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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 4, 2022

Rachel Bartlett
Pioneer Golden Estates Inc
312 McGuirk Dr.
Clare, MI 48617

RE: License #: AL180392022
Investigation #: 2022A0577016
Pioneer Golden Estates Assisted Living

Dear Mrs. Bartlett:

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 (231) 922-5309.

Sincerely,

Bridget Vermeesch

Bridget Vermeesch, Licensing Consultant
Bureau of Community and Health Systems
1919 Parkland Drive
Mt. Pleasant, MI 48858-8010
(989) 948-0561

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL180392022
Investigation #:	2022A0577016
Complaint Receipt Date:	01/03/2022
Investigation Initiation Date:	01/03/2022
Report Due Date:	03/04/2022
Licensee Name:	Pioneer Golden Estates Inc
Licensee Address:	312 McGuirk Dr. Clare, MI 48617
Licensee Telephone #:	(989) 903-5405
Administrator:	Wendy McJames
Licensee Designee:	Rachel Bartlett
Name of Facility:	Pioneer Golden Estates Assisted Living
Facility Address:	312 McGuirk Dr. Clare, MI 48617
Facility Telephone #:	(989) 903-5405
Original Issuance Date:	08/07/2018
License **Status:**	REGULAR
Effective Date:	02/07/2021
Expiration Date:	02/06/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A fell on December 27, 2021, had a large pump on her head and bruising of the face and medical attention was not sought.	No
Additional Findings	Yes

III. METHODOLOGY

01/03/2022	Special Investigation Intake 2022A0577016
01/03/2022	Special Investigation Initiated – Letter- Review of Incident Report.
01/03/2022	APS Referral
01/03/2022	Contact - Document Sent to Wendy McJames, Administrator.
01/04/2022	Contact - Telephone call made- Interview with Complainant.
01/04/2022	Contact - Document Received- Documents and pictures from Complainant regarding Resident A's injuries.
01/18/2022	Contact - Document Sent- Email to Wendy McJames requesting documents.
01/20/2022	Contact - Document Received- Email from Wendy McJames with documents requested.
01/21/2022	Contact - Document Received from Wendy McJames, Documents received.
01/21/2022	Contact - Telephone call made- Interviewed Sabrina Ridenour, DCS.
01/24/2022	Inspection Completed On-site- Interview with staff and resident.
01/25/2022	Contact - Telephone call made- Interview with medical staff from Mid-Michigan Palliative Care.
01/25/2022	Contact - Telephone call made to Ashley Lindsay, DCS.
01/25/2022	Inspection Completed-BCAL Sub. Compliance

01/25/2022	Exit Conference with Rachel Bartlett, Licensee Designee.

ALLEGATION: Resident A fell on December 27, 2021, had a large pump on her head and bruising of the face and medical attention was not sought.

INVESTIGATION:

On January 03, 2022, a complaint was received reporting on Dec. 27, 2021, at 12:30am, Resident A had a fall resulting in massive swelling of her face and a knot on her head yet the facility did not seek medical attention for Resident A's injuries.

On January 03, 2022, additional information was received by the department reporting on December 31, 2021, an Adult Protective Service (APS) Referral was received and denied for investigation. The APS referral provided the following information: Resident A is 69 years old, resides in an assisted living center, and is diagnosed with onset of Dementia, neuropathy in legs, fall risk, history of a broken femur, history of a broken shoulder, and depression. Complainant reported to APS that Complainant received a call on December 30, 2021, letting Complainant know Resident A's phone was not working. Complainant went to the facility to see Resident A and found Resident A looking as if she had been in a "boxing match." Complainant reported to APS that Resident A had a big goose egg over her eye and face was black and blue. Complainant stated the facility threatened to evict Resident A. Complainant reported to APS that Complainant took Resident A to the hospital and they found Resident A had a broken arm from about a month ago. Complainant reported to APS, Resident A complained to staff about her arm hurting, but the facility doctors would not allow Resident A to be seen by another doctor.

On January 03, 2022, I received an email from Wendy McJames, Administrator reporting an incident that occurred with Resident A's family member. Ms. McJames reported Resident A experienced a fall over the holiday weekend and staff reported Complainant was notified about the fall. Ms. McJames reported Resident A did have a bruise on her face as a result of the fall but her vitals were normal at the time of the fall. Ms. McJames reported she spoke with Nurse Practitioner Angela Miller about seeing Resident A on the morning of December 27, 2021,explaining she had experienced a fall with bruising. Ms. McJames reported Resident A was seen by nurse practitioner Angela Miller and no new treatment or medication were recommended for Resident A after this fall.

On January 03, 2022, Wendy McJames, Administrator provided a copy of an *AFC Licensing Division-Incident/Accident Report* (IR) that was originally submitted to the department on December 28, 2021. The IR documented that on December 27, 2021, at 12:25am, Sabrina Ridenour, staff explained Resident A hit her call button and staff responded and found Resident A on the floor. Resident A stated she was on her way back to the bed from her bathroom and tripped. Staff observed Resident A's knees

being a little red and had two bumps on her head. In the 'Action Taken' section of the IR it documented that Ms. Ridenour "assessed [Resident A] for injuries, then helped resident off of floor. Vitals were taken (BP:140/90, pulse 72) resident was given pain relief medication and assisted back to bed." In the 'Corrective Measures' section of the IR, it documented staff made sure Resident A's call button was within easy reach and "asked resident to please hit her button when she has to use the restroom so we can assist her to and from. Physicians Diagnosis of injuries-Angela Miller, Nurse Practitioner was at the facility on December 27, 2021, at 8:00am to assess Resident A, no new orders were written."

On January 04, 2022, I interviewed Complainant who stated he received a call from the facility on December 30, 2021, letting Complainant know that Resident A was crying, wanting Complainant to be called and asking Complainant to visit. Complainant reported he went to the facility to visit Resident A and found Resident A with a huge goose egg on her head and both eyes were black and blue. Complainant reported Resident A explained how she fell on December 27, 2021, crawled back to bed to call for help because she was not wearing her emergency alert button. Complainant reported he took Resident A to the hospital on December 30, 2021, because of the injuries Resident A sustained during her fall.

On January 21, 2022, I interviewed direct care staff, Sabrina Ridenour who reported she was working alone on December 27, 2021, when Resident A fell. Ms. Ridenour reported Resident A's alert alarm went off but when Ms. Ridenour entered Resident A's room Ms. Ridenour found Resident A on the floor trying to get up by using her walker. Ms. Ridenour reported Resident A had two small bumps on her head, but no bruising on her face. Ms. Ridenour reported she asked Resident A to rate her pain, from 1-10 and Resident A stated it was a 5 or 6. Ms. Ridenour reported she completed vitals on Resident A and Resident A's vitals were within normal range. Ms. Ridenour reported she asked Resident A if she wanted to go to the hospital but Resident A reported she did not want to go to the hospital. Ms. Ridenour reported she determined the injuries Resident A sustained in the fall did not require hospital treatment. Ms. Ridenour reported Resident A falls often, usually falls on her knees and always has bruised knees.

On January 24, 2022, I completed an unannounced onsite investigation and interviewed Resident A who reported she falls a lot and on December 27, 2021, she believed she tripped over the wheel of her walker and hit her head/face on the walker. Resident A reported she used her call button and DCS Sabrina Ridenour came to assist Resident A off of the floor. Resident A reported Ms. Ridenour took Resident A's vitals, asked if she was in pain and let Resident A know she had a small bump on her head. Resident A reported DCS Sabrina Ridenour asked Resident A if she wanted to go to the hospital and Resident A stated she refused. Resident A reported she did not realize how bad the bump was or how bruised her face was until a few days later when she looked in the mirror and called her son to come and take her to the hospital. Resident A reported she did not have any pain or headache at the time of the fall. Resident A reported she was

not sure if someone from her doctor's office came to check on her during the later morning of December 27, 2021.

On January 24, 2022, I interviewed Vickie Stimmel, Health and Wellness Director who reported she was not working on December 27, 2021, at the time of Resident A's fall. Ms. Stimmel stated she interviewed Angela Miller, Nurse Practitioner (NP) with Mid-Michigan Palliative Care and Ms. Miller reported she does not remember being asked to see Resident A but "has a feeling she did see [Resident A] and [Resident A] refused to be seen." Ms. Stimmel reported the facility keeps physician contacts or progress notes and for December 27, 2021, there are no notes regarding any resident, specifically Resident A being seen by Angela Miller, NP.

On January 25, 2022, I interviewed Angela Miller and Renee Dougherty, Nurse Practitioners with Mid-Michigan Palliative Care. Ms. Dougherty reported she is Resident A's primary nurse practitioner, but on December 27, 2021, Angela Miller, NP was making rounds at the facility. Ms. Miller reported December 27, 2021, reported she was at the facility and remembers talking with administrator Wendy McJames but does not remember the conversation nor does Ms. Miller remember checking in on Resident A.

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:	Based on the information gathered during the investigation, it has been found on December 27, 2021, Resident A fell and hit her face. She was immediately assisted and evaluated by direct care staff member Sabrina Ridenour who checked Resident A for injuries and took her vitals. Ms. Ridenour noted the "bumps" on Resident A's forehead but did not note any bruising at the time of the fall. Ms. Ridenour also took Resident A's vitals which were normal. Resident A was also asked if she wanted to be evaluated further at the hospital but she refused this treatment at the time of the fall. It is not clear if Resident A was evaluated by the hospice nurse at the facility on December 27, 2021, but she was evaluated and provided minimal first aid by direct care staff member Sabrina Ridenour.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On January 04, 2022, while interviewing Complainant, Complainant reported Resident A told him it took about an hour for staff to respond to the call light because there was only one direct care staff member working to cover two licensed AFC buildings. Complainant reported there are three licenses for the building, one for a memory care unit, one for an independent living unit, and assisted living unit. Complainant reported the facility only schedules one staff at night for the assisted living and independent living units because they are connected by hallways.

On January 21, 2022, I interviewed direct care staff member Sabrina Ridenour who reported she was the only direct care staff member working on December 27, 2021, covering two licensed AFC facilities referred to as the assisted living and independent living units. Ms. Ridenour reported there was another direct care staff member working on the memory care unit on December 27, 2021. Ms. Ridenour reported there is usually only two direct care staff members scheduled to cover the three licensed AFC facilities during third shift.

On January 24, 2022, during my unannounced onsite investigation, I reviewed the staff schedules for December 19, 2021-January 09, 2022, and per the night shift staff schedule from 10:00pm-6:00am, there were only two direct care staff members scheduled for all three licensed AFC buildings for a majority of the night shifts.

On January 24, 2022, I interviewed Vicky Stimmel, Health and Wellness Director who reported she thought per the rule only one direct care staff was required during the night shift given that the assisted living and independent living AFC facilities are connected by hallways.

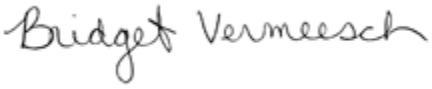
I completed an exit conference with licensee designee Rachel Bartlett on January 25, 2022, who reported being unaware that one direct care staff member was regularly scheduled to work in two separately licensed AFCs during the nighttime shift. Ms. Bartlett stated she would assure appropriate staffing levels would be scheduled at all three buildings immediately.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours.

ANALYSIS:	Based on the information gathered during the investigation it has been found the facility does not have adequate staffing at the facility during third shift to carry out the responsibilities and meet the needs of the residents. Given that one direct care staff member was scheduled to work in two separate licensed AFCs, residents were left unattended while that staff member was working in the other licensed AFC.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



01/25/2022

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Bridget Vermeesch Date
Licensing Consultant

Approved By:

02/04/2022

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Dawn N. Timm Date
Area Manager