GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 28, 2026

Rachel Bartlett
Eden Fields Assisted Living And Memory Care
3567 Deep River Rd.
Standish, MI 48658

RE: License #:	AL060380538
Investigation #:	2026A0123025
	Eden Fields Memory Care

Dear Rachel Bartlett:

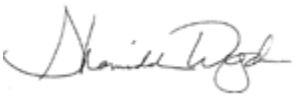
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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) 643-7960.

Sincerely,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL060380538
Investigation #:	2026A0123025
Complaint Receipt Date:	03/09/2026
Investigation Initiation Date:	03/10/2026
Report Due Date:	05/08/2026
Licensee Name:	Eden Fields Assisted Living And Memory Care
Licensee Address:	3567 Deep River Rd. Standish, MI 48658
Licensee Telephone #:	(989) 718-3117
Administrator:	Julie Illig
Licensee Designee:	Rachel Bartlett
Name of Facility:	Eden Fields Memory Care
Facility Address:	3567 Deep River Rd. Standish, MI 48658
Facility Telephone #:	(989) 718-3117
Original Issuance Date:	05/27/2016
License Status:	REGULAR
Effective Date:	11/27/2024
Expiration Date:	11/26/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
On 01/24/2026, Resident A had a fall. The facility failed to seek immediate medical care.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/09/2026	Special Investigation Intake 2026A0123025
03/10/2026	Special Investigation Initiated - On Site I conducted an unannounced on-site at the facility.
03/23/2026	Inspection Completed On-site I conducted a follow-up on-site at the facility.
04/01/2026	Contact - Telephone call made I spoke with Relative 1 via phone.
04/01/2026	Contact- Document Received Received requested documentation via email from Relative 1.
04/02/2026	Contact- Document Received Received requested documentation via email from Relative 1.
04/14/2026	Contact - Telephone call made I left a voicemail requesting a return call from staff Angel Pratin.
04/14/2026	Contact - Telephone call made I left a voicemail requesting a return call from staff Emily Jenkins.
04/14/2026	Contact - Telephone call made I interviewed staff Kelly Gould.
04/14/2026	Contact - Telephone call received I interviewed staff Emily Jenkins.
04/15/2026	Contact - Telephone call received I received a voicemail from staff Angel Pratin.
04/15/2026	Contact - Telephone call made I interviewed staff Angel Pratin.

04/27/2026	Contact- Document Sent I left a voicemail requesting a return call from Kelly Gould.
04/27/2026	Contact- Telephone call made I made a follow-up call to the facility. I spoke with Lisa Stein.
04/27/2026	Contact- Telephone call made I spoke with Relative 1.
04/27/2026	Contact- Telephone call made I made a call to Resident A's Residential Home Health nurse.
04/27/2026	Contact- Document Received Received requested documentation.
04/27/2026	Contact- Document Sent Sent email to facility requesting additional documentation.
04/27/2026	Contact- Document Received Received requested documentation.
04/28/2026	Exit Conference I spoke with designated person Sandy Altman-Elliott via phone.

ALLEGATION: On 01/24/2026, Resident A had a fall. The facility failed to seek immediate medical care.

INVESTIGATION: On 03/06/2026, the Bureau of Community and Health Systems received an online complaint regarding the allegations noted above. The complaint also notes that Relative 1 received a call on 01/24/2026 at 6:00 am reporting that Resident A had fallen, in the bathroom in her room. Staff were asked if Resident A hit her head, and staff reported no, and no recommendation to go to the hospital was made. Someone from the facility reported that a staff person forgot to put Resident A's bed alarm on her bed and did not want to disturb Resident A when they realized it, because Resident A was already asleep. Resident A died due to a brain bleed.

On 03/10/2026, I conducted an unannounced on-site at the facility. I interviewed staff Amanda Sexton, who reported filling in for management. Staff Sexton reported not being aware of Resident A's cause of death, and that Resident A died at the hospital. Staff Sexton stated Resident A did fall and hit her head. Staff Sexton stated that staff Brook Jenkins and staff Angel Pratin reported to Relative 1 that Resident A had a mark on her head. Staff Sexton stated that Relative 1 reported to staff that Resident A did not need to go to the hospital. Staff placed Resident A back in bed. Staff Sexton stated that Resident A was checked on through the shift, until they realized

something was not right. Relative 1 was contacted again, and staff insisted that Resident A go to the hospital. Resident A was sent via ambulance. Staff Sexton stated that the bed alarm was on the bed, but a box connected to the bed alarm was not working. The bed alarm was hooked up but was not going off.

On 03/10/2026, I interviewed staff Brooke Jenkins. Staff Jenkins stated that she started her shift on 01/24/2026 at 6:00 am. Staff Jenkins completed a medication count with staff Angel Pratin. Staff Pratin was telling Staff Jenkins about third shift and informed her that Resident A's bed alarm was sitting on a banister. Staff Jenkins stated Staff Pratin forgot to put the bed alarm in place when Resident A got into bed. Staff Jenkins stated Resident A was a fall risk. Staff Jenkins stated that they completed a walk-through of the facility. Staff Jenkins found Resident A face down in Resident A's bathroom. Staff Jenkins stated that Resident A was receiving home care services at the time. Staff Jenkins stated that Staff Pratin did a body assessment and called Resident A's family. Staff Jenkins stated she did Resident A's vitals. Resident A's blood pressure and oxygen levels were good at the time. Staff Jenkins stated that they helped Resident A up from the floor. Resident A was awake but was speaking nonsensically. Staff Jenkins stated that Resident A's norm was to go back and forth speaking normally and nonsensically. Staff Jenkins denied observing any marks or bruises during the time they helped Resident A up from the floor. Staff Jenkins stated that they assisted Resident A back into bed, with the bed alarm on the bed. Staff Jenkins stated that it was unknown how long Resident A had been on the floor. Resident A had urinated on the floor by her bed and did not have a brief on when Resident A was found in the bathroom. Staff Jenkins stated it is unusual for Resident A not to have the bed alarm. Staff Jenkins stated that a motion alarm was also turned on. Staff Jenkins stated that it is common practice for staff to ask family members if they want a resident to be sent to the hospital, but if it is an emergency, staff are to call 911 first then the family. Staff Jenkins stated that Resident A had a history of falls, which were common. Staff Jenkins stated the rest of the shift went okay. Staff Jenkins checked on Resident A more often, then around 10:00 am, Resident A's breathing had changed, so she asked the shift lead for assistance, then called 911, then the family. Staff Jenkins stated that she noticed at this time, Resident A had bruising on the left side of her head, and on one of her hands. Staff Jenkins stated that staff Emily Jenkins was the shift lead that day. Staff Brook Jenkins stated that the ambulance arrived, Resident A was sent out.

During this on-site, I took photos of documentation from Resident A's file. A copy of an *AFC Licensing Division- Incident/Accident Report* dated 01/24/2026 at 6:00 am was obtained. The incident report written and signed by Staff Brooke Jenkins states the following regarding what happened, action taken by staff, and corrective measures taken:

"*When staff Brooke came on the shift she did walk thrus with Staff Angel. [Resident A] was found on her bathroom floor. Staff Angel did body assessment and called family. Staff Brooke did vitals and called home care. Staff Brooke started 15 to 30 minute checks on [Resident A]. Motion and bed alarm turned on and where they*

could detect the resident. Increase number of checks done on resident. Talked to family about a pendant. Reminded resident to wait for help when transferring."

A *Post Fall Assessment* form dated 01/24/2026 for 6:00 am notes that the fall was not observed, and Resident A was alone. It has yes checked for resident getting out of bed/up from chair and going to the bathroom. It notes that before the fall, Resident A was not alert and oriented, confused but able to follow direction, and post-fall, Resident A was confused, not alert and oriented, and not able to following direction. Under *Physical status of resident prior to fall*, unsteady gait, incontinence, and impaired mobility/transfer were marked yes. *Environmental status at time of fall* has pendant/pull cord within reach, bed locked, and room light on marked yes. Under *measures taken to prevent further falls*, it notes that "*resident was sent to ER for eval*." The assessment was signed by staff Kelly Gould on 01/26/2026.

A second *Post Fall Assessment* dated 01/03/2026 for another unwitnessed fall was reviewed as well. The measures taken to prevent further falls was "*reminded resident to call for assistance before getting up by herself*." This form also noted that a pendant/pull cord was within reach.

Resident A's *Health Care Appraisal* dated 12/18/2025, had attached documentation that noted Resident A was diagnosed with Traumatic subdural hemorrhage without loss of consciousness, traumatic brain compression without herniation, altered mental status, dysphagia, cerebral infarction, epilepsy, etc.

Resident A's *Assessment Plan for AFC Residents* dated 12/22/2025, notes that Resident A was able to make basic needs known, experienced confusion in regard to being alert to surroundings, and follows instructions at times. Resident A required assistance with all personal care activities. For walking/mobility, Resident A used a wheelchair and walker. For physical limitations it notes that Resident A is a fall risk, and to not leave Resident A in the bathroom alone. Use of a bed alarm was not noted in the assessment plan.

Resident A's *Individualized Service Plan* dated 12/19/2025, notes for toileting that Resident A is continent with bladder and bowel movements, but needs assistance to the bathroom, and assistance with protective wear. Frequency is noted to be *Q 2 hours* (every two hours). For transfers, it notes that Resident A requires moderate assistance with transferring (*1 physical assist with transfers. Uses wheelchair to get around*). It notes that Resident A is at risk for falls, staff have to do checks every two hours, and that Resident A has had four to six falls in the last six months. Use of a bed alarm was not noted in the service plan.

On 03/20/2026, I spoke with designated person for the facility Sandy Altman. Sandy Altman stated that Resident A had a fall. The family was contacted. The family did not want Resident A to be sent to the hospital. Resident A had a change in status and was sent to the hospital.

On 03/23/2026, I interviewed senior operations manager Lisa Stein. Staff Stein stated that she remembered Relative 1 did not want Resident A to be sent to the hospital initially. The family expressed no issues to staff/nurse Kelly Gould at that time.

During this on-site, I observed residents in the common area of the facility. No issues were noted.

On 04/01/2026, I interviewed Relative 1. Relative 1 stated that staff suggested Resident A use a bed and chair alarm. Relative 1 was informed by management that staff forgot to use the bed alarm. Relative 1 stated she was not informed of all the information regarding what happened on 01/24/2026. Relative 1 stated that the staff did not recommend that Resident A go to the hospital, and Relative 1 was not informed that Resident A hit her head. Relative 1 stated that a physical therapist had just informed staff that if Resident A hit her head, Resident A needs to go to the emergency room. Relative 1 was informed on 01/24/2026 around 10:00 am that Resident A needed to go to the emergency room because Resident A hit her head. Staff were watching Resident A that morning because Resident A appeared to be breathing funny. Staff recommended Resident A go to the hospital, and Relative 1 agreed. Resident A had bruising all over her body. There was a bruise on top of Resident A's head/forehead and management at the facility was unable to say if it was from the fall on 01/24/2026 or a previous fall. The fall on 01/24/2026 was an unwitnessed fall. Relative 1 reported not understanding why staff did not say at 6:00 am that Resident A hit her head but stated so at 10:00 am. Relative 1 stated staff told Relative 1 that Resident A did not get up after the fall, and that Resident A was unresponsive by the time the EMTs arrived at the facility. Relative 1 stated that Resident A was asthmatic, and staff did not give Resident A any breathing treatment. Relative 1 stated that it was in Resident A's care plan to give nebulizer treatment as needed. Relative 1 stated their concern is about what the facility's protocol is. Relative 1 stated that staff reported Resident A was responsive and had gotten up from the floor after the fall. Relative 1 stated that Resident A hit her head during a previous fall. Relative 1 stated that the biggest concern is that staff did not use Resident A's bed alarm and reported not knowing if the bed alarm was in Resident A's care plan. Relative 1 stated when picking Resident A's belongings up, staff could not find Resident A's chair alarm, so Relative 1 questioned if the chair alarm was ever used. Relative 1 stated that Resident A had two massive brain bleeds that were shifting Resident A's brain. Resident A had onset dementia but was not officially diagnosed. Resident A also had history of stroke.

On 04/14/2026, I interviewed former staff/nurse Kelly Gould via phone. Staff Gould stated that the incident occurred on a weekend, and she was not present at the facility. Staff Gould stated that staff Emily Jenkins was the on call staff that weekend. Staff Gould stated that she was informed that following Monday (01/26/2026) about the fall. Staff Gould stated that staff called Relative 1, and Relative 1 asked staff to keep an eye on Resident A. At about 10:00 am, staff called Relative 1 again and told Relative 1 that Resident A needed to go to the hospital. Relative 1 asked staff to

administer a breathing treatment to Resident A. Staff said no and sent Resident A to the hospital. Per Relative 1, Resident A was intubated at the hospital and was eventually pulled off intubation. Kelly Gould stated that Resident A died of a brain bleed. Staff Gould stated that staff are supposed to call on-call and family when incident occurs in the facility. Staff Gould stated that she thinks Resident A fell during shift change. Staff Gould stated that she doesn't think Resident A's pressure sensor/bed alarm was on the bed. Staff Gould stated they also used the sensor on the wheelchair. Resident A was a very high fall risk. Resident A fell at home prior to being placed at the facility. Resident A had a previous brain bleed and stroke, went to the hospital, and was transferred to Health Source in Saginaw. Resident A reportedly had many falls at Health Source, then moved to Eden Fields Memory Care, where she also had multiple falls. Staff Gould stated that Resident A would rotate in bed to pull the bed alarm from under herself. Kelly Gould stated that she cannot recall if Resident A had bed rails, but Resident A did have a medical bed. Staff Gould stated that Resident A's family bought the bed alarm.

On 04/01/2026 and 04/02/2026, I received emails from Relative 1 containing requested documentation. A copy of Resident A's My Michigan Health medical records were received. On page 02 of 79, it notes that Resident A's date of services was 01/24/2026 at 10:36 am. It notes "*unresponsive, found down at assisted living facility, head trauma and duration found at 0600 today by assisted living facility staff, they called her daughter at that time and said she was "okay.""* On page 5 of 79, it notes "*hematoma left forehead*." Under ED Course on page 6 of 79, it notes "*Daughter said the assisted living facility found her down at 6am and the assisted living facility said she did not have any signs of trauma. They told her daughter she was "breathing funky" when they checked at her later at 10 am*. *Positive UTI which we will not treat at this time 2/2 comfort care measures*." Under *Clinical Impression*, it notes "*Intracranial hemorrhage concurrent with and due to complex wound of head*." On page 19 of 79, it states "*This is a 76-year-old white female who lives at assisted living who was found to be on the floor with head trauma. She was found to be unresponsive. She has left forehead bruising from previous fall. Initial fall was thought to be at 6 am. She was brought in with decreased level of consciousness. She is currently intubated. She is unresponsive*." "*Patient was admitted to hospital with intracranial bleed she was intubated. Case discussed by ER with neurosurgery no intervention. Discussions with family comfort care. Patient was terminally extubated this morning family at bedside. Patient was pronounced dead at 8:35 am January 25, 2026.*"

A copy of Resident A's State of Michigan *Certificate of Death* dated 01/25/2026 was obtained. Time of death was pronounced at 08:30 am on 01/25/2026. *Manner of death* is noted to be natural, and no autopsy was performed. The cause of death is noted to be Intracranial bleed, and the approximate interval between onset and death is listed as "*days*." The method of disposition is listed as cremation.

A copy of an undated voicemail recording from a person identifying themselves as Jo who works for Residential was received in the email as well. Jo stated in the

voicemail that she visited with Resident A, observed a bump/bruise on Resident A's left eyebrow. Informed Resident A if she experiences any pain to let staff know. She stated that she discussed safety with staff, and that Resident A walks with her feet close together and lacks safety awareness. She stated that she would report a fall Resident A had to a doctor, and that she educated staff that if Resident A falls, hits her head, that Resident A should be sent to the ER to get checked out.

On 04/27/2026, I made a follow-up call to Relative 1. Relative 1 reported that the copy of the voicemail I received on 04/01/2026, was dated 01/22/2026. Relative 1 reported not remembering the name of the company Jo worked for, and believed Jo was a physical therapist.

On 04/14/2026, I interviewed staff Emily Jenkins via phone. She stated that on 01/24/2026, she arrived at the facility around 10:00 am. Staff Brooke Jenkins asked her to check on Resident A. Staff Emily Jenkins stated that Resident A seemed off. Resident A was breathing normally, but Resident A was not responsive. Resident A's vitals were checked, 911 was called, and the family was called. She stated that they either gave Resident A oxygen or C-PAP and waited until EMTs arrived. Emily Jenkins stated that she thinks there was a bruise on the left side of Resident A's head (temple) about the size of a baseball. Staff Jenkins stated that Resident A was prone to falls, and to her knowledge just had a bed alarm. Emily Jenkins stated that staff Brooke Jenkins told her that when Staff Brooke Jenkins came in at 6:00 am the bed alarm was by the medication cart, and that they (staff Brooke Jenkins and staff Angel Pratin) found Resident A on the floor during shift change. Staff Jenkins stated that staff do bed checks every two hours. Emily Jenkins stated that she was on-call that morning prior to reporting to work, and that she did not receive any calls prior to arriving. When asked what the protocol for staff is to follow if there is an unwitnessed fall, Staff Emily Jenkins stated that if the resident is on hospice, they call hospice and the resident's family. Bed checks are increased, vitals are checked, and residents are checked for injury. Staff Jenkins stated that if there is an injury, depending on the seriousness of the injury, they may send them to the hospital. Staff Jenkins stated that from what she was told, Resident A was at baseline and was able to safely transfer back to bed. Initially staff did not notice any injuries or anything off with Resident A. Emily Jenkins denied having any knowledge of Resident A having a history of brain bleeding.

On 04/15/2026, I interviewed staff Angel Pratin via phone. Staff Pratin stated that she did not witness nor hear Resident A fall. Staff Pratin stated that she conducted a check shortly after 4:30 am. Resident A was moving around in her bed. Staff Pratin stated that at shift change (6:00 am), Resident A had gotten out of bed herself. Staff Pratin stated that she does not remember if Resident A had a bed alarm at that time. Staff Pratin stated that Resident A was a fall risk, but Resident A had never had a fall during any of her shifts prior to this day. Staff Pratin stated that Resident A was lying face down, was conscious and alert. Resident A told staff she was okay, her head hurt, but Resident A said she did not want to get checked out. Staff Pratin stated that she asked Relative 1 three times if Relative 1 wanted staff to call 911. Staff Pratin

stated that Relative 1 said no, so staff got Resident A back in bed. Staff Pratin stated that at the time staff found Resident A on the floor, Resident A had a little bump near her eyebrow, that Staff Pratin thought was from a fall that happened on a previous day shift. Staff Pratin stated that Resident A was not bleeding and did not have any observable new injuries. She stated that she thinks they got Resident A into a wheelchair, had Resident A sit up for a minute, then got Resident A back into bed. Staff Pratin stated that she signed out on the narcotic medications, then left her shift. Staff Pratin stated she thinks the protocol for an unwitnessed fall when there is suspicion that a resident may have hit their head is to call the family. If the family says don't send them to the emergency room, don't. Staff Pratin stated that she does not remember if she told Relative 1 Resident A hit her head, but that she did tell Relative 1 that Resident A's speech was slow. Staff Pratin stated Resident A was not slurring words but was just speaking slowly. Staff Pratin stated Relative 1 told her that the slow speech was normal, that Resident A was tired. She stated that she informed first shift staff to check on Resident A hourly because Resident A did hit her head. Staff Pratin stated that she said Resident A hit her head because of a mark/cut on Resident A's head. She stated that she doesn't recall a bump on Resident A's head at the beginning of the shift. Staff Pratin stated it was a mark or cut from a previous fall, and that same area was starting to swell. Staff Pratin stated she was informed Resident A died of a brain bleed. Staff Pratin states that she did not see any bruises, just swelling on the eyebrow area, and thinks it was Resident A's left eyebrow. Staff Pratin stated that at shift change, day shift staff asked Resident A orienting questions and took Resident A's vitals. When asked about the bed alarm, Staff Pratin stated that Resident A would refuse the bed alarm, start physically fighting staff, or would already be asleep before staff could put the alarm on the bed. She stated Resident A would yell "*Don't touch me*!"

On 04/27/2026, I made a follow-up call to senior operations manager Lisa Stein. I requested a copy of the facility's fall protocol policy, as well as additional incident reports for falls that occurred between 01/03/2026 and 01/24/2026.

On 04/27/2026, I received copies of additional incident reports via email. An incident report dated 01/13/2026 at 9:00 am written by staff Rachel LeFever states "*Resident attempted to stand from bed and fell. Resident was checked over for injury, and none were found."* The corrective measures were noted to be *"Reminded resident to use call light and ask for help*." A *Post Fall Assessment* dated 01/13/2026 and signed by Kelly Gould on 01/15/2026 notes that this was an unwitnessed fall. The incident report notes Relative 1 was notified.

An *AFC Licensing Incident/Accident* reported dated 01/20/2026 at 11:00 am notes "*Resident was attempting to stand from wheelchair by grabbing back of a reg chair. Fell and hit her head. Assessment for injury. Applied ice to knee (R) & L eye. Gave Tylenol for pain. Called family.*" Corrective measures notes "1-*2 hr checks. Pendant in place.*"

On 04/27/2026, I received a copy of Resident A's January 2026 MAR (medication administration record) which confirms Resident A was prescribed Clopidogrel TAB 75MG (Plavix), which is a blood thinner. Resident A was passed this medication, per the medication log from 01/01/2026 through 01/23/2026, each day at 8:00 am. In this email, senior operations manager Lisa Stein stated that she did not see any physician's order in Resident A's file for the bed alarm and chair alarm.

On 04/27/2026, I made a call to Jo, the individual whose voice was on the voicemail provided to me on 04/01/2026. Jo identified herself as a registered nurse who works for Residential Home Health. She stated that she does not remember who at the facility she spoke with but stated that educating individuals on the importance of sending someone to the emergency room after a fall and hitting their head is a normal thing to do when someone is prescribed blood thinners. She stated that she is sure she would have spoken to someone but does not remember who. She stated that she was not sure about anything related to Resident A's bed alarm. She ended this call and called back, referring me to Residential Home Health's office for answers to any further questions.

On 04/28/2026, I conducted an exit conference with designated person Sandy Altman-Elliott. I informed Sandy Altman-Elliott of the findings and conclusion. Sandy Altman-Elliott stated that she will respond to this report with a corrective action plan addressing the findings.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.
ANALYSIS:	On 03/10/2026, I conducted an unannounced on-site at the facility. I interviewed staff Amanda Sexton. Staff Sexton stated Resident A did fall and hit her head. Staff Sexton stated that Relative 1 reported to staff that Resident A did not need to go to the hospital. She stated that staff placed Resident A back in bed. During this on-site, I interviewed staff Brooke Jenkins at the facility. Staff Jenkins stated she found Resident A face down in Resident A's bathroom (at 6:00 am on 01/24/2026). She stated that Staff Pratin did a body assessment and called Resident A's family. She stated that they assisted Resident A back into bed, and it was unknown how long Resident A had been on the floor. She stated that around 10:00 am, Resident A's breathing changed, Resident A had bruising, and 911 was called.

	During the course of this investigation, I reviewed the *AFC Licensing Incident/Accident Report* dated 01/24/2026 at 6:00 am that notes staff did a walk-through, found Resident A on the bathroom floor. A second incident report dated 01/22/2026 at 11:00 am, also notes that Resident A fell and hit her head on this date as well. The incident report does not note that Resident A was sent to the emergency room for medical care. On 04/01/2026, I interviewed Relative 1 via phone. Relative 1 stated that the staff did not recommend that Resident A go to the hospital at 6:00 am on 01/24/2026, and Relative 1 was not informed that Resident A hit her head. Relative 1 stated that a physical therapist had just informed staff that if Resident A hit her head, Resident A needs to go to the emergency room. Relative 1 was informed on 01/24/2026 around 10:00 am that Resident A needed to go to the emergency room because Resident A had hit her head. Relative 1 stated that Resident A's fall on 01/24/2026 was unwitnessed. On 04/14/2026, I interviewed former staff/nurse Kelly Gould via phone. She stated that staff called Relative 1, and Relative 1 asked staff to keep an eye on Resident A. At about 10:00 am, staff called Relative 1 again and told Relative 1 that Resident A needed to go to the hospital. Resident A was then sent to the emergency room. A copy of Resident A's My Michigan Health medical records were received dated 01/24/2026 noting that Resident A had hematoma on the left forehead and an Intracranial hemorrhage concurrent with and due to complex wound of head. On 04/14/2026, I interviewed staff Emily Jenkins via phone. Staff Jenkins stated that when she arrived at 10:00 am at the facility, Resident A was not responsive. Vitals were checked, 911 and family were called. Staff Jenkins stated Resident A at the time had a bruise on the left side of her head about the size of a baseball. Staff Jenkins stated that staff Brooke Jenkins and staff Angel Pratin found Resident A on the floor at 6:00 am during shift change. On 04/15/2026, I interviewed staff Angel Pratin via phone. Staff Pratin stated that she did not witness nor hear Resident A fall. She stated that she conducted a check shortly after

	4:30 am and again at 6:00 am during shift change. Staff Pratin stated that Resident A was found lying face down, was conscious and alert. Resident A told staff she was okay, her head hurt, but Resident A said she did not want to get checked out. Staff Pratin stated that she asked Relative 1 three times if Relative 1 wanted staff to call 911. Staff Pratin stated that Relative 1 said no, so staff got Resident A back in bed. Staff Pratin stated that she informed first shift staff to check on Resident A hourly because Resident A did hit her head. Staff Pratin stated that she said Resident A hit her head because of a mark/cut on Resident A's head from a previous fall, and that same area was starting to swell. A copy of Resident A's State of Michigan *Certificate of Death* dated 01/25/2026 was obtained. The cause of death is noted to be Intracranial bleed. There is a preponderance of evidence to substantiate a rule violation. Resident A had an unwitnessed fall and was found face down on the floor. Emergency services were not called until about four hours after Resident A's unwitnessed fall.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 03/10/2026, I conducted an unannounced on-site at the facility. During this on-site, I took photos of documentation from Resident A's file. A copy of an *AFC Licensing Division- Incident/Accident Report* dated 01/24/2026 at 6:00 am was obtained detailing staff finding Resident A on the bathroom floor after an unwitnessed fall. I also obtained a copy of Resident A's *AFC- Resident Information and Identification Record* has Relative 1 listed as Resident A's power of attorney and designated representative for Resident A.

On 04/01/2026, I interviewed Relative 1. Relative 1 reported that a request was made for a copy of the incident report documenting what occurred on 01/24/2026, but Relative 1 did not receive a copy of the incident report from the facility.

On 04/27/2026, I left a voicemail requesting a return call from former staff Kelly Gould. I left a voicemail requesting a return call. This call was made to inquire whether she can recall Relative 1 received a copy of the 01/24/2026 incident report.

On 04/27/2026, I made a call to the facility and spoke with senior operations manager Lisa Stein via phone. Lisa Stein stated that the family probably did not get a copy of the incident report, as they don't release incident reports. I requested copy of

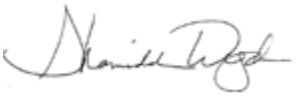
an incident report detailing Resident A being sent to the ER on 01/24/2026. She stated that she did not think there was an incident report filled out, but she would look and see. On 04/27/2026, I received additional copies of incident reports, but there was no incident report for the 1/24/2026 hospitalization.

On 04/28/2026, I conducted an exit conference with designated person Sandy Altman-Elliott. I informed Sandy Altman-Elliott of the findings and conclusion. Sandy Altman-Elliott stated that she will respond to this report with a corrective action plan addressing the findings.

APPLICABLE RULE	
R 400.693	**Incident notification, incident reports.**
	(1) If a resident has a representative identified in writing on the resident's care agreement, a licensee shall report to the resident's representative within 48 hours after any of the following: **(b) Unexpected and preventable inpatient hospitalization.**
ANALYSIS:	On 04/01/2026, I spoke with Relative 1 via phone. Relative 1, Resident A's designated representative reported not receiving a copy of an incident report for 01/24/2026. During the course of the investigation, I requested and did not obtain a copy of an incident report regarding Resident A's hospitalization on 01/24/2026. On 04/27/2026, I spoke with operations manager Lisa Stein who stated she did not think there was an incident report filled out for Resident A's hospitalization on 01/24/2026. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

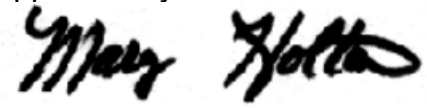
Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the current status of this AFC large group home license (capacity 13-20).



04/28/2026

Shamidah Wyden Date
Licensing Consultant

Approved By:



04/28/2026

Mary E. Holton Date
Area Manager