GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 2, 2024

Kim Lich
3014 Marvin Drive
Adrian, MI 49221

RE: License #: AF460402901
Investigation #: 2024A1032033
Liberty Place

Dear Kim Lich:

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.

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
350 Ottawa, N.W. Unit 13, 7th Floor
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AF460402901
Investigation #:	2024A1032033
Complaint Receipt Date:	04/04/2024
Investigation Initiation Date:	04/09/2024
Report Due Date:	06/03/2024
Licensee Name:	Kim Lich
Licensee Address:	3014 Marvin Drive Adrian, MI 49221
Licensee Telephone #:	(517) 265-9354
Name of Facility:	Liberty Place
Facility Address:	3014 Marvin Drive Adrian, MI 49221
Facility Telephone #:	(517) 265-9354
Original Issuance Date:	03/06/2020
License Status:	REGULAR
Effective Date:	09/06/2022
Expiration Date:	09/05/2024
Capacity:	6
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Relatives were prevented from visiting Resident A.	No
Resident A's healthcare needs were not met.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/04/2024	Special Investigation Intake 2024A1032033
04/09/2024	Special Investigation Initiated - Telephone Interview with complainant
04/09/2024	APS Referral
04/10/2024	Contact - Face to Face
04/11/2024	Referral - Law Enforcement Contact with Madison Township Officer Burke
04/15/2024	Contact - Document Received Hospice of Lenawee case notes
04/17/2024	Inspection Completed On-site
04/29/2024	Contact - Telephone call made Contact with Officer Burke
05/02/2024	Exit Conference

ALLEGATION:

Relatives were prevented from visiting Resident A.

INVESTIGATION:

On 4/8/24, I interviewed the complainant via telephone. I was advised that prior to Resident A admitted to the home there were no signs of edema, and that Resident A's skin was clear. Upon discharge, I was advised that Resident A had pitting edema in lower extremities, and that she must now receive once a day wound care. Resident A was also reportedly covered in bruises, on forehead and arms. Resident A was made to sit in a wheelchair and not allowed to rest. Resident A's family was told not to visit for at least 14 days to allow her to acclimate to the home.

On 4/9/24, I interviewed Relative A1, at the new home. Relative A1 stated that she was advised to postpone visits to Liberty Place for two weeks, so that Resident A could acclimate to the new environment. Relative A1 denied being prevented from visiting Resident A. Relative A1 reported that Resident A was receiving hospice care services.

On 4/17/24, I interviewed licensee Kim Lich in the home. Ms. Lich denied imposing restrictions on the family visits. She stated that she was asked about how long the family should stay away to allow Resident A to acclimate to the new home and she suggested five days.

APPLICABLE RULE	
R 400.1409	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, the licensee shall inform and explain to the resident or the resident's designated representative all of the following resident rights: **(k) The right to have contact with relatives and friends and receive visitors in the home at a reasonable time.**

ANALYSIS:	Relative A1 denied that she was prevented from visiting Resident A. There appears to be some discrepancy between parties as to how much time was recommended for Resident A to acclimate to the new surroundings, but relatives were not prevented from visiting the home.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's healthcare needs were not met.

INVESTIGATION:

On 4/17/24, Relative A1 stated that Resident A lived at home with her, but she was unable to provide care due to a decline in Resident A's physical condition, relative to Relative A1's ability to provide care, such as transferring her. Relative A1 stated that Resident A was able to ambulate with some assistance. She reported that Resident A was able to speak clearly as well, but her speech became confused recently, and she would forget things. Relative A1 described Resident A asking to use the bathroom, then being confused once she was in the bathroom, as to why she was there. Relative A1 stated that Resident A was left in a chair, and not allowed to have her feet elevated. Relative A1 stated that after Resident A left the home, she could no longer speak clearly, and she was completely dependent on others to feed her.

I interviewed Registered Nurse Aumend Cunningham at Resident A's new home. Ms. Cunningham reported that as a result of being made to sit in a chair, fluid pooled in Resident A's legs, resulting in several edemas. She also displayed a bruise on Resident A's upper left arm that she stated could have been attributed to the arm being gripped too tightly.

I observed Nurse Cunningham providing wound care to Resident A's legs.

I interviewed Nurse Practitioner Shane LaGore in the facility. Mr. Lagore stated that he had assessed Resident A after she left Liberty Place, and that Resident A was in a state of rapid decline. He advised that Resident A was having difficulty transferring and would have needed assistance moving from a chair to a bed. He stated that she would have needed a lift device.

I interviewed Nurse Practitioner McCowen in the facility. Ms. McCowen stated that Resident A had declined considerably, between going to Liberty Place. Ms. McCowan stated that there was a bruise to the back of Resident A's head that was not present before she was admitted to Liberty Place.

I was unable to interview Resident A due to her physical condition.

On 4/11/24, I was contacted by Officer Burke of the Madison Township Police Department. Officer Burke requested copies of my findings.
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On 4/15/24, I received case notes related to Resident A's care from Hospice of Lenawee.

On 4/17/24, I interviewed licensee Kim Lich in the home. Ms. Lich stated that Resident A was in the home for nine days. She discussed not noticing the bruising on Resident A's legs because that area was typically covered by garments, when she assisted Resident A with toileting. She stated that when she did notice bruising and edemas on Resident A's legs, she contacted Hospice of Lenawee Nurse Aumend Cunningham, who she said advised her to make sure that Resident A's legs were elevated. She stated that she also asked for some socks to be delivered. She discussed being cautious when transferring Resident A because of potential for bruising. She stated that when Resident A slept, they would place pillows under her legs.

Ms. Lich stated that Resident A did not sleep very well upon admission.

Ms. Lich denied requiring Resident A to be awake and alert during the day. She acknowledged that Resident A did spend the day in a lift chair that allowed the legs to be elevated. She stated that typically in the afternoon, she would engage Resident A in an activity, such as coloring, at the table, and surmised that Resident A's legs were not reclined for not longer than three hours.

Ms. Lich denied that during Resident A's nine day stay, that she fell. She mentioned receiving a report after Resident A left the home, that there was a bruise at the back of Resident A's head being attributed to falls.

Ms. Lich stated that Resident A required assistance with eating but was able to handle utensils.

I asked for a copy of Resident A's Health Care Appraisal but it was not available. Ms. Lich advised that she would forward a copy of the document to me once she found it.

I reviewed a copy of Resident A's assessment plan, which detailed a need for Resident A to have her food cut up into small pieces. I did not see instructions about raising Resident A's legs.

On 4/18/24, while reviewing Hospice of Lenawee notes, an entry was made indicating that Ms. Lich was frustrated that the family planned to visit for a long period of time, and that Resident A was not going to be allowed to sleep in the day

so that she could sleep at night and not upset the home's routine. A note dated 3/26/24 outlined the appearance of pitted edemas on Resident A's legs during a nursing visit, and continued resistance on Ms. Lich's part to allow Resident A to elevate her legs at all times rather than have her awake and alert in a seated position in a wheelchair.

On 4/29/24, I spoke with Officer Burke, who shared that an autopsy was conducted on Resident A, and that the report should be available within a month. He shared that while the autopsy did not conclude that Resident A's death was caused by the events in the home, the unofficial findings reflect signs of neglect.

APPLICABLE RULE	
R 400.1416	**Resident healthcare.**
	(1) A licensee, in conjunction with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician regarding medications, special diets, and other resident healthcare needs that can be provided in the home.
ANALYSIS:	While it is not known for sure how Resident A acquired the bruise to the back of her head, it does seem reasonable to associate her decline and development of pitted edemas related to her lack of repositioning and elevation of the legs. Hospice care notes reflect resistance on Ms. Lich's part, to elevate Resident A's legs. Ms. Lich acknowledged that there was at least a three-hour period where Resident A was in a seated position.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

I requested a copy of Resident A's health care appraisal as it was not in the resident's file during my onsite inspection. At the time this report was completed, the document had still not been furnished.

APPLICABLE RULE	
R 400.1422	**Resident records.**
	(1) A licensee shall complete and maintain a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: **(i) Health care appraisals.**
ANALYSIS:	No healthcare appraisal was provided.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 5/2/24, I attempted to conduct an exit conference with licensee Kim Lich. I left a voicemail where I shared my findings.

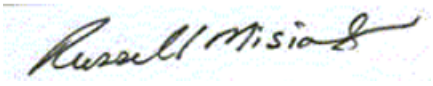
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change to the status of this license.

5/2/24

Dwight Forde — Date
Licensing Consultant

Approved By:



5/3/24

Russell B. Misiak — Date
Area Manager