GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 16, 2024

Theresa Posey & John Posey
7550 E. Allen Rd.
Fenton, MI 48430

RE: License #: AS470312590
Investigation #: 2024A0466054
Green Acres

Dear Theresa Posey & John Posey:

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 (517) 284-9727.

Sincerely,

Julie Elkins

Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AS470312590 |
| | |
| **Investigation #:** | 2024A0466054 |
| | |
| **Complaint Receipt Date:** | 08/01/2024 |
| | |
| **Investigation Initiation Date:** | 08/02/2024 |
| | |
| **Report Due Date:** | 09/30/2024 |
| | |
| **Licensee Name:** | Theresa Posey & John Posey |
| | |
| **Licensee Address:** | 7550 E. Allen Road<br>Fenton, MI 48430 |
| | |
| **Licensee Telephone #:** | (810) 210-8167 |
| | |
| **Administrator:** | Nancy Posey |
| | |
| **Name of Facility:** | Green Acres |
| | |
| **Facility Address:** | 5385 Green Road<br>Fenton, MI 48430 |
| | |
| **Facility Telephone #:** | (810) 459-6232 |
| | |
| **Original Issuance Date:** | 03/13/2012 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 09/13/2022 |
| | |
| **Expiration Date:** | 09/12/2024 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>ALZHEIMERS<br>AGED |

## II. ALLEGATION:

| | **Violation Established**? |
|---|---|
| On 07/14/2024, direct care worker Holly Walters did not follow Resident A's assessment plan for Resident A to be assisted to the bathroom. | No |
| Additional Finding | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 08/01/2024 | Special Investigation Intake 2024A0466054. |
| 08/02/2024 | Special Investigation Initiated – Telephone by licensing consultant Amanda Blasius. |
| 08/14/2024 | Inspection Completed On-site. |
| 08/14/2024 | Contact - Telephone call received from Complainant. |
| 09/05/2024 | Inspection Completed On-site. |
| 09/11/2024 | Contact - Telephone call to DCW Holly Walters, phone number not in service. |
| 09/11/2024 | Contact – Document sent to administrator Nancy Posey and licensee Theresa Posey. |
| 09/11/2024 | Contact – Document sent/received to/from administrator Nancy Posey. |
| 09/13/2024 | Contact - Telephone call to Nurse Misty Bell. |
| 09/13/2024 | Contact - Telephone call to DCW Holly Walters, interviewed. |
| 09/16/2024 | Exit Conference with licensee Theresa Posey. |

**ALLEGATION: On 07/14/2024, direct care worker Holly Walters did not follow Resident A's assessment plan for Resident A to be assisted to the bathroom.**

**INVESTIGATION:**
On 08/01/2024, Complaint reported that on 7/11/24 Resident A was admitted to Green Acres senior home care. Complainant reported that during the admission process, Relative A1 instructed administrator Nancy Posey that Resident A required

24-hour care because her legs are very weak and she can fall at any time. Complainant reported that Resident A has a walker, but a direct care worker (DCW) needs to always be behind her. Complainant reported administrator Nancy Posey was informed that Resident A uses the bathroom very frequently during the day and night due to a weak bladder condition and that she is on medication for this issue.

Complainant reported on 7/14/20024, Relative A1 came to visit Resident A around 11am. Complainant reported that the following incident happened after 11am on 07/14/2024 but before 3pm. Complainant reported Resident A told DCW Walters she needed to go to the bathroom and DCW Walters responded by telling Resident A that she can go to the bathroom by herself without assistance. Complainant reported that Resident A went to the bathroom by herself but while coming back to the living room she fell down in the tile entry way. Complainant reported Resident A screamed for help and DCW Walters picked her up off the floor. Complainant reported that during the fall, Resident A cut her right arm on the side of her walker. Complainant reported that it was around 2:30pm when Relative A1 received a voicemail from DCW Walters letting her know that Resident A cut her arm on her walker and that Resident A obtained care to her arm. Complainant reported Relative A1 called DCW Walters back and DCW Walters did not mention Resident A had fallen.

Complainant reported that at 3:00pm Relative A2 came to the facility to visit Resident A and saw Resident A sleeping on a reclining chair. Complainant reported Relative A2 stated that when Resident A woke up, she told Relative A2 that her leg hurt. Complainant reported that DCW Walters mentioned to Relative A2 that when Resident A had gotten up to go to the bathroom and she buckled at the knees, but DCW Walters reported that she was behind her and brought her down to her bottom on the floor. Complainant reported DCW Walters told Relative A2 this in front of Resident A who responded with “you were not behind me when I fell down.” Complainant reported according to Relative A2 DCW Walters repeatedly told Resident A she was behind her ready to catch her if she fell. Complainant reported during Relative A2’s visit, Resident A mentioned she needed to use the bathroom and when DCW Walters went to lower the recliner chair Resident A screamed in pain. Complainant reported that DCW Walters seemed confused and thought maybe Resident A hurt her knee as she buckled. Complainant reported that it took both Relative A2 and DCW Walters to get Resident A to the bathroom as she could not walk and needed to be rolled to the bathroom while sitting on her walker. Complainant reported Relative A2 witnessed Resident A screaming in pain while using the bathroom due to her leg hurting at which time Relative A2 removed the pants Resident A was wearing to get a better look at her leg. Complainant stated Relative A2 noted Resident A’s leg was very swollen. Complainant stated Relative A1 was called informing her something was wrong with Resident A’s leg. Complainant reported that once Resident A was done in the bathroom Relative A2 and DCW Walters helped Resident A back onto her walker seat and rolled her back out to the living room. Complainant reported Relative A2 observed Resident A aching in pain, rubbing her leg, and shaking uncontrollably while waiting for Relative

A1 to arrive. Complainant reported that once Relative A1 arrived, DCW Walters tried to retell the story of Resident A falling.

Complainant reported that Resident A told Relative A1 that she needs to go to the hospital. Complainant reported that Relative A1 told DCW Walters to call emergency medical service (EMS). Complainant reported that before the EMS arrived, Resident A needed to use the bathroom again. Complaint reported that Relative A1 and DCW Walters rolled Resident A on her walker back to the bathroom. Complainant reported that Relative A1 told DCW Walters that Resident A has a bladder problem and is on medication. Complainant reported that DCW Walters told Relative A2 and Relative A1 that she did not know about Resident A's bladder problem and mentioned she knew nothing about Resident A prior to the start of her shift.

Complainant reported that Resident A's fall resulted in a broken femur bone. Complainant reported that Resident A had a knee replacement in this leg and when she fell down her knee, her leg shifted caused the rod to move out of place leading a broken femur. Complainant reported that Resident A is 94 years and as a result of the fall required a two-hour surgery. Complainant reported that Resident A was only in this facility for four days and  was in worse condition than when she arrived. Complainant reported that after being discharged from the hospital, Resident A will go to a rehabilitation facility to regain strength in her leg to try and walk again. Complainant reported that this injury resulted by DCW Walters not following Resident A's assessment plan for Resident A to be always assisted to the bathroom.

On 08/05/2024, licensing consultant Amanda Blasius interievewed Complainant who reported that DCW Walters stated that she was behind Resident A and caught her before she fell to the ground. Complainant reported that Resident A stated that no one was behind her when she fell. Complainant reported that Resident A received an open wound from her walker and DCW Walters called Relative A1 to report this but did not report anything about pain in Resident A's knee, legs or a fall.

On 08/14/2024, I conducted an unannounced investigation and DCW Christina Kramer and DCW Gina Viviyard were both on duty.  Neither DCW Kramer nor DCW Viviyard denied having any knowledge about Resident A because neither had worked with her. Neither DCW Kramer nor DCW Viviyard could locate Resident A's record at the facility.

On 09/05/2024, I went to the facility for a second time and I reviewed Resident A's record which contained an *Adult Foster Care* (*AFC) Licensing Division-Incident/Accident Report* dated 7/14/2024 written by DCW Walters.  In the "explain what happened" section of the report it stated;

> *"While walking to the bathroom she kept seeming like knees were buckling in and could fall several times, so I lowered her to the floor to better position to sit her on walker.  She obtained a skin tear on right arm and complained of pain in the knee."*

In the “action taken by staff section of the report it stated:

*“Bandaged arm contacted Nancy and called [Relative A1]. [Relative A2] showed up for a visit shortly after.”*

In the “corrective measures “section of the report it stated:

*“She called [Relative A1] they decided to go have her looked at.”*

I reviewed Resident A’s written *Assessment Plan for AFC Residents* (assessment plan) dated 7/11/2024 and signed by Relative A1. In the “toileting “section of the report it stated, *“Standby assist. Frequent bathroom visits.”* In the “walking and mobility” section of the report it stated, *“Standby assist.”* In the “Special equipment used walker” section of the report it stated, *“Standby assist.”*

I reviewed Resident A’s *Health Care Appraisal* which was dated 07/09/2024 and documented under the “diagnosis” section: *“Unspecified fall, unsteady gait, acute kidney failure, chronic urinary condition.”*

On 09/11/2024, administrator Nancy Posey reported that DCW Walters no longer works at the facility. Administrator Nancy Posey reported that Resident A was discharged from a rehabilitation facility prior to admission at Green Acres. Administrator Nancy Posey reported that Resident A was at the rehabilitation facility due to a prior fall. Administrator Nancy Posey reported that nurse Misty Bell with Residential Homecare admitted Resident A into their case management program on 07/14/2024 and she observed DCW Walters assisting Resident A to bathroom while at the facility.

Administrator Nancy Posey provided a text message case note written by nurse Bell dated 7/14/2024 at 4:26 pm which stated, *“I saw [Resident A] as well. She is admitted to homecare after her fall. Rn, PT and OT are ordered. I spoke with [Relative A1] as well.”*

On 09/13/2024, I interviewed nurse Bell from Residential Homecare who reported that she was at the facility on 07/14/2024 to see Resident A prior to the fall. Nurse Bell reported she observed the DCW on duty walking Resident A to and from the bathroom. Nurse Bell did not remember the name of the DCW who performed this task. Nurse Bell reported that Resident A did not express being in any pain while she was at the facility which was around 11 am and prior to the fall.

On 09/13/2024, I interviewed DCW Walters who reported that she worked on 07/14/2024 and her shift began around noon. DCW Walters reported that when she was coming on shift, she was told by the DCW leaving shift (could not remember the name of the DCW) that Resident A had just taken a pain pill and that she had an unsteady gait. DCW Walters reported that based on that information she assisted Resident A to the bathroom every time she wanted to go. DCW Walters denied that Resident A fell. DCW Walters reported that while she was walking with Resident A to the bathroom, Resident A would start slouching toward the ground and it looked

like her knees were buckling. DCW Walters reported she assisted Resident A to stand/walk straight up while she was behind Resident A. DCW Walters reported that they safely made it to the bathroom and Resident A did not fall. DCW Walters reported that on the way back to the living room, the same thing occurred, Resident A was continued slouching toward the ground while walking but this time when DCW Walters tried to assist her up Resident A didn't stand straight up, she kept slouching. DCW Walters stated she made the decisions to assist Resident A to the ground so that she could get a better grip/re-adjust to ensure that Resident A would not fall. DCW Watter reported lowering Resident A to the ground which did result in a skin tear which she bandaged up. DCW Walters assumed that the skin tear was from the walker, but she was not sure. DCW Walters reported that once Resident A was on the ground she got a better hold of Resident A then she lifted her off the ground and assisted her back to the chair. DCW Walters reported that Resident A rested comfortably in the chair until Relative A2 arrived. DCW Watter reported that when Relative A2 arrived Resident A told her that she fell and that her leg hurt. DCW Walters reported that she told Relative A2 that Resident A did not fall but that she lowered her to the ground and the once she had better control she helped Resident A back up and into the chair she was sitting in. DCW Walters reported this was first time Resident A complained that her leg hurt. DCW Walters reported that Resident A asked for pain medication, but DCW Walters reported that not enough time had lapsed from the previous pain medication administration, so she could not administer her any medication at that time. DCW Walters reported that Relative A2 called Relative A1 who came to the facility and took Resident A to the hospital.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14301** | **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:**<br>**(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.** |

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|---|---|
| **ANALYSIS:** | Complainant reported that on 07/14/2024, DCW Walters did not assist/follow Resident A to/from the bathroom as documented in Resident A's written assessment plan. DCW Walters reported she assisted Resident A to/from the bathroom as necessary. Nurse Bell reported that while she was at the facility on 07/14/2024, the DCW on duty did walk Resident A to/from the bathroom. I reviewed Resident A's written assessment plan which documented "standby assist" as the personal care needed during toileting. Per interviews conducted, DCW Walters provided this personal care as needed. There is not enough evidence to establish a violation. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ADDITIONAL FINDING:**

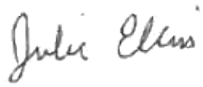
**INVESTIGATION:**
I conducted an unannounced investigation on 08/05/2024 and I interviewed DCW Kramer and DCW Viviyard who reported that Resident A did not currently live at the facility. Both DCW Kramer and DCW Viviyard reported Resident A's record was not at the facility. Consequently, I could not review Resident A's record at the time of the unannounced investigation.

On 09/13/2024, DCW Walters who worked at the facility on 07/14/2024 reported that she never saw Resident A's record at the facility when she lived there. DCW Walters reported the only document in the facility for Resident A was her medication administration record.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14316** | **Resident records.** |
| | **(2) Resident records shall be kept on file in the home for 2 years after the date of a resident's discharge from a home.** |
| **ANALYSIS:** | On 08/05/2024, at the time of the unannounced investigation Resident A's record was not available in the AFC facility for department review. Additionally, DCW Walters reported that Resident A's record was not in the facility while Resident A was living there and she was working there. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in license status.



09/16/2024

Julie Elkins Date
Licensing Consultant

Approved By:

09/16/2024

Dawn N. Timm Date
Area Manager