GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 19, 2023

Meagan Frye
A Place Called Home In Stevensville LLC
4167 N. Roosevelt Rd
Stevensville, MI 49127

RE: License #: AL110405928
Investigation #: 2023A0579030
A Place Called Home In Stevensville LLC

Dear Ms. Frye:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 (616) 356-0183.

Sincerely,

Cassandra Duursma

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(269) 615-5050

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL110405928
Investigation #:	2023A0579030
Complaint Receipt Date:	04/18/2023
Investigation Initiation Date:	04/18/2023
Report Due Date:	06/17/2023
Licensee Name:	A Place Called Home In Stevensville LLC
Licensee Address:	4167 N. Roosevelt Rd, Stevensville, MI 49127
Licensee Telephone #:	(269) 876-6523
Administrator:	Meagan Frye
Licensee Designee:	Meagan Frye
Name of Facility:	A Place Called Home In Stevensville LLC
Facility Address:	4167 N. Roosevelt Rd, Stevensville, MI 49127
Facility Telephone #:	(269) 281-0357
Original Issuance Date:	03/25/2021
License Status:	REGULAR
Effective Date:	09/25/2021
Expiration Date:	09/24/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

ALLEGATION(S)

	Violation Established?
Resident A had a fall at the home and expired.	No

II. METHODOLOGY

04/18/2023	Special Investigation Intake 2023A0579030
04/18/2023	Special Investigation Initiated - Telephone Meagan Frye, Licensee Designee
04/18/2023	Contact - Telephone call made Jessica Kimbrell, DCW
04/14/2023	Contact- Document received Meagan Frye, Licensee Designee
04/18/2023	Exit Conference Meagan Frye, Licensee Designee

ALLEGATION:

Resident A had a fall at the home and expired.

INVESTIGATION:

On 4/18/23, I entered this referral into the Bureau Information Tracking System after it was reported via *Incident/Accident Report* that Resident A had a witnessed fall on 4/14/23 when she was agitated~~, that was witnessed by staff, and that Resident A was~~ that resulted in her being taken to the hospital ~~after her fall~~. An additional *Incident/Accident Report* noted that licensee designee Meagan Frye, learned on social media on 4/16/23 that Resident A ~~expired~~ died at the hospital. I competed this investigation remotely due to the presence of active COVID within the home.

On 4/18/23, I placed a return phone call to Ms. Frye who had left me a voicemail and text message earlier in the day requesting a return phone call. Ms. Frye stated she and direct care worker (DCW) Jessica Kimbrell were working when Resident A had fallen on 4/14/23. She stated there are currently residents who are positive for COVID in the home. ~~and Resident A, in her advanced dementia, thought she was "the boss" of the home and would feel responsible for telling other residents what to~~

~~do or reporting to DCWs about other residents or visitors~~. She stated Resident A, who had advanced dementia, became upset when she thought a COVID positive resident was leaving their room. Resident A made an attempt to close the door so the resident could not leave her room. Ms. Fry stated Ms. Kimbrell was no further than three feet away from Resident A when Resident A fell. Ms. Fry stated she was in the dining room and did not directly witness the fall, but she ran over to Resident A and Ms. Kimbrell immediately. Ms. Fry stated Resident A did not express injury but when Resident A could not take "more than two or three steps" she and Ms. Kimbrell realized Resident A was injured. Ms. Fry stated she immediately called Resident A's hospice staff and then called Relative A. She stated everyone agreed 911 was to be contacted.

Ms. Frye stated Resident A was treated for a fractured hip, had surgery, and was recovering. Ms. Fry stated the last she had heard was that Resident A would be returning to the home on 4/17/23. She stated she was shocked when she learned on social media that Resident A had expired. She stated she did not learn specific details~~, as Resident A's relatives were no longer speaking to her,~~ until Resident A's hospice team returned to ~~was back in~~ the home. She stated it was reported to her that Resident A was recovering from surgery when a visitor fed her without asking or notifying hospital staff. At some point after eating, Resident A aspirated and was found dead ~~expired~~.

Ms. Frye reported Resident A used a walker to ambulate but due to her advanced dementia, she would forget to use her walker and would instead hold onto the rails lining the hallway of the home. She stated this was a known behavior and if staff saw her without her walker, they would rush over to physically assist her, verbally prompt her to use her walker, and she would comply. Ms. Frye stated ~~there was one incident approximately seven weeks ago where Resident A was ambulating without her walker, she was holding on to the railing in the hallway, she squatted down low to ground, and then dropped to her bottom as DCWs were approaching her. She stated she did not consider this a fall since Resident A was intentionally squatting and intentionally sat from the squat position because she was upset. She stated Resident A remained on the floor hitting and kicking because she was upset and once she had calmed, she proceeded to get up on her own. She stated that is the only previous fall like incident Resident A had in the home and she~~ Resident A ambulated "pretty well for someone who was 96 years old."

On 4/18/23, I completed a telephone interview with Ms. Kimbrell who stated she was approximately three to three-and-a-half feet from Resident A when Resident A fell on 4/14/23. She stated she witnessed Resident A in the hallway without her walker and began walking toward Resident A. She stated Resident A was agitated because she thought a COVID positive resident was coming out of her room. She stated Resident A was holding the railing in the hallway with her right hand and pulling the other resident's door closed with her left hand. She stated as she approached, Resident A's right hand slipped off the railing and Resident A fell on to her right hip. She stated she called for Ms. Frye who immediately came over. She stated Resident A

was not upset but when Resident A stated she could not move her leg, she and Ms. Frye agreed Resident A was likely injured. She stated Ms. Frye immediately began calling necessary parties and 911 was called.

Ms. Kimbrell stated Resident A would often forget to use her walker. She stated Resident A would either ambulate independently or use the railing in the hallway for assistance. She stated there were a few times when as DCWs were approaching Resident A, she would slowly be squatting down using the rails to sit on the floor, but she did not consider these incidents to be falls since it seemed intentional. She stated if DCWs saw Resident A without her walker, they would immediately assist her and then verbally prompt her to use her walker to which she would comply. She stated even when Resident A's family would visit, they would have to verbally prompt her to use her walker because she would forget. Ms. Kimbrell denied concerns for the care given to residents in the home. She reported she has worked as a caregiver/ DCW for multiple agencies and feels this home provides the best care out of all the caring agencies/AFCs she has worked for.

On 4/18/23, I received and reviewed Resident A's assessment plan and her *Health Care Appraisal.* Resident A's assessment plan, completed 3/22/23, noted "Resident will go from not being able to walk, to independently walking, remind to use walker." Her assistive devices included a walker and a wheelchair. The assessment plan also noted Resident A needs to use her assistive devices when she is feeling weak, but that staff should be by her when she is seen ambulating independently. Resident A's *Health Care Appraisal* noted she used a walker and a wheelchair at times. A history of falls was not noted.

APPLICABLE RULE	
R 400.15305	**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:	Ms. Frye and Ms. Kimbrell both reported Resident A was found without her walker, agitated, pulling on a resident's door prior to her falling on 4/14/23. Ms. Kimbrell reported she was approaching to assist Resident A, who she and Ms. Frye reported has a known behavior for forgetting to ambulate with her walker, at the time of the fall. Ms. Frye and Ms. Kimbrell reported necessary parties, including 911, were contacted when it was realized Resident A was injured. Ms. Frye reported she learned Resident A aspirated and expired as she was recovering from surgery on her hip at the hospital. Resident A's assessment plan and *Health Care Appraisal* confirmed she used

	~~a walker and a wheelchair at times and her ability to ambulate varied.~~ Resident a was 96 years old, had dementia, and was at risk of falling when not using her walker. Resident A did not have a history of falls and her resident care agreement conveyed that staff would remind her to use her walker. On the day of 4/14, Resident A perceived that a COVID positive resident was attempting to leave their room and tried to prevent their exit by pulling the door closed. Resident A, unsteady on her feet and without her walker, lost her grip of the handrail and fell. While staff were near and one witnessed the incident as it was occurring, they did not know she was without her walker and could not intervene fast enough to prevent the accident. Resident A suffered a fractured hip that required hospitalization and surgery. The home staff summoned emergency assistance and notified Relative A about the event. Staff later learned that Resident A died at the hospital unrelated to the injury from her accidental fall. Based on the interviews completed and documentation reviewed, the homes actions seem reasonable and consistent with Resident A's care agreement. ~~there is insufficient evidence to support allegations that Resident A was not treated with dignity and her personal needs, including protection and safety, were not attended to at all times~~.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On 4/18/23, I completed an exit conference with Ms. Frye who did not dispute my findings or recommendations.

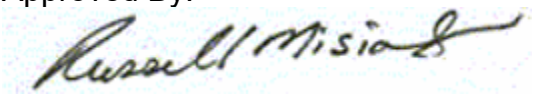
III. RECOMMENDATION

I recommend the status of the license remain the same.

Cassandra Duursma 4/18/23

Cassandra Duursma Date
Licensing Consultant

Approved By:



4/19/23

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Russell B. Misiak Date
Area Manager