GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 27, 2023

Catherine Reese
Vibrant Life Senior Living, Superior Township, LLC
4488 Jackson Road Ste 2
Ann Arbor, MI 48103

RE: License #: AL810401931
Investigation #: 2023A0122031
Vibrant Life Senior Living, Superior 2

Dear Ms. Reese:

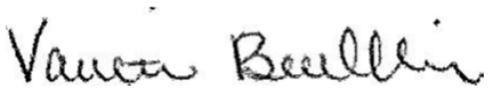
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (517) 284-9720.

Sincerely,



Vanita C. Bouldin, Licensing Consultant
Bureau of Community and Health Systems
22 Center Street
Ypsilanti, MI 48198
(734) 395-4037

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL810401931
Investigation #:	2023A0122031
Complaint Receipt Date:	06/09/2023
Investigation Initiation Date:	
Report Due Date:	08/08/2023
Licensee Name:	Vibrant Life Senior Living, Superior Township, LLC
Licensee Address:	4488 Jackson Road Ste 2 Ann Arbor, MI 48103
Licensee Telephone #:	(734) 819-7790
Administrator:	Catherine Reese
Licensee Designee:	Catherine Reese
Name of Facility:	Vibrant Life Senior Living, Superior 2
Facility Address:	1900 N. Prospect Road Ypsilanti, MI 48198
Facility Telephone #:	(734) 484-4740
Original Issuance Date:	12/23/2019
License Status:	REGULAR
Effective Date:	12/23/2022
Expiration Date:	12/22/2024
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 01/19/2023, Resident A got out of the facility and suffered injury.	Yes

III. METHODOLOGY

06/09/2023	Special Investigation Intake 2023A0122031
06/15/2023	Inspection Completed-BCAL Sub. Compliance Completed interviews with Josh Reese, Supervisor, and Jen Delano, Head Nurse. Reviewed Resident A's file.
06/15/2023	Contact - Telephone call made. Completed interview with Relative A.
06/20/2023	APS Referral
06/20/2023	Contact – Telephone call made. Completed interview with Faith Webster, staff member.
06/21/2023	Contact – Telephone call made. Completed interview with Bryana Robinson, staff member.
06/26/2023	Exit Conference Discussed findings with Catherine Reese, Licensee Designee.

ALLEGATION: On 01/19/2023, Resident A got out of the facility and suffered injury.

INVESTIGATION: On 06/15/2023, I completed an interview with both Josh Reese and Jen Delano. Both confirmed that Resident A had gotten out of his assigned facility, Vibrant Life Senior Living, Superior 2. Mr. Reese explained that the lock on the facility door, that is not an approved means of exit and is the door to the hallway that separates this facility from the attached licensed facility next to it, malfunctioned allowing Resident A the ability to exit the building. Per Mr. Reese, staff member, Bryana Robinson was present and Resident A always had staff supervision while out of the facility.

Mr. Reese stated he was informed that Resident A had exited the building via staff radios and Ms. Delano reported the same. Once they received the information, they went to assist with getting Resident A back into the building while Ms. Robinson went back inside the building to provide care to the other residents.

Mr. Reese and Ms. Delano stated that as Resident A was walking around the property, they were verbally redirecting him to return to the facility. Per Ms. Delano, she observed that Resident A was coming into close contact with the street where cars were driving. She also noted that Resident A began swinging a coffee mug that he had with him due to increased agitation. Mr. Reese stated he put his body in front of Resident A to prevent Resident A from getting closer to the street. Resident A then struck Mr. Reese on the head with the cup and in doing so Resident A lost his balance and fell.

Mr. Reese and Ms. Delano stated they assisted Resident A back into the facility, called family members, and Resident A was transported to the hospital where he received medical treatment.

On 06/15/2023, I completed an inspection in Vibrant Life Senior Living, Superior 2 adult foster care facility. I found the lock of the facility door where Resident A exited from to be in working order. Matthew Chapman, Maintenance Director explained that the magnetic locking mechanism was not working on 01/19/2023 and that is how Resident A was able to open the door and walk out of the building. Mr. Chapman stated since that incident the lock has been repaired and in working order.

On 06/15/2023, I reviewed Resident A's file. Resident A was admitted to Vibrant Life Senior Living, Superior 2 on 11/10/2022. Incident Reports dated 01/17/2023 and 01/19/2023 document that Resident A got outside of the building. On 01/17/2023 the Incident Report states that Resident A "was found in between building 200 and 300 wandering in the parking lot," however was returned to the building without injury. The Incident Report dated 01/19/2023 documents what was reported by Mr. Reese and Ms. Delano during their interview.

Resident A's University of Michigan Progress Note dated 11/06/2022 documents that he was diagnosed with "Alzheimer's dementia…and remote prostate cancer presenting for worsening agitation." The report further states Resident A was placed

on hospice and awaited placement assistance from the social work department to a memory care or similar unit.

On 06/15/2023, I completed an interview with Relative A. Relative A reported that Resident A had got out of the facility three times. Relative A confirmed that Resident A got out of the facility on 01/19/2023. Relative A believes that the injury Resident A suffered from his falling caused his death. Relative A submitted no documentation supporting that Resident A's injury caused his death.

On 06/20/2023, I completed an interview with Faith Webster. Ms. Webster confirmed that Resident A had exited the facility on 01/19/2023. She reported that staff member, Bryana Robinson, observed that Resident A got of the facility through an unlocked door while holding a coffee mug. Ms. Webster stated she and Ms. Robinson attempted to verbally redirect Resident A to return to the facility however he became agitated and started swinging a coffee mug that he was holding. Ms. Webster stated she then used the facility radio to alert Ms. Delano and Mr. Reese that Resident A had exited the building. Per Ms. Webster once Ms. Delano and Mr. Reese came to assist with Resident A she and Ms. Robinson returned to the facility. Ms. Webster confirmed that Resident A was able to exit the facility due to a malfunction of the lock from the door he exited.

On 06/21/2023, I completed an interview with Bryana Robinson. Ms. Robinson reported the same as Ms. Webster. Ms. Robinson confirmed that Resident A was able to exit the facility due to the malfunction of a lock on the door he exited.

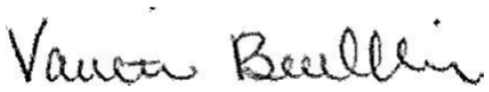
On 06/26/2023, I completed an exit conference with Catherine Reese, Licensee Designee and discussed my findings with her. Ms. Reese agreed with my findings and stated she would submit a corrective action plan for the rule violation found.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.

ANALYSIS:	On 01/19/2023, Resident A exited the facility due to a malfunction of the lock from the door he exited. On 06/15/2023, Josh Reese and Jen Delano confirmed that Resident A exited the facility due to a malfunction of the lock on the door he exited. Both stated that Resident A fell while outside of the facility on 01/19/2023. On 06/15/2023, Relative A confirmed that Resident A exited the facility and fell while. On 06/20/2023 and 06/21/2023, respectively Faith Webster and Bryana Robinson confirmed that Resident A exited the facility due to a malfunction of the lock on the door he exited. Based upon my investigation I find that the facility was not maintained to provide adequately for the health, safety, and well-being of occupants on 01/19/2023. On that Resident A was able to exit the facility due to a malfunction of the door lock.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt and approval of a corrective action plan I recommend no change to the status of the license.



Vanita C. Bouldin Date: 06/26/2023
Licensing Consultant

Approved By:

Ardra Hunter Date: 06/27/2023
Area Manager