GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 25, 2024

Ronisha Robinson
Cliffside Company
910 S. Washington Av
Royal Oak, MI 48067

RE: License #: AL110087629
Investigation #: 2024A0579028
Caretel Inns of Royalton - Bristol

Dear Ronisha Robinson:

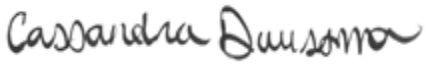
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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 (616) 356-0183.

Sincerely,



Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(269) 615-5050

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL110087629
Investigation #:	2024A0579028
Complaint Receipt Date:	06/12/2024
Investigation Initiation Date:	06/12/2024
Report Due Date:	08/11/2024
Licensee Name:	Cliffside Company
Licensee Address:	910 S. Washington Ave Royal Oak, MI 48067
Licensee Telephone #:	(947) 282-7555
Administrator:	Ronisha Robinson
Licensee Designee:	Ronisha Robinson
Name of Facility:	Caretel Inns of Royalton - Bristol
Facility Address:	3905 Lorraine Path Saint Joseph, MI 49085
Facility Telephone #:	(269) 363-1906
Original Issuance Date:	11/03/2000
License Status:	REGULAR
Effective Date:	12/11/2023
Expiration Date:	12/10/2025
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive appropriate supervision.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/12/2024	Special Investigation Intake 2024A0579028
06/12/2024	Special Investigation Initiated - Telephone Complainant
06/13/2024	Contact- Face to face Latrice Hadley, Direct Care Worker Celeste McGowan, Direct Care Worker Ronisha Robinson, Licensee Designee
07/25/2024	Exit Conference Ronisha Robinson, Licensee Designee

ALLEGATION: Resident A did not receive appropriate supervision.

INVESTIGATION: On 6/12/24, I received this referral which alleged Resident A did not receive appropriate supervision.

On 6/12/24, I completed a telephone interview with Relative A1 who reported Resident A was placed in Bristol Home for rehabilitation after being hospitalized. Relative A1 reported direct care worker (DCW), Arin Hejduk, came to the hospital to assess Resident A for placement at the home. Relative A1 reported relatives advised Ms. Hejduk at the time she assessed Resident A that Resident A needed assistance with transferring, toileting, and eating. Relative A1 stated Resident A's relatives were told Resident A would have a DCW present with her at all times.

Relative A1 stated on the first day Resident A was placed in the home, 4/19/24, relatives stayed with her until approximately 7:30 p.m. Relative A1 said Resident A was left without supervision from approximately 7:30 p.m. until she had a fall leading to injury at approximately 9:00 p.m. Resident A was hospitalized following this fall.

Relative A1 stated Resident A was very alert at the hospital and reported she had been left in her wheelchair for over an hour while at the home, was sore, and asked to move to a chair in the living room. Relative A1 stated Resident A reported a DCW pushed her wheelchair into the living room but did not transfer her to a different

chair, so Resident A attempted to transfer herself and she then fell. Relative A1 stated Resident A reported she laid on the floor and “yelled for help for a long time.”

Relative A1 stated she is Resident A’s Power of Attorney, but did not learn until Resident A returned to the home after her reported fall leading to her hospitalization, that Resident A had a fall prior to that fall that was not reported, and she had actually had two falls during the time she was not supervised. Relative A1 reported DCWs said Resident A should not have been placed in this home because they did not have the level of supervision Resident A needed. Relative A1 reported relatives ended up staying with Resident A at the home until a new placement was found because the level of supervision Resident A needed was not available in the home. Relative A1 reported she feels Resident A did not recover from the fall that led to her hospitalization which led to her death on 5/30/24.

On 6/13/24, I completed an unannounced on-site investigation at Bristol home. Interviews were completed with DCW Latrice Hadley, DCW Celeste McGowan, and Licensee Designee, Ronisha Robinson.

Ms. Hadley and Ms. McGowan stated they had not worked with Resident A. Ms. Hadley reported she was not on the schedule during the days Resident A was in the home. Ms. McGowan reported she was not an employee in April 2024.

Ms. Robinson confirmed Ms. Hejduk met Resident A and her relatives at the hospital to evaluate Resident A for placement and reported Resident A would be a good fit for placement in this home. Ms. Robinson reported Ms. Hejduk did not report that Resident A required 1:1 supervision and a physician’s order was not received noting Resident A required 1:1 supervision. Ms. Robinson reported Resident A would not have been admitted to this home if it was reported she required 1:1 supervision because that is not available at this home. Ms. Robinson reported Ms. Hejduk no longer works at this home.

Ms. Robinson stated she met with Resident A’s family, including Relative A1, at the time of Resident A’s admission, and it was never discussed with her that 1:1 supervision was needed. She stated it was discussed that Resident A could ambulate independently, but she was unsteady, so it was recommended Resident A use a walker. She stated after Resident A was found on the floor in her room after an unwitnessed fall, permission was requested from one of Resident A’s sons for Resident A to use a wheelchair.

Ms. Robinson reported on the day Resident A moved into the home, relatives stayed into the evening. She stated it was reported to her that shortly after relatives left Resident A’s room, Resident A had an unwitnessed fall in her room that did not result in injury. She stated after that fall, a DCW assisted Resident A into a wheelchair, and Resident A was taken to the staff desk while DCWs called the on-call manager to report Resident A’s fall. After reporting the fall, Resident A was moved to the living room, so she was more visible to DCWs.

Ms. Robinson stated she is aware that Resident A's first fall was reported to at least one of Resident A's sons, who gave permission for Resident A to use a wheelchair, and she believes some of Resident A's relatives were still in the home, but not in Relative A's room, at the time of the fall so they were made aware. She stated some relatives had left so it is possible that not everyone was notified by DCWs of the first fall and Relative A1 may not have been notified. She denied that Resident A had a Power of Attorney, as Power of Attorney paperwork was not provided, and reported Resident A's emergency contact was listed as Relative A2. She stated Relative A1 did assist with completing Resident A's intake assessment, but signatures were not obtained on the documentation at the time of intake.

I reviewed documentation regarding Resident A from Corewell hospital from 4/16/24 and 4/19/24. There was no order requiring 1:1 supervision in the documentation, including the "After Visit Summary" discharge paperwork for Resident A.

I reviewed Resident A's assessment plan. Regarding mobility, it was noted Resident A was independent in bed mobility and transferring. It was noted Resident A needs supervision when walking in her room and when toileting. It was noted Resident A was not assessed for walking in the common area, so her supervision requirements were not noted. It noted Resident A uses a walker and a wheelchair.

I reviewed an *Incident/Accident Report* form dated 4/19/24 at 7:55 p.m. It noted, "(Resident A) fell to her butt while trying to go to the bathroom by herself." It was reported in response, Resident A was checked for injuries, none were found, and Resident A was brought to the living room to be "more visible." It was noted this was reported to Resident A's Power of Attorney which was listed as Relative A2.

I reviewed an *Incident/Accident Report* form dated 4/19/24 at 8:25 p.m. It noted Resident A was in the living room after her previous fall and she "ended up on the living room floor saying her arm is broken." It was reported in response, Resident A's Power of Attorney was called, and Resident A was sent to the hospital. Resident A's Power of Attorney was listed as Relative A2.

I reviewed camera footage from the living room of the home at the time of Resident A's second fall. This revealed Resident A was pushed in her wheelchair to the living room and a DCW stepped away at 8:01 p.m. Resident A was observed in her wheelchair fidgeting with her blanket, wheelchair, and call button, although she did not press it. At 8:27 p.m. and 8:34 p.m. a DCW walked past the area and observed Resident A. At 8:43 p.m., Resident A stood up and began pushing her wheelchair before falling to the ground. A DCW and then an individual Ms. Robinson reported was Relative A2 immediately came over and responded to Resident A. It appeared Resident A spent less than a minute on the floor before being assisted to the couch in the home.

On 6/13/24, I exchanged emails with Relative A1 inquiring about her status as Power of Attorney. She provided documentation confirming she was appointed

Resident A's Power of Attorney. She reported no one at the home requested a copy of this document. She reported she was the only person who, no other relatives, have the legal authority to sign documents on behalf of Resident A.

APPLICABLE RULE	
R 400.15303	**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:	Resident A's assessment plan noted she needed supervision when ambulating in her room and when toileting. Relative A1, Ms. Robinson, and the *Incident/Accident Report* (I/AR) form dated 4/19/24 at 7:55 p.m., noted Resident A had a fall in her room while she was unsupervised. The I/AR noted Resident A was attempting to toilet herself prior to the fall. Based on the interviews completed and documentation observed, there is sufficient evidence that Resident A was not provided the supervision specified in her written assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING: On 6/12/24, Relative A1 reported Resident A required 1:1 supervision.

On 6/13/24, Ms. Robinson denied that there were orders received or that it was reported to her that Resident A required 1:1 supervision.

I reviewed Resident A's assessment plan. It was noted Resident A requires supervision when walking in her room and when toileting. It was noted Resident A was not assessed for walking in the common area, so her supervision requirements in that area were not noted.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the

	resident is suitable pursuant to all of the following provisions: **(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.**
ANALYSIS:	Relative A1 reported Resident A required 1:1 supervision. Ms. Robinson reported it was not ordered or reported that Resident A needed 1:1 supervision. Resident A's assessment plan noted Resident A needs "supervision" when walking in her room and when toileting. It noted Resident A's level of supervision in common areas was not assessed and therefore not noted. Based on the interviews completed and documentation reviewed, there is sufficient evidence that Resident A was accepted to the home without it being determined she was suitable for the amount of supervision available in the home. Her assessment plan noted she required "supervision" while in her room and while toileting but did not specify how this would be provided. In additional, her supervision in the common area of the home was not assessed and not noted to ensure it could be provided correctly.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING: On 6/12/24, Relative A1 expressed concern that she did not sign intake paperwork regarding Resident A's supervision needs when Resident A was admitted to the home.

On 6/13/24, while investigating the reported allegations, I reviewed Resident A's assessment plan which did not have signatures from Resident A's designated representative.

Ms. Robison reported relatives, including Relative A1, assisted with completing the assessment plan for Resident A but their signatures were not obtained on the documentation at the time of intake.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**

	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Resident A's assessment plan did not include the signature of her designated representative, Relative A1. Relative A1 denied signing Resident A's assessment plan at the time of Relative A's admission to the home. Ms. Robinson denied obtaining signatures, as confirmation that the assessment plan was completed with Resident A's designated representative, at the time of Resident A's admission to the home. Based on the interviews completed and documentation reviewed, there is sufficient evidence that at the time of admission, a signature was not obtained from Resident A's designated representative confirming Resident A's assessment plan was completed with Resident A's designated representative.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 7/25/24, an exit conference was completed Ms. Robinson who did not dispute my findings or recommendations and agreed to have a virtual training with me so consultation could be provided regarding completing assessment plans.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of corrective action, I recommend the status of the license remain the same.

Cassandra Duursma 07/25/2024

Cassandra Duursma Date
Licensing Consultant

Approved By:

07/25/2024

Jerry Hendrick Date
Area Manager