GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 24, 2025

Krishelle Wiley
The Coach Stop Manor, LLC
23445 W River Road
Grosse Ile, MI 48138

RE: License #: AS820410244
Investigation #: 2025A0116013
Island House

Dear Ms. Wiley:

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 (313) 456-0380.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820410244
Investigation #:	2025A0116013
Complaint Receipt Date:	02/10/2025
Investigation Initiation Date:	02/10/2025
Report Due Date:	04/11/2025
Licensee Name:	The Coach Stop Manor, LLC
Licensee Address:	23445 W River Road Grosse Ile, MI 48138
Licensee Telephone #:	(734) 692-9291
Administrator:	Krishelle Wiley
Licensee Designee:	Krishelle Wiley
Name of Facility:	Island House
Facility Address:	8504 Macomb Street Grosse Ile, MI 48138
Facility Telephone #:	(734) 692-0564
Original Issuance Date:	03/29/2022
License Status:	REGULAR
Effective Date:	09/29/2024
Expiration Date:	09/28/2026
Capacity:	6
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 2/5/25, Resident A fell over her walker and sustained fractures to her ribs and manubrium (upper breast bone). Resident A also was found to have bruises to her chest and back and did not receive medical attention until the following day.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/10/2025	Special Investigation Intake 2025A0116013
02/10/2025	APS Referral Received.
02/10/2025	Special Investigation Initiated - Telephone Interviewed Relative A1.
02/11/2025	Inspection Completed On-site Visually observed Resident A, interviewed Resident B and C, interviewed staff, Kimberly Dale, and reviewed Resident A's records.
02/11/2025	Inspection Completed-BCAL Sub. Compliance
02/21/2025	Exit Conference With licensee designee, Krishelle Wiley.

ALLEGATION:

On 2/5/25, Resident A fell over her walker and sustained fractures to her ribs and manubrium (upper breastbone). Resident A also was found to have bruises to her chest and back and did not receive medical attention until the following day.

INVESTIGATION:

On 02/10/25, I interviewed Relative A1, and he reported that he received a call from the licensee designee, Krishelle Wiley, informing him that on the morning of 02/06/25, Resident A walked to the kitchen table and put her head down and staff, Kimberly Dale, noticed that she appeared to be non-responsive and called 911.

Relative A1 reported that he eventually spoke with the emergency room doctor who informed him that Resident A had sustained three fractured ribs, a fractured manubrium (upper breastbone) as well as bruises to her chest and back area. Relative A1 reported he was livid when he found out that Resident A had fallen on 02/05/25, and that she was not immediately sent out for treatment. Relative A1 reported that she could have passed away from the seriousness of the injuries she sustained, coupled with her being 93 years old, and staff failure to seek immediate medical treatment. Relative A1 further reported that he learned that while another relative was visiting Resident A on 02/03/25, she fell off the toilet (unwitnessed fall) and that relative had to assist staff, Kimberly Dale, with picking her up. Relative A1 reported that after sustaining two falls within a day or two apart, staff, Kimberly Dale should have sought immediate medical treatment for Resident A. Relative A1 voiced his concerns regarding the staffing at the home and reported that Ms. Dale is the only staff working Monday through Thursday around the clock and is concerned that the residents may not be getting the supervision they need, because she may not be alert or attentive, or even sleeping instead of providing care to the residents. Relative A1 reported that he is also not aware of where Ms. Dale may have been in the home, when Resident A fell.

Relative A1 reported that Resident A is doing much better and should be discharged from the hospital later today or tomorrow.

On 02/11/25, I conducted an unscheduled on-site inspection and visually observed Resident A, interviewed Residents B and C, staff, Kimberly Dale, and reviewed Resident A's records. Resident A could not be interviewed due to her Dementia diagnosis; however, she was able to wave and say hello when spoken too. Resident A was neatly dressed and groomed and was finishing her lunch.

I interviewed Resident B, and she reported that on 02/05/25, she and the other residents had just finished dinner and were about to leave the dining room table, when she heard a thump noise and Resident A yell and cry out. Resident B reported that she stood up and saw Resident A on the floor on top of her walker. Resident B reported that staff, Kimberly Dale, was in the area but was unable to stop the fall. Resident B reported that Resident A was in a lot of pain because she was crying for a while, but later seemed to quiet down. I asked Resident B was there any additional staff in the home at the time and she reported that staff, Kimberly Dale, is the only staff that works in the home Monday morning through Thursday night. Resident B reported that Ms. Dale makes sure they have what they need and are in bed asleep before she goes to sleep. I asked Resident B, what happens if she or

any of the Residents need assistance during the night, she reported that they would wake Ms. Dale up and she would assist them. Resident B reported the same applies for the weekend staff person, who comes to work on Friday mornings and works until Monday morning when Ms. Dale returns.

I interviewed Resident C, and she reported that on 02/05/25, they had just finished dinner and were preparing to go to the living room, when Resident A tripped over her walker and fell on top of it and hit the floor. Resident C reported that Resident A was crying and in pain. She reported that Ms. Dale got Resident A off the floor into the chair. Resident C reported that Resident A eventually stopped crying and went to sleep in her chair. Resident C reported that Ms. Dale was in the vicinity when Resident A fell but was unable to catch her before she fell. Resident C reported that she believes Resident A went to the hospital the next day.

Resident C also confirmed the staffing pattern as previously reported by Resident B.

I interviewed staff, Kimberly Dale, and she confirmed that Resident A fell on Monday 02/03/25, while in the bathroom, and she and one of Resident A's relatives, who was visiting at the time, was able to pick Resident A off the floor. Ms. Dale reported that although neither of them witnessed the fall, Resident A appeared fine the remainder of the day. Ms. Dale reported that on 02/05/25, after eating dinner, Resident A got up from the table and was heading into the living room, while she was heading toward the kitchen, and she saw Resident A trip and fall on top of her walker onto the floor. Ms. Dale reported that the walker was almost intertwined/entangled with Resident A's body. Ms. Dale reported that she got Resident A off the floor and into her recliner and reported that she appeared to be fine the remainder of the evening and night. Ms. Dale reported that the following morning, Resident A walked into the kitchen, sat at the table holding a bowl, and was slumped over. Ms. Dale reported that Resident A was unresponsive, so she called 911. Ms. Dale reported that once emergency medical services arrived and touched her hand and began evaluating her, she came to and greeted them. Ms. Dale reported that due to her pulse being low, they transported her to the hospital. Ms. Dale reported later learning of the injuries sustained from the fall. I advised Ms. Dale, that based on the fact that Resident A sustained an unwitnessed fall on 02/03/25 and another serious fall on 02/05/25, that medical treatment should have been sought immediately. Ms. Dale agreed and reported that in the future she would err on the side of caution and send residents out for medical evaluation and treatment.

Ms. Dale also confirmed the staffing pattern and reported that she makes sure the residents are in bed and asleep before she takes her rest period. Ms. Dale also reported that if the residents need any assistance throughout the night, she is available to assist.

On 02/21/25, I conducted the exit conference with licensee designee, Krishelle Wiley, and informed her of the findings of the investigation as well as the specific rule cited. Ms. Wiley reported an understanding. I also provided technical assistance

to Ms. Wiley regarding rule 400.14206(2) staffing requirements, and her responsibility to have sufficient 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 care agreement and assessment plan. Further, I provided consultation regarding her responsibility, to familiarize and comply with the wage and hour laws, that require staff to have at least a five-hour uninterrupted sleep/rest period, and during that time ensure that another staff is in the home to continually met the needs of the residents. Ms. Wiley reported an understanding and stated that she has another staff that she employs who will work during the required sleep/rest periods to relieve the other staff. I also provided the US Department of Labor website for Ms. Wiley to reference for additional information.

APPLICABLE RULE	
R 400.14310	**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:	Based on the findings of the investigation, which included interviews of Relative A1, Residents B-C, and staff, Kimberly Dale, I am able to corroborate the allegation. Relative A1 reported concern that Resident A was not sent out to the hospital to be evaluated and treated after having two separate falls two days apart. Residents B and C reported that Resident A fell on top of her walker and reported that she was crying, but eventually quieted down. Ms. Dale admitted that Resident A had an unwitnessed fall on 02/03/25, in the bathroom, and then fell again on 02/05/25, and was not sent to the hospital until the following day (02/06/25), after she observed her unresponsive. This violation is established as staff, Kimberly Dale, did not obtain needed care immediately, after Resident had two separate falls, two days apart, that resulted in her sustaining three broken ribs and a fractured manubrium.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 02/11/25, I conducted an unscheduled on-site inspection and reviewed Resident A's records. Resident A's record did not contain an annual written assessment plan for 2024. The assessment plan was due to be completed December of 2024.

On 02/21/25, I conducted the exit conference with licensee designee, Krishelle Wiley, and informed her of the findings of the investigation. Ms. Wiley reported that she has the completed assessment plan. I informed Ms. Wiley that it was not in the home and available for my review on 02/11/25 and would be cited.

APPLICABLE RULE	
R 400.14301	**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 the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Based on my review and observation of Resident A's records, this violation is established as Resident A did not have an annual written assessment plan completed for 2024 at the time of my on-site inspection.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 02/11/25, I conducted an unscheduled on-site inspection and reviewed Resident A's records. Resident A's record did not contain an annual resident care agreement for 2024. The written care agreement was due to be completed December of 2024.

On 02/21/25, I conducted the exit conference with licensee designee, Krishelle Wiley, and informed her of the findings of the investigation. Ms. Wiley reported that

she has the completed care agreement. I informed Ms. Wiley that it was not in the home and available for my review on 02/11/25 and would be cited.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(9) A licensee shall review the written resident care agreement with the resident or the resident's designated representative and responsible agency, if applicable, at least annually or more often if necessary.
ANALYSIS:	Based on my review and observation of Resident A's records, this violation is established as Resident A did not have an annual care agreement completed for 2024 at the time of my on-site inspection.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

Pandrea Robinson
Licensing Consultant

02/24/25
Date

Approved By:

02/24/25

Ardra Hunter
Area Manager

Date