GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 11, 2023

James Seewald
Fa-Ho-Lo Family Incorporated
6266 Lazy Oak Trail
Muskegon, MI 49442

RE: License #:	AM610009197
Investigation #:	2023A0356027
	Fa-Ho-Lo Family

Dear Mr. Seewald:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On 03/20/2023, you submitted an acceptable written corrective action plan. It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Elizabeth Elliott

Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM610009197
Investigation #:	2023A0356027
Complaint Receipt Date:	03/20/2023
Investigation Initiation Date:	03/20/2023
Report Due Date:	05/19/2023
Licensee Name:	Fa-Ho-Lo Family Incorporated
Licensee Address:	6266 Lazy Oak Trail Muskegon, MI 49442
Licensee Telephone #:	(231) 557-8308
Administrator:	James Seewald
Licensee Designee:	James Seewald
Name of Facility:	Fa-Ho-Lo Family
Facility Address:	1585 S. Wolf Lake Road Muskegon, MI 49442-4881
Facility Telephone #:	(231) 788-1806
Original Issuance Date:	05/14/1984
License Status:	REGULAR
Effective Date:	02/07/2022
Expiration Date:	02/06/2024
Capacity:	8
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was seriously injured from a fall at the facility.	Yes
Resident A's injury was not reported in a timely manner.	No

III. METHODOLOGY

03/20/2023	Special Investigation Intake 2023A0356027
03/20/2023	Special Investigation Initiated - Telephone James Nate Seewald, LD
03/20/2023	Contact - Document Received Investigative report written by J. Nate Seewald.
04/03/2023	APS Referral Centralized Intake referral made.
04/03/2023	Contact - Telephone call made. Relative #1.
04/03/2023	Contact - Document Sent Linda Wagner, ORR Health West (CMH)
04/03/2023	Contact - Telephone call received. Ken Beckman assigned, meeting scheduled.
04/05/2023	Inspection Completed On-site With Ken Beckman, APS
04/05/2023	Contact - Face to Face Interviewed LD, Nate Seewald, staff Bri Rios, Lisa Arends, home manager, and staff Jasmine Barnes. Reviewed documents.
04/18/2023	Contact - Document Sent Emailed Relative #1
04/19/2023	Contact - Telephone call received. Relative #1
05/11/2023	Exit Conference-Licensee Designee, Nate Seewald.

ALLEGATION: Resident A was seriously injured from a fall at the facility.

INVESTIGATION: On 03/20/2023, I received a BCAL (Bureau of Children and Adult Licensing) Online complaint. The complainant reported that on Saturday, March 4, 2023, at approximately 1:50 pm Resident A fell from the battery-operated lift onto the leg of the lift or floor in her bedroom during a transfer. Resident A sustained a serious injury due to the fall. The type and severity of Resident A's injuries are not explained by the reported events. A report was made to CI (Centralized Intake) and APS (Adult Protective Services) Worker, Ken Beckman assigned.

On 03/20/2023, I reviewed an internal investigative report written by James (Nate) Seewald, Licensee Designee. The report included pictures of the Hoyer lift, the cradle they used on the day of Resident A's accident and the cradle they typically have on their Hoyer lifts. Also included were pictures of how the sling strap could have been positioned on top of the sling attachment point on the cradle and staff depiction of Resident A's position upon falling from the sling. Mr. Seewald documented the following information in report form; *'On 03/04/2023, shortly before 2:00p.m., (Resident A) was being transferred from her wheelchair to her bed via an electric patient lift (Hoyer Lift) with the assistance of two staff members. With (Resident A) in the lift sling, approximately halfway between the wheelchair and bed, one of the four sling straps suddenly came away from its lift cradle hook. (Resident A) fell to the floor, resulting in a severe laceration of their scalp. Upon examination of the patient lift and sling immediately following the incident*, *the sling was found hanging from the lift cradle by only three straps instead of the usual four as when correctly in use. The fourth strap, which would have been placed outside of Resident A's left arm/shoulder, was observed hanging loosely and pointing towards the floor. Upon closer examination of the sling and straps, there was little to no wear observed and no signs that the sling was structurally compromised in any way. All straps were intact and appeared safe for use. It seemed apparent that the cause of the fall was not due to a failure of any part of the sling or straps. The electric patient lift was also found to be in good condition and safe for use. It was also later determined that the lift actuator was approximately 85% extended, resulting in (Resident A's) head being around 48" from the floor, possibly up to 2-4" higher depending on the exact tilt of the head at the time of the fall. To confirm the above assessments, a test was conducted in which on-shift staff members demonstrated how they would have transferred Resident A, with me (Mr. Seewald) acting as a stand-in. The same lift and sling from the incident were used, and the staff members were able to safely transfer me out of and away from a bed, then return me safely. The only exception to a complete confirmation of this equipment's safety is due to what appeared to be a missing wire tension safety latch from the top of the cradle hoods. Upon further examination, it was determined that none of the four corner hooks used during the patient transfer had such a latch in place. It is the policy of FFI (FAHOLO Family Inc.) that such equipment is examined before and monitored during use, as well as given a more comprehensive check no less than annually. Documentation of this annual check was not yet necessary as records r*eveal*ed that this lift is less that a year old, purchased new from Airway Oxygen of Muskegon and delivered to the FFI*

home in July of 2022. Following the examination of the lift and sling, I further investigated the missing wire tension latches from the cradle hooks and was able to determine the following: The latches were in place upon delivery of the lift however, Assistant Home Manager, Lisa Arends stated she removed them at some point in the following weeks. She also stated that, to the best of her recollection, she had not approved this decision with me, or Anita Niswonger (home manager). Ms. Arends described the latches as being difficult to use, not always allowing the sling straps to be seated in the hook properly, becoming bent and otherwise not returning to their expected position, and (in at least one case) breaking completely. Ms. Arends reasoned that without the latches "they are the same as every other lift we've ever used, and that it would be impossible for the sling to come off short of the entire thing being flipped upside down." She also stated if she thought for even a moment that removing latches would make the lift cradle any less safe, she would not have done it. I was able to corroborate Ms. Arends statements regarding the latches, 6 of the 11 staff members acknowledged as least some issues that Ms. Arends described. None could recall exactly when the latches had been removed, but most stated it was either a few days or a few weeks after the lifts were delivered. All staff stated they assumed the latches were removed for the reasons stated above and done with approval. Additionally, none seemed to think it posed immediate safety concerns and it didn't seem any different to al the previous lift cradles with an open loop hook design. It was determined that Brianna Rios was the staff on the left side of Resident A and responsible for securing the sling strap that had ultimately caused the fall. On 03/05/2023, I had Ms. Rios carefully walk me through the entire series of events again. I interviewed Ms. Barnes over the phone. Staff members stated the following:

- *The shift went by without any issues or concerns. Nothing was out of the ordinary as Ms. Rios and Ms. Barnes were preparing to transfer Resident a with the lift.*
- *Mr. Rios is confident that the sling straps were initially appropriately place in the cradle hooks.*
- *After all four sling straps were placed, Ms. Barnes began to raise the lift with the control unit. Before the slack had been taken out of the sling straps, Resident A's left arm had started to move outside the sling. Ms. Barnes stopped lifting while Ms. Rios guided (Resident A's) arm back inside the sling.*
- *Ms. Barnes resumed lifting (Resident A) normally with the control unit. Neither staff member noticed anything out of the ordinary as they began to work together to maneuver the patient lift toward the bed.*
- *Midway through the process, (Resident A) was only a few feet away from both the bed and the wheelchair. As is protocol, Jasmine B. and Briana R. began to position (Resident A) over her bed. The upper sling gave out, and (Resident A) fell to the floor. Both staff members stated that it was sudden and seemingly without any warning.*
- *Briana R. stated that because (Resident A's) legs were still partially in the sling as she fell, she seemed to have fallen with her head coming down first and turned slightly left.*

- *Both Jasmine B. and Briana R. stated that they were shocked that the fall resulted in such a deep laceration, describing that a portion of (Resident A's) scalp appeared to have been partially pulled away from the skull.*
- *Neither Briana R. nor Jasmine B. could state whether (Resident A's) head struck the leg of the lift on the way to the floor.*
- *Briana R., Jasmine B. and Lisa A. all confirmed that (Resident A), though in pain, remained conscious and alert through the entire ordeal.*

At FFI, we prioritize the safety and wellbeing of our residents above all else. While we strive to maintain the highest standards, we must also be open to identifying areas where we can improve. I acknowledge that there were steps that could have been taken to prevent this incident from occurring.'

At the end of the internal investigative report completed by Mr. Seewald, he included a corrective action plan detailing the changes that will be implemented to prevent this type of incident from happening again.

On 04/03/2023, I interviewed Relative #1 via telephone. Relative #1 stated Resident A required 100 stitches, spent hours in surgery and five days in the hospital. Relative #1 stated hospital personnel had Resident A in a private, secured room because the injury was described by medical professionals as a "violent injury" and there was concern about how this injury occurred. Relative #1 stated extra measures were taken to make sure Resident A was safe in the hospital. Relative #1 stated Resident A is currently at home with Relative #1 and has not returned to the facility at this time. Relative #1 stated Resident A is nonverbal, requires total care and is unable to report what occurred on 03/04/2023.

On 04/03/2023, Relative #1 sent a picture of Resident A's injury. The injury is significant and shows a large injury and possibly the point of impact on the top of Resident A's head with many sutures across the side and top of her head and a large, curved section on the right side of Resident A's head.

On 04/05/2023, Mr. Beckman and I conducted an inspection at the facility and interviewed Mr. Seewald privately in the office. Mr. Seewald, Mr. Beckman, and I went through Mr. Seewald's detailed report and discussed the chain of events that led to Resident A's fall and injury. Mr. Seewald kept the Hoyer lift cradle to demonstrate everything he was explaining to help us understand how this could have occurred. Mr. Seewald reiterated that it was a normal day and a normal shift for the two direct care staff at the facility on 03/04/2023, Brianna Rios and Jasmine Barnes, when they used the sling to lift Resident A up to move her with the Hoyer lift from her wheelchair to her bed. Mr. Seewald stated Resident A's left arm came out of the sling, so staff repositioned her and put her arm back into the sling. Mr. Seewald stated upon allowing some slack to the sling to get Resident A's arm back into the sling so it would not be hanging out, he suspects it may have been at that time that the sling strap could have come out of the sling attachments on the cradle or that staff did not have it in the cradle but over the top of the sling attachment. Mr.

Seewald stated staff were able to successfully lift Resident A and began to roll her. As they started to turn the Hoyer lift to reposition her over the bed, they turned the lift, the sling tilted slightly, and staff did not notice the strap was not secured to the cradle, and the strap slipped off the cradle. Mr. Seewald stated this left three straps attached to the cradle and the fourth left shoulder area strap came off allowing Resident A to fall out of the sling and onto the floor hitting her head, most likely initially hitting her head on the footplate of the lift, and then sliding down to the floor which could explain the large scalping type of injury to her head. Mr. Seewald stated the lift is new, less than a year old, but the cradle on this Hoyer was different then the ones usually used in the facility. Mr. Seewald stated the sling attachment on the cradle typically were round with a small opening in which to slip the sling loops into. This one was square in shape with metal clips in which to slip the sling loops and the clips were meant to keep the sling from slipping out. Mr. Seewald stated upon further investigation, he discovered that all four metal clips were removed by Ms. Arends, because they were giving staff trouble and they did not think that the sling was any less safe to have them off.

On 04/05/2023, Mr. Beckman and I interviewed Ms. Rios, and Ms. Arends in the office at the facility. Ms. Barnes joined the interview via conference call. Ms. Rios, Ms. Barnes, and Ms. Arends confirmed the information provided by Mr. Seewald in the report and in our interview with him. Ms. Rios and Ms. Barnes stated they did not intend for this accident to happen to Resident A, Ms. Rios explained that they did everything the 9-1-1 operator told them to do to help Resident A after the accident occurred. Ms. Rios and Ms. Barnes stated they did not do this on purpose and did not mean to harm Resident A in any way. Ms. Rios stated she attached the sling on the left side and Ms. Barnes attached it on the right side and they thought the sling was securely attached to the cradle and it was safe to transfer Resident A. Ms. Barnes and Ms. Rios stated they use Hoyer lifts everyday for residents at the facility and have been trained and know how to use the lifts. Ms. Rios, Ms. Barnes and Ms. Arends acknowledged that the clips had been removed from the cradle because they were difficult to manage, and they did not foresee the removal of the clips would cause any kind of malfunction of the sling. Ms. Arends stated she was the one who took the clips off the cradle. Ms. Arends and Ms. Rios were visibly upset by recalling the incident.

On 04/05/2023, Mr. Beckman, Mr. Seewald, Ms. Rios, Ms. Arends and I looked at the Hoyer. Mr. Seewald demonstrated to Mr. Beckman and I what he deduced had occurred and Ms. Rios and Ms. Arends concurred that when Resident A fell, the top of her head possibly hit the footplate of the Hoyer and then slid down onto the ground causing the large laceration injury from sliding down the footplate onto the floor. We also observed Resident A’s bedroom and Ms. Rios showed us where they transferred Resident A from, where they were going to with her in the Hoyer and where the incident occurred. There was nothing about the room or the Hoyer demonstration that gave any indication that the information provided during this investigation was not accurate.

On 04/05/2023 & 05/11/2023 (upon completion of the SI report), I conducted an exit conference with Licensee Designee, Mr. Seewald and he stated he understands the information, analysis, and conclusion of this applicable rule. Mr. Seewald has submitted an acceptable corrective action plan.

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:	The complainant reported that Resident A sustained a serious injury due to a fall at the facility, the severity of Resident A's injuries are not explained by the reported events. Mr. Seewald's internal investigation detailed the incident and acknowledges their responsibility for Resident A's fall and injury. Resident A is nonverbal and unable to give information pertinent to this investigation. Ms. Rios, Ms. Arends and Ms. Barnes stated one of the sling straps was not properly attached to the cradle causing it to slip off and allowing Resident A to fall out of the sling. Based on investigative findings, there is a preponderance of evidence to show that while Resident A's fall and injury was accidental, staff did not provide protection and safety to Resident A on 03/04/2023 when using the Hoyer lift for a transfer. Mr. Seewald included a detailed corrective action plan in his internal investigation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A's injury was not reported in a timely manner.

INVESTIGATION: On 03/20/2023, I received a BCAL (Bureau of Children and Adult Licensing) Online complaint. The complainant reported **t**he home administrator completed an internal investigation; however, the incident was not reported until four days after the event.

On 03/31/2023, I interviewed Mr. Seewald, and he explained after the fall on 03/04/2023, staff immediately called 9-1-1 and began providing first aid to Resident A according to the directions given by the 9-1-1 operator. Mr. Seewald stated Resident A's legal guardian (Relative #1) was informed immediately after the incident occurred as was Health West (Community Mental Health) case management and nursing. Mr. Seewald sent email images of two emails sent to Health West dated 03/04/2023 at 3:33p.m. and on 03/04/2023 at 4:18 p.m. The first email notified Kara Kile, supports coordinator, and Jessica Sobers, nurse of the incident and stated, *'I am writing to inform you that (Resident A) fell out of her sling and onto the floor, hitting her head about 2:20p.m. today. IR was written, 911 was called and I called Relative #1. Lisa followed the ambulance.'* The second email has the IR (Incident Report) attached to it. The IR dated 03/04/2023, 2:20p.m. written by Jasmine Barnes documented the following information, *'(Resident A) was put into her sling, we hooked her up to the lift, she was in the air and being moved slowly to her bed when suddenly one hook came off the sling and fell to the floor and hit her head. She was bleeding. Called 911, called in home manager, called mother.'* The home manager, Anita Niswonger added to the IR, *'ambulance arrived shortly after me, they loaded (Resident A) and left for ER. Briana and I used spill kit to clean blood. Once done Home Administrator James Seewald was present and is actively investigating and interviewed each staff present.'* Mr. Seewald provided an in-depth internal investigation to licensing on 03/08/2023 that was reviewed and discussed with Mr. Seewald.

On 04/03/2023, I interviewed Relative #1 via telephone. Relative #1 stated she was notified immediately upon Resident A's injury, but she did not think an IR was completed and sent to the necessary agencies.

On 05/11/2023, I conducted an exit conference with Licensee Designee, Nate Seewald via telephone. Mr. Seewald stated he agrees with the information, analysis, and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: (b) Any accident or illness that requires hospitalization.
ANALYSIS:	The complainant reported Resident A was injured on 03/04/2023 and the incident was not reported until four days after the event.

	Mr. Seewald reported the incident to Health West supports coordinator, nurse, Relative #1 and followed up with an IR on 03/04/2023, the same date of Resident A's injury. Relative #1 stated she was notified immediately upon Resident A's injury, but she did not think an IR was completed and sent to the necessary agencies. There is not a preponderance of evidence to show when Resident A sustained an injury on 03/04/2023 requiring hospitalization, that staff failed to notify the necessary agencies according this this applicable rule. Therefore, a violation is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

An acceptable corrective action plan has been received. I recommend the status of the license remain unchanged.

05/11/2023

Elizabeth Elliott Date
Licensing Consultant

Approved By:

05/11/2023

Jerry Hendrick Date
Area Manager