GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 6, 2024

Connie Clauson
Pleasant Homes I L.L.C.
Suite 203
3196 Kraft Ave SE
Grand Rapids, MI 49512

RE: License #: AL390007089
Investigation #: 2025A0581004
Park Place Living Centre #A

Dear Connie Clauson:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, I recommend the current disciplinary action, refusal to renew, against your license remains and the license close effective 12/22/2024 per the signed settlement agreement dated 07/22/2024. You will be notified in writing of the department's action and your options for resolution of this matter.

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) 284-9730.

Sincerely,

Cathy Cushman

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL390007089
Investigation #:	2025A0581004
Complaint Receipt Date:	10/14/2024
Investigation Initiation Date:	10/15/2024
Report Due Date:	12/13/2024
Licensee Name:	Pleasant Homes I L.L.C.
Licensee Address:	Suite 203 3196 Kraft Ave SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Janet White
Licensee Designee:	Connie Clauson
Name of Facility:	Park Place Living Centre #A
Facility Address:	4214 S Westnedge Kalamazoo, MI 49008
Facility Telephone #:	(269) 388-7303
Original Issuance Date:	01/01/1989
License Status:	1ST PROVISIONAL
Effective Date:	05/22/2023
Expiration Date:	11/21/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION

	Violation Established?
Resident E sustained injuries from a fall on or around 10/11/2024; however, the licensee did not seek immediate medical attention.	Yes

****To maintain the coding consistency of residents across past investigations and renewal licensing study reports, the resident in this special investigation report is not identified in sequential order.*

III. METHODOLOGY

10/14/2024	Special Investigation Intake 2025A0581004
10/15/2024	APS Referral - APS received the allegations but denied investigating.
10/15/2024	Special Investigation Initiated – Telephone - Interview with Relative E1
10/15/2024	Contact - Telephone call made - Interview with PACE case manager, Elaine Catlin
10/17/2024	Contact - Document Received - Email from Elaine Catlin.
10/18/2024	Contact - Telephone call made - Left voicemail for direct care staff, Sabrina White.
10/18/2024	Contact - Document Sent - Requested report from medical examiner's office.
10/18/2024	Contact - Document Received - Email containing medical examiner’s scene report.
10/18/2024	Contact - Telephone call made - Interview with Relative E1.
10/18/2024	Contact - Telephone call made - Interview with direct care staff, Gloria Kiye
10/18/2024	Inspection Completed On-site - Interview with staff and obtained documentation.
10/21/2024	Contact - Document Sent - Requested calls for service from Kalamazoo County Consolidated Dispatch Authority

10/21/2024	Contact - Document Sent - Email to Kalamazoo Department of Public Service
10/21/2024	Contact - Face to Face - Picked up Resident E's medical records from Bronson Hospital
10/21/2024	Contact - Telephone call made - Left voicemail for Sabrina White
10/21/2024	Contact – Document Sent – Emailed Kalamazoo County Consolidated Dispatch requesting records
10/21/2024	Contact – Telephone call made – Interview with direct care staff, Sabrina White.
10/22/2024	Referral – Other - Referral to Director regarding PACE concerns.
10/23/2024	Contact – Document Sent – Requested Resident E's death certificate.
11/08/2024	Contact – Face to Face – Interview with Administrator, Janet White, at facility.
12/06/2024	Exit Conference with Connie Clauson via telephone.

ALLEGATION: Resident E sustained injuries from a fall on or around 10/11/2024; however, the licensee did not seek immediate medical attention.

INVESTIGATION: On 10/14/2024, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged on or around 10/11/2024, Resident E fell out of her bed and sustained injuries. Resident E neither had alarms on her bed nor was she provided with adequate supervision by direct care staff when she fell. The complaint alleged the facility's staff contacted Resident E's primary care physician through the Program of All-Inclusive Care for the Elderly (PACE) at approximately 2 am to report the fall and seek instruction. The complaint alleged the on-call PACE physician instructed the facility's staff to clean Resident E's forehead wound. The complaint also alleged the PACE physician indicated a PACE nurse would be sent to the facility to further evaluate Resident A; however, the complaint alleged the PACE nurse never showed up to the facility. The complaint alleged when the facility's incoming day staff observed Resident E's injuries they were concerned and requested Resident E be taken to the Emergency Room (ER) for treatment. The complaint alleged Resident E's injuries consisted of a broken nose and femur and resulted in five stitches to her forehead. The complaint further alleged Resident E's femur injury was unable to repaired, which would result in her being "bedbound" for the remainder of her life.

The complaint also alleged due to Resident E's injuries she was admitted to hospice for end-of-life services.

An additional complaint received on 10/15/2024 was consistent with the allegations in the first complaint. The additional complaint documented Resident E was over 100 years old and had a diagnosis of dementia. The additional complaint alleged Resident E was admitted to Rose Arbor Hospice agency and identified Relative E1 and Relative E2 as Resident E's Power of Attorneys (POA).

On 10/15/2024, I interviewed Relative E1 via telephone. Relative E1 clarified Resident E fell on 10/10/2024 rather than 10/11/2024. Relative E1 stated Resident E was capable of transferring herself out of bed but needed staff nearby because she was unable to use her right femur, which she broke approximately nine years ago. Relative E1 stated at approximately 7:30 am on 10/10/2024, Resident E was sent to the hospital from the facility due to the injuries sustained from her fall. He stated Resident E broke her nose and left femur, had a brain bleed, and required five stitches in her forehead. Relative E1 stated when he observed Resident E at the ER, she had blood matted in her hair and her leg, forehead and nose were observably swollen and injured. Relative E1 stated facility staff also changed Resident E's clothes prior to sending her to the ER.

Relative E1 stated he did not have any significant concerns relating to Resident E's health or physical abilities prior to her fall, but stated she would not have been strong enough to catch herself falling out of bed. He stated her bed did not have bed rails; however, she had a mat on the floor to soften any potential falls. He stated he observed the mat on the floor of Resident E's bedroom. He stated Resident E was not expected to live longer than a month and hospice was trying to keep her comfortable.

On 10/17/2024, PACE medical social worker, Elaine Catlin, emailed me two contacts completed by PACE staff pertaining to Resident E's fall. The first contact, dated 10/10/2024, was completed by PACE physician, Dr. Mark Brown, at 2:23 am. According to his contact, at 2:12 am, he documented, "Sabrina called to report that [Resident E] fell out of bed and her head has a skin tear with bleeding. No sign of concussion. Sabrina will apply a bandage to skin tear. Will plan to have [Resident E] seen in clinic or by RN. If condition worsens, Sabrina will call".

Elaine Catlin also provided a follow up contact from PACE occupational therapist, Delaney Acri, dated 10/11/2024 for 1:52 pm. The contact documented the following:

> "OT visited Park Place to complete fall f/u with PP administrator, staff from 3rd shift, and nurse present. PP staff stated that fall occurred during 3rd shift, at about 2 AM. Rounds were completed at 12 AM, 1 AM, and 2 AM. During 2 AM round, [Resident E] was found on the floor, laying on her L side with her adjustable bed elevated off

> the ground. Ppt was laying on her floor alarm mat but staff did not report that the mat had alerted them to the fall. 3rd shift staff noticed that her ppt had a laceration on her forehead. Controlled bleeding and checked vitals. Staff called PACE and reported the fall with on-call PCP stating that ppt could go to the clinic in the AM since she appeared stable and alert. Ppt was sent to the hospital next day d/t c/o hip and leg pain. Ppt was found to have a L distal femur fx as well as a subdrual[*sic*] and subarachnoid hemorrage[*sic*]. 3rd shift staff stated that prior to her fall, they had concerns regarding whether or not ppt had a UTI because she was more impulsive in the days leading up[*sic*] the fall, as evidenced by self-transferring without assistance from staff. Nurse present stated that she did not display any unusual behaviors, experience medication changes, or skip a meal prior to fall."

On 10/18/2024, I conducted an unannounced inspection at the facility in an attempt to interview direct care staff and the facility's Administrator, Janet White; however, Janet White was not working at the time of my investigation.

I interviewed direct care staff, Nichole Scott, who identified her position as a "Resident Care Specialist". Nichole Scott stated she was the incoming day staff on 10/10/2024 who made the determination to send Resident E to the ER. Nichole Scott identified staff, Sabrina White and Gloria Kiye, as the two overnight staff who were working when Resident E fell. Nichole Scott stated Sabrina White and Gloria Kiye reported to her at approximately 2 am, while they were completing hourly rounds, they discovered Resident E on her bedroom floor bleeding from her forehead. Nichole Scott stated hourly checks on residents were expected during the overnight shift. Nichole Scott stated Sabrina White and Gloria Kiye reported to her Resident E requested their assistance in getting off the floor and back into bed. Nichole Scott stated Sabrina White reported to her Resident E's vitals were "fine". She stated Sabrina White reported she contacted the on-call PACE physician who instructed her to not send Resident E to the ER because someone from PACE would come to the facility; however, a specific time frame in which someone would come to the facility was not provided.

Nichole Scott stated when she arrived to work she observed Resident E sleeping, which she stated was "normal" behavior for Resident A. Nichole Scott stated she did not observe a bandage on Resident E's forehead. She stated she changed Resident E's incontinence brief and clothes, and while moving Resident E she complained her leg hurt. Nichole Scott stated Sabrina White reported to her Resident E did not disclose or identify any leg pain when she was discovered on her bedroom floor or at any point during the overnight shift. Nichole Scott stated Resident E was actively bleeding on her forehead and there was wet and dried blood in her hair. She stated

Resident E's knee was swollen, and despite there being bruising between and under Resident E's eyes and on the top of her nose she did not complain of any pain on her face or head.

Nichole Scott stated after she dressed Resident E, she assisted her in transferring to her wheelchair and transported her to the bathroom in the facility's hallway near the main door. She stated Resident E continued communicating with her and her vitals did not reflect any concerns. She stated when Resident E observed herself in the mirror she only commented on the blood in her hair. Nichole Scott stated Sabrina White reported to her Resident E looked worse that morning compared to when the incident first occurred.

Nichole Scott stated due Resident E's forehead still bleeding, she contacted PACE at approximately 7:40 am and requested Resident E be sent to the ER; however, she reported a PACE staff instructed her to call back at 8 am because they were closed. Ms. Scott stated she stressed it was an emergency and did not get off the phone with PACE until she was informed someone would immediately call her back. She stated PACE staff called her back and asked about Resident E's vitals, which she reported continued to be normal. She stated PACE instructed her to send Resident E to the ER via ambulance.

Nichole Scott stated if an incident occurred whereas a resident required medical attention, and PACE was the resident's primary care physician then the facility's staff need to obtain permission from a PACE physician or staff member prior to sending that resident to the ER.

On 10/18/2024, I interviewed direct care staff, Gloria Kiye, via telephone. Gloria Kiye stated she has worked for the licensee since approximately 09/26/2024. She stated while completing hourly rounds on or around 1:50 am on 10/10/2024, she discovered Resident E lying on her left side, on her bedroom floor, just beside her bed, bleeding from her forehead. She stated Resident E was talking and told her "it hurt" when she and staff, Sabrina White, assisted her with getting off the floor and back into bed. Gloria Kiye stated when she and staff, Sabrina White, tried touching Resident E's left knee, Resident E reported, "no, ow". Gloria Kiye stated when she and staff, Sabrina White, looked at Resident E's knee it appeared normal; however, in the morning the knee was swollen.

Gloria Kiye stated Resident E also reported her head hurt. Gloria Kiye stated Resident E's forehead was "open and bleeding" and she had blood in her hair. She stated she and staff, Sabrina White, cleaned up the blood, put an antibiotic cream on it and bandaged the area. She stated staff, Sabrina White, took Resident E's vitals, including blood pressure, and there were no concerns. She stated they continued to check on Resident E hourly. Gloria Kiye stated Resident E slept throughout the night, like normal, and there were no concerns. She stated Resident E's bathroom light was left on so she could visually see how Resident E looked at each hour.

Gloria Kiye stated Resident E's forehead bandage came off sometime in the morning. She stated at approximately 5 am or 6 am she noticed Resident E's pillow had fresh blood on it where Resident E's head had been laying.

Gloria Kiye stated it was not necessary to contact 911 after discovering Resident E on the floor because staff, Sabrina White, contacted PACE and the facility's on call manager, Mary Daly.

On 10/18/2024, Relative E1 contacted me to report Resident E passed away on 10/17/2024.

On 10/18/2024, I reviewed the medical examiner's "Investigative Report" case #1017-24-JK-863-KC, which confirmed Resident E passed away on 10/17/2024. According to this report, Resident E "suffered an unwitnessed fall at her skilled nursing facility, resulting in a femur fracture, subdural hematoma and nasal bone fracture". The report documented the ER determined Resident E's injuries were "…a left femur fracture right subdural hematoma at the parietal occipital junction as well as a nasal bone fracture". Additionally, the report documented, "A review of epic records reveals a past medical history, significant for dementia, osteoporosis, and osteoarthritis, as well as a right femur fracture nine years ago".

On 10/21/2024, I reviewed Resident E's Bronson Hospital medical records, dated 10/10/2024 through 10/11/2024. The records documented Resident E was admitted to the ER on 10/10/2024 at 8:58 am. The records documented Resident E "…appeared to have a scalp laceration. Facility apparently reached out to the on-call primary care provider at Senior care partners, and was advised no need to take patient into the emergency department as her vitals were stable and she did not appear to have any evidence of concussion". The records documented the facility's morning staff observed continued bleeding from her scalp laceration, grew concerned and brought her to the ER.

The medical records documented the extent of Resident E's injuries as the following:

- Head: Laceration present
    - Comments: 4 cm irregular laceration on forehead, about 5 mm depth, no obvious contamination
- Nose: Signs of injury and nasal tenderness present
    - Comments: Bruising over nose, dried blood in nares
- Left shoulder: Tenderness present
- Left elbow: Tenderness present
- Left knee: Swelling, deformity, erythema and bony tenderness present. Decreased range of motion.
    - Comments: Skin tear left elbow

The results of Resident E's CT brain scan determined the following:

- Small volume acute subarachnoid hemorrhage within a single sulcus in the right parieto-occipital junction
- Trace acute subdural hemorrhage along the posterior interhemispheric falx
- Left frontal scalp soft tissue injury without underlying calvarial fracture
- Age-indeterminate bilateral nasal bone fractures

The results of Resident E's left femur x-ray determined the following:

- Osteopenia. Acute comminuted and moderately displaced fracture of the distal left femoral metadiaphyseal region.

The medical records documented Resident E required five sutures to close her forehead wound and to immobilize and opt for nonoperative management of her fractured left femur. She was discharged to hospice on 10/11/2024.

On 10/21/2024, I interviewed direct care staff, Sabrina White. Sabrina White stated she had been working for the licensee for approximately 14 years. She stated on 10/10/2024 she was working the overnight shift with staff, Gloria Kiye. Sabrina White's statement on how Resident E was discovered, how she was presenting, and how staff treated her injuries was consistent with Gloria Kiye's statement to me. Sabrina White also stated Resident E fell onto her mat. She stated Resident E was awake when she was discovered and when Sabrina White asked her if she was okay, Resident E responded, "it hurts" with her hand on her head in her hair, which Sabrina White stated she assumed Resident E was referring to her head hurting. Sabrina White stated Resident E's face appeared normal at that time. Sabrina White denied Resident Ecomplaining about any leg or knee pain at that time. Sabrina White stated she took Resident E's vitals, which were fine, contacted her supervisor, Mary Daly, and then contacted PACE.

Sabrina White stated she was unable to recall the name of the on-call physician from PACE but recalled him asking her if Resident E was responding to questions. Sabrina White stated Resident E was able to respond to her questions. She stated when she asked Resident E if she was doing ok, she responded "yes". Sabrina White stated she described how Resident E was presenting to the PACE physician, which included a description of her bleeding forehead. She stated the PACE physician instructed her to call back in the morning and she would be sent for treatment at that time, if necessary.

On 10/22/2024, I interviewed direct care staff and Resident Care Manager, Mary Daly, via telephone. Mary Daly stated due to Resident E being a PACE client, direct care staff were required to contact PACE and get approval prior to contacting an ambulance, 911 or sending her to the ER. Mary Daly stated she was informed by Sabrina White that PACE instructed her not to send Resident E to the ER because PACE staff would visit with Resident E in the morning.

Mary Daly stated Sabrina White reported to her Resident E was conscious and holding conversation after falling. She also stated Sabrina White reported to her she was also able to stop the bleeding from Resident E's forehead.

On 10/23/2024, I reviewed Resident E's death certificate, which listed her manner of death as an "Accident". The date of injury was documented as 10/10/2024 from an "unwitnessed fall in a skilled nursing facility". According to the death certificate, Resident E's death was directly caused by a "Subdural Hematoma" and "Fall on Level Ground". Other significant conditions contributing to Resident E's death but not resulting in the underlying causes were identified as "Multiple Fractures of Femur".

On 10/25/2024, I reviewed the facility's "Resident Evaluation", dated 02/07/2024, for Resident E. This was identified as the licensee's assessment plan for Resident E. Resident E's assessment plan did not identify any specific care or supervision for Resident E other than "hourly checks" were to be completed. Resident E's assessment plan also documented Resident E requires staff assistance in toileting, dressing, and ambulating due to her physical limitations.

I reviewed Resident E's Health Care Appraisal (HCA), dated 12/11/2023, which identified Resident E's diagnoses as "Dementia, osteoarthritis, osteoporosis, atheromatous aorta, psoriasis".

On 11/08/2024, I interviewed the facility's Administrator, Janet White, at the facility. Janet White's statement on contacting PACE and following their instruction on whether or not to send Resident E to the ER was consistent with statements from Gloria Kiye, Sabrina White, and Mary Daly.

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:	On 10/10/2024 at approximately 2 am, Resident A, who was over 100 years old with a diagnosis of dementia and osteoporosis, fell out of her bed and sustained injuries that were later determined to have caused her death on 10/17/2024. Direct care staff, Gloria Kiye and Sabrina White, discovered Resident E on her bedroom floor near her bed bleeding from a forehead laceration (later measuring at 4 cm in length and requiring 5 sutures). Both staff stated Resident E reported, “it hurts”, while holding her head and Gloria Kiye stated Resident E reported “no, ow” while they assisted her back into bed. Staff, Sabrina White, contacted Resident E’s primary care provider, PACE, via telephone to report the incident; however, PACE instructed staff not to send Resident E for emergency treatment; despite her obvious head injury and without assessing her. Rather, staff continued to monitor Resident E throughout the night and into the morning until day shift staff, Nichole Scott, arrived and expressed concern with how Resident Ewas presenting. Resident E was taken by ambulance to the ER and was seen by emergency medical professionals at approximately 9 am; approximately seven hours after she sustained an obvious head injury from falling out of bed. The ER physicians determined Resident E sustained the following injuries from her fall: • Small volume acute subarachnoid hemorrhage within a single sulcus in the right parieto-occipital junction, trace acute subdural hemorrhage along the posterior interhemispheric falx (*brain bleed*) • Left frontal scalp soft tissue injury without underlying calvarial fracture (*forehead laceration*) • Age-indeterminate bilateral nasal bone fractures (*fractured nose*) • Acute comminuted and moderately displaced fracture of the distal left femoral metadiaphyseal region (*fractured femur*) Despite facility staff contacting Resident E’s primary care physician, PACE, and seeking instruction, Resident E did not receive care after falling out of bed and sustaining an obvious head injury. The care provided by Resident E’s primary care physician was determined by the information provided by staff, who are not emergency medical personnel. Subsequently, Resident E did not receive the immediate care she required when the facility’s staff only contacted Resident E’s primary care

	physician and the facility's manager, Mary Daly, rather than Emergency Medical Services (EMS). Consequently, approximately seven hours lapsed until Resident E was adequately assessed by medical personnel and the extent of her injuries was determined.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/06/2024, I conducted my exit conference with the licensee designee, Connie Clauson, via telephone. She acknowledged my findings.

IV. RECOMMENDATION

I recommend the continuation of refusal to renew the license. I recommend closure of the license effective December 22, 2024, as agreed upon by the signed Settlement Agreement, dated 07/22/2024.

12/06/2024

Cathy Cushman Date
Licensing Consultant

Approved By:

12/06/2024

Dawn N. Timm Date
Area Manager