GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 4, 2023

Felicia Evans
Community Living Options
626 Reed Street
Kalamazoo, MI 49001

RE: License #: AS390396025
Investigation #: 2023A1024048
Bronson Circle

Dear Felicia Evans:

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 September 13, 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. 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,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems
427 East Alcott
Kalamazoo, MI 49001

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390396025
Investigation #:	2023A1024048
Complaint Receipt Date:	08/09/2023
Investigation Initiation Date:	08/09/2023
Report Due Date:	10/08/2023
Licensee Name:	Community Living Options
Licensee Address:	626 Reed Street Kalamazoo, MI 49001
Licensee Telephone #:	(269) 343-6355
Administrator:	Fiorella Spalvieri
Licensee Designee:	Felicia Evans
Name of Facility:	Bronson Circle
Facility Address:	1206 Bronson Circle Kalamazoo, MI 49008
Facility Telephone #:	(269) 343-6355
Original Issuance Date:	01/14/2019
License Status:	REGULAR
Effective Date:	07/14/2023
Expiration Date:	07/13/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A fell while in his bedroom and hours later passed away. There is concern protection and safety were not provided which caused Resident A to fall.	No
Resident A's bedroom rug did not have nonskid backing and was not safe.	Yes

III. METHODOLOGY

08/09/2023	Special Investigation Intake 2023A1024048
08/09/2023	Special Investigation Initiated – Letter-*AFC Licensing Division Accident/Incident* Report Received
08/09/2023	Contact - Document Received-email correspondence from licensee designee Felicia Evans
08/10/2023	Contact - Telephone call made with Guardian A1
08/10/2023	Contact - Document Received-Resident A's *Assessment Plan for AFC Residents* and *Health Care Appraisal* (HCA)
08/11/2023	Inspection Completed On-site with direct care staff member Nora Shaffer
08/11/2023	Contact - Document Received email correspondence with Felicia Evans
08/11/2023	Contact - Document Received-Resident A's AFC Licensing Division Incident/Accident Report, Bronson Hospital *After Visit Summary*
08/11/2023	Contact - Document Received-Resident A's *Health Care Chronology* Log
08/14/2023	Contact - Telephone call made with direct care staff member Liajah Miles
08/29/2023	Contact-Document Received-Resident A's *Death Certificate*
09/12/2023	Exit Conference with administrator Fiorella Spalvieri and LD Felicia Evans

09/12/2023	Inspection Completed-BCAL Sub. Compliance
09/12/2023	Corrective Action Plan Requested and Due on 10/01/2023
09/13/2023	Corrective Action Plan Received
09/13/2023	Corrective Action Plan Approved
10/01/2023	APS Referral- does not meet criteria as APS does not investigate residents who are deceased

ALLEGATION:

- **Resident A fell while in his bedroom and hours later passed away. There is concern protection and safety were not provided which caused Resident A to fall.**
- **Resident A's bedroom rug did not have nonskid backing and was not safe.**

INVESTIGATION:

On 8/9/2023, I received allegations via email that Resident A fell while in his bedroom and hours later passed away. There is concern protection and safety were not provided which caused Resident A to fall.

On 8/9/2023, I reviewed the facility's *AFC Licensing Division-Accident/Incident Report* dated 8/8/2023 and written by direct care staff member Leilani Myles. According to this report, around 2:20pm following a fall Resident A had taken earlier, direct care staff member Leilani Myles could hear Resident A making odd noises in his bedroom. The *AFC Licensing Division-Accident/Incident Report* documented direct care staff member Leilani Myles found Resident A vomiting while lying on his back in his bed. Direct care staff member Leilani Myles documented that she placed Resident A on his side while calling out his name and called 911 to get further instruction. The *AFC Licensing Division-Accident/Incident Report* further documented Resident A continued to vomit while waiting for EMS to arrive. Resident A was later placed on life support while in the hospital.

I also reviewed *AFC Licensing Division-Accident/Incident Report* dated 8/7/2023 and written by direct care staff member Leilani Myles which stated direct care staff members Nora Shaffer and Leilani Myles heard a noise in Resident A's bedroom and when they entered Resident A's bedroom, he was lying on the floor holding on to his walker on his left side near his bedroom rug that was observed folded up. The *AFC Licensing Division-Accident/Incident Report* documented Resident A informed the two direct care staff members that he tripped on his bedroom rug. The *AFC Licensing Division-Accident/Incident Report* documented direct care staff member Nora Shaffer assisted

Resident A with getting up off the floor and watched him get in his bed. The *AFC Licensing Division-Accident/Incident Report* documented direct care staff members Nora Shaffer and Leilani Myles took the rug out of Resident A's bedroom and monitored him for the rest of the night. The *AFC Licensing Division-Accident/Incident Report* stated a bruise on Resident A's shoulder was observed.

On 8/9/2023, I reviewed an email from licensee designee Felicia Evans who stated that Resident A passed away at 7:10am at Bronson Hospital. Felicia Evans' email stated Resident A had fallen around 10:22pm however stated that he was okay after the fall and got into bed. Felicia Evans stated at 2:20am direct care staff heard Resident A vomiting and called 911. Felicia Evans further stated direct care staff members Leilani Myles and Nora Shaffer were the two staff members that worked with Resident A during the day and evening on the day he fell before being transported to the hospital where he passed away.

On 8/10/2023, I conducted an interview with Guardian A1 who stated Resident A had a history of having multiple falls that resulted in him going to a nursing home for rehabilitation after being hospitalized from a fall prior to Resident A relocating to Bronson Circle. Guardian A1 stated Resident A suffered from both physical and mental health issues over the years. Guardian A1 further stated Resident A used a walker for mobility and she was told that Resident A passed away from a brain bleed. Guardian A1 stated Resident A recently suffered from a stroke. Guardian A1 further stated she was immediately notified when Resident A had his most recent fall before passing away and she believes direct care staff members handled the situation appropriately by immediately calling 911 when he started showing symptoms of distress such as vomitting.

On 8/10/2023, I reviewed Resident A's *Assessment Plan for AFC Residents* (assessment) dated 4/14/2023. According to this assessment, Resident A requires assistance in the community with mobility. Resident A also requires prompts from staff as he is not always alert to everything around him. This assessment also stated Resident A requires assistance with using his walker and monitoring. When long distance is needed a wheelchair is required. Resident A also required monitoring and minimal assistance with bathing however did not require assistance when toileting.

I also reviewed Resident A's *Health Care Appraisal* (HCA) dated 9/1/2022. According to this HCA, Resident A is diagnosed with Dementia, uses a walker and needs assistance with his activities of daily living.

On 8/11/2023, I conducted an onsite investigation at the facility with direct care staff member Nora Shaffer who stated Resident A fell on the night of 8/7/2023 at around 10pm while he was in his bedroom after tripping on his bedroom rug that was located at the end of his bed near his dresser. Nora Shaffer stated the rug was loose fitting however Resident A requested the rug in his bedroom as it was his personal rug. Nora Shaffer stated she assisted Resident A up from the bedroom floor after she another staff member found Resident A lying on his bedroom floor while holding on to his

walker. Nora Shaffer stated Resident A immediately informed them that he tripped on his rug, that he was fine and did not feel he needed medical attention. Nora Shaffer further stated Resident A appeared to have a bruise on his arm however there was no indication of any other injury nor did Resident A express being in any pain. Nora Shaffer stated she offered Resident A ice for his arm and she stated Resident A again reported he was fine. Nora Shaffer stated she also asked Resident A if he hit his head when he fell and Resident A told her that he did not hit his head rather he landed on his side. Nora Shaffer stated Resident A then walked back over to his bed with his walker and began to watch television. Nora Shaffer stated when she came to work the following day, she was notified that Resident A had passed away while at the hospital from having a stroke. Nora Shaffer stated Resident A had two other fall incidents since his admission in May of 2023 due to lack of stability, however, this was not a usual occurrence in the facility. Nora Shaffer stated Resident A was able to use his walker and transfer independently without direct care staff member assistance. Nora Shaffer stated staff members monitored Resident A moving around the facility when he came out of his bedroom prompted by a bell that was attached to his walker that notified direct care staff members when Resident A was up from bed. Nora Shaffer stated that Resident A's walker was always placed next to his bed to allow him to easily access his walker as soon as he got out of bed, and he required monitoring when he would go to the shower.

While at the facility, Nora Shaffer showed me where Resident A's rug was positioned when she found Resident A lying on the floor in his bedroom when he fell on 8/7/2023. The rug was observed to not have nonskid backing on the facility's hard finish floor.

On 8/11/2023, I reviewed an email from licensee designee Felicia Evans who stated Resident A was relocated to Bronson Circle from another adult foster care home owned by the licensee on 5/12/2023 due to not getting along with another resident however immediately went to the hospital on the day of admission for a fall where he was admitted and discharged to a nursing home to receive rehabilitation services. Prior to Resident A coming to Bronson Circle, he was also hospitalized on 5/3/2023 for a fall due to weakness when he resided at another adult foster care facility. Felicia Evans stated Resident A completed physical therapy and occupational therapy and has been routinely seen by medical providers since his return from the nursing home stemming from the hospitalization on 5/12/2023. Felicia Evans further stated Resident A used his walker for mobility independently and direct care staff monitored this use to ensure his safety however did not require 1:1 staff supervision and could use his walker independently without staff physical assistance.

On 8/11/2023, I reviewed the facility's *AFC Licensing Division Incident/Accident Report* dated 5/12/2023. According to this report, Resident A seemed very tired and when he got up to transfer from his bed to his walker he fell to the floor. Staff called 911 and EMS transported him to the hospital where he was admitted.

I also reviewed Resident A's Bronson Hospital *After Visit Summary* dated 5/15/2023. According to this summary, Resident A was admitted on 5/12/2023 for weakness and discharged from the hospital on 5/15/2023.

I reviewed *After Visit Summary* dated 5/9/2023 which stated that Resident A was admitted to the hospital on 5/3/2023 for having altered mental status and discharged on 5/9/2023.

On 8/11/2023, I reviewed Resident A's *Health Care Chronology* Log. According to this log, Resident A was admitted to a local nursing home on 5/15/2023 for having weakness. On 6/12/2023, Resident A was seen by neurologist for follow-up from a seizure occurrence. On 6/14/2023, Resident A was evaluated to begin physical therapy and occupational therapy with Elara. On 6/15/2023, Resident A was seen by primary physician for follow-up office visit from nursing home stay. On 7/19/2023, Resident A was seen by a nurse from primary care physician's office for medication refill. On 8/1/2023, 8/2/2023, and 8/3/2023, Resident A was seen by medical providers for various health issues such as blood pressure, blood sugar, gastro, stools, and throat issues.

On 8/14/2023, I conducted an interview with direct care staff member Leilani Miles who stated that shortly after her shift began on 08/08/2023, she heard Resident A go to the bathroom and minutes later she heard a loud noise come from Resident A's bedroom. Leilani Myles stated she then entered Resident A's bedroom and saw Resident A lying on the floor while on his side holding on to his walker that was also on the floor. Leilani Myles stated Resident A stated he tripped on his rug that was nearby his dresser. Leilani Myles further stated it was obvious that Resident A tripped over the rug because the rug was loose fitting, and it was folded over where Resident A was lying. Leilani Myles stated that Resident A told her that he was okay and when she checked him over, Leilani Myles stated she saw a bruise on his arm however Resident A did not seem like he was in any pain or appeared to need any medical attention. Leilani stated she watched Resident A get back into his bed with assistance from another direct care staff and observed Resident A watching television. Leilani Myles stated she then checked on Resident A an hour after this incident and heard Resident A snoring which was usual for Resident A was asleep. Leilani Myles stated a few hours later at around 2am, she heard gasping noises coming from Resident A's bedroom therefore she immediately entered Resident A's bedroom and saw him lying on his back and vomiting. Leilani Myles stated she immediately called 911 as Resident A continuously vomited and did not seem alert when she called out his name. Leilani Myles stated EMS arrived and transported Resident A to the hospital where he later passed away. Leilani Myles stated Resident A could use his walker independently and did not require assistance with transferring however staff monitored Resident A when he walked with his walker through the house and in the community. Leilani Myles further stated Resident A did not require bedroom checks when sleeping, and staff members could hear Resident A when he moved around in his bedroom with his walker as he had a bell on his walker which prompted staff members to check on Resident A to see if he needed assistance with any of his activities of daily living. Leilani Myles stated Resident A was verbal and

was able to yell out if he needed assistance from direct care staff members. Leilani Myles stated this was the first fall Resident A had while on her shift and Resident A was not known to have many falls since his admission to the facility in May 2023. Leilani Myles stated she believes prior to Resident A moving into the facility and on his first day at Bronson Circle, Resident A had two major falls that led him to being hospitalized and sent to a nursing home for rehabilitation services.

On 8/29/2023, I reviewed Resident A's *Death Certificate* dated 8/15/2023. According to this certificate, Resident A's cause of death was Intracerebral Hemorrhage and manner of death was listed as "natural."

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:	Based on my investigation interviewing direct care staff members Nora Shaffer, Leilani Myles, licensee designee Felicia Evans, and Guardian A1 along with my review of *AFC Licensing Division-Accident/Incident* Reports, Resident A's *Assessment Plan for AFC Residents*, *Death Certificate*, *After Visit Summary*, and Resident A's *Health Care Chronology* Log, there is not enough evidence Resident A's protection and safety needs were not attended to at all times prior to his fall. At the time he fell during the late-night hours on 08/08/2023, direct care staff members immediately assessed Resident A for any injury, verbally interviewed him to determine if he had any pain and continued to monitor him until he was asleep. Upon hearing Resident A in distress a few hours later on 08/09/2023, direct care staff members immediately called 911 for assistance. Although Resident A's bedroom rug did not have nonskid backing, this rug has not been a documented issue in previous falls so there is not enough evidence that direct care staff could have known having the rug present would cause Resident A harm.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(10) Scatter of throw rugs on hard finished floors shall have a nonskid backing.

ANALYSIS:	Although the rug located in Resident A's bedroom belonged to Resident A and was there per his request, the rug did not have nonskid backing even though it was located on a hard finish floor. This rug appeared to be involved in Resident A's fall as it was observed folded up and lying near Resident A at the time of his fall on 08/08/2023. This fall occurred shortly before Resident A experienced a medical emergency leading to his death.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/12/2023, I conducted an exit conference with licensee designee Felicia Evans. I informed Felicia Evans of my findings and allowed her an opportunity to ask questions or make comments.

On 9/13/2023, I received and approved an acceptable corrective action plan.

IV. RECOMMENDATION

An acceptable corrective action plan was received; therefore, I recommend the current license status remain unchanged.

Ondrea Johnson

Ondrea Johnson
Licensing Consultant

10/01/2023
Date

Approved By:

Dawn Timm

Dawn N. Timm
Area Manager

10/04/2023
Date