GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 19, 2023

Denise Sanders
Valley Residential Serv Inc.
P O Box 186
St Charles, MI 486550186

RE: License #: AS250010855
Investigation #: 2023A0871045
Joal Home

Dear Denise Sanders:

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) 643-7960.

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 #:	AS250010855
Investigation #:	2023A0871045
Complaint Receipt Date:	05/31/2023
Investigation Initiation Date:	06/02/2023
Report Due Date:	07/30/2023
Licensee Name:	Valley Residential Serv Inc.
Licensee Address:	300 S Saginaw St. Charles, MI 48655
Licensee Telephone #:	(231) 580-5204
Administrator:	Denise Sanders
Licensee Designee:	Stephanie Riley
Name of Facility:	Joal Home
Facility Address:	1217 Joal Drive Flint, MI 48532
Facility Telephone #:	(810) 230-8022
Original Issuance Date:	03/13/1990
License **Status:**	REGULAR
Effective Date:	02/07/2023
Expiration Date:	02/06/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 3rd shift going into Sunday, May 28th, Staff Presswood reported that Resident A fell out of bed. Resident A had a broken left arm from falling. Resident A did not receive medical treatment for this injury until Monday, May 29.	Yes

III. METHODOLOGY

05/31/2023	Special Investigation Intake 2023A0871045
06/02/2023	Special Investigation Initiated - Telephone Telephone call to Administrator Sanders
07/18/2023	APS Referral To Genesee County MDHHS
07/18/2023	Inspection Completed On-site Interviewed Administrator Sanders, Staff Members Glenn, and Lyons
07/18/2023	Contact - Telephone call made Telephone call to Staff Member Jackson, left message
07/18/2023	Contact - Telephone call made Telephone call to Staff Coleman
07/18/2023	Contact - Telephone call made Telephone call to Guardian A1
07/18/2023	Exit Conference Face to face exit conference with Administrator Sanders
07/19/2023	Contact - Telephone call made Telephone call to Staff Presswood
07/19/2023	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:
On 3rd shift going into Sunday, May 28th, Staff Presswood reported that Resident A fell out of bed. Resident A had a broken left arm from falling. Resident A did not receive medical treatment for this injury until Monday, May 29.

INVESTIGATION:
On January 2, 2023, I telephoned Administrator Sanders, and she reported that Resident A's injured arm was not noticed until Monday, May 29, 2023. Administrator Sanders indicated when she found out on Monday, she called staff that were working over the weekend. Administrator Sanders stated Staff Presswood said she "heard a big boom and [Resident A] fell out of bed." Staff Presswood told Administrator Sanders that she helped Resident A get up. Administrator Sanders advised that Staff Presswood was assigned to Resident A for her shift.

Administrator Sanders stated Staff Presswood changed her story many times and told Administrator Presswood an incident report should have been written. Administrator Sanders also told her she should have let someone know that Resident A fell out of bed.

On July 18, 2023, I conducted an unannounced onsite investigation and again interviewed Administrator Sanders. Administrator Sanders said Staff Presswood worked a double shift from Saturday, May 27th through Sunday, May 28th. When Administrator Sanders came into work on Sunday, May 28th and noticed that Resident A was in bed and not in the recliner where she usually is, Staff Presswood told her that Resident A was tired and stayed in bed. Administrator Sanders stated Staff Presswood gave Resident A a shower at 4:30 am on Sunday Morning, May 28th and then put her back to bed. Administrator Sanders reported Resident A has a matt by her bed because she likes to get out of bed and sit on the floor. Administrator Sanders said Resident A has never fallen out of bed and believes that Resident A fell in the shower when Staff Presswood was showering her.

On July 18, 2023, at the unannounced onsite investigation, I interviewed Staff Glenn. Staff Glenn indicated when back to work on Monday, May 29, 2023, and when Staff Colman came out of the shower with Resident A, Resident A's was "just hanging." Staff Glenn said she touched Resident A's arm and "it felt like it was popping." Staff Glenn indicated Administrator Sanders was gone from the home at the moment and waited for her to come back. Staff Glenn could tell something was wrong because Resident A could not move her arm. Staff Glenn indicated Staff Presswood said she fell out of bed. Staff Glenn said there is a matt by Resident A's bed and Resident A likes to sit on the matt on the floor.

I interviewed Staff Lyons on July 18, 2023, and Staff Lyons stated she worked third shift from Saturday, May 27 through Sunday Morning, May 28th @ 6 am. Staff Lyons indicated that Staff Presswood was working a double until 2 pm on Sunday. Staff Lyons said Staff Presswood told her that Resident A was on the floor but did not tell her that Resident A fell out of bed. Staff Lyons stated Resident A gets out of bed in

the middle of the night and either sits or crawls on the floor. Staff Lyons reported that after Staff Presswood showered Resident A, she set Resident A in the chair.

On July 18, 2023, I telephoned Staff Coleman and stated she did not work the weekend. Staff Coleman worked on Monday, May 29 and noticed Resident A's arm when she went to wake her up. Resident A was laying in the bed with her left arm laying on her chest and stomach. Staff Coleman touched Resident A's left arm elbow area and it "made like a bone cracking noise" and it was not normal. Staff Coleman indicated when she got her to the shower, Resident A did not use her left hand to grab the grab bar. Staff Coleman noticed that her arm and fingers were swollen, and "they were red and purple." Staff Coleman gave her a shower and told Staff Glenn "something is wrong with [Resident A's] arm." Staff Coleman thought maybe her arm "popped out of place." Staff Coleman and Staff Glenn waited for Administrator Sanders to return from the store and advised her about Resident A's arm. Staff Coleman said "she (Administrator Sanders) was so mad" Administrator and Staff Coleman took Resident A to the hospital. Staff Coleman indicated she thinks Resident A fell in the shower and not out of her bed. Staff Coleman said, "someone is not telling the truth."

On July 18, 2023, I observed Resident A sitting in a recliner. Resident A appeared clean, and no bruising was noted on her. Resident A is severely cognitively impaired and unable to be interviewed.

On July 19, 2023, I telephoned Staff Presswood. Staff Presswood indicated that she was working a double from 10 pm on Saturday through Sunday @ 2pm. Staff Presswood stated she checked on the residents around 5 am and put Resident A in the shower after that. Staff Presswood said when she went into Resident A's room, Resident A on the floor on her matt. Staff Presswood said she helped her up and Resident A did not appear to be in pain. Staff Presswood said she has not been employed at the facility very long and did not know Resident A's behaviors all that well. Staff Presswood said she gave her a shower and got her dressed. Staff Presswood indicated then said she did not work a double shift that weekend and does not know what happened to Resident A.

On July 19, 2023, I telephoned Guardian A1, and she indicated she did speak with Administrator Sanders about the fall. Administrator Sanders also indicated that staff are to report any falls, but no one was notified, and an incident report was not completed. Guardian A1 said "this is one of the better AFC homes" and has two clients that reside there. Guardian A1 has no concerns about the care the Resident A receives and said visits frequently.

Administrator Sanders gave me a copy of an *AFC Licensing Division – Incident/Accident Report* that was signed and dated by Administrator Sanders on May 29, 2023. What happened indicates "When I (Staff Coleman) started [Resident A's] client care, I observed [Resident A] not moving her left arm to hold onto the rails in the bathroom. [Resident A] was just letting her arm hang, which is not normal.

When staff helped [Resident A] transport from shower to toilet, I felt the bones in [Resident A's] elbow making movement from inside which was also not normal." Action taken indicates "Staff got [Resident A] dressed and comfortable on couch until home manager seen and I transported [Resident A] to the hospital." Corrective measures states "Keep an eye one [Resident A] to make sure she doesn't fall anymore." The time of the report indicates 7 am.

On July 18, 2023, I conducted a face-to-face exit conference with Administrator Sanders. Even though Administrator Sanders did take Resident A for medical care when staff noticed her arm, Resident A's arm had been injured the day before. No one reported to management that Resident A fell. Resident A's arm was broken on May 28th and did not receive medical attention until May 29th.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Resident A's arm was injured on May 28, 2023, and did not receive medical attention until May 29, 2023. Staff Presswood indicated Resident A fell on her pad in her bedroom but did not tell other staff or write an incident report. Resident A suffered with a broken arm all day on May 28, 2023. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

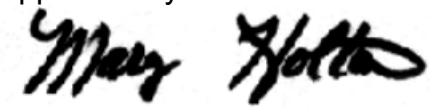
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of this adult foster care license remain the same (capacity 1-6).

07/19/2023

Kathryn A. Huber — Date
Licensing Consultant

Approved By:



07/19/2023

Mary E. Holton — Date
Area Manager