GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 3, 2024

Kenneth Jordan
Samaritan Homes, Inc.
22610 Rosewood
Oak Park, MI 48237

RE: License #: AS820068075
Investigation #: 2024A0116028
Vreeland Home

Dear Mr. Jordan:

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. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (313) 456-0380.

Sincerely,

Pandrea Robinson

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820068075
Investigation #:	2024A0116028
Complaint Receipt Date:	05/08/2024
Investigation Initiation Date:	05/08/2024
Report Due Date:	07/07/2024
Licensee Name:	Samaritan Homes, Inc.
Licensee Address:	22610 Rosewood Oak Park, MI 48237
Licensee Telephone #:	(248) 399-8115
Administrator:	Kenneth Jordan
Licensee Designee:	Kenneth Jordan
Name of Facility:	Vreeland Home
Facility Address:	17090 Ray Riverview, MI 48194
Facility Telephone #:	(734) 282-0230
Original Issuance Date:	10/01/1995
License Status:	REGULAR
Effective Date:	05/15/2024
Expiration Date:	05/14/2026
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 03/25/24, Resident A fell and sustained a gash on her head that needed staples and a broken neck. Staff reported that Resident A fell out of her bed, however, it appears that they do not know how Resident A fell. It is alleged that Resident A is now paralyzed.	No

III. METHODOLOGY

05/08/2024	Special Investigation Intake 2024A0116028
05/08/2024	Special Investigation Initiated - Telephone Left a message for assigned Adult Protective Services investigator (APS), Kya Lockett, requesting a return call.
05/08/2024	Referral - Recipient Rights
05/08/2024	Contact - Telephone call received Spoke to assigned ORR investigator, Nancy Foster.
05/15/2024	Inspection Completed On-site Interviewed home manager, Brianne Jones, staff, Doris Cook, Maliah Brown and Britney Jemison, and reviewed Resident A's Individual Plan of Service (IPOS) dated 08/23/23, health care appraisal and walker order.
05/16/2024	Contact - Telephone call made Spoke with assigned ORR investigator, Nancy Foster.
05/22/2024	Contact - Telephone call made Interviewed Guardian (A).
05/22/2024	Contact - Telephone call made Interviewed Resident A's supports coordinator, Annette Downey.
05/22/2024	Contact - Telephone call made Interviewed assigned APS investigator, Kya Lockett.
05/22/2024	Contact - Telephone call received Spoke to ORR investigator, Ms. Foster.

05/23/2024	Contact - Face to Face Interviewed Resident A.
05/29/2024	Exit Conference With licensee designee, Kenneth Jordan.

ALLEGATION:

On 03/25/24 Resident A fell and sustained a gash on her head that needed staples and a broken neck. Staff reported that Resident A fell out of her bed, however, it appears that they do not know how Resident A fell. It is alleged that Resident A is now paralyzed.

INVESTIGATION:

On 05/08/2024, I received a telephone call from ORR investigator, Nancy Foster. Ms. Foster reported that she would be investigating the allegations and would be in contact with me during the course of the investigation.

On 05/15/24, I conducted an unscheduled onsite investigation and interviewed home manager, Brianne Jones, staff Doris Cook, Maliah Brown and Britney Jemison. I also reviewed Resident A's current IPOS, health care appraisal and written order for her walker.

Home manager, Brianne Jones reported that she was in the home preparing for the upcoming renewal inspection and was not a part of the staff to resident ratio but heard what was going on and assisted the staff. Ms. Jones reported that the staff on duty during the afternoon shift (4:00 p.m.- 12:00 a.m.) on 03/25/24, was Doris Cook, who was assigned staff for Resident A and Resident B, Maliah Brown 1:1 staff for Resident C and staff Britney Jemison 1:1 staff for Resident D.

I interviewed staff, Doris Cook, and she reported that shortly before 9:45 p.m. Resident A had defecated on herself, so she showered her she went to bed. Ms. Cook reported that she completed a bed check on Resident A at 10:15 p.m. and again at 10:45 p.m. Ms. Cook reported shortly after the 10:45 p.m. bed check she heard a loud thud and she, along with staff, Ms. Brown, Ms. Jemison and Ms. Jones all ran to Resident A's bedroom. Ms. Cook reported thar she observed Resident A on the floor next to her dresser. Ms. Cook reported that Ms. Jones took over from there and advised all of them not to move Resident A as they were all unaware of how serious the fall may have been, and she proceeded to call 911. Ms. Cook reported that she followed the ambulance to the hospital and reported staying with Resident A until she was admitted early morning on 03/26/24 at around 5:00 a.m.

I interviewed staff, Maliah Brown, and she reported that while doing paperwork in the kitchen area, at about 10:50 p.m., on 03/25/24 she heard a loud noise, and jumped up and ran to Resident A's room. Ms. Brown reported that she observed Resident A sitting on her buttocks with her back leaning against the dresser. Ms. Brown reported she asked Resident A what happened, and she reported that told her she had tripped over her walker and fell. Ms. Brown reported that she observed Resident A's walker some distance from her bed which to her confirmed that when Resident A tried to get out of bed and tripped on the walker it must have pushed the walker away from her. Ms. Brown reported that Resident A is known to move fast, and they constantly remind her to slow down and get her balance before she starts moving.

I interviewed home manager, Brianne Jones, and she reported that she was the last person to make it to Resident A's room after hearing the noise coming from the back of the home. Ms. Jones reported that when she entered the bedroom, she observed Resident A sitting on her buttocks, leaning against her dresser. She reported that Ms. Brown, Ms. Cook and Ms. Jemison were standing around Resident A instructing

her not to move and asking her where she was hurting. Ms. Jones reported she instructed the staff not to move her. Ms. Jones reported that first aid training instructs them to make the person comfortable without moving them until medical help arrives. Ms. Jones reported that upon closer examination she observed blood dripping down the right side, toward the back area of Resident A's head. Ms. Jones reported Resident A was able to verbalize that her head and back was hurting. Ms. Jones reported that she retrieved the telephone and called 911 and Guardian A. Ms. Jones reported that while she was making the calls she could hear staff telling Resident A to be still and to stop attempting to get up. Ms. Jones reported that they then all observed Resident A roll over on her knees, use her arms to bear weight and crawl up into the recliner chair in her bedroom. Ms. Jones reported that they were still pleading with Resident A to not move because she could be doing more harm than good to her body. Ms. Jones reported that Resident A kept saying she was not comfortable and that her back was hurting. Ms. Jones reported that Resident A then started to complain that the recliner was hurting her back and she started moving and trying to get out of her recliner into the recliner in the living room area. Ms. Jones reported that Guardian A was on the speaker phone during this time, was advising Resident A to stop moving and to remain still until Emergency Medical Services (EMS) arrives. Ms. Jones reported by this time, Resident A had stood up, and grabbed a hold to Ms. Jemison and Ms. Jemison guided her to the recliner in the living room. Ms. Jones reported that Ms. Jemison did not want to risk Resident A falling again so she assisted her after she grabbed a hold of her. Ms. Jones reported that EMS was coming through the door at that time. Ms. Jones reported that EMS assessed Resident A and said she was fine, it was only a minor contusion to her head, and they were not going to take her to the hospital. Ms. Jones reported that she insisted they take her because she had hit her head and they wanted her examined to make sure she did not sustain a concussion. Ms. Jones reported they EMS reluctantly obliged. Ms. Jones reported that the emergency medical technicians (EMTs) allowed Resident A to stand up and get on the stretcher with minor assistance from them.

I interviewed staff, Britney Jemison, and she provided the same account previously provided by Ms. Brown and Ms. Jones. Ms. Jemison only added that no matter how many times they all instructed Resident A to remain still, she refused and was adamant about getting to the recliner in the living room. Ms. Jemison confirmed that Resident A stood up and grabbed a hold of her, and at that point she was forced to guide her to the living room recliner to sit, as she did not want to risk Resident A trying to get to the recliner on her own and end up falling and hurting herself again.

Ms. Cook, Ms. Brown, Ms. Jemison and Ms. Jones all denied ever telling EMS or the EMTs that Resident A fell out of her bed. They reported they all knew that a fall from her bed would not have caused her injuries. They reported being unaware of who or where that statement originated from. They all further reported that this is Resident A's first time falling since living in the home. Resident A was admitted on 06/04/21.

Ms. Jones added that she has been communicating with Guardian (A) and reported that he informed her that Resident A had to have surgery and during the procedure the doctors saw some inflammation on some of the nerves on her back and neck possibly from a previous fall years ago, prior to her moving into their home. Ms. Jones reported that Guardian A reported that the surgery went well, but shortly after they noticed a change in Resident A and she was unable to move her legs. Ms. Jones reported that Guardian A reported that Resident A may be paralyzed from her waist down.

Prior to leaving the home, I reviewed Resident A's IPOS dated 08/23/23. The IPOS documents that staff should be doing hourly checks on Resident A during sleeping hours as she at times will attempt to get up and pace the floor or attempt to go to the front door. The IPOS also documents that Resident A's gait is unsteady at times due to a previous back surgery. I also reviewed Resident A's health care appraisal dated 02/21/24 which documents the need for a walker to use for short distances or as needed. The written order from her physician for the walker was also attached and in the file.

I also observed the layout of Resident A bedroom and her bed while staff explained where she was found and their belief that she must have hit her head on the dresser based on its proximity to her bed and where she was found.

On 05/16/24, I interviewed ORR investigator, Nancy Foster. Ms. Foster reported that based on the information obtained during her investigation she will not be substantiating the allegations. Ms. Foster reported her belief that Resident A tripped over her walker and fell, and that staff acted appropriately by providing first aid and attempting not to move Resident A. Ms. Foster reported that the staff had no control over Resident A deciding to move even after repeatedly being told not to do so. Ms. Foster reported that the staff all shared the same sequence of events. Ms. Foster also reported she received and reviewed the progress notes from Henry Ford Hospital and reported there were no documented concerns or suspicious injuries to Resident A.

On 05/22/24, I interviewed Guardian A and he reported that he has not had any concerns regarding the care the staff at the home provide. Guardian A reported that the incident appears to have been accidental and that the staff did what they needed to do to ensure Resident A got immediate help after the fall. Guardian A reported that he and his sister are working to get Resident A assessed for skilled nursing care for at least the next few months so that she can continue to receive physical and occupational therapy.

On 05/22/24, I interviewed Annette Downey, supports coordinator with Community Living Services. Ms. Downey reported that Resident A's previous supports coordinator moved out of state recently and so she has just stepped in to help to get her assessed for nursing care. Ms. Downey reported that she saw Resident A on 05/15/24 at the nursing/rehabilitation facility. Ms. Downey reported she is making

progress, is able to stand and bear weight and can assist while being transferred. Ms. Downey reported that Guardian A would like for her to remain in the nursing/rehabilitation facility so that she can continue receiving the physical and occupational therapy before she is placed back in another group home setting. Ms. Downey reported that they are hoping to get a 90-day approval for Resident A to remain in the nursing/rehabilitation facility and after that she will be re-evaluated to determine the next best placement for her.

On 05/22/24, I interviewed assigned APS investigator, Kya Lockett, and she reported that she will not be substantiating the allegations. Ms. Lockett reported that she believes it was an accidental fall and that the staff acted appropriately. Ms. Lockett reported that during her last visit to Resident A on 05/09/24 she was working with physical therapy and was on a stationary bike moving her legs very well. Ms. Lockett reported that she did observe her with a neck brace on, but reported it was evident that she was making progress. Ms. Lockett reported that while she may have some paralysis in areas, she did not appear to be totally paralyzed from the waist down as initially reported. Ms. Lockett reported that Resident A did express to her that she fell, but due to her mental capacity was unable to provide any specific details.

On 05/23/24, I conducted a face-to-face interview with Resident A at Fountain Bleu Health and Rehabilitation Center. Resident A was sitting in a wheelchair and had a neck brace on. Resident A reported that she fell and forgot to use her walker. Resident A reported that “staff Bri helped me.” Resident A could not provide any other details and began repeating the questions asked of her. Resident A was observed using her legs to move herself around in the wheelchair and whispered that her legs were hurting. This concluded the interview.

On 05/29/24, I conducted the exit conference with licensee designee, Kenneth Jordan and informed him of the findings of the investigation. Mr. Jordan agreed with the findings and reported that it was an unfortunate incident but reported that his staff followed their training and acted appropriately.

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 the findings of the investigation, which included interviews of Ms. Cook, Ms. Brown, Ms. Jones, Ms. Jemison Guardian A and Resident A I am unable to corroborate the allegations. Ms. Cook, Ms. Brown, Ms. Jones, Ms. Jemison all reported that Resident A had an accidental fall while attempting to get out of bed causing her to sustain a contusion to her head and some form of paralysis to her lower extremities. Ms. Cook, Ms. Brown, Ms. Jones, Ms. Jemison acted appropriately during the incident and immediately sought medical attention for Resident A. Guardian A reported having no concerns regarding the care the home provided and believes Resident A's fall was accidental. Resident A reported that she fell because she forgot to use her walker. ORR and APS have concluded their investigations and will not be substantiating the allegations, after determining that Resident A's fall was accidental and the staff acted appropriately.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

I recommend the status of the license remain unchanged.

Pandrea Robinson
Licensing Consultant

05/31/24
Date

Approved By:

06/03/24

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Ardra Hunter Date
Area Manager