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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 4, 2025

Erin Gust
Dignitas Inc
P.O. Box 3460
Farmington Hills, MI 48333-3460

RE: License #: AM630409077
Investigation #: 2025A0612009
Orchard Lake House 4

Dear Ms. Gust:

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 (248) 975-5053.

Sincerely,

Johnna Cade, Licensing Consultant
Bureau of Community and Health Systems
Cadilac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
Phone: 248-302-2409

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM630409077
Investigation #:	2025A0612009
Complaint Receipt Date:	01/07/2025
Investigation Initiation Date:	01/07/2025
Report Due Date:	03/08/2025
Licensee Name:	Dignitas Inc
Licensee Address:	Suite 112 - 24380 Orchard Lake Road Farmington Hills, MI 48336-3460
Licensee Telephone #:	(248) 442-1170
Administrator:	Erin Gust
Licensee Designee:	Erin Gust
Name of Facility:	Orchard Lake House 4
Facility Address:	24445 Orchard Lake Rd Farmington Hills, MI 48336
Facility Telephone #:	(248) 442-1170
Original Issuance Date:	10/21/2022
License Status:	REGULAR
Effective Date:	04/21/2023
Expiration Date:	04/20/2025
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A fell out of her wheelchair while the van was driving. Resident A fractured her femur.	Yes

III. METHODOLOGY

01/07/2025	Special Investigation Intake 2025A0612009
01/07/2025	Special Investigation Initiated - Telephone Telephone call to clinical director Krisanne George. There was no answer left voicemail requesting a return call.
01/08/2025	Contact - Telephone call received Telephone interview with clinical director Krisanne George.
01/08/2025	APS Referral I made a referral to Adult Protective Services (APS) via electronic file.
01/09/2025	Contact - Telephone call received Telephone interview completed with reporting source.
01/09/2025	Contact - Document Received Hospital discharge paperwork received via email.
01/09/2025	Contact - Document Received Email received from clinical director Krisanne George.
01/09/2025	Contact - Telephone call made Telephone interview completed with assistant recreational therapist Devon Gruskin.
01/13/2025	Contact - Telephone call made Telephone interview completed with Resident A's guardian.
01/15/2025	Contact - Document Received Facility documentation received via email: Dignitas, Inc company vehicle training checklist and the training checklist for new hires.

01/23/2025	Contact - Document Received Hospital discharge paperwork received via email.
01/29/2025	Contact - Document Received Text message received from clinical director Krisanne George.
01/31/2025	Contact - Document Received Text message received from clinical director Krisanne George.
02/03/2025	Inspection Completed On-site I completed an onsite inspection. I interviewed Resident A and home manager, Britney Malacara.
02/04/2025	Exit Conference I placed a telephone call to licensee designee Erin Gust to conduct an exit conference.

ALLEGATION:

Resident A fell out of her wheelchair while the van was driving. Resident A fractured her femur.

INVESTIGATION:

On 01/07/25, I received an intake that alleged on 01/03/25, Resident A fell out of her wheelchair while riding in the car. Staff Devon Gruskin was driving the car. Resident A is now in the hospital. On 01/07/25, I initiated my investigation by placing a telephone call to clinical director Krisanne George. There was no answer, I left voicemail requesting a return call. On 01/08/25, I made a referral to Adult Protective Services (APS) via electronic file.

On 01/08/25, I completed a telephone interview with clinical director Krisanne George. Ms. George stated on 01/04/25, Resident A fell out of her wheelchair while the van was driving. Ms. George explained Resident A was out on an activity; while coming back from the movie's assistant recreational director Devon Gruskin was driving down Orchard Lake Rd when Resident A fell out of her wheelchair and landed on the floor of the van. According to Ms. Gruskin the four point wheelchair tie downs, that secure the wheelchair to the van, remained in place. Ms. Gruskin pulled over, called 911, and assisted Resident A. Resident A was taken to Corewell Health Farmington Hills hospital, she was diagnosed with a right and left leg fracture. Resident A was discharged back to the home on 01/07/25, both of her legs are in immobilizers. Ms. George stated Quality Home Medical is scheduled to come out to the home on 01/09/25, to assess Resident A's wheelchair to determine if it is in proper condition. Ms.

George stated Ms. Gruskin is trained to transport residents and regularly takes residents on activities in the van.

On 01/09/25, I received an email from Ms. George that indicated Resident A returned to Corewell Health Farmington Hills hospital on 01/08/25, secondary to mental status change. Resident A was diagnosed with a urinary tract infection (UTI). Cardiac issues may also be present. On 01/23/25, I received an email from Ms. George stating Resident A was discharged on Tuesday, 01/21/25. On 01/29/25, I received a text message from Ms. George stated Resident A was transported to the hospital via EMS due to low pulse oxygen. On 01/31/25, I was notified via text message that Resident A was discharged and returned home.

On 01/09/25, I completed a telephone interview with the reporting source (RS). RS stated Resident A was riding back from the movies, Ms. Gruskin was driving. Ms. Gruskin made a sharp turn and slammed on the breaks. Resident A fell to the floor. EMS was called and she was taken to the hospital. Resident A has fractures in both of her legs. RS stated Ms. Gruskin was negligent and placed Resident A's life at risk. RS would like for the staff to be terminated and her driver's license to be revoked.

On 01/09/25, I completed a telephone interview with assistant recreational therapist Devon Gruskin. Ms. Gruskin started her employment in February 2024, she stated that she is trained to operate the company vehicles and she has been trained on how to load wheelchairs into the van. Ms. Gruskin stated on 01/04/25, she took Resident A to the movies, she loaded Resident A's wheelchair into the van. She assured that her seatbelt was hooked, the breaks were on, and all four of the hooks that secure the wheelchair to the van were tightened. Ms. Gruskin stated she did a Michigan left turn into the driveway of the group home on Orchard Lake road. When she pressed on the breaks, she heard a noise then, Resident A moaned and said, "my legs hurt." Ms. Gruskin turned her hazard lights on and pulled over. Resident A was folded over on the floor of the van, she had fallen out of her wheelchair, her head was near the wheels of the wheelchair. Ms. Gruskin stated none of the straps that secure the wheelchair to the van had come unloose. Ms. Gruskin unhooked the straps and moved the wheelchair out of the way to allow Resident A space to lay flat on the floor of the van. A pedestrian pulled over and called 911. When EMS arrived, Resident A was transported to the hospital. Ms. Gruskin followed EMS to the hospital and called to inform her boss of the incident.

On 01/13/25, I completed a telephone interview with Resident A's guardian. Resident A's guardian stated she is aware of the accident that occurred while Resident A was riding in the van with staff. Resident A sustained femur fractures to her right and left legs. Resident A's guardian remarked, Resident A has a traumatic brain injury and a spinal cord injury, she has not walked since 1993, her bones have degenerated a lot, they are like chalk. Resident A cannot correct her posture independently, she is wheelchair or bedbound, she is 252 lbs., and she requires a two to three person assist to transfer using a Hoyer. Resident A's guardian stated she visited Resident A in the hospital on Friday, Resident A is not in pain as a result of this injury. Further, Resident A

did not have loss of functional ability as she was not walking previously. Resident A's guardian stated the facility has a protocol/ training for staff who drive residents, and it is her understanding and belief that there was no departure from the protocol. Resident A's guardian stated Resident A uses a Tilt in Space wheelchair, the chair is in working order. Resident A's guardian suspects Resident A may have unbuckled her seatbelt causing her to fall out of the wheelchair when the van turned. Resident A's guardian stated since April 2024, Resident A has been exhibiting cognitive decline and therefore she would not admit to unbuckling, but perhaps she dropped something, likely a tissue, and wanted to reach for it. Resident A's guardian stated the Michigan left turn on Orchard Lake road, that is front of the facility can only be done at a slow speed and therefore she does not suspect that the driver was speeding. Resident A's guardian stated Resident A's second hospital admission was not related to the recent accident it was due to her having abnormal vitals. Resident A had an echo to rule out a cardiac event. It was determined that she did not have a heart attack. Resident A has heart disease, which is a diagnosis she had previously, and is unrelated to the recent accident.

On 02/03/25, I completed an onsite inspection. I interviewed Resident A and home manager, Britney Malacara. While onsite I observed Resident A's wheelchair. The wheelchair has two seatbelts one that goes across the lap and the other that goes across the chest. The lap belt is Velcro, the Velcro is worn and easily manipulated.

On 02/03/25, I interviewed Resident A. Resident A was observed lying in bed, her left leg was in a brace. Resident A stated she went to the movies with Ms. Gruskin. After the movies, Ms. Gruskin put her into the van and on the way home, while at the light near the house, Ms. Gruskin stepped on the breaks, and she fell out of her wheelchair. Resident A remarked, it all happened so suddenly. I was almost in the front seat. Resident A said her left leg went straight out in front of her and her right leg curled. Resident A stated she does not think that Ms. Gruskin tied down all the wheels on her wheelchair securing her into the van. Resident A stated her lap belt on her wheelchair was bucked and her chest belt was secured. Resident A stated there is a should strap seatbelt in the van, but she was not wearing it. Resident A stated she can unbuckle the lap belt on her wheelchair, but she did not unbuckle it while in the van. Resident A stated because of the accident she is in pain from her knee to her hip, and she is bedbound until she can sit upright in her wheelchair.

On 02/03/25, I interviewed home manager Britney Malacara. Ms. Malacara has been with the company for 14 years. Ms. Malacara stated she worked the morning Resident A went to the movies with Ms. Gruskin. Ms. Malacara got Resident A up and ready to go. Ms. Malacara stated Resident A is knowledgeable of her routine, it is common for her to verbally remind staff to put on her lap belt and her chest belt when getting in the van to be transported. Ms. Malacara stated not only does Resident A's wheelchair have seatbelts (lap and chest) the van also has a traditional seatbelt that should be secured before driving. Ms. Malacara stated Resident A has a custom wheelchair, the company completed an evaluation of the wheelchair while Resident A was in the hospital.

Resident A is currently bedbound until her leg is healed. When Resident A can sit in her wheelchair the company will complete a second evaluation. The lap belt is going to be changed from a Velcro strap to a traditional seatbelt clip.

I reviewed Resident A's Corewell Health Farmington Hills hospital After Care Summary for hospitalizations 01/04/25 – 01/07/25 and 01/08/25 – 01/21/25. In summary, Resident A sustained a closed fracture to the left femur, unspecified fracture morphology, initial encounter (HCC) due to a fall. It is recommended that she follow up with an orthopedic surgeon in 4 weeks for continued management.

I reviewed Dignitas, Inc company vehicle training checklist and the training checklist for new hires which includes an in-service on the tie down of wheelchairs, vehicle operation and policies.

On 02/04/25, I placed a telephone call to licensee designee Erin Gust to conduct an exit conference. There was no answer. I left a detailed voicemail regarding my findings.

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:	Based on the information gathered during this investigation there is sufficient information to conclude Resident A's needs including protection and safety were not attended to. While being transported home from an outing in the company van Resident A fell out of her wheelchair and sustained a closed fracture to the left femur. Assistant recreational therapist Devon Gruskin was driving the van. Ms. Gruskin is trained to transport residents in wheelchairs. Ms. Gruskin stated that she assured Resident A's seatbelt was hooked, the breaks were on, and all four of the hooks that secure the wheelchair to the van were tightened. However, Resident A stated that she does not think Ms. Gruskin tied down all the wheels on her wheelchair securing her into the van. Resident A was wearing her wheelchairs lap belt and her chest belt however, there is a traditional shoulder strap seatbelt in the van that Resident A said she was not wearing while being transported.
CONCLUSION:	**VIOLATION ESTABLISHED**

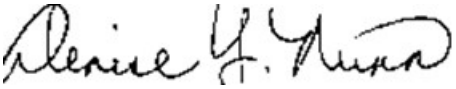
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend that this special investigation be closed with no change to the status of the license.

02/04/2025

Johnna Cade — Date
Licensing Consultant

Approved By:



02/04/2025

Denise Y. Nunn — Date
Area Manager