GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 18, 2022

Todd Dockerty
The Reflections
14316 S. Helmer Rd.
Battle Creek, MI 49015

RE: License #: AH130403566
Investigation #: 2022A1028011
The Reflections

Dear Mr. Dockerty:

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 on 2/2/2022 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.
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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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,
Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
Cell (616) 204-4300

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

I. IDENTIFYING INFORMATION

License #:	AH130403566
Investigation #:	2022A1028011
Complaint Receipt Date:	11/16/2021
Investigation Initiation Date:	11/16/2021
Report Due Date:	1/16/2022
Licensee Name:	Battle Creek Assisted Living Operator, LLC
Licensee Address:	111 W. Ferry St. #1 Berrien Springs, MI 49103
Licensee Telephone #:	(574) 261-1124
Administrator:	Jonathan Zima
Authorized Representative:	Todd Dockerty
Name of Facility:	The Reflections
Facility Address:	14316 S. Helmer Rd. Battle Creek, MI 49015
Facility Telephone #:	(269) 969-2500
Original Issuance Date:	12/09/2020
License **Status:**	REGULAR
Effective Date:	06/09/2021
Expiration Date:	06/08/2022
Capacity:	45
Program Type:	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff did not provide Resident A care in accordance with the service plan.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/16/2021	Special Investigation Intake 2022A1028011
11/16/2021	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
11/16/2021	APS Referral APS referral emailed to Centralized Intake
12/20/2021	Inspection Completed On-site 2022A1028011
12/20/2021	Contact – Face to Face Interviewed Administrator, Jonathan Zima, at the facility.
12/20/2021	Contact – Face to Face Interviewed Executive Director, Cortney Banker, at the facility.
12/20/2021	Contact – Face to Face Interviewed care staff person, Destiny Jones, at the facility.
12/20/2021	Contact – Telephone call made Interviewed the complainant by telephone.
12/22/2021	Contact – Telephone call made Interviewed Elara Home Care and Hospice manager, Raegan Radke, by telephone.
12/22/2021	Contact – Telephone call received Received return phone call from Elara Home Care and Hospice manager, Raegan Radke.
1/18/2022	Exit Interview

ALLEGATION:

Staff did not provide Resident A care in accordance with the service plan.

INVESTIGATION:

On 11/16/2021, the Bureau received the allegations from the online complaint system.

On 11/16//21, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 12/20/21, I interviewed the facility administrator, Jonathan Zima at the facility. Mr. Zima reported no issues were brought to his attention concerning the care of Resident A at the facility from April 2021 to July 2021.

On 12/20/21, I interviewed executive director, Cortney Banker, at the facility. Ms. Banker reported Resident A was at the facility from April 2021 to July 2021. Ms. Banker reported no issues were reported to her concerning staff care of Resident A. Ms. Banker reported Resident A required assist with all care due to diagnosis of dementia. Ms. Banker reported Resident A had significant dementia but did not have behaviors and “went downhill quickly after several falls”. Resident A incurred several falls which later resulted in Resident A becoming chair bound. Due to being chair bound, Resident A developed a pressure ulcer in the tailbone area. Ms. Banker reported Elara Home Care came into the facility to address wound care for Resident A and Resident A was placed on a rotation schedule to aid in healing. Ms. Banker reported Resident A’s spouse requested to keep Resident A in the recliner instead of the bed during the day, but care staff explained several times that the recliner compromised the rotation schedule and wound healing. Ms. Banker also reported Resident A was incontinent and required assist with toileting, so Resident A was monitored throughout the day and placed on hourly checks. Resident A also received physical therapy and occupational therapy from Elara Home Care for a short time but was discharged for lack of progress. Ms. Banker reported Elara Home Care staff communicated with the facility and Resident A’s spouse, but Elara Home Care provided all wound care. Ms. Banker reported the facility care staff were to report to Elara Home Care if Resident A’s bandage fell off or if there was a change in condition for Resident A. Ms. Banker reported the spouse was at the facility daily and was very involved with Resident A’s care as well and to her knowledge the spouse made no complaints about Resident A’s care. Ms. Banker reported Resident A went to the hospital in July 2021 for debridement of the pressure sore and returned to the facility. Resident A passed away at the facility in July 2021. Ms. Banker provided me a copy of Resident A’s admission contract, service plan, medication administration

record, record notes, hourly check log, and Elara Home Care contract with record notes.

On 12/20/21, I interviewed care staff person, Destiny Jones, at the facility. (Please note: Ms. Jones is the only facility care staff left that provided direct care to Resident A. The rest of the facility care staff involved with Resident A's care are no longer employed at the facility). Ms. Jones reported Resident A had dementia and incurred several falls resulting in Resident A becoming chair bound. Ms. Jones reported Resident A required assist with all care. Ms. Jones reported Resident A required increased changing of briefs due in incontinence and care staff monitored Resident A hourly due to this. Ms. Jones reported Resident A had a pea sized pressure sore on the tailbone that eventually grew larger due to being chair bound. Ms. Jones reported Resident A's spouse requested care staff keep Resident A in the recliner during the day, but Ms. Jones reported care staff explained to the spouse that Resident A should be in the bed for appropriate pressure relieving techniques. Ms. Jones provided detailed description of the rotation and positioning techniques Resident A required to relieve the pressure sore and aid in healing. Ms. Jones reported Resident A was on a rotation schedule for every two hours and required certain positioning as well and it could not be performed if Resident A was in the recliner. Ms. Jones reported with Resident A's spouse in agreement, Resident A was eventually moved back to the bed so care staff could provide appropriate pressure relieving techniques. Ms. Jones reported Elara Home Care handled all Resident A's wound care. Ms. Jones reported care staff was to call Elara Home Care if Resident A's bandage became compromised or fell off or if there was change in condition. Ms. Jones reported Resident A's spouse visited almost daily and would ask for assistance to change briefs, but to her knowledge, there were no complaints from Resident A's spouse. Ms. Jones reported Resident A went to the hospital in July 2021 due to the pressure sore and returned but passed away shortly after returning to the facility.

On 12/20/21, I interviewed the complainant by telephone. The complainant reported Resident A resided at the facility from April 2021 until Resident A passed at the facility in July 2021. The complainant reported Resident A had dementia and had incurred several falls resulting in Resident A becoming chair bound. The complainant reported Resident A developed a pea sized pressure sore in the tailbone area with Elara Home Care treating at the facility. The complainant reported Resident A went to the hospital in July 2021 due to the significant size the pressure sore had grown to. Resident A completed a debriding procedure to treat the pressure sore, returning to the facility and later passing away at the facility. The complainant reported Resident A was often found with wet briefs, wet clothing, wet chair pad, and the recliner was often wet as well. The complainant reported care staff were often called to assist with the changing of the wet brief and clothing during visits and it "happened a lot, daily I would say." The complainant reported [they] do not believe Resident A was rotated by care staff as often as ordered and it contributed to the pressure sore increasing in size. Resident A was to be rotated and/or repositioned every two hours. The complainant reported Resident A did like to sit in the recliner but had to be

moved back to bed later because it was too difficult for care staff to reposition Resident A in the recliner. The complainant reported [they] believe that Resident A sitting in the recliner did not affect the pressure sore because “I didn’t want [Resident A] in lying in bed all day, and [Resident A] liked sitting in the recliner”. The complainant reported care staff “did not do a job keeping [Resident A] dry or rotating [Resident A] contributing to the pressure sore increasing in size.”

On 12/22/21, I interviewed office manager, Raegan Radke, by telephone. Ms. Radke reported Resident A was seen by Elara Home Care and later Elara Hospice Care at the facility and was cared for by different home care and hospice staff. Ms. Radke reported she would review Resident A’s file and report back to me if home care staff noted any concerns in the file about the facility’s care of Resident A. Ms. Radke reported no concerns were reported to her about the facility care of Resident A.

On, 12/22/21, I received a return phone call from Ms. Radke. Ms. Radke reported the following:

- Start of care for Resident A began 7/15/21.
- On 7/17, the nurse changed Resident A’s bandaged.
- On 7/18, Resident A’s wound was draining, and it was re-dressed. Facility care staff, Mindy (unsure of last name) was provided education on wound and importance of rotation schedule by Elara hospice nurse.
- On 7/19, Resident A’s wound was reassessed and facility care staff, Mindy, was provided education wound and importance of rotation schedule by Elara hospice nurse.
- On 7/20, education was provided again to facility care staff Mindy on wound, importance of rotation schedule, and keep Resident A’s briefs dry by Elara hospice nurse.
- On 7/21, education was provided again to facility care staff Sue (unsure of last name) on wound, importance of rotation schedule, and keep Resident A’s briefs dry by Elara hospice nurse.

On 12/22/21, I reviewed Resident A’s service plan with record notes. The review revealed the following:

- Resident A entered the facility on 4/20 requiring assistance with donning/doffing of socks, toileting, medication administration and ambulated with a cane.
- Resident A incurred falls on 4/22, 4/27, 5/26, and 5/28.
- Resident A required assist with eating, toileting, hygiene, dressing, and medication administration after 5/26 due to third fall resulting in pelvic fracture. Ambulation and transferring were not updated on the service plan.
- The service plan lists the following dates as being updated 4/22, 4/23, 4/27, and 7/16 for Resident A’s care.

I reviewed Resident A’s Elara Home Care record provided by the facility. The review revealed the following:

- Elara Home Care began seeing Resident A in June 2021.
- Elara Home Care provided nursing, physical therapy and occupational therapy from June 2021 to July 2021 and Resident A was discharged to hospice services in late July 2021 due to non-healing and lack of progress with therapy.
- On 6/29, Elara Home Care nurse, Ashley Oliver, documented Resident A's wound care. Ms. Oliver communicated with facility care staff with the initials of M.B. (signature is illegible on document) about continuing wound care three times weekly and to notify Elara Home Care for questions or concerns.
- On 7/1, Elara Home Care nurse, Tina Folkers, documented coccyx dressing change and pain level relative to left hip, with resistance to care. Ms. Folkers to contact Dr. Bhan to discuss wound measurement for possible updated orders. Ms. Folkers communicated with facility care staff Courtney H. (no last name given) about no pressure to coccyx and rotation schedule.
- On 7/2, Elara Home Care nurse, Ashley Oliver, documented Resident A's wound dressing was saturated with drainage. Ms. Oliver updated wound care orders and recommended wound care clinic referral. Ms. Oliver communicated with facility care staff Mashion Zimmer about wound care three times weekly and to notify Elara Home Care for questions or concerns.
- On 7/6, Elara Home Care nurse, Ashley Oliver, documented Resident A's wound was not showing signs of healing. Ms. Oliver communicated visit findings with facility staff with the initials of M.B. (signature is illegible on document) about continuing wound care three times weekly and to notify Elara Home Care for questions or concerns.
- Elara Home Care Hospice services start of care was 7/15. The services included wound care, bed baths, and monitoring for decline.
- On 7/15, Elara Hospice Care nurse, Sara Ward, assessed Resident A for hospice services. Ms. Ward provided orders for diet, medication, Hoyer lift with sling, and shower chair. Ms. Ward documented continue to monitor Resident A, a 24-hour follow-up visit would be completed 7/16, and Resident A was placed on BYS 1. Ms. Ward documented Elara Home Care was to be called 24/7 with any questions, concerns, or changes. However, it was not documented if Ms. Ward communicated with any facility care staff, as this section is blank.
- On 7/23, Elara Hospice Care nurse, Sara Ward, documented Resident A had a new pressure sore on the left hip. Wound care was continued, and Resident A was to be monitored for decline. Ms. Ward documented Elara Home Care was to be called 24/7 with any questions, concerns, or changes. However, it was not documented if Ms. Ward communicated with any facility care staff, as this section is blank.

I reviewed Resident A's physician and facility orders after incurring the third fall on 5/26 resulting in hip fracture. The review revealed Resident A incurred a hip fracture with bed rest, pain management, home health care services, and ice to area prescribed. The facility requested a standard wheelchair with cushion and

foot pedals for ambulation and safety within the facility. Resident A was no longer able to use cane or walker despite therapy.

I reviewed the facility hourly checks logs for Resident A. The review revealed only days 5/30, 5/31, 6/2, 6/3 were provided to me by the facility. For 5/31, the log was incomplete for the hours of 2:00pm to 9:00pm.

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:	Resident A entered the facility on 4/20/21 and incurred falls on 4/22, 4/27, 5/26, and 5/28, with the 5/26 fall resulting in a hip fracture. Due to the hip fracture, Resident A became chair bound and developed a significant pressure sore on the coccyx and later developed an additional pressure sore on the left hip. Resident A's service plan required a two-hour rotation schedule to aid in wound healing and pressure relief, and hourly checks to address bladder incontinence to prevent wet briefs and clothing, which compromised wound healing. There is evidence that facility care staff did not appropriately adhere to Resident A's pressure relief schedule to relieve pressure sores and aid in wound healing. The initial pressure sore significantly increased from a pea size diameter to greater than the size of a half dollar from May 2021 to July 2021. Additionally, Resident A developed a second pressure sore on the left hip in July 2021. There is evidence facility care staff was provided education from Elara home care staff and hospice staff in both June and July 2021 on wound healing, pressure relieving schedule, and bladder incontinence. Facility care staff did not take the appropriate measures to adhere to Resident A's service plan or to assist Resident A with wound healing, pressure relieving techniques, and bladder incontinence.
CONCLUSION:	**VIOLATION ESTABLISHED**

Additional Findings

On 12/22/21, I reviewed Resident A's service plan with record notes. The review revealed the following:

- The service plan was updated by the facility on 4/22, 4/23, 4/27, and 7/16 for Resident A's care. Resident A's authorized representative was notified of the service plan update on 7/16.
- Resident A incurred falls on 4/22, 4/27, 5/26, and 5/28.
- Resident A's service plan was updated, and Resident A required increased assist with eating, toileting, hygiene, dressing, and medication administration after 5/26 fall. However, ambulation and transferring were not updated on the service plan.
- The service plan was last updated on 7/16. Resident A was still listed as independent for ambulation and transfers. The service plan read*: [Resident A] ambulates independently with walker. RCS will continue to monitor safety needs and report any issues to nurse or supervisor. [Resident A] is independent with transfers. RCS will continue to monitor safety needs and report any issues to nurse or supervisor.*
- After 5/26 fall, facility care staff requested a standard wheelchair with cushion and foot pedals for ambulation and safety within the facility. The request read: *Despite therapy, the patient can no longer use cane or standard walker to ambulate. A wheelchair is a necessity to ensure patient safety.* The request was signed by facility care staff person, Mashion Smith-Zimmer.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.

ANALYSIS:	Resident A incurred four falls on 4/22, 4/27, 5/26, and 5/28, with the third fall resulting in a hip fracture. Resident A's service is noted to have been updated on 4/22, 4/23, 4/27, and 7/16 to address Resident A's increasing care needs. However, while dated and signed as being updated, Resident A's service plan was not appropriately updated to reflect appropriate care in relation to Resident A's multiple falls. Resident A became chair bound after the third fall on 5/26 resulting in a hip fracture. However, the last updated service plan on 7/16 did not address Resident A's fall history or that Resident A required a wheelchair and assist for ambulation and transfers after the third fall on 5/26. The 7/16 service plan listed Resident A as still being independent with ambulation using a walker and transfers, despite evidence of facility care staff requesting a wheelchair with cushion for ambulation to ensure Resident A's safety at the facility. It also noted Elara Hospice care staff requested a Hoyer lift with sling for ambulation and a shower chair for safety on 7/15 and it is not reflected in Resident A's service plan. Therefore, the facility is in violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend the status of this license remain unchanged.

Julie Viviano

12/22/2021

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Julie Viviano Date
Licensing Staff

Approved By:

Andrea L. Moore

01/13/2022

_____

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section