STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

RICK SNYDER
GOVERNOR

SHELLY EDGERTON
DIRECTOR

February 1, 2018

Troy Ganton/Lisa Pritchard
Arbor Woods Assisted Lvg
2100 Springport Road
Jackson, MI 49202

RE: License #: AH380313452
Investigation #: 2018A1011003
Arbor Woods Assisted Lvg

Dear Mr. Ganton/Ms. Pritchard:

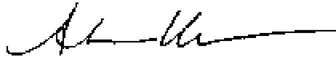
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames (dates) 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 home for the aged authorized representative 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,



Andrea Krausmann, Licensing Staff
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(586) 256-1632

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH380313452
Investigation #:	2018A1011003
Complaint Receipt Date:	10/25/2017
Investigation Initiation Date:	10/25/2017
Report Due Date:	12/24/2017
Licensee Name:	Ganton's Arbor Woods, LLC
Licensee Address:	2100 Springport Road Jackson, MI 49202
Licensee Telephone #:	(517) 787-4400
Administrator:	Lisa Pritchard
Authorized Representative:	Troy Ganton in process of changing to Lisa Pritchard
Name of Facility:	Arbor Woods Assisted Lvg
Facility Address:	2100 Springport Road Jackson, MI 49202
Facility Telephone #:	(517) 787-4400
Original Issuance Date:	07/08/2011
License Status:	REGULAR
Effective Date:	05/31/2016
Expiration Date:	05/30/2017
Capacity:	59
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A slid out of her recliner chair while two staff persons were providing care to her.	No
Additional findings.	Yes

III. METHODOLOGY

10/25/2017	Special Investigation Intake 2018A1011003
10/25/2017	Special Investigation Initiated - Telephone Interviewed assigned adult protective services (APS) worker Heather North by telephone.
11/03/2017	Contact - Document Received APS worker Heather North emailed that she is waiting on medical records.
11/08/2017	Contact - Document Received Documentation received from APS worker Heather North.
11/09/2017	Contact - Document Received Email from APS worker H. North.
11/09/2017	Contact - Document Sent Email back to APS worker H. North.
01/19/2018	Inspection Completed On-site Interviews conducted, observations made, records reviewed.
01/20/2018	Contact - Telephone call made Interviewed staff Kathy Rutkowski and Katelyn Kulinski via telephone.
01/22/2018	Contact - Telephone call made Interviewed former staff Cynthia King via telephone.
01/22/2018	Contact - Telephone call made Called administrator Lisa Pritchard - unavailable. Left message with staff requesting call back.

01/22/2018	Contact - Telephone call received Follow-up interviews with administrator Lisa Pritchard and Care Manager Amanda Goodband via telephone.
01/22/2018	Contact - Telephone call made Called assigned APS worker Heather North and left voice mail message requesting a call back.
01/22/2018	Contact - Document Sent Email to H. North requesting call back.
01/23/2018	Contact - Telephone call received Heather North called - she did not substantiate.
01/24/2018	Contact - Telephone call made Called L. Pritchard requesting additional documentation.
01/24/2018	Contact – Document received Copy of medication administration record (MAR) received from L. Pritchard via email.
01/26/2018	Contact - Telephone call made Called facility a couple times to provide exit conference to authorized representative (AR) Troy Ganton – unavailable. Left message requesting call back.
01/26/2018	Contact - Document Sent Email sent to T. Ganton requesting to provide exit conference call.
01/28/2018	Contact – Document received Email from T. Ganton that he will be in facility Monday 1/29/18 9:30 – 10 am.
01/29/2018	Contact - Document Sent Email sent to T. Ganton that I will be on the road at that time. Please provide cell phone number.
01/29/2018	Contact – Document received Email from T. Ganton that he will be in office today to catch up with Lisa 2:00 – 2:30 pm. Also, he wrote that he will not give out his cell phone number.
01/29/2018	Contact - Document Sent Email to T. Ganton - please provide a contact phone number where you can be reached.

01/29/2018	Contact - Telephone call received Called facility at 2:32 pm but Lisa Pritchard said T. Ganton already left. Also, L. Pritchard said T. Ganton wants her to be the authorized representative so that exit conferences can be conducted with her instead of him.
01/29/2018	Contact - Document Sent Email sent to T. Ganton that in respect to his “catch up with Lisa” 2-2:30 pm time, I called the facility at 2:32 pm but he already left. Also, I informed him that L. Pritchard said T. Ganton wants to change the authorized representative from himself to L. Pritchard. I provided the BCAL 1603 form for completion of this process.
02/01/2018	Contact – Document Received Received via email from Lisa Pritchard with a BCAL 1603 form attached - changing the authorized representative from Troy Ganton to Lisa Pritchard. Background check is required to complete process.
02/01/2018	Contact - Telephone call made I called facility to provide an exit conference to newly appointed authorized representative Lisa Pritchard but she had left for the day.
02/01/2018	Exit conference – Multiple attempts have been made to provide authorized representative Troy Ganton an exit conference, but I was unable to reach him. I also attempted to contact the newly appointed authorized representative Lisa Pritchard but she had left for the day.

ALLEGATION:

Resident A slid out of her recliner chair while two staff persons were providing care to her.

INVESTIGATION:

On 10/25/17, the department received the allegations by way of adult protective services (APS) therefore; a referral to APS was unwarranted. The complainant was not identified. The complaint read that on 10/21/17 Resident A slid out of her recliner chair. Staff assisting her did not assist properly and resident fell. On 10/22/17 Resident A was found alone in the dining room, way past breakfast time, with dry oatmeal on her face. Resident A's wrists were swollen and bruised. Resident had fever, was taken to emergency room and it was determined both wrists had broken bones. Released from hospital, Resident A was taken to Allegiance Hospice Home where they told family she did not have broken bones.

On 10/25/17, I interviewed the assigned APS worker Heather North. On 11/8/17, Ms. North emailed a copy of Resident A's hospital radiology report dated 10/22/17. The document read "Ill-defined right trapezium and first CMC joint may relate to remote trauma versus erosive process... Blunted ulnar styloid processes may relate to remote trauma versus erosive process. Moderate soft tissue swelling about the bilateral wrists. No definite acute fracture or dislocation is appreciated. "

On 11/9/17, Ms. North emailed that Resident A passed away on 11/4/17.

On 1/19/18, I interviewed administrator Lisa Pritchard at the facility. Ms. Pritchard said Resident A was sent to the hospital on 10/22/17. Ms. Pritchard stated all aides receive training to conduct transfers with a resident that requires two staff to transfer safely.

On 1/19/18, I interviewed care manager Amanda Goodman at the facility. Ms. Goodman's statements regarding resident transfers coincided with Ms. Pritchard's. Ms. Goodband supervises the resident care staff and maintains incident reports. Ms. Goodband confirmed there was no incident report completed for the 10/21/17 incident. Ms. Goodband provided a copy of Resident A's service plan dated 12/29/16 and an update assessment dated 10/19/17 that includes the need for "Requires 2 assist for transfers".

According to notes contained within Resident A's record, she was hospitalized on 10/13/17 for confusion, shaking and reaching for things that were not there. Resident A returned to Arbor Woods Assisted Living on 10/19/17, and Ms. Goodband documented that Resident A was lethargic and required two-person assist for transfers. Staff Cynthia King documented that on 10/21/17 at "1600" meaning 4:00 pm, Resident A was observed on the floor and she was complaining of back pain. Resident A's vitals were taken, PRN medication was administered, and Resident A's authorized representative was notified of the incident. Ms. King documented in Resident A's notes the following day "10/22/17 1st [shift] Resident observed lethargic and feverish. Resident transported and later admitted to HFAH [Henry Ford Allegiance Health]". Ms. King also documented on an *Inter-Building Notification* form that Resident A was sent to the HFAH hospital on 10/22/17 at "0930" meaning 9:30 am.

On 1/19/18, I interviewed staff Rachel Robbins at the facility. Ms. Robbins recalled working the afternoon shift on 10/21/17. Ms. Robbins said she believes it was Ms. King who told her that staff Katelyn Kulinski and Kathy Rutkowski were transferring Resident A from her recliner to her wheelchair and attempted to put on Resident A's chest/back brace while she was standing. She believed that Resident A possibly lost her balance and sat on the floor. Ms. Robbins stated neither she nor Ms. King were present for the incident but Ms. King went into the room and assisted staff in getting Resident A up. Ms. Robbins recalled having observed Resident A later in the dining area and that the resident seemed lethargic. Ms. Robbins stated that Resident A had

been that way since she returned on 10/19/17 from the hospital. Ms. Robbins said she recalled Ms. Kulinski felt bad about Resident A going down to the floor, like it was her fault. Ms. Robbins said she believes she and another staff assisted Resident A into bed that night and that Resident A seemed “out of it but like usual since her return from the hospital”. Ms. Robbins confirmed having been trained in conducting a two-person transfer.

On 1/20/18, I interviewed staff Katelyn Kulinski by telephone. Ms. Kulinski confirmed she had been trained on two-person transfers. Ms. Kulinski had no recall of the 10/21/17 incident repeatedly saying “I don’t remember”. Ms. Kulinski said of Resident A, “She never fell with me. I heard she fell. I assume a resident aide was with her or they found her on the floor. I think Kathy [Rutkowski] might have been in the room. I don’t think I was.”

On 1/20/18, I interviewed staff Kathy Rutkowski by telephone. Her statements coincided with Ms. Kulinski’s regarding the incident and training received. Ms. Rutkowski said she did not remember Resident A ever falling with her but said, “I remember putting the brace on her. I was shown one time by someone [how to do it]. She was sitting down, I think.”

On 1/22/18, I interviewed former staff Cynthia King by telephone. Ms. King recalled that on 10/21/17 she was paged to Resident A’s room and said there were two staff present but she could not specifically recall who they were. I read the *Nurse’s Notes* written by Ms. King, and she confirmed having documented the entries. Ms. King said the two staff persons told her that Resident A slid out of her lift recliner and she observed the recliner was in the up position. Ms. King confirmed that Resident A was wearing her back brace when she saw her. Ms. King said Resident A was complaining of back pain. Ms. King did not notify Resident A’s doctor of the incident but confirmed she did administer medication. Ms. King also confirmed having notified Resident A’s authorized representative and said she wrote an incident report that she placed in Ms. Goodband’s mailbox. Ms. King said she would be expected to write an incident report for a fall such as this, but not for going to the hospital for illness, as Resident A did the next day.

On 1/22/18, in a follow-up telephone interview, Ms. Pritchard said she was unaware of Resident A falling on 10/21/17 because there was no incident report. After Resident A went to the hospital on 10/22/17, she then moved directly into a hospice home. This placement option had been discussed prior to her hospitalization, so it was not unexpected.

On 1/22/18, I also interviewed Ms. Goodband by telephone. Ms. Goodband again confirmed having not received or located any 10/21/17 incident report for Resident A. Ms. Goodband said she reviews *Nurse’s Notes* periodically but since Resident A did not return to the facility, she did not review Ms. King’s 10/21/17 note until after Resident A moved out of the facility.

On 1/23/18, APS worker Heather North said via telephone, that in her investigation, she did not substantiate improper treatment of Resident A.

On 1/24/18, Ms. Pritchard provided a copies of the front and back of Resident A's medication administration record (MAR) by email. According to the MAR, Resident A had an order for Roxicodone 5mg every 6 hours "PRN" meaning as needed. Ms. King initialed the MAR on 10/22/17, indicating that was the date she administered the medication to Resident A. On the back of the MAR, Ms. King documented "10/22/17 1200 Roxycodone (sic) PO pain" meaning she administered the medication on 10/22/17 at 12:00 pm by mouth for pain. This date and time are inconsistent with the notes that Resident A was found on the floor on 10/21/17 at 4:00 pm and the medication was administered then. Also, the 12:00 pm time of administration is inconsistent with the *Inter-Building Notification* note that read Resident A had been sent the hospital on 10/22/17 at 9:30 am. Resident A would not have been in the facility at 12:00 pm. It should be noted that documentation on the MAR indicates the 10/22/17 administration of Roxicodone is the only time Resident A received the medication in the month of October.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	The complaint allegations, staff interviews, and Resident A's record notes had conflicting and inconsistent information as to how Resident A landed on the floor. Resident A had a short history of lethargy. She required the assistance of two staff for transfers. Staff statements and documentation support that there were two staff present during the time of the transfer. It is unknown whether Resident A fell while staff attempted to put on her brace in the standing or seated position. It is also unknown if the swelling of Resident A's wrists was the result of trauma from a fall, a physical ailment, or some other event. There is no substantial evidence to confirm Resident A's slid from the recliner or fell from a standing position as a result from an improper transfer.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(1) The home shall complete a report of all reportable incidents, accidents, and elopements. The incident/accident report shall contain all of the following information: (a) The name of the person or persons involved in the incident/accident. (b) The date, hour, location, and a narrative description of the facts about the incident/accident which indicates its cause, if known. (c) The effect of the incident/accident on the person who was involved, the extent of the injuries, if known, and if medical treatment was sought from a qualified health care professional. (d) Written documentation of the individuals notified of the incident/accident, along with the time and date. (e) The corrective measures taken to prevent future incidents/accidents from occurring.
For reference: R 325.1901	**Definitions.**
	(17) “Reportable incident/accident” means an intentional or unintentional event in which a resident suffers harm or is at risk of more than minimal harm, such as, but not limited to, abuse, neglect, exploitation, or unnatural death.
ANALYSIS:	On 10/21/17, Resident A was found on the floor due to some undetermined situation and she suffered back pain requiring medication. Ms. King said she documented an incident report but Ms. Goodband could not locate one.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident’s authorized representative, if any, and the resident’s physician.

ANALYSIS:	Ms. King did not notify Resident A's physician of the 10/21/17 incident when she was found on the floor for some unknown reason and she complained of back pain. Also, the home did not report the incident to the department.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(1) A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.
For Reference: MCL 333.20201	2(e) A patient or resident is entitled to receive adequate and appropriate care, and to receive, from the appropriate individual within the health facility or agency, information about his or her medical condition, proposed course of treatment, and prospects for recovery, in terms that the patient or resident can understand, unless medically contraindicated as documented in the medical record by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services.
ANALYSIS:	Resident A was observed on the floor with two staff present. The specifics of the circumstance are unknown. Ms. King documented a note that on 10/21/17 at 4 pm she observed the resident on the floor complaining of pain, she assessed the resident and administered "PRN" medication. Contrary to this note, Ms. King's documentation on Resident A's MAR indicates the medication was administered the following day 10/22/17 at 12 pm. However, Resident A had already left the building at 9:30 am on 10/22/17. Ms. King said she did not notify Resident A's physician of the 10/21/17 incident but she administered the medication based on her assessment.

	Given the 10/21/17 incident of Resident A landing on a floor and complaining of back pain, it would be expected that an incident report be written and that Resident A's physician be immediately notified to ensure adequate and appropriate care is applied. Therefore, it cannot be determined that Resident A received adequate and appropriate care.
CONCLUSION:	**VIOLATION ESTABLISHED**

Over several days, multiple attempts were made to provide authorized representative Troy Ganton an exit conference, but I was unable to reach him. Upon receipt that the authorized representative is changing to Lisa Pritchard, I called the facility to provide her an exit conference, but she had left for the day.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

1/23/2018

Andrea Krausmann Date
Licensing Staff

Approved By:

1/25/18

Russell B. Misiak Date
Area Manager