GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 3, 2024

Betty Awere
Key Assisted Living LLC
851 Turner NW
Grand Rapids, MI 49504

RE: License #: AM410360748
Investigation #: 2024A0340033
Key Assisted Living

Dear Ms. Awere:

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 May 27, 2024, 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,

Rebecca Piccard

Rebecca Piccard, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 446-5764

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM410360748
Investigation #:	2024A0340033
Complaint Receipt Date:	04/30/2024
Investigation Initiation Date:	04/30/2024
Report Due Date:	06/29/2024
LicenseeName:	Key Assisted Living LLC
Licensee Address:	851 Turner NW, Grand Rapids, MI 49504
LicenseeTelephone #:	(616) 322-9120
Administrator:	Betty Awere
Licensee Designee:	Betty Awere
Name of Facility:	Key Assisted Living
Facility Address:	851 Turner NW, Grand Rapids, MI 49504
Facility Telephone #:	(616) 350-9008
Original Issuance Date:	01/06/2015
License Status:	REGULAR
Effective Date:	07/05/2023
Expiration Date:	07/04/2025
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 4/26/24 Resident A fell and hurt his arm. The licensee Betty Awere did not bring him to the ER or Urgent Care at the time.	Yes

III. METHODOLOGY

04/30/2024	Special Investigation Intake 2024A0340033
04/30/2024	APS Referral reported by APS
04/30/2024	Special Investigation Initiated – Telephone call made Michael Kuik-ORR
05/23/2024	Inspection Completed On-site
05/23/2024	Inspection Completed-BCAL Sub. Compliance
05/24/2024	Exit Conference
05/24/2024	Corrective Action Plan Requested and Due on 06/03/2024
05/27/2024	Corrective Action Plan Received
05/27/2024	Corrective Action Plan Approved

ALLEGATION: On 4/26/24 Resident A fell and hurt his arm. The licensee Betty Awere did not bring him to the ER or Urgent Care at the time.

INVESTIGATION: On April 30, 2024, a complaint was received from Adult Protective Services. It stated that on 4/26/24, Resident A fell at the home and hurt his arm. Ms. Awere did not offer him ice to put on it nor did she take him to the hospital or urgent care.

April 30, 2024, I contacted Michael Kuik from the Office of Recipient Rights (ORR) and informed him of the allegation. He stated there are no Network180 residents at the home.

On May 23, 2024, I conducted an unannounced home inspection. I interviewed Resident A privately on the porch. He remembered me from a previous visit. He stated it was early in the morning on 4/26/24 and he thinks he was “still sleepy”

when he fell down, unsure how or why he fell. He did not feel any pain at first but the next day (4/27/24) it was swollen. Ms. Awere gave him a towel with some ice in it. Resident A asked Ms. Awere if he needed to call 911 but Ms. Awere said it was "not an emergency". The next day (4/28/24) Resident A called the doctor to make an appointment and he was seen on Monday (4/29/24). His hand was fractured. Resident A was not angry with Ms. Awere that he did not go to the ER because he said his hand did not hurt at the time and he didn't know it was broken. I informed Resident A that he does not need permission from Ms. Awere if he feels there is a need to go to the hospital. If he is able to call and wants to go he can call or ask someone to call for him and he should not be denied.

I then interviewed Ms. Awere. I asked her why she did not call 911 or bring Resident A to the Med Center. She stated that Resident A is very independent and believed that if he wanted to go to the Med Center, he would make arrangements to go. She does not provide any transportation. Ms. Awere knew that Resident A fell but he did not complain of pain. She also knew his hand didn't swell until the next day. She stated she would've helped him arrange to go to the Med Center, but Resident A told her he called his doctor and made an appointment for Monday. She stated Visiting Physicians arrived on Monday with a mobile X-Ray machine and that's when they found out he fractured his hand.

I discussed with Ms. Awere that while he did not complain of pain, it is still her responsibility to ensure Resident A receives proper medical attention quickly to make sure he is okay. She could have called family or his guardian to transport him to a Med Center or ER if she was unable to provide transportation or she could have called 911. I stressed to Ms. Awere that although she believes Resident A to be independent, he still resides in an AFC so it is her responsibility to ensure his well-being. I also advised Ms. Awere that it is not for her to determine if he needs care or not and that it is recommended she err on the side of caution. Ms. Awere understood.

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:	The allegation was made that on 4/26/24 Resident A fell and injured himself. Ms. Awere would not bring him to the ER or call 911. Resident A stated he did fall and his hand began to swell the next day. Ms. Awere gave him some ice. She told Resident A he should not call 911 because this was "not an emergency". Resident A called his doctor and made an appointment for the

	following Monday. Ms. Awere stated she does not provide transportation. She did not call 911 or ensure Resident A received medical attention sooner because he had made an appointment with his doctor. Resident A was seen by visiting physicians three days after the event and it was discovered he had broken his hand. There is a preponderance of evidence that Ms. Awere did not seek immediate needed care.
CONCLUSION:	**VIOLATION ESTABLISHED**

On May 23, 2024, I conducted an exit conference with Ms. Awere. I informed her I did find a rule violation in this incident that she should have sought medical care for Resident A after he fell and his hand began to swell. She understood and agreed to send a corrective action plan which she sent on 5/27/24.

II. RECOMMENDATION

After receiving an approved Corrective Action Plan, I recommend no change to the current license status.

Rebecca Piccard June 3, 2024

Rebecca Piccard Date
Licensing Consultant

Approved By:

Jerry Hendrick June 3, 2024

Jerry Hendrick Date
Area Manager