GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 16, 2023

Jonica Ingram
Kindred Spirit
2320 W Dodge Rd
Clio, MI 48420

RE: License #: AM250273429
Investigation #: 2023A0871018
Kindred Spirit

Dear Ms. Ingram:

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 (989) 732-8062.

Sincerely,

Kathryn A. Huber, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(989) 293-3234

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM250273429
Investigation #:	2023A0871018
Complaint Receipt Date:	01/26/2023
Investigation Initiation Date:	01/30/2023
Report Due Date:	03/27/2023
Licensee Name:	Kindred Spirit
Licensee Address:	2320 W Dodge Rd Clio, MI 48420
Licensee Telephone #:	(810) 686-1710
Administrator:	Jonica Ingram
Licensee Designee:	Jonica Ingram
Name of Facility:	Kindred Spirit
Facility Address:	2320 W. Dodge Road Clio, MI 48420
Facility Telephone #:	(810) 686-1710
Original Issuance Date:	10/05/2005
License **Status:**	REGULAR
Effective Date:	06/03/2022
Expiration Date:	06/02/2024
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A fell to the floor during a Hoyer lift transfer on 01/21/2023. It is unsure why he fell.	Yes

III. METHODOLOGY

01/26/2023	Special Investigation Intake 2023A0871018
01/26/2023	APS Referral Denied to Genesee County MDHHS
01/30/2023	Special Investigation Initiated - Telephone Telephone contact with Recipient Rights Officer Matt Potts
02/14/2023	Inspection Completed On-site Interviewed Assistant Home Manager Becky LaLonde, observed Resident A
02/14/2023	Inspection Completed On-site Home Manger Jonica Ingram not available to provide information
02/16/2023	Inspection Completed On-site Home Manager Jonica Ingram out with resident at appointment
03/10/2023	Contact - Telephone call made Telephone call to Staff Shayonna Key
03/10/2023	Contact - Telephone call made Telephone call to Staff Ilene McDonald
03/10/2023	Contact - Telephone call made Telephone call to Staff Susan Doyle, left voicemail message
03/13/2023	Contact - Document Received Received Incident Report in regard to incident
03/13/2023	Contact - Telephone call made Telephone call to Resident A's Guardian A1
03/13/2023	Inspection Completed-BCAL Sub. Compliance

03/13/2023	Exit Conference Telephone exit conference with Licensee Designee Jonica Ingram
03/13/2023	Contact -Telephone call received Telephone call received from Staff Terri Novak
03/14/2023	Contact - Telephone call received Telephone call received from Staff Susan Doyle
03/16/2023	Contact - Document received Received AFC Licensing Division Incident/Accident Report

ALLEGATION:

Resident A fell to the floor during a Hoyer lift transfer on 01/21/2023. It is unsure why he fell.

INVESTIGATION:

On January 30, 2023, I telephoned Recipient Rights Officer Matt Potts. Mr. Potts informed me that he was at the facility and interviewed several of the staff. Mr. Potts stated the staff that was assisting Resident A is Staff Susan Doyle. He also informed me that Ms. Doyle is out of state and will not return until April. Mr. Potts stated that while he was at the facility, Ms. Doyle happened to call, and he interviewed her. Mr. Potts indicated that Ms. Doyle informed her that she was placing Resident A in the recliner in the up position. Ms. Doyle stated that she pressed the up button instead of the down button, and that is why he fell. Mr. Potts indicated that this “was an extreme act of carelessness.”

On February 14, 2023, I conducted an unannounced onsite investigation and interviewed Assistant Home Manager Becky LaLonde. Ms. LaLonde indicated Resident A had cuts on his face and he was taken to the emergency room. Ms. LaLonde said the hospital used liquid glue to treat his wounds.

On February 14, 2023, I observed Resident A. He is nonverbal and unable to provide any information. Resident A appeared clean and receiving adequate care.

On March 8, 2023, I telephoned Licensee Designee Jonica Ingram. Licensee Ingram indicated that there were four staff working at that time and that two of the staff were in other residents’ rooms. Licensee Ingram stated no one saw what happened because the other staff were assisting the other residents.

On March 10, 2023, I telephoned Staff Shayonna Key. Ms. Key stated she was in another resident’s room, and she heard a scream. Ms. Key went out to see what

happened and she saw Resident A on the floor. Ms. Key asked Ms. Doyle what happened, and Ms. Doyle replied, “he fell out of the recliner.” Ms. Key said Resident A was bleeding on his face. Ms. Key said, “Susan was distraught” and they were all trying to help Resident A.

On March 10, 2023, I telephoned Staff Ilene McDonald. Ms. McDonald indicated that she was in the kitchen, and she did not see Resident A fall. Ms. McDonald said Ms. Doyle was putting Resident A in his recliner and “I heard her scream.” Ms. McDonald said Resident A was on the floor bleeding. Ms. McDonald said she called her boss, and all the staff were “trying to calm down.” Ms. McDonald said Ms. Doyle had the chair slightly up. Ms. McDonald said Ms. Doyle “felt really bad” and that she is a sweet lady. Ms. McDonald said Ms. Doyle has worked there a long time and she knows how the chair works.

On March 13, 2023, I telephoned Resident A’s Guardian A1. Guardian A1 was asked if she had any concerns about the care Resident A receives and she replied, “he gets absolutely great care.” Guardian A1 said it “was just one of those mishaps, an accident.” Guardian A1 indicated she was called immediately, and staff went to the hospital with him. Guardian A1 said Resident A has been there a long time and he likes it there.

On March 13, 2023, I received a telephone call from Staff Terri Novak. Ms. Novak said she was in the med room “when I heard a scream from Susan.” Ms. Novak came out of the med room and Resident A was on the floor. Ms. Novak called 911 and said, “I couldn’t believe what happened.” Ms. Novak said Staff Susan Doyle was “visibly and emotionally upset.” Ms. Novak said Ms. Doyle told her that she was going to put Resident A in the recliner, but it was up the up position instead of the down position.

On March 14, 2023, I received a telephone call from Staff Susan Doyle. Ms. Doyle stated that she was working with Resident A, and she took him to his room to change his brief. Ms. Doyle said that because he has an eating disorder, he cannot be laid down after eating to change his brief. Ms. Doyle indicated she was then taking him to the great room to set him in his chair so he could get his meds. Ms. Doyle reported the great room “was a little crowded by the tb because there was another resident there.” Ms. Doyle said she was going to put him in his Hoyer lift and his chair was up. Ms. Doyle said she thought she lowered it “but in hindsight the chair did not go down. I pushed the wrong button.” Ms. Doyle said she pushed the up button instead of the down button. Ms. Doyle said she did not realize the chair had elevated and Resident A fell. Ms. Doyle was “very upset about what happened.”

On March 15, 2023, I received an *AFC Licensing Division – Incident/Accident Report* that was signed and dated by Licensee Jonica Ingram on January 21, 2023. What happened indicates “Recliner from the Hoyer lift. Staff “thought” lift chair was down. Staff used remote to lower. Staff was moving Hoyer lift and saw [Resident A] fall forward out of the chair.” Action taken by staff indicates “He had head injury.

[Resident A] had a CT scan of the brain and head w/o contrast and a CT scan of the spine w/o contrast. All scans came back normal. He also received liquid stitches." Corrective measures indicated "Staff is not to position [Resident A] in lift chair."

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:	Staff Susan Doyle admitted to Recipient Rights Officer Matt Potts and me that she pushed the up button instead of the down button. Because the chair was in the up position, Resident A fell and was injured. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On March 13, 2023, I conducted a telephone exit conference with Licensee Jonica Ingram. Licensee Ingram was advised this is a rule violation.

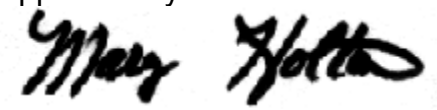
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of this adult foster care medium group home remain unchanged (capacity 1-12).

03/16/2023

Kathryn A. Huber Date
Licensing Consultant

Approved By:



03/16/2023

Mary E. Holton Date
Area Manager