GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 3, 2024

Sunil Bhattad
Memory Mission, LLC
415 N Chippewa St.
Shepherd, MI 48883

RE: License #: AL370377901
Investigation #: 2025A0466005
Stone Lodge Supportive Senior Living

Dear Mr. Bhattad:

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 #:	AL370377901
Investigation #:	2025A0466005
Complaint Receipt Date:	10/16/2024
Investigation Initiation Date:	10/18/2024
Report Due Date:	12/15/2024
Licensee Name:	Memory Mission, LLC
Licensee Address:	415 N Chippewa St. Shepherd, MI 48883
Licensee Telephone #:	(989) 828-5683
Administrator:	Sunil Bhattad
Licensee Designee:	Sunil Bhattad
Name of Facility:	Stone Lodge Supportive Senior Living
Facility Address:	415 N. Chippewa Street Shepherd, MI 48883
Facility Telephone #:	(989) 828-5683
Original Issuance Date:	04/01/2016
License Status:	REGULAR
Effective Date:	10/01/2024
Expiration Date:	09/30/2026
Capacity:	14
Program Type:	AGED ALZHEIMERS

II. ALLEGATIONS:

	Violation Established?
Resident A fell which resulted in severe injury to her head and back due to the facility not being adequately staffed.	No
Resident A's designated representative was not provided with an incident report after fall on 10/11/2024 which resulted in hospitalization.	Yes
Additional Finding	Yes

III. METHODOLOGY

10/16/2024	Special Investigation Intake 2025A0466005.
10/17/2024	Contact - Telephone call made to assigned licensing consultant Jennifer Browning.
10/18/2024	Special Investigation Initiated – Telephone call to Complainant interviewed.
10/18/2024	Contact - Telephone call made to Luke Sawyer, Chief of Police for Shepard Police department, interviewed.
10/18/2024	Contact - Document Received Pictures received.
10/21/2024	Contact - Telephone call received Police Chief Luke Sawyer, interviewed a second time.
10/21/2024	Contact - Document Received Police report.
10/21/2024	APS Referral not required no suspicion of abuse/neglect per police investigation/report.
11/07/2024	Contact - Document Sent Email sent to Complainant.
11/07/2024	Contact - Document Received Email from Complainant.
12/03/2024	Exit Conference with Sunil Bhattad, attempted by phone, message left.

ALLEGATION: Resident A fell which resulted in severe injury to her head and back due to the facility not being adequately staffed.

INVESTIGATION:
On 10/16/2024, Complainant reported that Resident A fell while on the facility patio resulting in a severe head and back (lower lumbar) injury. Complainant reported an ambulance was called and Resident A was taken to Alma Hospital but was later transferred to Midland Hospital due to severity of her head wounds. Complainant reported concern that the facility is understaffed given the number of residents living in the facility. Complainant reported attempting to provide a walker for Resident A previously. Complainant reported requesting on 10/14/24, to see surveillance camera footage of the fall however the request was denied by the owner of the facility.

On 10/18/2024, I interviewed Complainant who reported there are typically two to three direct care workers (DCW)s per shift to provide care to residents. Complainant reported that he was told that Resident A was standing on a flat surface outside when she fell. Complainant is concerned that the description of the fall does not match the injures Resident A has and Complainant is further concerned because he was not allowed to see the video footage of the fall even though Resident A is the only resident in the video footage.

On 10/18/2024, Luke Sawyer, Chief of Police for Shepard Police department confirmed that he was opening an investigation regarding Resident A's fall on 10/11/2024.

On 10/21/2024, Chief Sawyer reported that he viewed the video footage from Resident A's fall on 10/11/2024 at the facility. Chief Sawyer reported that it was around dinner time when Resident A went outside on the patio carrying a cup of coffee. Chief Sawyer reported that the porch swing was about 10 feet from the door. Chief Sawyer reported that Resident A went to set down her coffee on the cement patio when she fell headfirst into the concrete patio floor. Chief Sawyer reported that Resident A was on the pavement for 22 seconds before DCW Courtney Millmine came to her aid. Chief Sawyer reported that Resident A was alone out by the patio when she fell. Chief Sawyer reported that he did not suspect any abuse, neglect or anything criminal and therefore was closing his case. Police Chief Sawyer provided a written report which documented that the case was closed. Chief Sawyer also reported that Relative A1 was informed of the findings of his investigation.

On 10/23/2024, I conducted an unannounced investigation and I interviewed manager/DCW Melissa Baker who reported that on 10/11/2024, 10 residents were living at the facility and two DCWs were on shift (DCW Jessica Foster and DCW Millmine) when Resident A fell. DCW Baker reported that none of the residents require one to one supervision and that no residents require two-person assistance for transfers or personal care. DCW Baker reported that the facility has an electric Hoyer which can be utilized by one DCW. DCW Baker confirmed that Resident A

was sent to the hospital via emergency medical services(EMS) on 10/11/2024 immediately following the fall and that she has not returned to the facility. DCW Baker reported that neither DCW Foster nor DCW Millmine were currently at the facility as they work second shift which is from 2pm-10pm.

I reviewed Resident A's record which contained an *Adult Foster Care (AFC) Licensing Division Incident/Accident Report* (IR) dated 10/11/2024 at 5:30pm, written by DCW Foster and signed by licensee designee Sunil Bhattad. In the "Explain what happened" section of the report it stated:

"Courtney called for me so I ran out to the back patio where I saw [Resident A] laying on her side with a head wound. She was bleeding pretty bad [sic], Courtney ran to get clean cloths so we could apply pressure on the wound. Pressure was held until EMS arrived."

In the "Action taken by staff" section of the report it stated:

"Home manager was notified, owner was notified, family was notified 911 contacted and IR was written."

The "corrective measures taken to remedy and/or prevent recurrence" was blank.

I reviewed Resident A's *Health Care Appraisal* that was dated 02/01/2024 and documented in the "mobility" section of the report that Resident A is "fully ambulatory." Resident A's record did not contain any written physician order for Resident A to utilize any assistive devices for mobility.

I reviewed Resident A's written *Assessment Plans for AFC Residents* (assessment plan) that was dated 08/30/2022, signed by Relative A1 and licensee designee Bhattad that documented Resident A "is able to walk independently without any devices."

I reviewed 10 resident records for residents admitted to the facility on 10/11/2024. Resident A was included in the record review. I reviewed all resident *Health Care Appraisals* and written *Assessment Plans for AFC Residents* which documented that none of the residents require a two person assistance for transfer or personal care needs. According to the resident records for mobility assistance, five residents do not require the use of any assistive devices, one resident uses a cane, four residents use a walker and no residents require the use of a wheelchair.

I reviewed the *Staff Schedule* for October 2024 and it documented that there were two DCWs scheduled per shift for all three shifts.

I observed the facility to be clean and free of any foul odor. I observed residents walking around the facility, sitting in the family room and others in the kitchen eating. I observed the residents to be in clean clothing, well-groomed and free of any foul odor.

On 11/07/2024, Complainant and Relative A1 reported seeing the video footage of Resident A's fall and reported being "satisfied with the whole thing." Complainant and Relative A1 reported that Resident A did fall completely on her own accord.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours. **(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.**
ANALYSIS:	On 10/23/2024, I conducted an unannounced investigation that confirmed that on 10/11/2024, the facility had 10 residents with two DCWs on duty. I conducted a resident record review and based on the documentation of the *Health Care Appraisals* and written *Assessment Plans for Adult Foster Care (AFC) Residents*, none of the residents require two person assistance for transfers or any personal care needs. Additionally, I observed the facility to be orderly and free of any foul odor, the residents appeared clean and well-groomed. Video surveillance of Resident A's fall verified that she fell on her accord while attempting to set her coffee down on the patio and did not fall due to inadequate staffing. Therefore although Complainant expressed concern about that the facility not having enough DCWs on shift to care for the needs of the residents, there was not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A's designated representative was not provided with an incident report (IR) after fall on 10/11/2024 which resulted in hospitalization.

INVESTIGATION:
On 10/16/2024, Complainant reported requesting the IR from Resident A's fall on 10/14/2024 in person at the facility and again on 10/15/24 over the phone.

Complainant reported that the site supervisor was told by the owner that a copy of the IR cannot be provided to Complainant.

On 10/23/2024, I conducted an unannounced investigation and I interviewed DCW Baker who reported that an IR was completed but that she was instructed not to provide a copy of the IR to anyone.

On 11/07/2024, Complainant and Relative A1 reported that they still have not received an IR for Resident A's fall on 10/11/2024.

APPLICABLE RULE	
R 400.15311	**Incident notification, incident records.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(c) Incidents that involve any of the following:** **(ii) Hospitalization.**
ANALYSIS:	Complainant, Relative A1and DCW Baker all reported that the written incident report regarding Resident A's fall on 10/11/2024 which resulted in hospitalization was never provided to Resident A or her designated representative despite Relative A1 requesting this document on 10/14/2024 and again on 10/15/2024, therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:
On 10/23/2024, I conducted an unannounced investigation and I reviewed Resident A's written assessment plan that was dated 08/30/2022 and signed by Relative A1 and licensee designee Bhattad. I reviewed Resident A's record and could not locate an updated written assessment plan.

I reviewed Resident B's written assessment plan that was dated 08/01/2023 and signed licensee designee Bhattad. I reviewed Resident B's record and could not locate an updated written assessment plan.

I interviewed manager/DCW Baker who reviewed Resident A's written assessment plan dated 08/30/2022 and Resident B's written assessment plan dated 08/01/2023.

At the time of the investigation, DCW Baker could not provide an updated assessment plan for Resident A and Resident B for review.

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 licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	At the time of the unannounced investigation the only written assessment plan that could be located for Resident A was dated 08/30/2022 and Resident B's written assessment plan was dated 08/01/2023. Therefore a violation has been established as there was no documentation that Resident A's written assessment plan had been updated annually in 2023 or in 2024 as required and Resident B's written assessment plan had not been updated since August 2023 or annually as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Julie Elkins

12/03/2024

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Julie Elkins Date
Licensing Consultant

Approved By:

Dawn Timm

12/03/2024

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Dawn N. Timm Date
Area Manager