GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 4th, 2021

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

RE: License #:	AH390236863
Investigation #:	2021A1021016
	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 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 (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

License #:	AH390236863
Investigation #:	2021A1021016
Complaint Receipt Date:	01/13/2021
Investigation Initiation Date:	01/19/2021
Report Due Date:	03/12/2021
Licensee Name:	The Kalamazoo Area Christian Retirement Assoc Inc
Licensee Address:	2920 Crystal Lane Kalamazoo, MI 49009
Licensee Telephone #:	(269) 372-1928
Administrator/ Authorized Representative:	Melissa Peebles
Name of Facility:	Park Village Pines
Facility Address:	2920 Crystal Lane 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:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident Y was injured at the facility.	Yes
Additional Findings	No

III. METHODOLOGY

01/13/2021	Special Investigation Intake 2021A1021016
01/19/2021	Special Investigation Initiated - Letter APS referral sent to centralized intake
01/19/2021	Contact - Telephone call made Bronson Hospital social worker Megan Packard
01/21/2021	Contact - Telephone call made interviewed authorized representative by telephone
01/21/2021	Contact - Document Received service plan, chart notes, training documents
01/25/2021	Contact-Telephone call made Interviewed caregiver Lamarcus Graves
01/26/2021	Contact-Telephone call made Interviewed caregiver Catherine Loewe
01/26/20201	Contact-Telephone call made Interviewed caregiver Dayanna Porter
2/4/2021	Exit Conference Exit conference with authorized representative Melissa Peebles

ALLEGATION:

Resident Y was injured at the facility.

INVESTIGATION:

On 1/13/21, the licensing department received a complaint with allegations Resident Y was dropped out of a mechanical lift and suffered injuries.

On 1/19/21, the allegations in this report were sent to centralized intake at Adult Protective Services (APS).

On 1/19/21, I interviewed Bronson Hospital social worker Megan Packard by telephone. Ms. Packard reported Resident Y was transferred to the hospital on 1/13/21. Ms. Packard reported Resident Y was transferred in Hoyer lift, Resident Y started to slip, and caregivers lowered Resident Y to the ground. Ms. Packard reported Resident Y complained of pain to the caregivers and was transferred to the hospital. Ms. Packard reported Resident Y suffered three fractures: left femur fracture, left tibia fracture, and left fibula fracture.

On 1/21/21, I interviewed facility authorized representative Melissa Peebles by telephone. Ms. Peebles reported the incident occurred on second shift on 1/12. Ms. Peebles reported their investigation revealed caregiver Lamarcus Graves used the sit-stand lift and not the Hoyer Lift to transfer Resident Y. Ms. Peebles reported caregiver Laurie Stevens came into Resident Y's room and assisted Mr. Graves in lowering Resident Y to the floor and then they transferred Resident Y to her bed. Ms. Peebles reported Mr. Graves and Ms. Stevens reported Resident Y did not complain of pain and they did not observe any injuries. Ms. Peebles reported the following morning Resident Y complained of pain and told caregivers a "small guy dropped me." Ms. Peebles reported Resident Y was transferred to the hospital for an evaluation. Ms. Peebles reported the facility completed an investigation into the events that occurred on 1/12. Ms. Peebles reported Mr. Graves and Ms. Stevens did not immediately report nor document the incident that occurred on 1/12. Ms. Peebles reported on 1/13, Ms. Stevens documented the incident and completed the incident report. Ms. Peebles reported the facility completed an investigation and Mr. Graves was terminated on 1/13 as this was the second occurrence of Mr. Graves inappropriately transferring a resident. Ms. Peebles reported Ms. Stevens was terminated on 1/21 following the investigation due to not following the facility policy on reporting incidents. Ms. Peebles reported when an event like this occurs, caregivers are to report the incident to the management team.

On 1/25/21, I interviewed caregiver Lamarcus Graves by telephone. Mr. Graves reported on 1/12, he transferred Resident Y in the sit-stand device. Mr. Graves reported Resident Y was listed as a sit-stand or a Hoyer Lift for transfers. Mr. Graves reported Resident Y started to slip out of the device and he contacted Ms. Stevens for assistance. Mr. Graves reported Ms. Stevens and himself transferred Resident Y into bed. Mr. Graves reported Resident Y did not complain of any pain. Mr. Graves reported he checked on Resident Y a few hours after the incident and Resident Y did not complain of any pain. Mr. Graves reported he did not provide this information to the ongoing shift.

On 1/26/21, I interviewed caregiver Catherine Loewe by telephone. Ms. Loewe reported she provided care to Resident Y on third shift on 1/12. Ms. Loewe reported at the beginning of her shift, Mr. Graves reported to her that he had changed Resident Y and the Resident was set for the night. Ms. Loewe reported no other information was passed along to her. Ms. Lowe reported she went into Resident Y's room at 12:00am and Resident Y did not complain of pain. Ms. Loewe reported she went back into Resident Y's room at 2:00am and changed Resident Y. Ms. Loewe reported Resident Y did not complain of pain. Ms. Loewe reported she provided care to Resident Y at 5:00am and Resident Y said, "please don't hurt me." Ms. Loewe reported she did not understand why Resident Y said that and that it was odd for Resident Y to say. Ms. Loewe reported she told Resident Y she would not hurt her, and that Resident Y did not make any additional comments. Ms. Loewe reported Resident Y was to be transferred using the Hoyer Lift. Ms. Loewe reported Resident Y is to be transferred using two persons, but it is typically done using only one person. Ms. Loewe reported there was no information passed to her or other staff members regarding the incident that happened on second shift.

On 1/26/21, I interviewed caregiver Dayanna Porter by telephone. Ms. Porter reported she provided care to Resident Y on 1/12 on second shift. Ms. Porter reported she fed Resident Y around 4:30pm. Ms. Porter reported she told Mr. Graves when needed that she would assist him in transferring Resident Y to her bed. Ms. Porter reported later in the shift a call light was going off for 20 minutes and Mr. Graves was not responding to the call light. Ms. Porter reported she went looking for Mr. Graves and found Resident Y's door to be locked. Ms. Porter reported Ms. Stevens told her Mr. Graves was in Resident Y's room washing her up. Ms. Porter reported following that she could not locate Ms. Stevens nor Mr. Graves for approximately twenty minutes. Ms. Porter reported bedroom doors are not to be locked. Ms. Porter reported she was training, and it was a busy shift, so she did not think much of the events with Ms. Stevens and Mr. Graves. Ms. Porter reported Mr. Graves and Ms. Stevens did not report to her any incidents that happened with a transfer. Ms. Porter reported Resident Y is a two-person transfer using a Hoyer Lift. Ms. Porter reported if Resident Y is to take a shower, the sit-stand device is to be used. Ms. Porter reported sometimes Resident Y is transferred using only one staff person.

I attempted to contact Ms. Stevens but received no response.

I reviewed the incident report that was completed. The incident report read,

> *"(medical caregiver) entered room to see resident slipping from sit-to-stand. Assisted (personal caregiver) in lowering resident safely to floor in a sitting position, then into bed. (Personal caregiver) stated that resident did not fall. Visual check of body for injuries. None noted. (Range of motion) not done as her (range of motion) is limited."*

I reviewed the chart notes for Resident Y. The chart notes read,

> *1/12 7:30pm: medical caregiver) entered room to see resident slipping from sit-to-stand. Assisted (personal caregiver) in lowering resident safely to floor in a sitting position, then into bed. (Personal caregiver) stated that resident did not fall. (Range of motion) not done due to residents (range of motion) being limited. Visual body inspection showed no apparent injuries at this time.*
> *1/13 9:30am: (personal caregiver) called (medical caregiver) to room to help assist resident up in bed. (Medical caregiver) noticed a small amount of vomit by her pillow, asked resident if she was okay and resident stated she hurt her arm and she thought it was broke. (Medical caregiver) tried to help (personal caregiver) put on a new shirt and resident was screaming in pain. Also noticed a swollen left knee cap. Ambulance was called and resident was transferred to Bronson.*

I reviewed the service plan for Resident Y. The service plan revealed Resident Y was a two person assist transfer and was to be transferred using the Hoyer Lift.

I reviewed training documents for caregiver Laurie Stevens. Ms. Stevens completed training on incident reports, sending a resident to the hospital, following the care plan, and transfers and ambulation.

I reviewed training documents for Lamarcus Graves. Mr. Graves completed training on incident reports, sending a resident to the hospital, following the care plan, and transfers and ambulation.

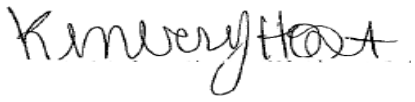
APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised 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.
ANALYSIS:	Resident Y's service plan revealed Resident Y is a two person assist transfer using a Hoyer Lift. Employee reports revealed at times Resident Y has been transferred incorrectly by using one staff person or using the sit-stand device. By doing so, this places Resident Y at an unreasonable risk of harm each time. Therefore, the facility is in violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 2/4/21, I conducted am exit conference with authorized representative Melissa Peebles by telephone.

IV. RECOMMENDATION

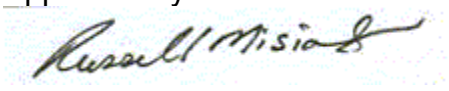
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.



1/26/21

Kimberly Horst Date
Licensing Staff

Approved By:



2/3/21

Russell B. Misiak Date
Area Manager