GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 22, 2021

David Zebley
Cambrian Assisted Living
333 N. Occidental Highway
Tecumseh, MI 49286

RE: License #: AH460277873
Investigation #: 2022A1019003

Dear Mr. Zebley:

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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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.

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,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH460277873
Investigation #:	2022A1019003
Complaint Receipt Date:	10/11/2021
Investigation Initiation Date:	10/11/2021
Report Due Date:	12/10/2021
Licensee Name:	Cambrian of Tecumseh, LLC
Licensee Address:	333 N. Occidental Tecumseh, MI 49286
Licensee Telephone #:	(517) 414-8881
Administrator:	Stacey Short
Authorized Representative:	David Zebley
Name of Facility:	Cambrian Assisted Living
Facility Address:	333 N. Occidental Highway Tecumseh, MI 49286
Facility Telephone #:	(517) 423-5300
Original Issuance Date:	10/24/2005
License Status:	REGULAR
Effective Date:	02/10/2021
Expiration Date:	02/09/2022
Capacity:	70
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Emergency medical care was not provided to Resident A timely.	No
Additional Findings	Yes

II. METHODOLOGY

10/11/2021	Special Investigation Intake 2022A1019003
10/11/2021	Special Investigation Initiated - Letter Notified APS of the allegations via email referral template.
10/11/2021	APS Referral
10/11/2021	Contact - Document Sent Emailed admin and AR for record request, correspondence is ongoing.
10/15/2021	Inspection Completed BCAL Sub. Compliance
10/22/2021	Exit Conference

ALLEGATION:

Emergency medical care was not provided to Resident A timely.

INVESTIGATION:

On 10/11/21, the department received a complaint regarding Resident A's care the facility. The complaint read that Resident A's blood pressure had dropped and the facility failed to obtain physician instruction or administer medication to help stabilize her blood pressure. The complaint also read that staff failed to administer CPR to Resident A when she was found unresponsive and ultimately passed away.

On 10/11/21, licensing staff began correspondence with the facility administrator Stacey Short and authorized representative David "Gareth" Zebley. Per documentation provided by Ms. Short, Resident A moved into the facility on 11/19/20

from a rehabilitation center after having a stroke and passed away at the facility on 11/21/20. Regarding low blood pressure, on 11/20/20, facility nurse Patsy Evans documented:

> 1415pm Writer was called to resident's apartment, resident C/O dizziness and near syncope. BP 78/52 right arm. Resident states her blood pressure drops this time every day. Resident asked for a wash cloth and a fan turned on. Writer discussed BP med Metoprolol that has been ordered tid. Resident states, Dr wants her blood pressure low. Writer called Dr. Doman's office, left a detailed message with Lori, and to call back. Resident is aware of the above.

Ms. Evans attested that Dr. Doman did not call back during her shift and she did not receive any instruction pertaining to Resident A's low blood pressure.

A progress note dated 11/21/20 authored by nurse Cheryl Lerch read:

> 1045 A writer stopped in to check on resident she was moaning a little and her legs were moving back and forth but for the most part she looked comfortable and writer told her husband she looked comfortable. He also said she had been moaning slightly. 11:30 A RAS Lynsey went into to [sic] give her a noon pain pill and she noted her to be not responding and her coloring was blue to her nail beds and lips, her eyes were rolled back into her head she called writer to her room when entering writer noted no blood pressure and or pulse, writer tried some stimulation with no response. 911 was dispatched and Amy DON was called and daughter was called as well. Tecumseh police arrived at 11:40A and EMS about the same time. EMS examined resident did a EKG with only a flat line. Time of death called at 12:01P. ME was called and arrived at 1:40P did his exam and called Handler's funeral home. Handler's arrived and removed body at 1400P.

Ms. Short attested that Resident A had not executed a do no resuscitate order, which means the facility defaults to a "full code" status. Ms. Short attested that facility nurses and supervisors are trained in CPR and acknowledged that in Resident A's case, CPR was not given. Ms. Short attested that med tech Lindsay Lynn observed the following:

> The resident was nonresponsive, pulseless, eyes rolled back, cold to the touch, slightly stiff with blue nailbeds and lips. Resident did not respond to sternum rub. Her observation was that the resident had been expired for some time. She alerted the on-floor nurse Cheryl and asked for confirmation of code status (full code vs DNR) which is kept in the resident chart in the med room. Cheryl did not find a signed DNR form so, by default, the resident is considered a full code. Cheryl proceeded to the apartment and checked for pulse, took Bp (non-detect), performed sternum rub and spoke to resident. There was zero response from the resident. Based on the condition of the resident they did not initiate CPR.

Ms. Short provided a copy of the medical examiner's report dated 11/21/20. Resident A's husband (who resided with her at the facility) was interviewed by the medical examiner's office. The report read "The decedents health had been steadily declining over the course of the last several months. To his, or family's knowledge, the decedent was not experiencing any new or worsening symptoms over the course of the last few days." The report read:

> The decedent had an extensive medical history of essential hypertension, chronic back pain, obesity, colitis, anxiety, depression, previous closed head injury, breast cancer, hyperlipidemia, CVA. Decedent was a former social drinker of alcohol, never abused tobacco or recreational drugs. The decedent was non ambulatory as reported by staff of the nursing home.

The report also read "Contact made with Dr. Doman and medical history discussed. Dr. Doman agreed to sign the decedents death certificate citing an extensive medical history."

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: **(c) Assure the availability of emergency medical care required by a resident.**
ANALYSIS:	When Resident A's blood pressure was noted to be low, facility staff contacted Resident A's physician, however staff did not attest to receiving a call back and no documentation was provided to support that the physician gave any instruction to facility staff on the matter. Additionally, staff contacted emergency medical services promptly upon the discovery of Resident A's being nonresponsive. Based on this information, facility staff acted in accordance with the expectations of this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of medication administration records reveal that Resident A is prescribed Metoprolol tartrate three times daily. Metoprolol is the generic name for the medication Lopressor and is commonly used to treat high blood pressure. On 11/20/20, staff withheld the medication and documented the reason for not administering as “no pass per vitals”. Nurse Cheryl Lerch attested via a signed statement “After taking her blood pressure prior to med pass made the decision to hold her Lopressor due to a low blood pressure.” This directive did not come from Resident A’s physician and Ms. Lerch made the determination to adjust the medication on her own.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) If a home or the home's administrator or direct care staff member supervises the taking of medication by a resident, then the home shall comply with all of the following provisions: **(e) Adjust or modify a resident’s prescription medication with instructions from a prescribing licensed health care professional who has knowledge of the medical needs of the resident. A home shall record, in writing, any instructions regarding a resident's prescription medication.**
ANALYSIS:	Resident A’s metoprolol was held by staff without obtaining instructions from her physician to do so.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/22/21, I shared the findings of this report with authorized representative David “Gareth” Zebley. Mr. Zebley verbalized understanding of the citation, however feels that his staff acted appropriately from a clinical standpoint.

III. RECOMMENDATION

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

10/22/21

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

10/22/21

Russell B. Misiak Date
Area Manager