GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 17, 2024

Keith Marshall
All Care, Inc.
PO Box 247
Hillsdale, MI 49242

RE: License #: AS460338821
Investigation #: 2024A1032011
All Care @Life's Junction

Dear Keith Marshall:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Dwight Forde, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS460338821
Investigation #:	2024A1032011
Complaint Receipt Date:	12/13/2023
Investigation Initiation Date:	12/14/2023
Report Due Date:	02/11/2024
Licensee Name:	All Care, Inc.
Licensee Address:	113 LaFayette Street, Hudson, MI 49247
Licensee Telephone #:	(517) 306-6187
Administrator:	Keith Marshall
Licensee Designee:	Keith Marshall
Name of Facility:	All Care @Life's Junction
Facility Address:	113 LaFayette Street, Hudson, MI 49247
Facility Telephone #:	(517) 306-6187
Original Issuance Date:	05/17/2013
License Status:	REGULAR
Effective Date:	11/17/2023
Expiration Date:	11/16/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Employees did not properly supervise Resident A.	No
Additional Findings	No

III. METHODOLOGY

12/13/2023	Special Investigation Intake 2024A1032011
12/14/2023	Special Investigation Initiated - Telephone Interview with complainant
12/28/2023	Inspection Completed On-site
01/11/2024	APS Referral
01/17/2024	Exit Conference

ALLEGATION:

Employees did not properly supervise Resident A.

INVESTIGATION:

On 12/14/23, I interviewed the complainant via telephone. The complainant verified the accuracy of the complaint information.

On 12/18/23, I interviewed employee Jamie Muller via telephone. Ms. Muller stated that she was the employee on shift when Resident A sustained a fall. She reported that Resident A fell in the bathroom. Ms. Muller described following protocol after the fall, which was to notify EMS. She denied picking Resident A up from the floor as the home's policy is not to do so. She advised that Resident A would leave her walker

outside of the restroom while she used it, but since the fall, Resident A now takes the walker into the restroom, while an employee stands outside.

On 12/28/23, I interviewed manager Tonya Bernath in the home. Ms. Bernath advised that Resident A had been engaging in self-injurious behavior, pressing her skin and leaving bruises. Ms. Bernath advised that Resident A had been also engaged in some bizarre behavior; she reported that on one of her falls, a doctor reviewed a picture of Resident A fallen in the shower, where her clothing appeared unruffled and her glasses were not disturbed. In addition, there was no bruising on her back where she was resting on the lip of the shower entrance.

I reviewed Resident A's *Resident Assessment Plan*. I advised Ms. Bernath to adjust Resident A's plan to reflect the noted changes in the level of supervision and care provided by the home.

I interviewed Resident A in the home. I observed a walker located nearby for her use. I tried to ask Resident A about her bruising and she pulled back her sleeve, to reveal no bruises. I asked Resident A about her recent falls, but she did not respond directly to my question. I asked Resident A if she was aware of any change in protocol to address her falls and she stated that she did not know.

On 1/11/24, I interviewed Adult Protective Services Specialist Samantha Garcia by telephone. I advised her that in speaking to the home manager, it was apparent that the bruises on Resident A's arms were self-inflected. Ms. Garcia advised that she had closed her case and that she was not able to establish any violations.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on my interviews with the staff and APS, and my review of the *Resident Assessment Plan*, there does not appear to be sufficient information to establish a violation. The home was advised to update Resident A's plan to reflect the new fall precautions and interventions to address self-injurious behavior.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 1/17/24, I conducted an exit conference with licensee designee Keith Marshall. I shared my findings and Mr. Marshall agreed with the conclusions reached.

IV. RECOMMENDATION

I recommend no change to the status of this license.

1/26/24

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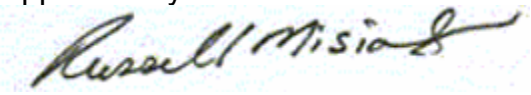
Dwight Forde Date
Licensing Consultant

Approved By:



1/26/24

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Russell B. Misiak Date
Area Manager