GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 14, 2024

Kory Feetham
Big Rapids Fields Assisted Living LLC
4180 Tittabawassee Rd
Saginaw, MI 48604

RE: License #: AL540402190
Investigation #: 2024A1029044
Big Rapids Fields Assisted Living

Dear Mr. Feetham:

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. Failure to submit an acceptable corrective action plan will result in disciplinary action.

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 (231) 922-5309.

Sincerely,

Jennifer Browning

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
browningj1@michigan.gov - 989-444-9614

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL540402190
Investigation #:	2024A1029044
Complaint Receipt Date:	04/24/2024
Investigation Initiation Date:	04/24/2024
Report Due Date:	06/23/2024
Licensee Name:	Big Rapids Fields Assisted Living LLC
Licensee Address:	18900 16 Mile Road, Big Rapids, MI 49703
Licensee Telephone #:	(989) 450-8323
Administrator:	Kenda Gilbert
Licensee Designee:	Kory Feetham
Name of Facility:	Big Rapids Fields Assisted Living
Facility Address:	18900 16 Mile Road, Big Rapids, MI 49703
Facility Telephone #:	(810) 931-1961
Original Issuance Date:	12/21/2020
License Status:	REGULAR
Effective Date:	06/21/2023
Expiration Date:	06/20/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A fell in her bedroom burning herself on her heater and direct care staff members did not seek immediate medical treatment.	No
The residents at Big Rapids Fields Assisted Living eat microwaved meals and sometimes do not eat at all.	No
Additional Findings	Yes

III. METHODOLOGY

04/24/2024	Special Investigation Intake 2024A1029044
04/24/2024	Special Investigation Initiated – Letter to APS supervisor, Emily Pierce
04/25/2024	APS Referral - Emily Pierce stated it was sent back for review and then denied.
05/03/2024	Inspection Completed On-site - Face to Face with administrator Kenda Gilbert, direct care staff members Tricia Hottman, Betty Hubbard, Heather Fennema, Samantha Shopp, Sydney Worth, Wyatt Gilbert, Resident B, Resident C at Big Rapids Fields Assisted Living
05/07/2024	Contact - Document Received Email From Kenda Gilbert
05/29/2024	Contact - Telephone call made to Kenda Gilbert
06/07/2024	Contact - Document Received - Email from Kenda Gilbert regarding heaters.
06/12/2024	Contact - Telephone call made licensee designee Kory Feetham, left message.
06/12/2024	Contact – Telephone call to Starr Felde, RN – Corewell Hospice, Lee, left a message, direct care staff member Shawn Ring, left message, Bridget Lapinsky, left message, Alianna Sanford, left message, licensee designee Kory Feetham

06/13/2024	Contact - Telephone call to direct care staff member Bridget Lapinsky, administrator Kenda Gilbert
06/13/2024	Exit conference with licensee designee Kory Feetham, left message.

ALLEGATION: Resident A fell in her bedroom burning herself on her heater and direct care staff members did not seek immediate medical treatment.

INVESTIGATION:

On April 24, 2024 a complaint was received via a denied Adult Protective Services (APS) complaint from Centralized Intake with allegations Resident A fell in her bedroom and burned herself on the heater and direct care staff members did not seek immediate medical treatment. According to the complaint allegations, Resident A fell on April 20, 2024 and then cried out in her room throughout the night for assistance for seven hours before direct care staff members helped her.

On May 3, 2024, I completed an unannounced on-site investigation at Big Rapids Fields Assisted Living and interviewed administrator Kenda Gilbert. Ms. Gilbert stated Resident A's fall was not on April 20, 2024, but instead on April 7, 2024. Ms. Gilbert stated Resident A injured the inside of her leg but Ms. Gilbert was not sure how this injury occurred. Ms. Gilbert stated when she completed the skin assessment before Resident A was sent to the hospital, there was a skin tear near the knee on both legs. Ms. Gilbert stated Resident A fell on her hands and knees but she did not fall on a space heater because there was not one in the room. Ms. Gilbert stated each resident bedroom has a small heater along the wall in the bedroom but this would be difficult to fall onto because of the location. Ms. Gilbert stated direct care staff members immediately sent Resident A for treatment and contacted her primary care provider. Ms. Gilbert stated the skin tears were noted on the skin assessment but her legs did not have any other severe injury when she left the facility. Ms. Gilbert stated upon Resident A's return from the hospital, she noticed the injuries looked much worse covering her entire knee area. Ms. Gilbert stated Corewell Hospice was involved after Resident A's return from the hospital until she passed away on April 17, 2024.

During the on-site investigation, I reviewed the *Skin Assessment* that was completed by Ms. Gilbert after Resident A's fall on April 7, 2024 at 1:45 PM. I observed there was a notation there was a skin tear on both knees from the fall.

I reviewed the *AFC Incident / Accident Report* April 7, 2024 1:45 PM written by direct care staff member Bridget Lapinsky which included the following documentation:

"Explain what happened: Staff and I got resident up for lunch and she has been weak the last couple days. She did get up fine, just needed assistance, I walked through to check on her and she was on the ground.

<u>Action taken by staff:</u> I immediately took vitals to make sure she was okay and she was unresponsive and breathing heavy. I checked her eyes and pupils were not dilated but she was not awake. After a few minutes of checking her over, she woke up and opened her eyes but her heart rate was high. I called on call. They told me to call 911 and call POA. I called and stayed with her until EMS arrived, I called her POA and gave EMS her medication list. Vitals: 152 Heart rate, Temp 98.3, Oxygen 84, Blood pressure 183/66."

According to the AFC Incident / Accident Report the incident occurred on April 7, 2024 1:45 PM and Corewell Health Hospital was contacted at 2:15 PM.

I also reviewed the resident register showing Resident A moved into Big Rapids Fields Assisted Living on January 8, 2024 and passed away April 17, 2024.

I reviewed the *Corewell Health Transfer of Care* showing an admission date of April 7, 2024 and a discharge date of April 11, 2024. According to the wound assessment on her discharge paperwork the following wounds are listed with a placement date of April 7, 2024 and listed as present at admission:

1. "Pretibial right upper anterior proximal
2. Left knee lower anterior medial.
3. Left thigh upper anterior medial.
4. Right thigh upper anterior medial"

The discharge orders include the following instructions: Wash gently with sudsy wash cloth, rinse, and pat dry. Apply Critic-Aid Barrier Cream or other silicone cream to soothe and protect two times per day. No dressings at this time because they may stick and cause pain.

On May 3, 2024, I interviewed direct care staff member whose current role is Operations Manager, Tricia Hottmann. Ms. Hottman stated the fall occurred on April 7, 2024 and the direct care staff members completed an AFC Incident / Accident Report stating it occurred at 1:45 PM and EMS came around 2:15 PM. Ms. Hottman stated the two direct care staff members working that day was Bridget Lapinsky and Arianna Burnell. Ms. Hottmann stated Ms. Burnell does not work there any longer, but Ms. Lapinsky is still employed at Big Rapids Fields Assisted Living. Ms. Hottman stated Resident A was first sent to Big Rapids Hospital and then transferred to Meijer Heart Center for other medical reasons. Ms. Hottman stated they were asked by Meijer Heart Center / Corewell Health if they knew where her leg injuries came from.

On May 3, 2024 I interviewed Resident Care Director, Betty Hubbard. Ms. Hubbard stated there was no delay of Resident A receiving treatment because she went to the hospital right after the fall. Ms. Hubbard stated right after Resident A fell, Ms. Lapinsky contacted her to inform her of Resident A's vitals and Ms. Hubbard instructed her to hang up and call 911 because her oxygen was low and she was not responding.

On May 3, 2024, I interviewed direct care staff members Samantha Shopp, Sydney Worth, Ms. Fennema, and Wyatt Gilbert and none of them were present on April 7, 2024 when Resident A fell. All interviewed reported that direct care staff respond promptly after a resident fall. The procedure confirmed by all four direct care staff included doing an assessment of the resident, contact Hospice if applicable, complete their vitals, and call their power of attorney or guardian.

On May 3, 2024, I interviewed Resident B and Resident C. Neither resident reported concerns regarding residents not receiving prompt attention in case of falls. Resident B stated there have been times where he has observed a fall and he would report it to the direct care staff members before the resident can call for assistance. Resident B stated if he saw a resident not getting treatment immediately after a fall, he would report it because he's not shy when something is not right or when he does not like how something is being done. Resident C stated he has not had a fall, but several other residents have and the direct care staff members all respond appropriately.

On June 12, 2024, I interviewed licensee designee Kory Feetham. Mr. Feetham stated he has never had concerns regarding staff members not responding to a fall immediately. Mr. Feetham stated there is a strict policy regarding contacting administration, primary care provider, and the family when an incident occurs and they are required to do so within two hours but they try to keep it within a half hour of the incident. Mr. Feetham stated his assumption is that Resident A's injury became worse over time. Mr. Feetham has not seen the pictures and did not have knowledge of the injury at the hospital.

On June 12, 2024, I contacted Corewell Hospice and RN Felde was not available but I was able to speak with manager, Erica Kirshman. Ms. Kirshman stated she was able to review the notes from RN Felde. Ms. Kirshman stated she was not receiving services through Hospice at the time of the fall but started after she returned from the hospital. Ms. Kirshman stated according to the notes from Resident A's hospice admission notes, Resident A had large blister wounds of an unknown cause.

On June 13, 2024, I interviewed direct care staff member Bridget Lapinsky. Ms. Lapinsky she was familiar with Resident A falling around lunch time on April 7, 2024. Ms. Lapinsky stated when she tried to have Resident A get up for lunch, Resident A did not complain of pain but then changed her mind about going to the dining area after she was up. Ms. Lapinsky stated 10 minutes later she went back to check on Resident A and she was on the floor by her bed, still awake, but not unconscious. Ms. Lapinsky notified another staff and stayed with her while they retrieved the vital equipment. Ms. Lapinsky stated Resident A was not responding well so she called 911 while they were taking Resident A's vitals. Ms. Lapinsky stated after calling 911, she called the manager on call that day. Ms. Lapinsky stated she stayed with Resident A until EMS arrived shortly after. Ms. Lapinsky stated she fell on the ground on her butt but she did have a mark on her left knee that she noticed that was likely a carpet burn. Ms. Lapinsky stated when she found her, she was about five feet away from the heater. Ms. Lapinsky stated at the time of her fall Resident A was not verbal and she was not crying out in

pain. Ms. Lapinsky stated she has never noticed a time where someone did not receive immediate treatment after a fall at Big Rapids Fields Assisted Living. Ms. Lapinsky stated she did see her legs when she returned from the hospital and the injuries were worse than when she left for the hospital. Ms. Lapinsky stated she asked EMS when she came back to the facility and they did not report any injury occurring when she was in the hospital. Ms. Lapinsky stated when she saw her legs after she returned it appeared she had burns on her legs, however, she does not believe she fell on the heater because she was found five feet away from it.

APPLICABLE RULE	
R 400.15310	**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:	According to the documentation from Corewell Health and Corewell Hospice, it does not appear there was a delay in seeking treatment after Resident A's fall. According to the *AFC Incident / Accident Report* the incident occurred on April 7, 2024 1:45 PM and Corewell Health Hospital was contacted at 2:15 PM within 30 minutes of the reported fall. I reviewed the *Corewell Health Transfer of Care* document showing an admission date of April 7, 2024 which was the same date of the fall.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The residents at Big Rapids Fields Assisted Living eat microwaved meals and sometimes do not eat at all.

INVESTIGATION:

On April 24, 2024 a complaint was received via a denied Adult Protective Services (APS) complaint from Centralized Intake with allegations the residents are given microwaved meals and sometimes do not eat at all at Big Rapids Fields Assisted Living.

On May 3, 2024, I completed an unannounced on-site investigation at Big Rapids Fields Assisted Living and interviewed administrator Kenda Gilbert. Ms. Gilbert stated residents do not receive frozen meals and she has no concerns that residents do not get enough to eat.

During the onsite investigation, I observed a variety of food in the refrigerators, freezers, and a large pantry. I also reviewed the menu which included a variety of foods offered to the residents. In the dining room, there was also a bowl of fruit, granola bars, and various snacks for residents to enjoy at any time.

On May 3, 2024 I interviewed Resident Care Director, Betty Hubbard. Ms. Hubbard stated she has no concerns with the lack of food. Ms. Hubbard stated there are times when they need to use the microwave to heat up food but they do not receive TV dinners like Banquet meals. Ms. Hubbard stated all residents receive three meals per day and there are always snacks available to the residents.

On May 3, 2024, I interviewed direct care staff member Heather Fennema. Ms. Fennema was concerned the residents were not getting adequate food because sometimes they will create a menu but the food will not be there so they must improvise and make something else. Ms. Fennema stated the residents do not receive microwaved meals or frozen meals but they will heat it up in the microwave. Ms. Fennema stated there is a good variety of food for the residents and the menu is available so the residents can have it in their rooms. Ms. Fennema stated if a resident does not like what is served, the resident is given other options like leftovers, hot dog, sandwich, or soups.

On May 3, 2024, I interviewed direct care staff members Samantha Shopp, Sydney Worth, and Wyatt Gilbert and none of them had concerns regarding the food choices for the residents and all reported they do not eat microwaved meals unless something is reheated for them. Mr. Gilbert reported the residents always have enough food.

On May 3, 2024, I interviewed Resident B and Resident C. Both reported they like the food served and they receive three meals per day and snacks. Resident B stated the food is okay but it depends on who is cooking. Resident B stated he does not like the coffee they serve so he has a coffee pot in his room. Resident C stated if he does not like the food, he will request a hamburger or hot dog.

On June 12, 2024, I interviewed licensee designee Kory Feetham. Mr. Feetham stated he hasn't had concerns were there was a lack of food in the home. Mr. Feetham has observed them grocery shop so they always have enough food or portions. Mr. Feetham stated there is a designated cook for the facility and fully staffed in the kitchen. Mr. Feetham stated the residents have never been fed microwaved pre-made food at Big Rapids Fields Assisted Living.

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.

ANALYSIS:	Based on interviews with administrator Kenda Gilbert, direct care staff members Tricia Hottman, Betty Hubbard, Heather Fennema, Samantha Shopp, Sydney Worth, Wyatt Gilbert, Resident B, and Resident C there was no indication the residents are given frozen meals or miss meals. Ms. Gilbert stated sometimes the microwave will be used to heat up a meal however, they are not given frozen meals. Resident B and C both stated the food is good and had no complaints. During the onsite investigation on May 3, 2024, I observed a variety of food in the refrigerators, freezers, and a large pantry.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the on-site investigation on May 3, 2024, Ms. Gilbert showed me room 17 where Resident A resided before she passed and I felt the heater in her room which was very hot. The heater was approximately 4 inches wide and it's under the window near the baseboards. The heater was extremely hot to the touch and I could not keep my hand on it for a long time due to the high temperature of the metal. Ms. Gilbert touched it as well and was also surprised at the temperature. Ms. Gilbert and I went into another resident room, turned up the heat, and the heating unit was hot within two minutes. I observed these heating units throughout the resident bedrooms located in the facility. Based on the design of these heating units, residents will be at risk due to how hot to the touch these units become when the heat is on. Mr. Feetham and Ms. Gilbert are trying to work out a solution to the heaters and they are in the process of changing them to a safer option. I advised Ms. Gilbert to contact Bureau of Fire Services to discuss further options to assure the new option is in compliance with Bureau of Fire Services administrative rules.

On June 12, 2024, I interviewed licensee designee Kory Feetham. Mr. Feetham stated he did speak with Ms. Gilbert about swapping out the heaters and they are trying to work with the property owners to figure out the best option. Mr. Feetham stated there are email threads from a couple weeks ago between them trying to figure out a plan that is best but they are still in discussion and nothing has been finalized. Mr. Feetham stated since it is warmer the heat is not running but he would like this issue resolved well before the weather gets cold.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	During the on-site investigation, I observed Resident A's bedroom and the heating unit in her room. The heater was approximately 4 inches wide and located under the window near the baseboards. The heater was extremely hot to the touch. Ms. Gilbert touched it as well and was also surprised at the temperature. Ms. Gilbert and I went into another room to turn the heating unit and it only took minutes for it to become dangerously hot. These heating units are located in each resident bedroom and are not safe for residents due to the risk of being burned. Mr. Feetham and Ms. Gilbert are in the process of changing them to a safer option.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change in the license status.

Jennifer Browning _____06/13/2024_____

Jennifer Browning
Licensing Consultant
Date

Approved By:

Dawn Timm 06/14/2024

_____

Dawn N. Timm
Area Manager
Date