GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 5, 2023

Stephanie Riley
Valley Residential Serv Inc.
P O Box 186
St Charles, MI 486550186

RE: License #: AS730016089
Investigation #: 2023A0576039
Navaho Trail Home

Dear Stephanie Riley:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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) 643-7960.

Sincerely,

Christina Garza, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 240-2478

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS730016089
Investigation #:	2023A0576039
Complaint Receipt Date:	05/09/2023
Investigation Initiation Date:	05/11/2023
Report Due Date:	07/08/2023
Licensee Name:	Valley Residential Serv Inc.
Licensee Address:	300 S Saginaw, St. Charles, MI 48655
Licensee Telephone #:	(231) 580-5204
Administrator:	Stephanie Riley
Licensee Designee:	Diane Carrillo
Name of Facility:	Navaho Trail Home
Facility Address:	3161 Navaho Trail, Hemlock, MI 48626
Facility Telephone #:	(989) 642-3603
Original Issuance Date:	08/01/1994
License Status:	REGULAR
Effective Date:	02/22/2023
Expiration Date:	02/21/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 4/19/2023 around 9:00pm, Resident A rolled out of bed and fractured her right leg between her foot and knee.	Yes

III. METHODOLOGY

05/09/2023	Special Investigation Intake 2023A0576039
05/09/2023	APS Referral
05/11/2023	Special Investigation Initiated – Letter Sent email to Juwan Chapman, Saginaw County Office of Recipient Rights (ORR)
05/15/2023	Contact - Document Received Reviewed Incident Report (IR)
05/15/2023	Inspection Completed On-site Interviewed Home Manager, Diane Carrillo, and Resident B
06/05/2023	Contact - Telephone call made Interviewed Diane Carrillo
06/29/2023	Contact - Telephone call made Interviewed Juwan Chapman, ORR
06/29/2023	Contact - Telephone call made Left message for Staff, Gena LaFleur to return call
06/29/2023	Contact - Telephone call made Interviewed Staff, DeShon Stewart
06/29/2023	Contact - Telephone call made Interviewed Guardian A
06/29/2023	Contact - Document Sent Sent email to Rebecca Robelin, Saginaw County APS
06/29/2023	Contact - Document Received Received email from Rebecca Robelin

06/29/2023	Contact - Telephone call made Left message for Staff, Jessica Soupes to return call
06/29/2023	Contact - Telephone call made Interviewed Home Manager, Diane Carrillo
07/03/2023	Contact - Telephone call made Left message for Staff, Gena LaFleur to return call
07/03/2023	Contact - Telephone call received Interviewed Staff, Jessica Soupes
06/29/2023	Exit Conference Exit Conference conducted with Licensee Designee, Stephanie Riley

ALLEGATION:

On 4/19/2023 around 9:00pm, Resident A rolled out of bed and fractured her right leg between her foot and knee.

INVESTIGATION:

On May 11, 2023, I sent an email to Juwan Chapman, Saginaw County Office of Recipient Rights Officer (ORR) regarding his investigation involving Resident A. Officer Chapman confirmed he is investigating this matter however has no updates at this time. On June 29, 2023, I spoke to Officer Chapman who advised Resident A requires to 2 person staff assist and Staff Gena LaFleur may be cited for neglect.

On May 15, 2023, I completed an unannounced on-site inspection at Navaho Trail Home and interviewed Home Manager, Diane Carrillo regarding the allegations. Manager Carrillo stated that Staff, Gena LaFleur went to give Resident A her medications. Resident A was soiled, and Staff LaFleur was changing her. Resident A was going to roll off the bed and Staff LaFleur grabbed her so she would not fall. Staff LaFleur called for help and Staff, Deshon Stewart came to assist. Staff, Jessica Soupes came on duty for Staff LaFleur, and no one immediately realized Resident A was injured. Later, Staff Stewart and Staff Soupes noticed Resident A had a blister on her leg and called Supervisor, Holly Bigelow. Resident A was taken to the hospital, and it was discovered Resident A's leg under her knee was broken. According to Manager Carrillo, Resident A has resided at the home since 1994 and is nonverbal. Resident A has brittle bones and had surgery for a broken femur many years ago.

On May 15, 2023, I interviewed Resident B who reported she heard Resident A went to the hospital because her leg was hurt. Staff did not do anything to hurt Resident A and Resident A's bones are brittle. Resident B did not think staff would hurt Resident A and she believes the injury was the result of an accident. According to Resident B, staff would not hurt residents and they are nice.

On May 15, 2023, I reviewed an AFC Licensing Division – Incident / Accident Report (IR) dated for April 19, 2023, and authored by Deshon Stewart. The IR documented that on April 19, 2023, at 8:45pm Staff, Gena LaFleur was giving Resident A her medications. A "loud thud noise" was heard so Staff Stewart and Staff, Jessica Soupes ran to see what it was. Staff LaFleur was holding Resident A under her arms from the back. Staff Stewart assisted Staff LaFleur with putting Resident A back in the bed. At 10pm, staff noticed a blister/bruise on Resident A's right leg that continued to get bigger throughout the shift. The Home Manager was called and directed staff to have Resident A sent to the hospital. Resident A was admitted for a fractured right leg. The doctor will be ordering bed rails for Resident A.

On May 15, 2023, I reviewed a second IR dated for April 19, 2023, and authored by Staff, Gena LaFleur. The IR documented the following: On April 19, 2023, at approximately 8pm, Staff LaFleur went to change Resident A's diaper. On the side of Resident A's bed are side pillows that tuck under all Resident A's sheets. When the shift before changed Resident A's bedding, they did not tuck them in under all her bedding. Staff LaFleur shifted Resident A to her side to tuck the diaper under her and from Resident A's weight, the pillow fell out of the bedding causing Resident A to go down the side of the bed. Staff LaFleur grabbed Resident A by her nightgown and chest and used her other hand to unhook her oxygen and feeding tube as she called for help. Staff LaFleur shifted to the side of Resident A's bed and pulled Resident A into her chest. Staff, Deshon Stewart came in to see what was going on and helped put Resident A back into bed. Staff looked Resident A over and did not see anything. Staff put a diaper on Resident A and checked her again at 9pm and did not see anything.

On May 15, 2023, I reviewed Resident A's AFC Assessment Plan and Individual Plan of Service (IPOS), which revealed Resident A is completely dependent on staff as she is blind, nonverbal, and non-ambulatory. Regarding toileting, Resident A is incontinent, wears briefs, and dependent on staff for all toileting needs. Regarding transferring, Resident A requires a two-person assist.

On June 5, 2023, I interviewed Home Manager, Diane Carrillo who reported Resident A's leg is healing and she will not require surgery to repair. Resident A will be going to the doctor today to get a brace for her leg.

On June 29, 2023, and July 3, 2023, I left a message for Staff, Gena LaFleur to return call.

On June 29, 2023, I interviewed Staff, Deshon Stewart who reported to working at the facility for one year. Regarding the allegations, Staff Stewart reported she was talking

with Staff, Jessica Soupes and heard a noise from Resident A's bedroom. Staff Stewart went into Resident A's bedroom and saw Staff, Gena LaFleur holding Resident A under her arms from the back. Staff Stewart picked up Resident A's legs and the 2 staff put Resident A back in her bed. Staff Stewart asked what happened and Staff LaFleur stated Resident A "jumped out of bed" which did not make sense to Staff Stewart as Resident A is immobile. Resident A was checked, and no visible injuries were noted however about an hour later, Staff Stewart noticed bubbles on Resident A's leg. The assistant manager was called and directed staff to have Resident A transferred to the hospital. Staff Stewart reported Resident A usually has two staff change her brief however only Staff LaFleur was changing Resident A at the time of her injury. Staff Stewart advised she believes the injury to Resident A was likely an accident however Staff LaFleur may have been rushing and pushed Resident A too hard causing her to fall from the bed.

On June 29, 2023, I interviewed Resident A's guardian, Guardian A regarding the allegations and they reported Resident A has to be rolled from side to side when staff are changing her brief. Staff rolled Resident A and she somehow hit the side of the bed. Guardian A believes the incident involving Resident A was likely an accident however "it woke staff up to pay more attention." Guardian A is not certain Resident A fell out of bed and her leg may have gone over the side of the bed while staff put her in a bear hug from behind. Resident A had blisters on her leg, and she is not sure if that is because Resident A's leg scraped the bed, or they were the result of an antibiotic medication. Resident A is supposed to have 2 staff change her and now Resident A has bed rails installed on her bed. Resident A is a 2-person assist, has brittle bone disease, and is unable to move or shift her body on her own.

On June 29, 2023, Rebecca Robelin, Saginaw County APS provided her interview with Staff, Gena LaFleur that occurred on June 26, 2023. Staff LaFleur explained she was changing Resident A and had 2 pillows on both sides that she uses when she changes Resident A by herself. Staff LaFleur was holding Resident A and giving her a suppository when she sank down and the pillow collapsed. Staff LaFleur was holding Resident A by her pajamas by her chest and yelled for help while she was unplugging her feeding tube and oxygen. Staff LaFleur felt bad about what occurred and stated it was an accident.

On June 29, 2023, I left a message for Staff, Jessica Soupes to return call. On July 3, 2023, I interviewed Staff Soupes regarding the allegations, and she reported she was talking with Staff, Deshon Stewart. They heard a noise from Resident A's room that sounded like something hit a wall and the 2 staff went to see what the noise was. Staff Stewart went into the bedroom and Staff, Gena LaFleur said "she didn't fall, I caught her". During bed checks, staff noticed a quarter size blister on Resident A's leg and by the early morning the leg started bruising. 911 was contacted and Resident A was transported to the hospital. Staff Soupes reported she believes the injury to Resident A was an accident and maybe Staff LaFleur was moving too fast when changing Resident A. When Staff LaFleur rolled Resident A onto her side to change her, her leg may have hit the floor causing the injury. Staff Soupes has no concerns regarding Staff LaFleur,

and denied she is rough or rude to the residents. According to Staff Soupes, Staff LaFleur would not hurt or mistreat any residents. Staff Soupes stated that one staff person can change Resident A's brief however 2 staff change her when she is soiled. Additionally, one staff member can administer her an enema or suppository when called for.

On June 29, 2023, I interviewed Home Manager, Diana Carrillo who confirmed per medication records that Staff, Gena LaFleur administered Resident A an enema on April 19, 2023, at 8pm.

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:	It was alleged that Resident A rolled out of bed and suffered a broken leg. Upon conclusion of investigative interviews and a review of documentation, there is a preponderance of evidence to conclude a rule violation. Staff, Gena LaFleur, DeShon Stewart, and Jessica Soupes were on duty when Resident A's leg was injured. Staff, LaFleur changed Resident A's brief and administered an enema to the resident per records. An IR written by Staff LaFleur indicated that she was using pillows to assist her in changing Resident A's brief due to changing Resident A by herself. However, the pillows were not installed correctly under Resident A's sheets causing the pillows to move when Resident A was shifted to her side. Resident A went over the side of her bed and Staff LaFleur grabbed her from behind. Resident A may have hit her leg on the floor causing the fracture to her leg. Attempts to interview Staff LaFleur were unsuccessful. Interviews with Staff Stewart and Staff Soupes reveal no concerns with Staff LaFleur mistreating Resident A or intentionally harming her however both indicate Staff LaFleur may have been moving too fast. Resident A is completely dependent on staff for all her needs, as she is nonverbal and immobile. Resident A is blind and also has brittle bone disease according to her guardian. Staff indicate that it is not unusual for Resident A to have 2 staff changing her brief given the Resident A's needs and fragile state.

	There is a preponderance of evidence to conclude Resident A's safety and protection was not adhered to at all times given the injury she sustained. Although it does appear Resident A's injury was accidental, additional safeguards are needed to ensure her safety as she is a medically fragile resident.
CONCLUSION:	**VIOLATION ESTABLISHED**

On July 3, 2023, I contacted Licensee Designee, Stephanie Riley for the purposes of conducting an Exit Conference. I advised Licensee Designee Riley that I would be requesting a corrective action plan for the cited rule violation.

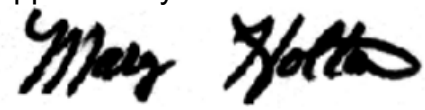
IV. RECOMMENDATION

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

7/4/2023

Christina Garza Date
Licensing Consultant

Approved By:



7/5/2023

Mary E. Holton Date
Area Manager