GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 15th, 2021

Melissa Peebles
Park Village Pines
2920 Crystal Lane
Kalamazoo, MI 49009

| | |
|---|---|
| RE: License #: | AH390236863 |
| Investigation #: | 2021A1021009 |
| | Park Village Pines |

Dear Ms. Peebles:

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 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 (517) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

## I. IDENTIFYING INFORMATION

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|---|---|
| **License #:** | AH390236863 |
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| **Investigation #:** | 2021A1021009 |
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| **Complaint Receipt Date:** | 11/25/2020 |
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| **Investigation Initiation Date:** | 11/25/2020 |
| | |
| **Report Due Date:** | 1/25/2020 |
| | |
| **Licensee Name:** | The Kalamazoo Area Christian Retirement Assoc Inc |
| | |
| **Licensee Address:** | 2920 Crystal Lane<br>Kalamazoo, MI 49009 |
| | |
| **Licensee Telephone #:** | (269) 372-1928 |
| | |
| **Administrator/ Authorized Representative:** | Melissa Peebles |
| | |
| **Name of Facility:** | Park Village Pines |
| | |
| **Facility Address:** | 2920 Crystal Lane<br>Kalamazoo, MI 49009 |
| | |
| **Facility Telephone #:** | (269) 372-1928 |
| | |
| **Original Issuance Date:** | 03/01/1975 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 03/31/2020 |
| | |
| **Expiration Date:** | 03/30/2021 |
| | |
| **Capacity:** | 215 |
| | |
| **Program Type:** | AGED<br>ALZHEIMERS |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| There are increased falls at the facility. | Yes |
| The facility has insufficient staff. | Yes |
| Additional Findings | No |

## III. METHODOLOGY

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|---|---|
| 11/25/2020 | Special Investigation Intake<br>2021A1021009 |
| 11/25/2020 | Special Investigation Initiated - Letter<br>APS referral sent to centralized intake |
| 11/30/2020 | Contact - Telephone call made<br>interviewed Area Agency director |
| 12/02/2020 | Inspection Completed On-site |
| 12/07/2020 | Contact - Document Received<br>Received service plans and incident reports |
| 12/11/2020 | Contact-Documents Received<br>Received hospice documentation |
| 1/12/2021 | Contact-Telephone call made<br>Interviewed scheduler Stephanie Junker |
| 1/15/2021 | Exit Conference<br>Exit Conference with authorized representative Melissa Peebles |

**ALLEGATION:**

**There are increased falls at the facility.**

**INVESTIGATION:**

On 11/25/20, the licensing department was made aware of increased falls and deaths at the facility.

On 11/25/20, the allegations in this report were sent to centralized intake at Adult Protective Services (APS).

On 11/30/20, I interviewed Kalamazoo county death task force lead worker Samantha Carlson by telephone. Ms. Carlson reported there is a task force in Kalamazoo that looks at elder deaths. Ms. Carlson reported this year the task force is focused on deaths in facilities. Ms. Carlson reported the task force includes adult protective service, police, area agency on aging, medical examiner, and the ombudsman. Ms. Carlson reported the committee has determined the facility has had increased falls resulting in deaths. Ms. Carlson reported residents have fallen and their death is hastened due to the fall. Ms. Carlson provided eight residents that have fallen and then died at the facility.

On 12/2/20, I interviewed authorized representative Melissa Peebles at the facility. Ms. Peebles reported the facility has not had increased falls resulting in deaths. Ms. Peebles reported every fall has different circumstances. Ms. Peebles reported when a resident falls, management reviews the fall to determine if the fall could have been prevented, if there are patterns to the falls, what are the safety concerns, and risk for continued falls. Ms. Peebles reported the facility will work with the physician to determine if the resident's health is decreasing, if medication changes are needed, and/or if there is an underlying health issue. Ms. Peebles reported the facility can not completely prevent falls but can put in place interventions to prevent future falls from occurring. Ms. Peebles reported the clinical nurse and administrator meet weekly to discuss falls and appropriate corrective interventions to put in place. Ms. Peebles reported the facility has different levels of care and a resident can be moved to a higher level of care, if needed. Ms. Peebles reported interventions that are implemented are put into the resident's service plan and updated in the electronic medical chart system. Ms. Peebles reported if there is a new care added, it pops up in red to alert the caregiver of the new care. Ms. Peebles reported the facility is very attentive to the needs of the residents and they work hard to keep the residents safe.

On 12/2/20, I interviewed clinical nurse Kate Long at the facility. Ms. Long reported she is responsible for reviewing chart notes for each resident in Park Village Pines. Ms. Long reported if a resident has repeated falls, she alerts the clinical team. Ms. Long reported the clinical team will start to discuss what interventions need to be implemented to keep the resident safe. Ms. Long reported the interventions could include fall alarms, moving the resident closer to the common area, or a 1:1 sitter. Ms. Long reported she has not noticed a trend with increased falls and deaths at the facility. Ms. Long reported Resident V fell on 12/24/19 and a fall alarm was implemented, and Resident V was moved to the first floor for increased monitoring. Ms. Long reported Resident V fell again on 12/30/19 and passed away on 1/6/20. Ms. Long reported Resident V's health was declining prior to fall. Ms. Long reported no concerns with the care the facility provided to Resident V.

I reviewed chart notes for Resident V. The chart notes read,

*12/20: PRN Ativan administered.*
*12/21: Administered PRN Lorazepam for restlessness.*
*12/23: Resident was observed on the floor in his room around 12:20pm. He was unable to tell this (medical caregiver) what happened, nor could he answer questions, only stated "help me." Hospice was contacted and Shawn RN was here in the building to assess (Resident V). States she is going to order a wheelchair alarm and daily stool softeners."*
*12/24: added safety alarm care and safety data for the safety alarm he now has.*
*12/28: PRN Ativan administered for feeling anxious*
*12/29: PRN Ativan administered for feeling anxious.*
*12/30: At 10:47am resident was observed on the floor in his room. He states he fell out of bed hitting his head on the nightstand. Hematoma present on the center back of his head. (Vital signs) are (within normal limits), neuro checks started, and (range of motion within normal limits) as well. Left voicemail for Dr. Shay, (Relative V1) and Nurse Shawn from Hospice was in the building and was able to asses (Resident V) as well. Will continue to monitor.*
*12/30: Administered .5mg Ativan and .5ml Morphine for pain and agitation.*
*12/30: Resident fell out of his bed, he was found on his left side on the floor by (medical caregiver) during her routine med pass. (Medical caregiver) notifed this (personal caregiver) and I came to his room where I assisted in picking him up. She then took his vitals and called hospice. (Resident V) was not able to answer simple questions that (Medical caregiver) was asking. Resident is currently being supervised by staff.*
*12/30: went into (Resident V)'s room to pass medication and observed him on the ground laying on his left side. (Resident V) was responsive and able to sit up with assistance. Observed a 1 inch skin tear on his left elbow. Resident was able to tell me his name but unable to answer any other simple questions. Vitals are BP:118/72, P:78, RR:16, T:97.8. Assisted resident to his bed. Called HSWM and a nurse will be sent out later. Advised (Relative V1) about fall."*

I reviewed the incident report that was sent to the licensing unit following the 12/23 fall. The incident report revealed the interventions were,

*"hospice came in and gave (Resident V) a seat alarm to help monitor him. They also gave him some added medications to calm and checked his urine for UTI."*

I reviewed Hospice Care of Southwest Michigan documentation. The documentation read,

*"12/23: Met with client in his room. Client sitting on wheelchair. Recent fall today. No injury observed. Unknown (loss of consciousness). Client declines pain, (vital signs) as expected for client. Client with (altered mental status) vs (hard of hearing)/confusion. No (signs/symptoms) of UTI observed. Called and reviewed today's visit findings with Dr. Raphelson. Call and left vm with CNNx2 to (Relative*

*V1). Plan to monitor client, increase nurse visits and order tab alarm for safety. Called carelinc ordered pressure wheelchair alarm."*
*12/23: ask to see client and was complaining of pain post earlier in the day fall. Client was sitting in wheelchair with staffing attendance and was continually trying to get out wheelchair and stand up. Client was unable to answer any questions, stared at this RN but not talking. This is not new behavior today as it was observed by Park Village Pines staff as well. Client was sitting in wheelchair with Stephen attendance and was continually trying to get out of wheelchair and stand up. Client was unable to answer any questions, stared at this RN but not talking. This is not new behavior today as it was observed by facility staff as well. Client behavior and breathing had gotten better after they applied oxygen in the morning after the fall. This evening they found client in his bed with his hands out yelling for help and he was not able to communicate anything else and hospice was called. Facility administered 0.5mg Lorezam and 0.25ml morphine and one hour post administration client was still restless and anxious with labored breaths from multiple attempts to stand up and walk on own. Client currently has worn himself out from standing and sitting or he's become more relaxed. He is answering questions and he is following instructions for a very brief moment and restlessness is diminishing. Call made to doctor Raphelson and to doctor Shay to change frequency of Lorazepam and Morphine. Will update staff with additional orders and plan of care as needed. Labs are still pending with Bronson from earlier in the day. Spoke with (Relative V1) who is in agreement with (plan of care).*

I reviewed the service plan for Resident V and service plan updates for Resident V. There was no mention of a fall alarm or safety data for the resident. In addition, the service plan updates read, "Ativan 0.5mg -give one tablet PO Q4 hrs PRN for anxiety/SOB. Resident will be restless unable to sleep or be visibly SOB."

Ms. Long reported Resident W had a seat alarm, was a fall risk, and would get up on his own at times. Ms. Long reported Resident W had dementia but was high functioning. Ms. Long reported Resident W was appropriate for Crystal Woods, the secure memory care unit, but the unit was full. Ms. Long reported Resident W was placed in the 100 hall in Park Village Pines close to the care station for increased supervision.

I reviewed chart documentation for Resident W. The chart notes read,

*"4/23: He has been out of it today he pulled his cath out 5 times and said he wants to go home and get on his tractor he was a little rude just seems very confused. He has been doing this since I came in this morning. His hole (sic) bed was wet with urine from him pulling out the cath.*
*4/25: Resident got aggressive tonight about staying in bed, wanted his shoes, put on. As assisting resident to lay down and stay in bed he slapped me on the left arm. Told resident he needed to take his medication and gave him a Ativan 0.5mg, also had him talk to his daughter on the phone. Resident eventually gave*

*up idea of getting out of bed and laid down. Resident is confused talking about going out to the farm.*
*5/1: At 5:30pm notified by dining staff that resident had fallen. Observe resident on the floor by his entrance door. Resident hit his head and was bleeding. Bleeding slowed with washcloth and towel. Noted bump to back of head with slow bleeding. Resident had been sitting in his W/C at his table eating supper. Noted the phone ringing, answered it and it was one of his daughters. Notified her of fall. Resident unable to come to phone. VS 130/80, 90, 16, 97.8, pox=95% R/A. Neuro check started. Resident unable to state what happened. ROM checked resident c/o mild pain to right hip. Resident was assisted to W/C and then bed. Hospice was immediately notified. Lori here by 6:30pm. Assessed resident and determined not to send to hospital. Moving right leg ok. Lori state he has a small cut to the back of the head. She will call again in the morning. Relative W was notified and also called to check on him later. She will call again in the morning. (Relative W1) had initially stated she will leave it up us about resident going to the hospital or not. V/S stable tonight. Lori had also suggested ice pack for back of head. This provided much relief to resident. Ice pack applied at 8:15pm for ½ hour."*

I reviewed the incident report sent to the licensing unit on 5/4. The incident report corrective measures read,

"*residents hospice nurse is aware of this and we agreed to add care to assist him (with) feeding at all meals. This care has been added. We need to continue to keep his eat alarm under him at all possible times and remind (Resident W) we are to assist him (with) walking."*

I reviewed the service plan for Resident W. There was no mention of Resident W being a fall risk, having a seat alarm, or memory issues. In addition, Resident W was prescribed Lorazepam 0.5mg tablet prn for anxiety. There was no information in Resident W's service plan what behaviors constitute the administration of this medication.

I reviewed facility records for Resident X. The service plan revealed Resident X was not a fall risk and had no history of falls. Resident X had an unanticipated fall at the facility on 8/11/20 and was transferred to the hospital for evaluation. Resident X had underlying health conditions and died at the hospital due to these conditions.

I reviewed facility records for Resident Y. The facility documentation revealed Resident Y had one fall at the facility but died due to declining health status unrelate to the fall.

I reviewed facility records for Resident Z. The service plan revealed the resident had an alarm to alert caregivers when the resident attempted to transfer himself. While there are inconsistencies between staff interviews and whether the alarm sounded, the alarm mechanism was not meant to be the sole monitor of the resident's activity. On 4/22 at 2:15pm Resident A's alarm did not alert caregivers that he had fallen but

interviews with caregivers revealed they found Resident Z within an appropriate timeframe. Caregivers documented they checked the batteries in the alarm at 6:45am and also provided care at 2:00pm. Although the alarm did not work properly, caregivers followed Resident Z's service plan.

I reviewed past investigation and facility records for Resident A. The documents revealed Resident A did have a fall at the facility, but the fall was not related to a lack of supervision but rather lack of staff compliance with the service plan.

I reviewed facility records for Resident Z. The facility documentation revealed Resident Z had a history of falls but after each fall, 1/18/20 and 1/31/20, the service plan was updated each fall and fully implemented to reflect additional supervision for the resident.

I reviewed facility records for Resident AA. The facility documentation revealed Resident AA did have falls at the facility. Following a fall, the facility updated the service plan.

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1921** | **Governing bodies, administrators, and supervisors.** |
| | **(1) The owner, operator, and governing body of a home shall do all of the following:**<br>**(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.** |
| **For Reference: R 325.1901:** | **Definitions.** |
| | **(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.** |

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| **ANALYSIS:** | A total of eight resident names that had suffered falls and deaths were provided by the complainant for review. Two of the eight residents: Resident V and W were a fall risk as demonstrated by trying to get up unassisted, demonstrating anxious behaviors, and having been issued fall alarms. The facility did not appropriately update service plans nor implement appropriate corrective methods to prevent future falls from occurring for these two residents. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION:**

**The facility has insufficient staff.**

**INVESTIGATION:**

Ms. Carlson reported concerns related to whether the facility has sufficient staff at the facility to ensure resident safety.

Ms. Peebles reported the facility is currently hiring. Ms. Peebles reported the facility has lost some staff members due to concerns on the Covid19 pandemic. Ms. Peebles reported the facility has used agency staff to fill staff shortages. Ms. Peebles reported the census has decreased in the facility which has resulted in decreased amount of staff needed. Ms. Peebles reported the facility has three care areas: park village pines, Oakview Terrace, and Crystal Woods. Ms. Peebles reported park village pines is the general assisted living portion of the facility. Ms. Peebles reported Park village Pines has 85 residents and the staffing guidelines call for 7 caregivers on first shift, 6.5 caregivers on second shift, and five caregivers on third shift. Ms. Peebles reported Oakview Terrace is the higher acuity residents and the unit has 21 residents. Ms. Peebles reported the staffing guidelines call for 3-4 caregivers on first shift. 3-4 caregivers on second shift, and three caregivers on third shift. Ms. Peebles reported Crystal Woods is the memory care unit and the unit has 26 residents. Ms. Peebles reported the staffing guidelines call for three-four caregivers on first shift, 3-4 caregivers on second shift, and three caregivers on third shift. Ms. Peebles reported caregivers are assigned to the same unit. Ms. Peebles reported in Oakview Terrace there are six residents that are two-person assist, five residents on oxygen, three residents on catheters, twenty-one residents require assistance with dressing/bathing, and one resident that is impulsive. Ms. Peebles reported staff members communicate to each other through an iPod. Ms. Peebles reported no concerns about staffing levels have been brought to her attention. Ms. Peebles reported there is sufficient staff to meet the needs of the residents.

On 12/2/20, I interviewed personal caregiver Keenan Lewis at the facility. Mr. Lewis reported there are only two or three personal caregivers on first shift in Oakview Terrace. Mr. Lewis reported he is responsible for 11 residents. Mr. Lewis reported all 11 residents are a two person assist, 11 residents require assistance with dressing/bathing, two residents on oxygen, and three residents require assistance in the bathroom. Mr. Lewis reported two person assist transfers are not done with two people due to lack of staff. Mr. Lewis reported the facility has had increased falls because of lack of staff. Mr. Lewis reported the daily needs of the residents are met but not the personal needs, such as spending time with the residents.

On 12/2/20, I interviewed personal caregiver Brittney Hinton at the facility. Ms. Hinton reported she is responsible for nine residents. Ms. Hinton reported eight residents are a two-person assist, one resident on oxygen, three residents are a fall risk, and nine residents require assistance with dressing/bathing. Ms. Hinton reported residents must wait on average five-seven minutes to receive assistance. Ms. Hinton reported two person transfers are done with one person. Ms. Hinton reported there have been increased falls due to staff shortages.

On 12/2/20, I interviewed medical caregiver Michelle Bogema at the facility. Ms. Bogema reported there is lack of staff at the facility. Ms. Bogema reported residents must wait around ten minutes for their call light to be answered. Ms. Bogema reported residents have fallen because of lack of staff.

On 12/2/20, I interviewed Resident T at the facility. Resident T reported at times there is only one or two caregivers to assist with resident care. Resident T reported on 12/2, she was put in the bathroom and left there for an increased time with no assistance. Resident T reported her call light was not answered in a timely manner. Resident T reported she was eating her cold breakfast at 11:00 because she was left in the bathroom.

On 12/2/20, I interviewed Resident U at the facility. Resident U reported there is a staff shortage at the facility. Resident U reported it takes increased time for caregivers to respond to call lights. Resident U reported there are usually only two personal caregivers which results in increased wait times for assistance.

On 1/12/21, I interviewed facility scheduler Stephanie Junker by telephone. Ms. Junker reported the schedule is determined by the care needs of the residents. Ms. Junker reported the resident to staff ratio is discussed during team meetings. Ms. Junker reported management discusses the care needs of the residents, location of the residents, and the number of staff needed. Ms. Junker reported if a resident moves units, such as Park Village Pines to Oakview Terrace, then the care needs increase for Oakview Terrace which results in increased staff. Ms. Junker reported if a unit needs additional assistance, the unit can contact another unit or management for assistance. Ms. Junker reported there is adequate staff to meet the care needs of the residents.

I reviewed the service plans for twenty residents in Oakview Terrace. In Oakview Terrace, four residents require assistance with transfers, 13 residents require assistance with showers, four residents require assistance with showers, thirteen residents require assistance with ambulation, 18 residents require assistance with dressing, 13 residents are a two-person transfer, 4 residents on oxygen, 4 residents are provided fall alarms for use, and 4 residents have a catheter.

I reviewed the staff schedule for Oakview Terrace for 11/22-11/28. The schedule revealed on 11/22, 11/23, 11/24, 11/25 on first shift there was only three caregivers that worked and on 11/27 and 11/28 there was only two caregivers that worked. The schedule revealed on 11/22 on second shift there was two caregivers that worked and on 11/25 on second shift there was three caregivers that worked. On 11/25 on third shift there was one caregiver. On 11/22, 11/24, 11/27, and 11/28 on third shift there was two caregivers. On 11/23 and 11/26 on third shift there was three caregivers that worked.

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1931** | **Employees; general provisions.** |
| | **(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.** |
| **ANALYSIS:** | Interviews with staff, and residents, consideration of care needs as identified in their plans of care, along with schedule review revealed the facility has lack of staff to provide care to the residents especially in the Oakview Terrace unit. There are 13 residents that require two staff persons to assist, yet on multiple occasions there are only two caregivers in that unit, indicating other residents that require supervision or assistance are without it during that time. The utilization of others from other areas of the facility potentially leaves those areas understaffed if not already understaffed. While my investigation focused on one unit, all units are scheduled by Ms. Junker and utilize the same staffing process based on resident needs identified within their service plans. Therefore, I have determined the entire facility is not adequately staffed. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

On 1/15/21, I conducted an exit conference with Ms. Peebles and CEO Dave Bos by telephone. Mr. Bos reported it has been difficult to fill staff vacancies due to the Covid-19 global pandemic.

## IV. RECOMMENDATION

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| Upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license. |

1/11/21

Kimberly Horst — Date
Licensing Staff

Approved By:

1/12/21

Russell B. Misiak — Date
Area Manager