GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 29, 2021

Rochelle Lyons
Heritage Hill Assisted Living
1430 Cleaver Rd.
Caro, MI 48723

RE: License #: AH790297374
Investigation #: 2021A0784040
Heritage Hill Assisted Living

Dear Ms. Lyons:

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. 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 (810) 787-7031.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
4809 Clio Road
Flint, MI 48504
(517) 230-2778

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AH790297374 |
| | |
| **Investigation #:** | 2021A0784040 |
| | |
| **Complaint Receipt Date:** | 07/27/2021 |
| | |
| **Investigation Initiation Date:** | 07/28/2021 |
| | |
| **Report Due Date:** | 09/25/2021 |
| | |
| **Licensee Name:** | Heritage Hill Assisted Living, LLC |
| | |
| **Licensee Address:** | Suite 200<br>3196 Kraft Ave SE<br>Grand Rapids, MI 49512 |
| | |
| **Licensee Telephone #:** | (616) 464-1564 |
| | |
| **Administrator:** | Amanda Mort |
| | |
| **Authorized Representative:** | Rochelle Lyons |
| | |
| **Name of Facility:** | Heritage Hill Assisted Living |
| | |
| **Facility Address:** | 1430 Cleaver Rd.<br>Caro, MI 48723 |
| | |
| **Facility Telephone #:** | (989) 672-2900 |
| | |
| **Original Issuance Date:** | 07/14/2009 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 07/08/2021 |
| | |
| **Expiration Date:** | 07/07/2022 |
| | |
| **Capacity:** | 56 |
| | |
| **Program Type:** | AGED<br>ALZHEIMERS |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Inadequate supervision of Resident A by staff | Yes |
| Additional Findings | No |

## III. METHODOLOGY

| | |
|---|---|
| 07/27/2021 | Special Investigation Intake<br>2021A0784040 |
| 07/28/2021 | Special Investigation Initiated - Telephone<br>Interview with office manager/administrator in training Carmen Laabs |
| 07/28/2021 | Exit Conference – Telephone<br>Conducted with authorized representative Rochelle Lyons |

**ALLEGATION:**

**Inadequate supervision of Resident A by staff**

**INVESTIGATION:**

On 7/27/21, the department received an incident report from the facility regarding Resident A. Under a section titled *Explain What Happened/Describe Injury*, the report indicates that on 7/25/21, "Alekzander Creason, Resident Care Specialist, observed [Resident A] on the ground near the curb. When asked what happened, [Resident A] stated that he did not know. [Resident A's] wheelchair was next to him. Alekzander assessed for Injuries, noted a scrap on right knee. [Resident A], also was observed in his apartment on the floor in front of his recliner on 7/23/21 with no injuries noted. Resident is not orientated to person, place, and requires prompting due to intermittent confusion.".

On 7/27/21, additional information was requested from the facility regarding the circumstances of Resident A's fall on 7/25/21.

On 7/27/21, the department received a revised incident report regarding Resident A's fall on 7/25/21. Under the section titled *Explain What Happened/Describe Injury*, the report read "Alekzander Creason, Care Team Lead, observed [Resident A] on the ground near the curb, sitting on his bottom with his leg bent upwards, next to his wheelchair. [Resident A] was outside on the front patio next to the front entrance door, being monitored by [care associate] Stacia Cohee from inside the building.

Stacia states that she stepped away, and the last time she witnessed [Resident A], he was playing with the flowers; Alekzander was still inside the care station which faces the entrance door. [Resident B] was also outside on the front patio. [Resident B] stated that he watched Andrew self-propel his wheelchair to the edge of the patio area and then [Resident A] was moving across the parking lot. Due to the position [Resident B] was sitting in, he did not see [Resident A] fall. There is a slight declining slop from the entrance door across the parking lot to the curb. When asked what happened, [Resident A] stated that he did not know. Alekzander assessed for Injuries, noted a scrap on right knee. [Resident A], also was observed in his apartment on the floor in front of his recliner on 7/23/21 with no injuries noted. Resident is not orientated to person, place, and requires prompting due to intermittent confusion". Under a section titled Corrective Measures Taken to Remedy and/or Prevent Recurrence, the report read "Received order to start antibiotic for a UTI on 7/28/21. No further instructions from hospice".

I reviewed Resident A's service plan provided by administrator Amanda Mort. Under a section titled Community Movement, the plan read, in part, "Has limited safety awareness and needs to be supervised outside on campus grounds. May stay in secured area unsupervised. Must have supervision for off campus trips".

On 7/28/21, I interviewed office manager Carmen Laabs by telephone. Ms. Laabs stated she is currently in transition with the facility to be placed into the administrator role. Ms. Laabs stated associate Stacia Cohee, who was supervising Resident A from inside the building, "stepped away for about five minutes" during which time the fall happened.

| **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.** |
| **ANALYSIS:** | According to reporting from the facility, Resident A had a fall on 7/23/21 and on a subsequent fall 7/25/21 outside of the facility at which time he sustained a scrape on his knee. Review of Resident A's service plan revealed Resident A is person who requires staff supervision when outside of the building. Further review of the reporting revealed that staff responsible to Resident A's supervision at the time not only did so from inside of the building, but also that the supervising staff "stepped away" leaving Resident A without any supervision for a period of time at which time he fell out of his wheelchair next to the curb outside. Based on the lack of reasonably adequate supervision as it pertains to the supervision needs of Resident A and staff actions, the facility is not in compliance with this rule. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

On 7/28/21, I discussed the findings of the investigation with authorized representative Rochelle Lyons.

## IV. RECOMMENDATION

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

Aaron L Clum 7/28/21

Aaron Clum Date
Licensing Staff

Approved By:

Russell Misiak 7/28/21

Russell B. Misiak Date
Area Manager