RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

June 7, 2018

Amanda Maleche
Autumn Ridge of Clarkston
5700 Water Tower Place
Clarkston, MI 48346

RE: License #: AH630365890
Investigation #: **2018A0585018**
Autumn Ridge of Clarkston HFA

Dear Ms. Maleche:

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.

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,

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(313) 268-1788

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630365890
Investigation #:	2018A0585018
Complaint Receipt Date:	03/26/2018
Investigation Initiation Date:	05/16/2018
Report Due Date:	07/25/2018
Licensee Name:	ARHC ARCLRMI01 TRS, LLC
Licensee Address:	106 York Road Jenkintown, PA 19046
Licensee Telephone #:	(215) 887-2582
Administrator:	Amanda Maleche
Authorized Representative:	Amanda Maleche
Name of Facility:	Autumn Ridge of Clarkston HFA
Facility Address:	5700 Water Tower Pl Clarkston, MI 48346
Facility Telephone #:	(248) 625-0500
Original Issuance Date:	01/20/2015
License Status:	REGULAR
Effective Date:	07/20/2016
Expiration Date:	07/19/2017
Capacity:	72
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident fell while going to bathroom and was not found until the next day. He also had an additional fall.	Yes
Staff is not documenting all falls or the information regarding the falls for Resident A.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/26/2018	Special Investigation Intake 2018A0585018
05/16/2018	Special Investigation Initiated - Telephone Conducted interview with complainant.
05/16/2018	APS Referral Provided initial allegations to Adult Protective Services (Laura)
05/16/2018	Contact - Telephone call received Call received from APS Nina Higgins.
05/17/2018	Inspection Completed On-site Investigation included observation, interview and record review.
05/18/2018	Contact - Document Received Additional documents received from the Administrator.
06/08/2018	Exit Conference Conducted with Authorized Representative Amanda Maleche.

ALLEGATION:

Resident fell while going to bathroom and was not found until the next morning. He also had an additional fall.

INVESTIGATION:

On 3/26/18, the department received the online complaint.

On 5/16/18, a referral was made to Adult Protective Service (APS).

On 5/16/18, I interviewed the complainant by telephone. The complainant stated that Resident A fell out of the bed 3/17/18 around 9:00 p.m., but was not found until the next morning when an aide went into the room to give him his medicine. She stated that he had a urinary tract infection (UTI). The complainant stated that the resident is a one person assist and the staff are to check on him every two hours. She stated that he has fallen a lot at the facility, but she doesn't think the home documented every time the resident fell. The complainant stated that when they left the hospital and returned to the facility, the staff did not check on the resident for a long time. She stated that resident had to go to the bathroom and she attempted to assist him, and he fell again. She stated that she pulled the cord, and no one came. The complainant stated she left him and went to the nurses' station for help.

On 5/17/18, I interviewed Kathy McMonagle at the facility. Ms. McMonagle stated that Resident A fell on 3/17/18, hit his head and went to the hospital. She stated that Restorative Aide Scott Wendelken and Med passer Meaghan Wichtman found the resident on the floor. She stated that they checked on Resident A every 2 hours. She stated that the family hired a private duty person to assist resident. Ms. McMonagle stated that although they do two hour checks they do not document it. She stated that it is the expectation of the staff to respond to call pendants within 7 minutes. Ms. McMonagle stated that Resident A does not always use his call pendant.

On 5/17/18, I interviewed the Restorative Aide Mr. Wendelken. He stated that it was the med passer Meagan who found Resident A on the floor on 3/17/18 around 8 or 9 in the morning. He stated that Meagan called him, and he saw the resident on the floor conscious, but the resident did not remember how long he had been on the floor.

I interviewed med passer Meaghan Wichtman. She stated that she walked into Resident A's room around 8:15 a.m. She stated that resident was on the floor and she immediately called the supervisor. She stated that Resident A is on blood thinner and they sent him out to the hospital. She stated that Resident A was taking himself to the bathroom and he slipped and fell. She stated that he was independent.

On 5/17/18, I interviewed Resident A at the facility. Resident A stated that he remembers he got up in the night to use the bathroom. He stated he never made it to the bathroom because he fell. He stated that he laid on the floor until the next morning when the aide came in to give him his medicine. Resident A stated that staff don't have a specific time that they come in to check on him. He stated that some nights they don't come in at all. He stated that it was around 8:00 in the morning when the aide came in and found him on the floor. He stated when he woke up, Meaghan was over top of him to see if he was alive.

I reviewed the service plan dated 4/11/18 for Resident A. The plan notes that staff is instructed to do two-hour checks.

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 complainant alleges that Resident A fell and was not found until the following day. Resident A sustained an injury and had to be sent to the hospital. While there does seem to be some discrepancy between the complainant, resident, and staff regarding the frequency the resident was monitored throughout that night, the facility was unable to provide evidence of doing checks every 2 hours as indicated on the service plan. The resident was not diagnosed with dementia and had good memory skills, oriented to person, place and time. Based on interview, and record review, the allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff is not documenting all the falls or the information regarding the falls for Resident A.

INVESTIGATION:

On 5/17/18, I reviewed three incident reports for Resident A contained in the licensing file. The incident reports showed the following:

"On 3/17/18 at 9:00 a.m., Resident A was found on the floor between his bedroom and bath complaining of right hip pain. He had an apple size bruise above and to the right of navel. No other visible injuries. The responsible party and physician notified. Action taken: Upon discharge, Autumn Ridge will implement all new orders and reconcile medications with new and previously scheduled orders"

"On 3/17/18 at 4:30 p.m., Resident A fell out of the bed while his wife was helping him get his brief changed. Physician and responsible party notified. Action taken: Wife and resident was reminded to ask for assistance with grief changes" No injuries were noted on the form.

"On 3/18/18 at 4:20 p.m., Resident A slid onto the floor out of his bed. He was trying to get up to go to the bathroom. Responsible party and physician called." No injuries were noted on the form. No action taken.

Resident A stated that he doesn't remember if the alarm pendant was on or not. He stated he hurt his right leg and had to go to the hospital. He stated the hospital diagnosed him with a leg sprain. Resident A stated that he fell again on Friday (5/11/18).

There was no incident report for a fall for Friday, 5/11/18.

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.**

ANALYSIS:	Resident A had multiple falls at the home. The incident report for 3/17 and 3/18 did not indicate what actions would be taken to prevent the accidents/falls from happening again. There was no incident report for alleged fall of 5/11/18. Based on interview and record review, the allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

The service plans are not updated.

INVESTIGATION:

According to the Administrator Amanda Maleche, the facility does not have a service plan prior to 4/11/18. She noted that the previous care plan was discarded by a manger who is no longer employed with the community.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(1) A home shall have a written resident admission contract, program statement, admission and discharge policy, and a resident's service plan for each resident.
ANALYSIS:	The facility did not have a service plan for the Resident prior to 4/11/18.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 5/8/2018, I shared the findings of this report with the licensee authorized representative Amanda Maleche at the facility.

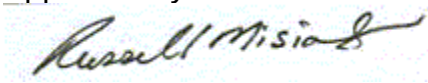
IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan I recommend no change to the status of the license.

6/8/18

Brender Howard — Date
Licensing Staff

Approved By:



6/7/18

Russell B. Misiak — Date
Area Manager