STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

September 24, 2021

Catherine Reese
Vibrant Life Senior Living OC Temperance, LLC
5720 Williams Lake Road
Waterford, MI 48329

RE: License #: AL580355938
Investigation #: 2021A0116031
Jackman Lodge

Dear Ms. Reese:

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 (313) 456-0380.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL580355938
Investigation #:	2021A0116031
Complaint Receipt Date:	08/24/2021
Investigation Initiation Date:	08/26/2021
Report Due Date:	10/23/2021
Licensee Name:	Vibrant Life Senior Living OC Temperance, LLC
Licensee Address:	5720 Williams Lake Road Waterford, MI 48329
Licensee Telephone #:	(734) 847-3217
Administrator:	Catherine Reese
Licensee Designee:	Catherine Reese
Name of Facility:	Jackman Lodge
Facility Address:	7342 Jackman Rd Temperance, MI 48182
Facility Telephone #:	(734) 847-4096
Original Issuance Date:	05/09/2014
License **Status:**	REGULAR
Effective Date:	11/09/2020
Expiration Date:	11/08/2022
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 8/20/2021, at 9:00 p.m. Resident A sat on the floor, refused to move and was combative. This behavior continued throughout the night and morning. On 8/21/2021, at 10:00 a.m. staff called EMS for assistance getting Resident A off the floor. Resident A was found covered in her own urine and had not eaten.	Yes
Resident A had not received her morning medication on 08/21/21.	No

III. METHODOLOGY

08/24/2021	Special Investigation Intake 2021A0116031
08/24/2021	APS Referral Received
08/26/2021	Special Investigation Initiated - On Site Interviewed staff Tajanik Rease and Jade Wooden, resident care coordinator Jack Williams, executive director Molly Bowman, reviewed Resident A's assessment plan.
08/26/2021	Contact - Document Received Copies of staff Antionette Chenier's training.
08/27/2021	Contact - Telephone call made Interviewed staff Jericka Smith.
08/27/2021	Contact - Telephone call made Left a message for director of nursing Angela Arquette requesting a return call.
08/27/2021	Contact - Telephone call made Left a message for staff Antionette Chenier requesting a return call.
08/27/2021	Contact - Telephone call received Interviewed staff Antoinette Chenier.
08/27/2021	Contact - Telephone call received Interviewed director of nursing Angela Arquette.
08/27/2021	Inspection Completed-BCAL Sub. Compliance

09/07/2021	Contact - Telephone call made Interviewed Guardian (1).
09/17/2021	Exit Conference With Licensee designee Catherine Reese

ALLEGATION:

On 8/20/2021, at 9:00 p.m. Resident A sat on the floor, refused to move and was combative. This behavior continued throughout the night and morning. On 8/21/2021, at 10:00 a.m. staff called EMS for assistance getting Resident A off the floor. Resident A was found covered in her own urine and had not eaten.

INVESTIGATION:

On 08/23/21, I received and reviewed the incident report related to this event. The incident report was dated 08/21/21 and was completed by staff Tajanik Rease. Ms. Rease documented that Resident A was combative and aggressive toward staff and other residents and when re-directed became more combative. Resident A was sent to the hospital for evaluation and treatment.

On 08/26/21, I conducted an unscheduled onsite inspection and interviewed staff Tajanik Rease, resident care coordinator Jack Williams, executive director Molly Brown, visually observed Resident A, and interviewed Resident B.

On 08/26/21, Ms. Rease reported that she was not on shift the evening or night of 08/20/21 and reported she worked the morning of 08/21/21 from 7:00 a.m. to 3:00 p.m. Ms. Rease reported that when she arrived at work Resident A was on the floor in the hallway and was combative, had urinated on herself and was refusing all assistance from staff. Ms. Rease reported she attempted to talk with Resident A to see if she would allow her to clean her up, but she refused and was yelling and swinging her arms at her.

Ms. Rease further reported that the midnight staff Antionette Chenier stayed over and provided her with a synopsis of what had occurred with Resident A overnight and continued trying to persuade Resident A to get off the floor so that she could be showered, fed, and moved to her bedroom where she would be more comfortable.

Ms. Rease reported that Resident A continued the behaviors, so she made the decision to call non-emergency transport who came and took Resident A to the

hospital. Ms. Rease reported once the medical technicians arrived Resident A listened to them and did exactly what they asked with no problems. Ms. Rease reported that it was around 9:30 a.m. when she called non-emergency transport. Ms. Rease reported that Resident A did not eat breakfast as she was leaving for the hospital at the time breakfast was being served.

I asked Ms. Rease if there was an internal policy or process in place when it comes to seeking medical treatment for residents. Ms. Rease reported that the staff are not able to send a resident out to the hospital without first contacting their administration. Ms. Rease reported that a lot of times especially on the weekends, the administration team does not answer their phones which makes it difficult on the staff. Ms. Rease reported that she tries to follow the rules but, reported that if she cannot reach administration, she will seek medical treatment as she does not want a resident to suffer or make a bad situation worse. I explained to Ms. Rease that as a trained direct care staff that it her responsibility to assess situations pertaining to a resident health and make a decision based on that assessment. I informed her that resident health is the priority and that after the resident is stable/safe then contact with her administration team was in order. Ms. Rease agreed and reported that the administration team needs to be aware of that.

On 08/26/21, I interviewed resident care coordinator Jack Williams. Mr. Williams reported he was made aware of the incident once returning to work. Mr. Williams could not recall if he had been contacted Friday evening (08/20/21) or early Saturday morning (08/21/21) regarding Resident A.

On 08/26/21, I interviewed executive director Molly Bowman and she reported that she was contacted on 08/20/21 and made aware of the situation. Ms. Bowman reported she was informed that Resident A was combative but does not recall being informed that Resident A was refusing care. I asked Ms. Bowman if she provided staff any instruction on next steps of whether or not to medical treatment should be sought. Ms. Bowman reported that she did not speak directly to staff, so therefore did not provide any instruction. I asked Ms. Bowman did she at any time call the facility to follow up on the situation or offer any guidance to staff and she reported that she did not. Ms. Bowan reported that staff are supposed to contact Mr. Williams or Angela Arquette (director of nursing). Ms. Bowman reported that the staff did not contact her directly regarding the incident. I asked Ms. Bowman if staff were allowed to seek medical treatment for residents without having to contact the administration team. Ms. Bowman responded, “absolutely”.

On 08/26/21, I interviewed staff Jada Wooden. Ms. Wooden reported that she is a new staff and reported working from 3:00 a.m. to 3:00 p.m. on Saturday 08/21/21. Ms. Wooden reported when she came on shift Resident A was sitting on the floor, refusing staff assistance and was very combative. Ms. Wooden reported she attempted to talk with Resident A in hopes that she would allow her to toilet her and get her cleaned up, to no avail. Ms. Wooden reported that Resident A had urinated on herself and continually refused assistance from her and the other staff on shift,

Ms. Chenier. Ms. Wooden reported that she went on to assist the other residents as Ms. Chenier continued to attempt to re-direct and offer assistance to Resident A.

I asked Ms. Wooden about the protocol in place relating to staff's ability to seek medical treatment for a resident. Ms. Wooden reported that she had only been working for about three weeks and reported she was not aware of the procedure. Ms. Wooden added that she would assume that if a resident is in distress and or required medical attention staff would call 911.

On 08/26/21, I attempted to interview Resident A. Resident A was unable to answer questions and was talking and mumbling about things that did not pertain to my questions. Resident A was clean and neatly groomed.

On 08/26/21, I interviewed Resident B and he reported that he was glad that Resident A had returned home from the hospital and reported that she was doing well. Resident B reported that he missed her while she was gone. Resident B appeared clean and was neatly dressed and groomed. I visually observed the remaining 10 residents sitting at tables in the dining room area playing games or watching television. All of the residents appeared clean and were neatly dressed and groomed.

On 08/26/21, I reviewed Resident A's records and observed that she was admitted into the facility on 07/01/21. Resident A's assessment plan documents her diagnosis of Dementia as well as her behaviors associated with her diagnosis.

On 08/26/21, I requested to review staff Antionette Chenier's employee file, however, Ms. Bowman reported that the office manager was off work today and she was not aware of her filing system and the location of the employee records. Ms. Bowman reported that she would make sure the requested documents were sent to me the following day.

On 08/26/21, I received and reviewed staff Antionette Chenier's direct care and Dementia/Alzheimer's related training, job description and responsibilities as a direct care staff. Ms. Chenier completed the required training in August of 2020.

On 08/27/21, I interviewed staff Jericka Smith. Ms. Smith reported that she started her shift at 10:00 p.m. on 08/20/21. Ms. Smith reported that when she arrived Resident A was okay and was sitting at a table in the dining room area. Ms. Smith reported that the Resident A had eaten dinner on the prior shift and had taken her evening medications. Ms. Smith reported she went to assist another resident and while doing so heard Resident C start screaming at Resident A to get out of his room. Ms. Smith reported she went to see what was going on and observed Resident A in Resident C's room and she asked her to leave. Ms. Smith reported that Resident A grabbed her hair and pulled it and was grabbing and pulling her arm. Ms. Smith reported that she re-directed Resident A and she let go of her. Ms. Smith further reported that Resident A then attempted to swing and hit Resident C.

Ms. Smith reported that Resident A left out of Resident C's room, attempted to enter another resident's room before flopping to the ground in the hallway, where she began yelling and screaming. Ms. Smith further reported that she attempted to redirect and calm Resident A down but was unsuccessful. Ms. Smith reported that Resident A then began urinating on herself and refused assistance from her. Ms. Smith reported she contacted team leader and scheduler Tami Hardison via telephone and informed her of what was going on and asked if she could finish her shift at the adjacent licensed facility. Ms. Smith reported that she had just recently returned back to work after an injury to her hand and was afraid she would re-injure it trying to provide care to Resident A in this combative stage. Ms. Smith reported that Ms. Hardison told her that she could and that she needed to call staff Antionette Chenier and have her come over to complete her shift there. Ms. Smith reported that she believes that she left at 11:30 p. m. once Ms. Chenier arrived to relieve her.

On 08/27/21, I interviewed staff Antionette Chenier. Ms. Chenier reported that she began her shift on 08/21/21 at 9:00 p.m. at the company's other licensed facility that sits behind this one. Ms. Chenier reported that between 11:15 p.m.-11:30 p.m. she received a call from staff Jericka Smith telling her that she needed to leave the facility she was working in and report to Jackman to complete her shift and Ms. Smith would be completing her shift at the building she was at. Ms. Chenier reported she was upset at the arrangement but finished what she was doing and walked over to the facility to complete her shift. Ms. Chenier reported when she arrived Ms. Smith informed her that Resident A was being combative, was yelling and screaming and was sitting on the floor in the hallway refusing to move. Ms. Chenier reported she made several attempts to speak with Resident A trying to persuade her to allow her to shower her and get her to her room where she would be comfortable. Ms. Chenier reported that the closer she got to Resident A the more aggressive she became. Ms. Chenier reported that Resident A was hitting and kicking her so be created some space between them.

Ms. Chenier further reported that Resident A had urinated on herself, and her pants were soaking wet. Ms. Chenier reported that she left Resident A in the hallway and went to check in on the other residents to make sure they did not need anything and then went back to Resident A to make another attempt to get her off the floor and cleaned up. Ms. Chenier reported that after all of her failed attempts to get Resident A off the floor she went to see if Resident B (Resident A's husband) could talk to her. Ms. Chenier reported that Resident A will often listen to Resident B opposed to staff, so she was hoping she would listen to him. Ms. Chenier reported that Resident B attempted to talk to Resident A and asked her to get up off the floor and allow staff to shower and get her to bed. Ms. Chenier reported Resident A would not budge.

Ms. Chenier reported that she continued with her other responsibilities throughout the night but continued to check on Resident A and offer her beverages and snacks, which she refused and started the combative and aggressive behaviors.

I asked Ms. Chenier if she had contacted any of the administrative staff during the night to inform them of what was going on and she reported that she did not. Ms. Chenier added that most times they do not answer staff calls so it would have been a waste of time. I asked Ms. Chenier why she did not seek medical evaluation/treatment for Resident A based on her behaviors and physical condition she did not have an answer.

Ms. Chenier reported that the staff are not allowed to call 911 or non-emergency transport without permission from someone on the administration team. Ms. Chenier reported that although she understands the internal policy, in case of an emergency where the resident is in distress, she would call 911 first and then let her administration know. Ms. Chenier reported that in retrospect she should have sought treatment for Resident A after she continued to refused staff assistance and was clearly not getting better. Ms. Chenier also reported that Ms. Smith also could have sought medical treatment for Resident A during the time she was responsible for her care.

Ms. Chenier reported that dayshift staff Ms. Rease came in at 7:00 a.m. the following morning (08/21/21) and she stayed over providing her with details of Resident A's behaviors through the night. Ms. Chenier reported before leaving she made another attempt to assist with getting Resident A off the floor and showered, which she again refused and became aggressive.

On 09/07/21, I interviewed Guardian (1) and he reported that when he was initially informed that Resident A was being sent out to the hospital, the facility left out all of the details regarding what had actually occurred. Guardian (1) reported that he was made aware of everything upon his arrival to the hospital and reported being upset that the staff allowed Resident A to sit on the floor in the hallway in urine-soaked pants all night, instead of sending her out to be evaluated. Guardian (1) reported that some things are just common sense. Guardian (1) further reported that he is upset that the facility withheld the details of what really happened and because of that it will be difficult to believe anything they say. Guardian (1) reported that he is working with Resident A's doctor and the facility in hopes to get a geriatric psychological evaluation so that Resident A can be prescribed some different medications to help reduce or alleviate Resident A's aggressive and combative behaviors.

On 09/17/21, I conducted the exit conference with licensee designee Catherine Reese and informed her of the findings of the investigation. I provided technical assistance to Ms. Reese sharing with her that trained direct care should be able to make an assessment pertaining to the need for medical treatment for a resident and based on that assessment make a decision that is in the best interest of the resident, without having to contact the administration team. I shared with Ms. Reese that any delay in treatment could be the difference between life and death in certain situations. Ms. Reese reported an understanding and reported she would be meeting with staff and administration to address and correct this immediately. Ms.

Reese reported that she would submit an acceptable corrective action plan to address the rule violation.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Resident A began exhibiting behaviors around 10:30 p.m. on the night of 08/20/21. Staff Jericka Smith reported that Resident A was combative and aggressive with residents and staff and reported that Resident A had pulled her hair and was grabbing her arm. Ms. Smith left at 11:30 p.m. to complete her shift at the adjacent licensed facility. Ms. Smith did not seek medical treatment for Resident A. Ms. Chenier came on shift at the facility at around 11:30 p.m. on 08/20/21 and observed Resident A to be sitting on the floor in the hallway in urine-soaked pants. Ms. Chenier reported that all throughout the night and early morning hours of 08/21/21 Resident A was combative, was yelling, screaming, and refusing all staff assistance. Ms. Chenier did not seek medical treatment for Resident A. Ms. Wooden came on shift at 3:00 a.m. on 08/21/21 and observed Resident A sitting on the floor in the hallway in urine-soaked pants, yelling, screaming, and being combative. Ms. Wooden reported that she made multiple attempts to assist Resident A off the floor so that she could be showered and moved to her bedroom. Ms. Wooden reported Resident A continuously refused. Ms. Wooden did not seek medical treatment for Resident A.

	Ms. Rease came on shift at 7:00 a.m. on 08/21/21 and observed Resident A sitting on the floor in the hallway in urine-soaked pants, yelling, screaming and being combative. Ms. Rease reported that after Resident A continued to be combative and refuse staff assistance, she called non-emergency transport around 9:30 a.m. 11 hours after Resident A began exhibiting these behaviors. Resident A was taken to the hospital for evaluation and treatment where she remained for four days. This violation is established as the home failed to obtain needed care immediately, after observing an adverse change in Resident A's physical condition and adjustment.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A had not received her morning medication on 08/21/21.

INVESTIGATION:

On 08/26/21, I conducted an unscheduled onsite inspection and interviewed staff Tajanik Rease. Ms. Rease reported that she came on shift at 7:00 a.m. on 08/21/21 and observed Resident A to be combative, aggressive, and reported she was yelling, screaming, and refusing staff assistance. Ms. Rease reported she attempted to administer Resident A's 8:00 a.m. medications, however she refused. Ms. Rease reported that she contacted Angela Arquette, director of nursing and explained to her what was going on with Resident A. Ms. Rease reported that Ms. Arquette told her to try to administer Resident A her PRN medication (5mg Buspirone) to see if that would calm her down. Ms. Rease reported that she informed Ms. Arquette that Resident A had refused her 8:00 a.m. medications so it was unlikely that she would take the PRN. Ms. Rease reported that she attempted to administer Resident A's 8:00 a.m. medications along with the 5mg Buspirone PRN and again Resident A refused the medication and continued to act out.

On 08/26/21, I reviewed Resident A's electronic medication administration record (MAR) and confirmed that the MAR documented Resident A's medication refusal on 08/21/21 at 8:00 a.m.

On 08/27/21, I interviewed Angela Arquette, director of nursing. Ms. Arquette reported that she received a call from Ms. Rease the morning of 08/21/21 informing her of Resident A's behaviors and a synopsis of what Ms. Chenier reported took place throughout the night and early morning hours. Ms. Arquette reported that Ms.

Rease informed her that Resident A had refused her 8:00 a.m. medications. Ms. Arquette reported that she advised Ms. Rease to attempt to administer Resident A her 5mg Buspirone PRN medication to see if it would calm her. Ms. Arquette was later informed that Resident A refused the PRN and was sent to the hospital.

On 09/17/21, I conducted the exit conference with licensee designee Catherine Reese. I informed Ms. Reese of the findings of the investigation, and she agreed with the findings.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident A was exhibiting aggressive and combative behaviors throughout the evening and morning hours of 08/20/21 and 08/21/21. Ms. Rease attempted to administer Resident A's 8:00 a.m. medications on 08/21/21 according to the label instructions, however Resident A refused all medications. Ms. Arquette was notified by Ms. Rease of Resident A's behaviors and medication refusal. Ms. Arquette reported that she instructed Ms. Rease attempt to administer her 5mg Buspirone PRN. Resident A refused all medications. This violation is not established, as the staff attempted to administer Resident A's medication according to label instructions, however Resident A refused to take them, and staff documented the refusal on Resident A's MAR as required.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

09/24/21

Pandrea Robinson Date
Licensing Consultant

Approved By:

09/24/21

Mary Holton Date
Area Manager