will be substantiated based on the fact that Resident B was injured at the AFC group home.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on my findings and information gathered, Resident B was injured as a result of falling in the AFC group home on 07/02/2022. According to the doctor, Resident B fell flat on her face because she could not catch herself. Although staff was present, Resident B's protection and safety were not attended to at all times.
CONCLUSION:	**VIOLATION ESTABLISHED**

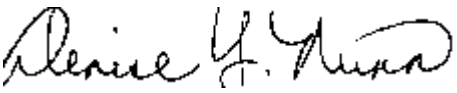
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



07/15/22
Sheena Bowman Date
Licensing Consultant

Approved By:



07/15/2022
Denise Y. Nunn Date
Area Manager