

GRETCHEN WHITMER GOVERNOR STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

MARLON I. BROWN, DPA DIRECTOR

August 22, 2024

Jody Pettit Precious Days LLC 811 S. Garden Street Alpena, MI 49707

> RE: License #: AS040397418 Investigation #: 2024A0360017 Precious Days of Alpena

Dear Jody Pettit:

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 (616) 356-0100.

Sincerely,

Matter ;

Matthew Soderquist, Licensing Consultant Bureau of Community and Health Systems Ste 3 931 S Otsego Ave Gaylord, MI 49735 (989) 370-8320

enclosure

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

I. IDENTIFYING INFORMATION

1:00000 #	40040207440
License #:	AS040397418
Investigation #:	2024A0360017
Complaint Receipt Date:	06/28/2024
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Investigation Initiation Date:	06/28/2024
investigation initiation pate.	
Banart Dua Data:	08/27/2024
Report Due Date:	00/27/2024
Licensee Name:	Precious Days LLC
Licensee Address:	351 Pinecrest
	Alpena, MI 49707
Licensee Telephone #:	(989) 340-1056
Administrator/Lissness	lady Dattit
Administrator/ Licensee	Jody Pettit
Designee:	
Name of Facility:	Precious Days of Alpena
Facility Address:	351 Pinecrest Street
	Alpena, MI 49707
Facility Telephone #:	(989) 916-8412
Original Issuance Date:	03/21/2019
Oliginal issuance Date.	03/21/2019
License Status:	REGULAR
Effective Date:	09/21/2023
Expiration Date:	09/20/2025
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Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED
	AGED

II. ALLEGATION(S)

Violation Established?

Resident A was injured during a transfer.	No

III. METHODOLOGY

06/28/2024	Special Investigation Intake 2024A0360017
06/28/2024	Special Investigation Initiated - Telephone Complaint Source
07/08/2024	Inspection Completed On-site Resident A, DCS Carla Johnson, Licensee Jody Pettit
07/17/2024	Contact - Document Received Jody Pettit
08/19/2024	Inspection Completed On-site Resident A, Licensee Jody Pettit
08/20/2024	Contact - Telephone call made DCS Ayla Gougen
08/20/2024	Contact - Telephone call made McLaren Hospice RN Jessica Srebnik
08/20/2024	Contact - Telephone call made Guardian A
08/22/2024	Exit Conference with Jody Pettit

ALLEGATION:

Resident A was injured during a transfer.

INVESTIGATION:

On 6/28/24, I was assigned a complaint from the LARA online complaint system.

On 6/28/24, I contacted the complaint source by telephone who stated that a resident fell during a transfer and was injured at the beginning of June.

On 7/8/24, I conducted an unannounced onsite inspection at the facility. I interviewed the direct care staff Carla Johnson. Ms. Johnson stated Resident A did fall in early June and received a small bruise on her face. Ms. Johnson stated she was not aware of any documentation of the fall. I then observed Resident A at the facility. I observed a small quarter sized bruise that was yellow in color on Resident A's face. Resident A was not oriented to time or place. Ms. Johnson stated Resident A fell and hit her face but was unable to provide any further details.

On 7/8/24, while at the facility I interviewed licensee Jody Pettit. Ms. Pettit stated during a transfer in early June Resident A fell forward and received a bruise on her face. She stated the direct care staff doing the transfer was Ayla Gougen. Ms. Pettit stated they immediately contacted McLaren Hospice who came to the home to complete an evaluation of Resident A. She stated Resident A was determined to have no injuries requiring medical attention. Ms. Pettit stated that they also contacted Resident A's guardian. Ms. Pettit stated that prior to the fall Resident A required assistance transferring and the use of a sit to stand as needed. She stated after the fall, Hospice recommended use of the sit to stand for all transfers.

On 7/17/24, I received hospice sit to stand order documentation from Ms. Pettit for Resident A.

On 8/19/24, I conducted another onsite inspection at the facility. I interviewed licensee Jody Pettit in person at the facility. Ms. Pettit provided me with Resident A's written assessment plan dated 5/1/24. The written assessment plan documented that Resident A required assistance for walking/mobility. The description of needs included use of the sit to stand.

I then attempted another interview with Resident A. Resident A was not oriented to time and place. Resident A stated she was doing fantastic.

On 8/20/24, I interviewed direct care staff Ayla Gougen by telephone. Ms. Gougen stated she was transferring Resident A from her wheelchair to her recliner on June 4th. She stated Resident A usually helped assist with the transfer but started falling forward. Ms. Gougen stated she was unable to stop the fall and Resident A fell forward hitting her face on the floor. Ms. Gougen stated she immediately called McLaren Hospice and Resident A's guardian. Ms. Gougen stated McLaren Hospice came to the home immediately and evaluated Resident A and determined that she did not need medical attention. She stated McLaren Hospice then changed the order for the use of the sit to stand from as needed to always.

On 8/20/24, I interviewed McLaren Hospice RN Jessica Srebnik by telephone. Ms. Srebnik stated on June 4th they were notified of Resident A's fall. She stated they sent a nighttime on call nurse to the home for an evaluation. Ms. Srebnik stated it was determined that Resident A did not need further medical attention and they changed the order for the sit to stand from as needed to always. Ms. Srebnik stated

all the staff have been very proactive in learning proper transferring techniques. Ms. Srebnik stated she has no concerns whatsoever about the ability of the staff to meet the residents needs and transfer them safely.

On 8/20/24, I interviewed Guardian A by telephone. Guardian A stated she was notified immediately of the fall. Guardian A stated she has no concerns with the home and that they are doing a great job. Guardian A stated she is in the facility four times a week. She stated the fall appeared to be an isolated occurrence and an accident and the staff are more than capable of meeting Resident A's needs.

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:	While Resident A did have one fall during a transfer, it was the result in a change in condition that Ms. Gougen could not have anticipated. Interviews with Ms. Johnson, Ms. Pettit, Ms. Gougen, Ms. Srebnik and Guardian A all revealed that hospice and the guardian were notified immediately, Resident A was assessed for injury, and Resident A's assessment plan was updated to reflect the use of the sit to stand for all transfers due to her change in condition. The facility reasonably complied with the intent of this rule.	
CONCLUSION:	VIOLATION NOT ESTABLISHED	

On 8/22/24 I conducted an exit conference with licensee Jody Pettit. Ms. Pettit concurred with the findings of the investigation.

IV. RECOMMENDATION

I recommend no change in the status of the license.

Mart of

8/21/24

Matthew Soderquist Licensing Consultant

Date

Approved By:

Russell Misial

8/22/24

Russell B. Misiak Area Manager

Date