GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 8th, 2021

Terry Langston
The Jackson Friendly Home
435 W North St.
Jackson, MI 49202

| | |
|---|---|
| RE: License #: | AH380236825 |
| Investigation #: | 2021A1021046 |
| | The Jackson Friendly Home |

Dear Mr. Langston:

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

| | |
|---|---|
| **License #:** | AH380236825 |
| | |
| **Investigation #:** | 2021A1021046 |
| | |
| **Complaint Receipt Date:** | 08/19/2021 |
| | |
| **Investigation Initiation Date:** | 08/23/2021 |
| | |
| **Report Due Date:** | 10/18/2021 |
| | |
| **Licensee Name:** | The Jackson Friendly Home |
| | |
| **Licensee Address:** | 435 W North St.<br>Jackson, MI 49202 |
| | |
| **Licensee Telephone #:** | (517) 784-1377 |
| | |
| **Administrator:** | Gabriella Tackett |
| | |
| **Authorized Representative:** | Terry Langston |
| | |
| **Name of Facility:** | The Jackson Friendly Home |
| | |
| **Facility Address:** | 435 W North St.<br>Jackson, MI 49202 |
| | |
| **Facility Telephone #:** | (517) 784-1377 |
| | |
| **Original Issuance Date:** | 02/28/2000 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 08/16/2021 |
| | |
| **Expiration Date:** | 08/15/2022 |
| | |
| **Capacity:** | 45 |
| | |
| **Program Type:** | AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A eloped from the facility. | Yes |
| Facility did not provide medical attention | No |
| Resident A is not fed. | Yes |
| Facility has insufficient staff. | No |
| Additional Findings | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 08/19/2021 | Special Investigation Intake<br>2021A1021046 |
| 08/23/2021 | Special Investigation Initiated - Telephone<br>called and left message with complainant |
| 08/23/2021 | APS Referral<br>complaint came from APS |
| 08/24/2021 | Inspection Completed On-site |
| 08/24/2021 | Contact-Telephone call made<br>Interviewed APS worker Rebecca Belcher |
| 09/08/2021 | Exit Conference<br>Exit Conference with authorized representative Terry Langston |

**ALLEGATION:**

**Resident A eloped from the facility**.

**INVESTIGATION:**

On 8/19/21, the licensing department received a complaint from Adult Protective Services worker (APS) Rebecca Belcher. Ms. Belcher alleged Resident A left the facility on multiple occasions without staff knowing.

On 8/24/21, I interviewed Ms. Belcher by telephone. Ms. Belcher reported Resident A has been discharged to another facility.

On 8/24/21, I interviewed care coordinator Beth Svinicki at the facility. Ms. Svinicki reported Resident A never left the facility without staff knowing. Ms. Svinicki reported Resident A has diagnosis of dementia and has memory loss. Ms. Svinicki reported Resident A would try to leave the facility to see her family. Ms. Svinicki reported when this occurred, staff members were able to re-direct Resident A. Ms. Svinicki reported on 8/3, Resident A was observed to walk out the back door of the facility. Ms. Svinicki reported she was always with the resident when Resident A was outside the facility. Ms. Svinicki reported Resident A walked into the parking lot and around the facility. Ms. Svinicki reported Resident A was able to be re-directed and was escorted back into the building. Ms. Svinicki reported Resident A was then sent out to the hospital for a psychological evaluation due to making suicidal statements and exit seeking behaviors. Ms. Svinicki reported the facility then turned on the hallway and doorway cameras on all computers and set the door alarms. Ms. Svinicki reported the facility is not a locked facility and residents are able to leave the facility. Ms. Svinicki reported upon move in, it is determined if a resident can leave the facility unattended and Resident A was not to leave the facility without assistance. Ms. Svinicki reported Resident A was then issued a 30-day discharge due to the Resident A requiring a higher level of care.

On 8/24/21, I interviewed resident care associate Jewel Payton at the facility. Ms. Payton reported Resident A was observed to be outside and reported she was going for a walk. Ms. Payton reported staff members were outside with her. Ms. Payton reported following the incident Resident A was then placed on two-hour checks.

On 8/24/21, I interviewed resident care associate Molly Moore at the facility. Ms. Moore's statements were consistent with those made by Ms. Payton.

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

> *"7/16: Resident in room 204 came to (resident care coordinator) office stating that resident was out in back parking lot looking for a ride to her doctor's appointment. (Resident care coordinator) out to back parking lot to assist resident back inside. Resident stared pointing at red car in parking lot stating, "that's my ride. I need to go to my appointment." (Resident care coordinator) continued to help resident back in building.*
> *8/3: While admin assistant, MCC, RCM, and activities director were leaving for an out of facility meeting, resident was seen trying to leave the building. Resident was able to be redirected by staff listed and walked back into the building by activities director.*
> *8/3: MCC walking to restroom on first floor when maintenance alerted that resident was trying to leave the building. Resident was in Foyer stating that she was going to leave to go home as she needed to check on her kids. MCC stated that resident's kids were here (resident has two stuffed animals). Resident stated*

*that they weren't and that she was going to leave no matter what anyone said. Resident then proceeded to walk out of the back door leading to parking lot. Admin assistant and Admin also tried to redirect resident multiple times without success. MCC stayed with resident while she walked down the driveway towards the front of the building. Resident stated that the house across the street looks a lot like her house. MCC did redirect resident to walk down sidewalk towards front door of building as MCC concerned that resident was going to walk across the street. Resident did comply after several attempts. RCS staff came out and walked with MCC and resident to front door and assisted with walking up the steps. MCC stated hat she wanted to walk resident to where her kids were in the home. Resident agreed to this. When walking through first floor siting room, resident stated that all of her friends were there as room had around 5 residents sitting and watching TV. When we got to resident's room, she stated it was the place that she was looking for, and that it took us a lot less than an hour to get there. Resident then insisted that MCC hold resident's bear. MCC attempted x3 to have resident watch TV in her room and spend time with her kids, or visit with other residents in sitting room, but resident refused. MCC walked with resident to Admin office, where resident stated she would stay for a bit as resident was attempting to leave the facility again.*
*8/3: Resident was petitioned out of the facility today due to resident making multiple elopement attempts and threatening to leave facility for multiple days.*
*8/3: Resident's son contacted today as resident tried to elope x3 today alone (and has made attempts previously) and resident given 30 day notice due to elopement risk.*
*8/10: Alarms have ben turned on for all doors as resident has been running throughout the home between floors, going in residents' rooms, going up and down stairs by RCS office, tried chasing (maintenance) men gong to basement. Resident is not pleasant when redirected, she is also not using her walker. Please be mindful keeping a close eye throughout the shift.*

I reviewed the service plan for Resident A. The service plan read,

*"Resident redirected throughout the day for safety as she believes she is leaving with family throughout the day."*

| **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: 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 A was known to exit seek, enter other residents' rooms unwelcomed, and at times was uncooperative with staff redirection. Resident A exhibited these behaviors in July and August 2021. Resident A's service plan was not updated to reflect her increasing need for supervision and her as well as other residents need for protection. Specifically, it lacked the frequency of time staff were to spend with her and the level of supervision she required due to her consistently demonstrated behaviors due to cognitive deficits. The facility lacked an organized program of supervision and reasonable protective measures to keep the resident safe. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION:**

**Facility did not provide medical attention.**

**INVESTIGATION:**

Ms**.** Belcher alleged on 8/17, Resident A was found to be covered in food and soiled in her bed. Ms. Belcher alleged Resident A appeared to be suffering from a stroke. Ms. Belcher alleged staff were not available to assist Resident A.

Ms. Moore reported she provided care to Resident A on 8/17. Ms. Moore reported in the morning, Resident A did not want to get out of bed and requested to have breakfast in her room. Ms. Moore reported she was getting ready to administer lunchtime mediations and went into Resident A's room. Ms. Moore reported Resident A was sitting on her bed and laughing. Ms. Moore reported on this day, Resident A was to leave the facility with Relative A1 to visit a new facility. Ms. Moore reported Resident A kept making statements that she did not want to go. Ms. Moore reported she assisted Resident A to the restroom and helped her get dressed. Ms.

Moore reported Relative A1 came to the staff office and reported she was not going to take Resident A out of the facility due to Resident A's behaviors. Ms. Moore reported she went back into Resident A's room and observed she was wet and changed her brief. Ms. Moore reported Resident A was then placed in her chair in her room. Ms. Moore reported then Relative A2 came to the facility to check on Resident A. Ms. Moore reported Relative A2 requested staff assistance because it appeared Resident A was having a stroke. Ms. Moore reported she went back into Resident A's room and Resident A was at her baseline. Ms. Moore reported Relative A2 believed Resident A was having a stroke and the facility called 911. Ms. Moore reported Resident A was dressed, was not covered in urine, and lunch was just delivered prior to Relative A2's arrival. Ms. Moore reported Resident A was then transferred to the hospital due to 911 was called. Ms. Moore reported the facility acted timely and Resident A was provided the medical attention she required.

Ms. Svinicki reported on 8/17, Relative A2 came to her office and stated resident's mouth was slanted, lips were blue, and she was concerned Resident A was having a stroke. Ms. Svinicki reported she immediately went to evaluate Resident A. Ms. Svinicki reported Resident A was in her chair, was not blue, and her mouth was not slanted. Ms. Svinicki reported 911 was called for an evaluation. Ms. Svinicki reported Resident A complained of hip pain, so she was transferred to the hospital. Ms. Svinicki reported staff assisted Resident A 15 minutes prior to this and Resident A was at her baseline. Ms. Svinicki reported Resident A was provided the medical attention she required.

I reviewed the chart notes for 8/17. The chart notes read,

> *"8/17: (Relative A2) came to RCS office stating that resident seemed to be talking with her mouth slanted and that her lips were blue. MCC went down to resident's room where resident was found sitting in her chair. Admin assistant and RCS were also present. MCC did not see any cyanosis on or around resident's lips. MCC also did not notice any abnormalities drooping of resident's face on one side. Resident asked to smile and there was no noticeable difference from one side of mouth to the other. Resident did, however, seem very weak. She was talking so quietly that it was hard to make out what she was saying. Resident stating that her left knee was hiring. MCC went to assess, and upon lightly touching her knee, resident visibly in pain and resident stating that it hurts to the touch. MCC unable to lift pant leg high enough to look at her knee due to paints being too tight, and resident not able to move to be able to stand to remove pants so we could look. Knee did seem larger in size compared to right knee, but unable to tell for sure as left leg was out straight and right knee was bent. When EMT's arrived they state that resident's left leg looks substantially shorter than her right leg and asking if resident had fallen today. Explained that there were no reportable falls today, but resident could have injured herself and not notified staff. EMT states that resident could have dislocated hip as they could cause legs to be uneven. Resident was transported to HFA hospital by ambulance to be assessed. (Relative A2) was going to meet resident there."*

| 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>**(c) Assure the availability of emergency medical care required by a resident.** |
| **ANALYSIS:** | On 8/17, Relative A2 informed staff that Resident A was exhibiting symptoms of a stroke. The facility acted in a timely manner by contacting emergency medical services, evaluating resident, and assisting with transfer to the hospital. There is lack of evidence to support this allegation. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**Resident A is not fed.**

**INVESTIGATION:**

Ms. Belcher reported Resident A is unable to feed herself and staff are not assisting Resident A with eating.

Ms. Svinicki reported residents are to come to the dining hall for all meals expect for if they are on hospice/palliative care or if they are feeling ill. Ms. Svinicki reported Resident A was on hospice services but was taken off and put on palliative care services. Ms. Svinicki reported Resident A preferred to eat meals in her room which the facility accommodated. Ms. Svinicki reported sometimes resident required additional assistance with cutting up food but was able to feed herself.

Ms. Payton reported Resident A was offered room trays to due being on palliative care services. Ms. Payton reported caregivers would encourage Resident A to come down to the dining hall to eat. Ms. Payton reported at times Resident A required caregivers to cut up her food.

Ms. Moore reported Resident A was able to feed herself but did require kitchen assistance with cutting up food.

I interviewed kitchen manger Liz Wilding at the facility. Ms. Wilding reported Resident A would often eat meals in her room, especially breakfast. Ms. Wilding reported if a resident eats the meal in the room, then kitchen staff would collect the

room tray. Ms. Wilding reported if a resident did not eat the meal, the floor staff would be made aware to follow up with the resident.

I reviewed meal census log for August 2021. The logs revealed Resident A had a meal tray or came to the dining hall for all meals in August. The logs revealed Resident A was eating most of the food served to her.

I reviewed Resident A's service plan. The service plan read,

*"Resident eats a regular diet. Staff are to prompt for meals."*

| **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:** | Interviews with staff members revealed Resident A required staff assistance with cutting up food. However, the service plan for Resident A lacked this information. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION:** F

**Facility has insufficient staff.**

**INVESTIGATION:**

Ms. Belcher alleged the facility has lack of staff to assist the residents.

Ms. Svinicki reported the facility has 43 residents. Ms. Svinicki reported for all shifts there are two employees working the floor. Ms. Svinicki reported direct care employees provide resident care and administer medications. Ms. Svinicki reported typically there is one caregiver for each floor. Ms. Svinicki reported during the day the management team is always available for additional assistance, if needed. Ms. Svinicki reported if an employee calls in for their shift, a manager will work the floor until a replacement is found. Ms. Svinicki reported the facility is currently hiring. Ms. Svinicki reported there is three residents that require assistance with dressing and bathing, five residents on oxygen, and one resident that is a fall risk. Ms. Svinicki reported the facility can meet the needs of the residents.

Ms. Payton reported the facility recently hired additional caregivers. Ms. Payton reported there is always two employees working the floor. Ms. Payton reported the

schedule is never posted without two people on per shift. Ms. Payton reported the acuity of the residents is very low with many of the residents able to dress and bath themselves independently. Ms. Payton reported the resident needs are met.

Ms. Moore reported there is always two employees working the floor. Ms. Moore reported the acuity of the residents is very low. Ms. Moore reported she can meet the needs of the residents.

On 8/24/21, I interviewed Resident B at the facility. Resident B reported she has lived at the facility for four years. Resident B reported the staff is excellent and provide great care. Resident B reported the staff assist her when requested. Resident B reported no concerns with living at the facility.

On 8/24/21, I interviewed Resident C at the facility. Resident C reported the staff is very good at the facility and assist her. Resident C reported no concerns with living at the facility.

I reviewed the staff schedule for the previous two weeks. The schedule revealed the staffing ratios were met as described by Ms. Svinicki.

| **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 employees and residents revealed there is adequate staff at the facility to meet the needs of the residents. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

Resident A was transferred to the hospital due to change in condition on 8/3 and 8/17.

| 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**: | Resident A was transferred to the hospital on 8/3 and 8/17. The facility completed an incident report, but the incident report was not submitted to the state licensing department. |
| **CONCLUSION** | **VIOLATION ESTABLISHED** |

On 9/8/21, I conducted an exit conference with authorized representative Terry Langston by telephone.

## IV. RECOMMENDATION

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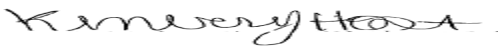
|---|
| Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license. |



8/26/21

Kimberly Horst — Date
Licensing Staff

Approved By:

9/1/21

Russell B. Misiak — Date
Area Manager