GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 19, 2024

Connie Clauson
Pleasant Homes I L.L.C.
Suite 203
3196 Kraft Ave SE
Grand Rapids, MI 49512

RE: License #: AL390007090
Investigation #: 2024A0581023
Park Place Living Centre #B

Dear Connie Clauson:

Attached is the Special Investigation Report for the above referenced facility. Due to the continued quality of care violations, the recommendation of refusal to renew remains in effect. You will be notified in writing of the department's action and your options for resolution of this matter.

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) 284-9730.

Sincerely,

Cathy Cushman

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL390007090
Investigation #:	2024A0581023
Complaint Receipt Date:	02/23/2024
Investigation Initiation Date:	02/27/2024
Report Due Date:	03/24/2024
Licensee Name:	Pleasant Homes I L.L.C.
Licensee Address:	Suite 203 3196 Kraft Ave SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Janet White
Licensee Designee:	Connie Clauson
Name of Facility:	Park Place Living Centre #B
Facility Address:	4218 S Westnedge Kalamazoo, MI 49008
Facility Telephone #:	(269) 388-7303
Original Issuance Date:	01/01/1989
License Status:	1ST PROVISIONAL
Effective Date:	06/05/2023
Expiration Date:	12/04/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION

	Violation Established?
Resident Q fell out of her wheelchair while being transported back to her facility and sustained a skull fracture.	Yes

***To maintain the coding consistency of residents in multiple reports, the resident in this special investigation is not identified in sequential order.

III. METHODOLOGY

02/23/2024	Special Investigation Intake 2024A0581023
02/26/2024	Contact - Telephone call made Left message with Complainant.
02/27/2024	Special Investigation Initiated - On Site Interview with Administrator, staff, and obtained documentation.
02/27/2024	Contact - Document Sent Requested death investigative report from Wmed pathology.
02/27/2024	Contact - Telephone call received Received voicemail from Complainant.
02/27/2024	Contact - Document Sent Requested death certificate from Kalamazoo Clerk's office.
02/28/2024	Contact – Document Sent Requested death certificate from Michigan Vital Records.
02/28/2024	Contact - Document Received Received death certificate
02/28/2024	APS Referral APS referral made online
02/28/2024	Contact - Telephone call made Interview with Christine Brown, Activities Director
02/28/2024	Contact - Telephone call made Interview with Complainant
02/28/2024	Contact - Telephone call made Left message with Jessica Griffin, volunteer

03/07/2024	Inspection Completed On-site Attempted to interview Ms. Griffin; however, she wasn't present at the facility.
03/07/2024	Contact - Telephone call made Interview with Ms. Griffin.
03/11/2024	Inspection Completed-BCAL Sub. Non-Compliance
03/12/2024	Contact – Document Sent Requested any police reports / case contacts from Kalamazoo Department of Public Safety (KDPS) relating to incident.
03/14/2024	Contact – Document Received Received KDPS incident/investigative report #24-002632.
03/15/2024	Exit conference with the licensee designee, Connie Clauson.

ALLEGATION:

Resident Q fell out of her wheelchair while being transported back to her facility and sustained a skull fracture.

INVESTIGATION: On 02/23/2024, I received this complaint from the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged on 12/28/2023, Resident Q fell out of her wheelchair while being transported down a handicap ramp outside of the facility to an activity in a neighboring facility across the parking lot. The complaint alleged Resident Q, who was non-ambulatory, was being transported face forward down the ramp rather than backwards, which would have prevented her from falling out of the wheelchair. The complaint alleged Resident Q fell out of her wheelchair and subsequently hit her head on the pavement. The complaint alleged Resident Q remained in the parking lot until paramedics arrived 10-15 minutes after falling out of her wheelchair. The complaint documented the facility's staff stayed with Resident Q in the parking lot until paramedics arrived.

The complaint alleged Resident Q was transported to a local hospital and extensive testing revealed Resident Q had a brain bleed because of the fall and was diagnosed with a "C2 fracture". The complaint also alleged Resident A had a two-inch protruding hematoma on the upper left side of her skull.

The complaint alleged Resident Q was moved to hospice on 01/06/2024 and died on 01/11/2024. The complaint alleged an extensive review of Resident Q was completed by the Kalamazoo County Medical Examiner who documented on

Resident Q's death certificate that her death was the result of the fall from her wheelchair and subdural hematoma.

On 02/27/2024, I conducted an unannounced inspection at the facility. I interviewed the facility's Administrator, Janet White. Ms. White stated she wasn't working at the time of Resident Q's fall; therefore, she had no firsthand knowledge of the incident. Ms. White stated an Incident/Accident Report (IR) was completed pertaining to the fall, which documented the licensee's volunteer, Jessica Griffin, was transporting Resident Q in her wheelchair when the incident occurred. Ms. White was unsure if Ms. Griffin received any training on how to transport residents in wheelchairs because the licensee's Activities Director, Christine Brown, was responsible for this training. Ms. White did not have Ms. Griffin's volunteer file available in the facility at the time of my inspection. I requested she send it to me and to include Ms. Griffin's volunteer description and any training she received.

I interviewed direct care staff, Farren Banks. Ms. Banks stated she was not immediately present or witness to Resident Q falling out of her wheelchair on 12/28/2023; however, she was working in the facility when the incident occurred and observed Resident Q on the ground after she had fallen. Ms. Banks stated on the morning the incident occurred, Resident Care Manager, Isabelle Sanhou, informed her the Activities Director, Ms. Brown, and a volunteer (later identified as Ms. Griffin) came to the facility to transport Resident Q to another building for activities. Ms. Banks stated approximately 45 minutes after Resident Q originally left the building, Ms. Sanhou came to her and told her Resident Q had fallen.

Ms. Banks stated she and Ms. Sanhou went outside and saw Resident Q out of her wheelchair laying in the facility's parking lot. Ms. Banks stated the wheelchair was still upright and a blanket was over Resident Q. She stated she observed Ms. Brown on the ground holding Resident Q's head but did not observe Ms. Griffin. Ms. Banks stated no one told her exactly what happened to cause Resident Q to fall out of her wheelchair. Ms. Banks did not recall if Resident Q's wheelchair had a belt or strap to prevent Resident Q from falling out of it.

Ms. Banks stated she's worked in the facility off and on for approximately two years and received wheelchair training. She stated she knows to transport a resident backwards slowly down a ramp rather than front wards because the person could fall out. Ms. Banks stated she was unsure what kind of training Ms. Griffin received as a volunteer. She stated Ms. Griffin would often come get residents and transport them to activities.

During the inspection, I observed the concrete ramp where the incident with Resident Q occurred. The ramp is connected to Park Place Living Centre #C's porch and sidewalk and is approximately six feet in slope. The rise of the ramp is approximately two to three inches in height. I observed an expansion joint in the middle of the ramp and at the bottom of it.

I reviewed the facility's IR relating to Resident Q's fall. According to this IR, on 12/28/2023, at approximately 11:15 am, Ms. Griffin "was transporting [Resident Q] home after and[*sic*] activity. [Resident Q] leaned forward and fell out of chair landing on left side of face/falling to ground". The IR documented Ms. Griffin called for Ms. Brown and Ms. Brown subsequently contacted 911. The IR documented Ms. Sanhou gathered together Resident Q's "paperwork" and brought blankets. The IR documented due to Resident Q's injury; she was left on the ground until the ambulance arrived. The IR documented Resident Q would not be transported between the licensee's buildings for activities due to Resident Q's "apparent lack of strength".

I reviewed Resident Q's *Assessment Plan for AFC Residents*, dated 12/21/2022, which documented Resident Q utilized a manual wheelchair. I also reviewed the physician's order for Resident Q's wheelchair, which documented Resident Q was prescribed a standard wheelchair with leg rests on 02/26/2019. The order documented Resident Q's associated diagnosis as seizures, post-traumatic subdural hematoma, without loss of consciousness, subsequent encounter, and arthritis. The duration of the wheelchair was identified as Resident Q's lifetime.

On 02/27/2024, I reviewed Kalamazoo County Medical Examiner's Investigative Report case # 0111-24-JSC-028-KC. The contents of this report were consistent with the information provided in the complaint. According to the report, Relative Q1 did not report any overall concerns of abuse or neglect to the medical examiner. Additionally, because Resident Q's body did not show any signs of abuse or neglect then the case would remain a "release with records review." The report documented Resident Q was released to the funeral home "as a suspected accidental death".

On 02/28/2024, I interviewed the licensee's identified Activity's Director, Christine Brown. Ms. Brown stated on 12/28/2023, she went to Resident Q's facility around 9:30 am and transported her to neighboring building for a church service. Ms. Brown stated Ms. Griffin was responsible for transporting Resident Q back to her building after church ended. Ms. Brown stated she observed Ms. Griffin leave the building in which the activity was taking place but did not actually witness Resident Q fall out of her wheelchair. She stated shortly after Ms. Griffin left the building, she came back in requesting assistance and help stating Resident Q had fallen out of her wheelchair. Ms. Brown stated she contacted Park Place Living Centre #B's Resident Care Manager, Ms. Sanhou, for assistance as well. Ms. Brown stated when she observed Resident Q she saw blood coming from Resident Q's head; therefore, she didn't move her, but placed a pillow under her head for comfort. She stated Resident Q's wheelchair did not fall over and she observed one of the wheels in the concrete's expansion joint.

Ms. Brown stated Ms. Griffin is an "official" volunteer for the licensee. She stated Ms. Griffin signed forms to be hired as a volunteer. Ms. Brown stated Ms. Griffin originally volunteered for the licensee under a different Activities Director from 2010 through 2012; however, she started again as a volunteer in November 2023.

Ms. Brown stated Ms. Griffin works Mondays and Thursdays from 8 am until 4 pm. She stated Ms. Griffin helps with transporting residents to and from their respective facility to wherever an activity is taking place. She stated as a volunteer, Ms. Griffin, assists with activity tasks such as setting up projects, as well as, getting beverages like coffee and drinks prepared and/or served during the activity. Ms. Brown stated if a resident required toileting assistance or any type of assistance while an activity is taking place then a facility staff member or Resident Care Manager would provide that assistance rather than Ms. Griffin. Ms. Brown stated Ms. Griffen received training on lifting or transferring residents into their wheelchairs; however, she stated typically residents are already in their wheelchairs at the time they need to be transported to an activity. Ms. Brown stated it was her understanding volunteers could transport residents to and from activities.

Ms. Brown stated all volunteers, including Ms. Griffin, received an orientation and training at the time she become a volunteer, which included transporting a resident in a wheelchair. She stated she trained Ms. Griffin on how to properly transport a resident in a wheelchair and addressed concerns such as getting wheelchairs through doorways, getting up and down ramps and avoiding elbow injuries in wheelchairs. Ms. Brown stated volunteers don't sign any documentation acknowledging they are competent with transporting; however, she stated Ms. Griffin observed her “for some time” and only transported residents once she felt comfortable. Ms. Brown stated Ms. Griffin appeared competent to transport resident in their wheelchairs.

Ms. Brown confirmed the appropriate and safest way to transport a resident down a ramp is backwards; however, she stated the ramp in which Resident Q was transported down was “minimal” and only a “slight decline”. She stated there was a “little ledge” or “lip” at the bottom of the ramp where the sidewalk contraction joint was located and stated she thinks when the wheelchair hit this ledge and Resident Q fell forward because it was Resident Q’s instinct to stand. She stated due to Resident Q not having the strength to stand she then fell on the ground. Ms. Brown stated Resident Q’s wheelchair did not have any straps or a seatbelt to keep her secured in the wheelchair. She stated Resident Q had a pillow under her arm and a cushion on her seat. Ms. Brown also stated she believed Resident Q’s wheelchair footrests were lower than normal footrests; indicating it was possible Resident Q’s foot also caught on the raised concrete at the contraction joint.

On 02/28/2024, I interviewed Complainant via telephone. Complainant’s statement to me was consistent with the allegations. Complainant confirmed Resident Q’s wheelchair was not equipped with any straps, seatbelts, or restraints on it to prevent Resident Q from slipping or falling out.

On 02/29/2024, Ms. White sent me an email containing Ms. Griffin’s volunteer application, dated 11/04/2023, her position summary titled “Volunteer Activity Assistant”, and a pamphlet titled “How to push a person in a wheelchair”. According

to the position summary, Ms. Griffin's volunteer position would be responsible for the following:

> "Assist the Activity Director and/or Activity Assistant in implementing a program of therapeutic activities designed to meet the social, spiritual, and physical needs of the residents in accordance with the individual care plan. Duties involve personal contact with a varying resident population."

Additionally, one of the requirements of the position included "Assist residents to and from group activities".

The pamphlet titled "How to push a person in a wheelchair" contained three pages of instructions on helping someone onto a wheelchair and pushing them. The pamphlet's origin appeared to be the Loddon Mallee Regional Palliative Care Consortium (LMRPCC) out of Australia. The instructions contained information for helping someone into a wheelchair, tips for pushing safely, pushing a wheelchair up onto a footpath or "curb" and pushing a wheelchair down a footpath or "curb."

On 02/29/2024, I conducted a Google search of the pamphlet by LMRPCC to determine the pamphlet was sent in totality as there was no information specific to pushing a wheelchair up or down a ramp. Upon reviewing the pamphlet from the LMRPCC website, www.lmrpcc.org.au, I determined the fourth page of the pamphlet submitted by Ms. White was missing, which included instructions for pushing a wheelchair down a slope and folding a wheelchair. According to the instructions for pushing a wheelchair down a slope, a person should do the following:

1. Check for any obstacles before moving.
2. If the slope is very steep, find someone to assist you.
3. Go down backwards slowly using your leg muscles and body weight to slow the chair down.
4. Try not to twist to look behind you whilst moving.

On 03/06/2024, I received Resident Q's death certificate, signed 01/12/2024, from Michigan Vital Records Fraud Unit, which documented Resident Q's causes of death were "Subdural Hematoma" and "Fall from Wheel Chair" and the manner of death was identified as an "Accident", which occurred on 12/28/2023. The death certificate documented Resident Q "Fell from wheelchair on ramp at assisted living center" with the address identified as 4222 South Westnedge Avenue, Kalamazoo, Michigan 49008. I later identified this address building C.

On 03/07/2024, I interviewed volunteer, Jessica Griffin, via telephone. Ms. Griffin's statement to me was consistent with Ms. Brown's statement. Ms. Griffin stated she transported Resident Q in her wheelchair back to Resident Q's facility after an activity in building C. Ms. Griffin stated she pushed Resident Q face forward down a

concrete ramp right outside of building C. She stated while pushing Resident Q down the ramp, Resident Q fell out and hit the pavement. Ms. Griffin stated there had been a “little bump” in the concrete near the end of the ramp, which she stated she thought the wheelchair wheel hit and caused Resident Q to fall out. Ms. Griffin stated she yelled for Ms. Brown to help her and to contact 911. Ms. Griffin’s statement regarding Resident Q not having a seatbelt or strap to keep her in the wheelchair was consistent with Ms. Brown’s and Complainant’s statements to me.

Ms. Griffin stated she’d been volunteering at the facility since approximately 11/06/2023. Ms. Griffin stated she did not receive any kind of training at the time she became a volunteer, but observed direct care staff on how they transported residents. She stated when she observed staff transporting wheelchairs down ramps, she observed staff pushing residents face forward rather than backward. Ms. Griffin stated on 02/29/2024, she had a meeting with Ms. Brown on how to properly transport a resident in a wheelchair. She stated the information provided to her during the meeting was a handout titled “How to push a person in a wheelchair”. I confirmed with Ms. Griffin the document she was provided was the same document provided to me by the facility’s Administrator, Ms. White. Ms. Griffin stated Ms. Brown went over the handout during the training. Ms. Griffin stated she now transports residents down ramps backwards as instructed in the training packet provided by Ms. Brown. Ms. Griffin’s statement about not providing any assistance with resident ADL’s was consistent with Ms. Brown’s statement.

On 03/14/2024, I received Kalamazoo Department of Public Safety’s (KDPS) Incident/Investigative Report # 24-002632. According to report, KDPS officers were called to the facility on 12/28/2024 to assist with Resident Q falling from her wheelchair. Responding officers did not investigate at the time of the incident because they didn’t observe any suspicious activity and they only provided medical assistance to Resident Q. The report also documented Officer Neko Anthony responded back to the facility on 02/28/2024 after receiving similar allegations as the complaint. Officer Anthony documented in his report he interviewed Ms. White, Ms. Sanhou, Ms. Brown, and Ms. Griffin. Ms. White’s statement to Officer Anthony was consistent with her statement to me. The content of Ms. Sanhou’s, Ms. Brown’s and Ms. Griffin’s statements to Officer Anthony were more focused on Resident Q’s injuries at the time of the incident rather than additional detail on how Ms. Griffin was pushing Resident Q or what caused her to fall out of her wheelchair.

APPLICABLE RULE	
R 400.15305	**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 licensee hired volunteer, Jessica Griffin, in November 2023 to assist the licensee's identified Activity's Director, Christine Brown, with implementing a program of therapeutic activities designed to meet the social, spiritual, and physical needs of the residents in accordance with the individual's care plan. Despite one of Ms. Griffin's job requirements being to assist residents to and from group activities, the licensee was unable to provide any documentation confirming Ms. Griffin received training relating to transporting residents who required the use of wheelchairs. Though Ms. Griffin observed direct care staff transporting residents in wheelchairs she stated she observed staff transporting them face forward rather than backwards down ramps, which is not the proper technique when safely moving someone in a wheelchair. Subsequently, on 12/28/2023, Ms. Griffin was transporting Resident Q back to her facility after an activity in a neighboring facility and while transporting her down a concrete ramp, albeit it being short with a minimal decline, she continued to do so face forward rather than backward. Consequently, Resident Q fell out of her wheelchair after her wheelchair wheel either became lodged in the concrete's expansion joint or due to hitting a raised portion in the concrete. Upon falling out her wheelchair, Resident Q hit her head on the sidewalk concrete/pavement sustaining a subdural hematoma. Additionally, Resident Q's death certificate documented her causes of death as "Subdural Hematoma" and "Fall from Wheel Chair" with the manner of death identified as an "Accident", which occurred on 12/28/2023. Based on my investigation, which included interviews with the licensee's Administrator, Janet White, Activities Director, Christine Brown, direct care staff, Farren Banks, volunteer, Jessica Griffin, KDPS incident/investigative report # 24-002632, and my review of Resident Q's death certificate and Ms. Griffin's volunteer file, Resident Q was not provided with adequate protection and safety when Resident Q was transported by the licensee's volunteer, Jessica Griffin, on 12/28/2023 because Ms. Griffin had not received proper training relating to transporting residents in wheelchairs and was also not implementing proper technique when transporting a resident in a wheelchair down a ramp. Ultimately, Resident Q sustained injuries from falling out of her wheelchair, which caused her death per her death certificate on 01/11/2024.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 03/15/2024, I attempted to conduct the exit conference via telephone with the licensee designee, Connie Clauson, via telephone; however, I was unable to reach her. I left a voicemail requesting she contact me. Additionally, I sent an email informing her of my findings and recommendation. I requested she contact me the following week to ask questions or provide input relating to the investigation.

IV. RECOMMENDATION

Due to continued quality of care violations, I continue to recommend refusal to renew the license as previously recommended in the renewal licensing study report dated November 28, 2023.

03/14/2024

Cathy Cushman Date
Licensing Consultant

Approved By:

03/14/2024

Dawn N. Timm Date
Area Manager