GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 5, 2022

Lauren Gowman
Linden Square Assisted Living
650 Woodland Drive East
Saline, MI 48176

RE: License #: AH810334704
Investigation #: 2022A0784039
Linden Square Assisted Living

Dear Ms. Gowman:

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. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH810334704
Investigation #:	2022A0784039
Complaint Receipt Date:	03/28/2022
Investigation Initiation Date:	03/28/2022
Report Due Date:	05/27/2022
Licensee Name:	Linden Square Assisted Living, LLC
Licensee Address:	950 Taylor Avenue Grand Haven, MI 49417
Licensee Telephone #:	(616) 846-4700
Administrator:	Jessica Richardson
Authorized Representative:	Lauren Gowman
Name of Facility:	Linden Square Assisted Living
Facility Address:	650 Woodland Drive East Saline, MI 48176
Facility Telephone #:	(734) 429-7600
Original Issuance Date:	06/21/2013
License Status:	REGULAR
Effective Date:	01/10/2022
Expiration Date:	01/09/2023
Capacity:	187
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Inadequate care and protection for Resident A	Yes
Additional Findings	Yes

III. METHODOLOGY

03/28/2022	Special Investigation Intake 2022A0784039
03/28/2022	Special Investigation Initiated - Telephone contact attempted with complainant. Message left requesting a return call.
03/28/2022	Contact - Telephone call received Interview with complainant
03/28/2022	Contact - Telephone call made Attempted with Resident A's Guardian. Message left requesting a return call
03/28/2022	Contact - Telephone call made Interview with Hospice Nurse with Supervisor present.
03/29/2022	Inspection Completed On-site
04/13/2022	Contact - Telephone call made Interview with administrator Jessica Richardson
04/13/2022	Contact - Document Received Email from Ms. Richardson
05/05/2022	Exit Conference – Telephone Conducted with authorized representative Lauren Gowman

ALLEGATION:

Inadequate care and protection for Resident A

INVESTIGATION:

On 3/28/2022, the department received this online complaint.

According to the complaint, on 3/24/2022, Resident A was reportedly “Thrown to the ground” by another resident. Resident A was placed in bed after the altercation and provided a pressure sensitive mat to alert staff if she moved out of bed. Later in the evening on 3/24/2022, Resident A was found on her floor. On the morning of 3/25/2022, Resident A was found “walking in the hallway” when she was supposed to be in her bed. Resident A was discovered to have sustained a “non-displaced fracture L [left] femoral neck” from being pushed to the ground. The altercation on 3/24/2022 and subsequent discovery of Resident A on the floor were reported to supervision until Resident A’s hospice nurse reported it on 3/25/2022. On the morning of 3/25/2022, Resident A was unable to physically attend breakfast in the dining room because of the injuries sustained in the altercation and was not brought any breakfast or liquids.

On 3/28/2022, I interviewed Complainant by telephone. Complainant stated the altercation was reported as having happened at approximately 9:30am on 3/24/2022 during or around the time of breakfast. Complainant stated Resident A’s injuries were confirmed by mobile x-ray taken later in the afternoon on 3/24/2022. Complainant stated Resident A was reportedly discovered on the ground at the same time staff showed up from the mobile x-ray service to perform her x-ray. Complainant stated the facility has worked with Resident A’s hospice nurse on a plan of protection and supervision but is unsure if the facility is adhering to the plan. Complainant stated that the facility has reported confidence that they are able to adequately supervise Resident A. Complainant stated Resident A was living in the memory care (MC) of the facility and is now in the assisted living (AL) since her injury. Complainant stated Resident A was moved to a room across from the nurse's station for more consistent supervision. Complainant stated she is unsure of the nature or history of behaviors of the resident who reportedly pushed Resident A down. Complainant stated she is her feelings that an incident like this should not have happened and the facility lacked proper supervision.

On 3/28/2022, I interviewed Resident A’s hospice nurse by telephone. The hospice nurse's supervisor, the hospice administrator, was present by three-way call during the interview. The hospice nurse provided statements consistent with those provided by Complainant. The hospice nurse stated that on the morning of 3/24/2022, between approximately 9:45am and 10:30am, facility staff contacted her to notify her that Resident A had just finished her breakfast when another Resident pulled her out of her chair onto the ground. The hospice nurse stated Resident A reportedly voiced pain when staff attempted to transfer her and so it was determined that emergency

medical services (EMS) would be contacted to come help transfer Resident A to her bed until the hospice nurse could get to the facility to conduct and assessment of her condition. The hospice nurse stated that after her assessment, she spoke with Resident A's guardian and that it was determined a mobile x-ray would be ordered for Resident A. The hospice nurse confirmed Resident A was discovered to have a non-displaced fracture L [left] femoral neck after the x-ray was taken on the evening 3/24/2022. The hospice nurse confirmed Resident A had reportedly been discovered on her floor at the time she was to receive her x-ray. The hospice nurse stated staff had been instructed to ensure Resident A stayed bed bound until further determination could be made regarding her possible injuries. The hospice nurse state that she visited Resident A on 3/25/2022 and also met with staff to discuss updates to Resident A's service plan regarding her need for additional supervision and assistance. The hospice nurse stated she was informed later in the day on 3/25/2022 that on the morning of 3/25/2022 Resident A had been found walking around the facility. The hospice nurse stated that on the morning of 3/28/2022 she was a part of a meeting with the facility, Resident A's guardian and family of Resident A to discuss Resident A's service plan and the additional measures being put in place for her safety. The hospice nurse stated Resident A was moved from the MC to the AL to a room in a high staff traffic area for greater supervision. The hospice nurse stated the additional measures put in place are that she now has a Brody chair which staff are to transfer her into to ensure she does get some movement and is not always bed bound, she has two additional alarms, a mat and pull cord alarm, she is to be checked on by staff every fifteen minutes and her medications are going to be adjusted to help manage her anxiety. The hospice nurse stated she feels Resident A's service plan is adequate for her supervision and that facility staff have been instructed on the details of Resident A's updated needs. The hospice nurse stated she is not familiar with the Resident who pulled Resident A from her chair to the floor and is unsure if the circumstances were foreseeable or not.

On 3/29/2022, I interviewed administrator Jessica Richardson at the facility. Ms. Richardson stated that on the morning of 3/24/2022, Resident A was just finishing breakfast, still sitting in her chair in the dining room, when Resident B walked up to her and abruptly pulled her out of her chair unto the ground. Ms. Richardson stated Resident B had not acted with such behavior prior to this incident and would not have been suspected of doing something like that. Ms. Richardson stated Resident B had been known to be a person with anxiety but had not displayed her anxiety in aggressive or harmful ways to other residents. Ms. Richardson stated that due to the newly displayed behaviors of Resident B being unpredictable and potentially harmful to other residents, the facility has issued a discharge notice for Resident B. Ms. Richardson provided statements consistent with those of Complainant and the hospice nurse regarding Resident A's updated service plan and subsequent move to AL. Ms. Richardson stated she was not aware of all the details regarding events after Resident A's incident and the following day and referred to facility charting notes for the remainder of the interview. Statements provided by Ms. Richardson, in reference to the charting notes, were consistent with those provided by the hospice

nurse as it pertains to events after the incident. Ms. Richardson stated clinical director Alisha Jones was working on the morning of 3/24/2022 and would be more familiar with the events as they unfolded. Ms. Richardson confirmed the facility did have a care planning meeting on the morning of 3/28/2022 with the hospice nurse and family to discuss the details of Resident A's updated service plan.

On 3/29/2022, I interviewed Alisha Jones at the facility. Ms. Jones referenced facility charting notes during the interview as she stated she was not immediately present for all the circumstances surrounding the incident or events and actions following the incident. Ms. Jones confirmed she was working on the morning of 3/34/2022. Ms. Jones stated she was summons by staff in the MC after the incident with Resident A and Resident B. Ms. Jones stated that emergency medical services (EMS) were called for a "lift assisted" with Resident A. Ms. Jones stated a lift assist is usually requested in a situation where staff are uncomfortable with transferring a resident related to the condition of the resident. Ms. Jones stated that the lift assist was request due to Resident A reporting significant pain when staff initially attempted to position her for a transfer. Ms. Jones stated Resident A's hospice nurse had already been contacted, prior to calling EMS, and was already in route to the facility. Ms. Jones stated that after the hospice nurse arrived at the facility, she evaluated Resident A's condition. Ms. Jones stated the hospice nurse ordered a "stat" mobile x-ray to be conducted on Resident A and gave instructions that Resident A was to stay in bed. Ms. Jones stated the mobile x-ray service arrived at the facility sometime in the late afternoon, early evening of 3/24/2022 and that the results were received at approximately 11pm on 3/24/2022. Ms. Jones stated that at that time the x-ray technician arrived, Resident A was observed on a mat which had been placed next to her bed as a part of her safety plan. Ms. Jones stated it is unknown if Resident A fell or laid there as it did not appear she had any new injuries. Ms. Jones stated Resident A was observed by staff, on the morning of 3/25/2022 at approximately 7am, walking in the hall of the facility. Ms. Jones stated Resident A is currently not mobile and has a comprehensive service plan for her safety. Ms. Jones stated that based on her experience and observations of Resident B, she would not have expected Resident B to act out aggressively toward a resident in such a manner. Ms. Jones stated Resident B is a person with anxiety but did not previously express it in aggressive ways.

On 3/29/2022, I observed Resident A to be well groomed and sleeping peacefully in her bed.

On 3/29/2022, I spoke with Resident B at the facility. Resident B appeared very jovial and was talkative, however I was unable to formally interview her as she appeared to be oriented only to self.

Review of the facility licensing file revealed a timely incident report was submitted by the facility regarding the incident with Resident A on the morning of 3/24/22. The report read consistently with statements provided by Ms. Richardson, Ms. Jones and the hospice nurse.

I reviewed *Observations For [Resident A]*, provided by Ms. Richardson, which she explained are entered by staff to ensure notation of important ongoing updates and information regarding residents. Notes entered on 3/24/2022 at 9:15am by Associate A1 read “Per Careline Hospice, it was requested that the resident has assistance with feeding at mealtimes. The writer added 1 person assistance with meals to resident’s service plan”. Notes entered on 3/24/2022 at 6:30pm by Associate A1 read “the writer was called to the courtyard for a “code white” by Medtech [Associate A2]. Upon the writer’s arrival, the resident was observed laying on her fall mat, on her back, with the x-ray technician taking scans of the resident’s left leg. The resident was wearing a shirt, a dry brief, and no footwear. The surrounding area was dry and free of any trip hazards. The RSC [Resident Services Coordinator] was then notified at 5:31pm. It was reported to the writer by Medtech [Associate A2] that the resident was found lying in the exact position on the floor by the x-ray technician. After the technician was finished x-raying the resident the writer began to assess the resident. The writer found no recent bruising on the resident and nothing to suggest that the resident hit her head. Range of motion was not performed because the resident was still expressing pain from her left leg due to the previous incident she had earlier in the day. The writer and RSA [Resident Services Associate] [Associate A3] then fed the resident dinner in bed, and the writer contacted Careline Hospice at 5:40pm. The Case Manager was contacted at 5:44pm, a message and a call back number were left. Per hospice to prevent further incidents, the resident should be visually checked on by staff every 15-30 minutes”. Notes entered on 3/24/2022 at 11:00pm by Associate A4 read “[Careline Associate A1] returned a call regarding x-ray. Res [Resident] has both hips fractured and at this time family opted not to do surgery. A message was sent to RSC regarding this information. Supervisor also spoke to the MT [Med Tech] on duty and she sated res is comfortable at this time”. Notes entered on 3/25/2022 at 2:45pm by Associate A5 read “post/fall/behavior she has not had a fall today on the morning shift she has been in bed all day today I was told she was up walking around 7 am other than that she been in bed”. Notes entered on 3/25/2022 at 7:45pm by Associate A6 read “The resident was visited and assed [assessed] by [Hospice Nurse] at approximately 6:50pm. After the assessment the nurse stated that the resident did not appear to e in any pain while laying down but was showing physical signs of pain and verbalizing pain when 2 staff members assisted her to stand her up and that the pain was coming from the left hip joint. The nurse stated that the resident should not be allowed to ambulate even with assistance at this time but did recommend that the resident cold be transferred from bed to Broda chair by the staff while pivoting only the right leg. The nurse also stated no new medication changes will occur at this time, but that the resident may continue to receive the PRN Haldol throughout the night if anxiousness/restlessness is observed by staff. The hospice nurse also stated that the staff should not be utilizing the hoer for any transfers with the resident at this time as it runs the risk of causing further injury to the resident’s left hip”. Notes entered on 3/25/2022 at 11:30pm by Associate A6 read “The resident has been displaying anxiety and agitation despite prn medications during the 6-11pm portion of 2nd shift as evidenced by repeatedly attempting to swing her legs out of bed and

saying she is being picked up for a car ride and trying to get up over and over again. Staff has been staying with the resident near 1 on 1 supervision to keep the resident safe".

I reviewed Resident A's x-ray results, provided by Ms. Richardson, which read consistently with statements provided within interviews and observations notes regarding Resident A's injuries obtained during the incident on 3/24/2022.

On 4/13/2022, I interviewed Ms. Richardson by telephone to clarify information regarding whether Resident A was provided breakfast on the morning of 3/25/2022, during which time she was supposed to be bedbound. Ms. Richardson stated she did not have any specific knowledge of the circumstances relative to that morning and would need to review notes relative to that morning.

On 4/13/2022, I received an email from Ms. Richardson which read, in part, "I have reviewed charting for breakfast on March 25th for Nancy, she did not have breakfast. There is no observation note with information in regard to breakfast. It is charted that she did have lunch and dinner on that day".

I reviewed Resident A's service plan, provided by Ms. Richardson. The plan read consistently with statements provided by the hospice nurse, Ms. Richardson and Ms. Jones regarding the implemented updates for Resident A's safety plan and need for assistance with eating. Under a section titled *Eating – 1 Person Full Assistance*, with an implementation date of 3/24/2022, the plan read "Instructions: I need assistance of one person to provide assistance with eating". Under a section titled *Visual Checks*, with an implementation date of 3/27/2022, the plan read "Instructions: Please check on me every 15-30 minutes around the clock to see if I need anything and assure that I am safe".

I reviewed Resident A's TASK ADMINISTRATION RECORD for March 2022, provided by Ms. Richardson, which she explained is the form used by staff to note that they have completed individual tasks required for resident care. The record provided sections corresponding to the service plan. each section of the record provides a box associated with the date and day of the task provided. When staff provide the task associated service, staff are instructed to note the completed task in the facilities computer system with generates their initials in the corresponding date/day box. Under a corresponding section titled *Visual Checks*, with directions which read "Please check on me every 15-30 minutes around the clock to see if I need anything and assure that I am safe*",* the record indicated that staff did not increase visual checks for Resident A until 3/28/22 with prior dates on the record indicating checks were completed by staff every two hours in March 2022 up until 3/28/2022. Under a corresponding section titled *EATING – 1 PERSON FULL ASSISTANCE*, with directions that read "I need assistance of one person to provide assistance with eating", date/day boxes associated with several meals were blank including 3/25/2022 for breakfast, 3/26/2022 for breakfast lunch and dinner,

3/27/2022 for breakfast and lunch and 3/29/2022, 3/30/2022 and 3/31/2022 for breakfast lunch and dinner.

I reviewed an additional internal incident report for Resident B provided by Ms. Richardson. Under a section titled *Briefly Describe What Occurred*, the report, dated 3/07/2022 with a time of 1:25pm and entered by Associate A7, read “on 3/7/2022 the writer was called to the Courtyard at 11:15am, the Med-Tech [Associate A8] said that she was letting a visitor into the Courtyard, the resident followed behind her. When [Associate A8] went to let the door close she felt it hit the back of her leg from being pushed back open by the resident. [Associate A8] turned around and saw that it was the resident. The resident had shoved the door open when [Associate A8] went to grab the side of the door to try to keep the resident from coming out the door, the resident grabbed the bar on the door, and shut her hand in the door. The resident had been agitated for about an hour prior to the incident. Going in and out of other resident rooms. Threatening to hit other residents. The writer sat down on the couch next to the resident to try to calm her down, the resident stated, “Get your fat ass off the couch, I will kill when it comes to my mother, father and my sister”. The resident’s POA was notified at 12:50pm, the residents PCP [physician] was notified at 1:05pm and the RSC was notified at 11:45am”.

I reviewed Resident B’s face sheet which includes basic information relevant to the resident. Under a section titled Diagnoses, the face sheet indicated several diagnoses including “Unspecified dementia with behavioral disturbance, Generalized anxiety disorder, Other specified anxiety disorders, adjustment disorder with mixed anxiety, depressed mood” and “Alzheimer’s disease with late onset”.

I reviewed Resident B’s service plan, provided by Ms. Richardson. Under a section titled *Behaviors*, with an implementation date of 1/24/2022, the plan read “Instructions: Intervene as follows to address the inappropriate behaviors”. Under a section titled *Behaviors-Emerald* [level of care], with an implementation date of 2/10/2022, the plan read “Instructions: as an emerald I may lose my personal timeline or past places and events. I may think I am a small child or start looking for my parents. Pleas correct my mistakes gently and discreetly. Spend time chatting with me before you begin assisting me with care. Please present one step at a time when completing task/care. I enjoy humor”.

I reviewed *Observations For [Resident B]* for March 2022 provided by Ms. Richardson. Notes entered on 3/04/2022 at 2:45pm by Associate A9 read “BEHAVIORAL CHARTING: The resident refused to take her morning medication this morning x3. She became agitated with the writer and tried to throw the medication in the trash”. Notes entered on 3/04/2022 at 8:30pm by Associate A10 read “BEHAVIOR CHARTING: resident refused to take medication. The writer tried x3. The resident has been anxious all evening”. Notes entered on 3/5/2022 at 2:30pm by RCA read “Resident exhibiting signs of increased anxiety since after breakfast this morning AEB [as evidenced by] pacing, clenching fists, heavy breathing, increased pacing. Writer attempted 1:1 conversation. All unsuccessful at

this time. Writer called and spoke with daughter who asked that staff make tea for resident, and she would come in to see mom. Writer made tea for resident per daughter's instructions. Resident is currently sitting in the kitchenette drinking tea. Daughter stated she will be here by 3:30". Notes dated 3/07/2022 at 12:15pm by Associate A11 read "Late entry for 3/6/22- Resident started pacing the unit around 12:45pm. She was packing up her entire room and moving all of her belongings into the hallway. Resident was asking the staff to help her carry things to her car and to get her sheets folded and put them by the door. The staff explained to thee resident that her car was not here at the moment but that the staff would not take all of her things out and put them by the main exit door. The staff tried to give the resident her space due to her being very agitated at this time. She was breathing heavily and rapidly and pointing her fingers in the staffs face and into other residents faces. She was also going into other resident rooms on the unit and trying to remove others belongings from their rooms. The staff was not successful in redirecting the resident after multiple attempts. Another resident's family was here visiting, and she was getting aggressive with [other residents] family that was visiting. The resident was running up on the family members and the resident, pointing her fingers in the family's face and trying to enter [the other residents] room as well. Writer stepped into the doorway and tried to calmly explain to the resident that she could not go in there at this time and resident would run off and come back a few minutes later and try to enter the room again. The residents daughter was called due to the behaviors, and she came to the facility a while later. The resident continued to be agitated even after her daughter arrived. The resident was still breathing heavily and rapidly all through the afternoon and evening. When the residents daughter left around 6:20pm, the resident stayed in her room for around 20 minutes and then came out displaying aggressive behaviors again. The resident was demanding that the staff find her son and tell him to get back and come get her. The resident was also going into other residents and telling them to "get the hell out of this room". The staff tried to calm the resident down and let her know that her son was at home safe with his wife and his kids. The resident continued to pace the unit and pound on other resident doors while they were trying to sleep. Staff called for the supervisor at this time. The supervisor came over and tried to calmly redirect the resident as well, but the resident was upset with that. Eventually, the resident did go to her room and stay there for the evening". Notes entered on 3/07/2022 at 4:30pm by Associate 7 were consistent with the previously referred to with the internal incident report for Resident B. Notes entered on 3/09/2022 at 1:45pm by Associate A11 read, in part, "the resident is showing signs of anxiety as well as heavy/labored breathing and frantically looking for a way out of the unit". Notes entered on 3/09/2022 at 11:30pm by Associate A11 read, in part, "Resident was pacing the unit this afternoon before dinner showing signs of anxiety such as heavy/rapid breathing and exit seeking". Notes entered on 3/13/2022 at 2:45pm by Associate A5 read, in part, "right after lunch [Resident B] became very upset and started to pack her room up me and [Associate A12] put her room back together that's when she [Resident A] started to attack us both hitting and putting her hand in are [our] faces pulling on the door trying to get out yelling trying to take are [our] keys from us we stop talking to her and locked her room door until she calms down that did not work". Notes entered on

3/13/2022 at 8:15pm by Associate A13 read, in part, Resident has been showing high signs of anxiety and agitation throughout the shift". Notes entered on 3/14/2022 at 11:30pm by Associate A11 read, in part, "Resident pacing the unit this afternoon, exit seeking, breathing heavily, and asking where her daughter was at". Notes entered on 3/18/2022 at 6:15am by Associate A13 read, in part, "The Resident was anxious and agitated from 11pm until she was able to fall asleep around 1:30am".

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: **(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: R 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:	The complaint alleged the facility did not provide adequate supervision leading to an incident in which Resident A was harmed after being pulled to the ground by Resident B and subsequently was found on her floor once and observed walking in the facility once. The complaint also alleged Resident A was not provided adequate care in that she was not provided meals as required due to her condition after the incident with Resident B. The investigation revealed Resident A sustained a fracture in her left hip and femur after being abruptly pulled to the ground by Resident B on the morning of 3/24/2022 and confirmed she was subsequently discovered on the mat next to her bed on the evening of 3/24/2022 and also observed walking in the facility on the morning of 3/25/2022. Statements provided by the hospice nurse and recorded in the facilities observation notes indicated the facility was aware Resident A was supposed to be bed bound after the incident and have increased supervision, however, increased supervision was not implemented until 3/28/2022. Ms. Richardson and Ms. Jones reported that prior to the incident Resident B had not expressed her known anxiety in aggressive ways towards staff or residents, however review of notes for Resident B indicated Resident B had increased anxiety and displayed physical and verbal aggression on several occasions in the weeks leading up to the incident. Additionally, reporting by Ms. Richardson indicated Resident A was not provided breakfast on 3/25/2022 which was supported by facility documentation which also indicated several other meals were not noted as having been provided to Resident A. Based on the findings, the allegations are substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Notes entered on 3/13/2022 at 2:45pm by Associate A5 read, in part, “right after lunch [Resident B] became very upset and started to pack her room up me and [Associate A12] put her room back together that’s when she [Resident A] started to attack us both hitting and putting her hand in are [our] faces pulling on the door trying to get out yelling trying to take are [our] keys from us we stop talking to her and locked her room door until she calms down that did not work”

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include: **(l) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician or physician's assistant. In case of a chemical restraint, a physician shall be consulted within 24 hours after the commencement of the chemical restraint.**
ANALYSIS:	Review of observational notes for Resident B revealed that on 3/13/2022, staff locked Resident B in her room. Based on the findings the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

I reviewed Resident B's service plan, provided by Ms. Richardson. Under a section titled *Behaviors*, with an implementation date of 1/24/2022, the plan read "Instructions: Intervene as follows to address the inappropriate behaviors". Under a section titled *Behaviors-Emerald* [level of care], with an implementation date of 2/10/2022, the plan read "Instructions: as an emerald I may lose my personal timeline or past places and events. I may think I am a small child or start looking for my parents. Pleas correct my mistakes gently and discreetly. Spend time chatting with me before you begin assisting me with care. Please present one step at a time when completing task/care. I enjoy humor".

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.
For Reference: R 325.1901	**Definitions**
	(21) "Service plan" means a written statement prepared by the home in cooperation with a resident and/or the resident's authorized representative or agency responsible for a resident's placement, if any, and that identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical, social, and behavioral needs and well-being and the methods of providing the care and services while taking into account the preferences and competency of the resident.
ANALYSIS:	Review of internal incident reporting and observational notes for Resident B revealed Resident B displayed increasing behaviors, including verbal and physical aggression toward staff and residents, on several occasions over the course of at least three weeks leading up the incident on 3/24/22. While review of facility charting notes indicated consistent communication with Resident B's authorized representative regarding her behaviors, review of Resident B's service plan revealed the plan lacked sufficient updates regarding these increased behaviors or additional measures to mitigate potential harm to herself or other residents in the facility. Based on the findings, the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Aaron L Clum 4/14/2022

Aaron Clum Date
Licensing Staff

Approved By:

Andrea L Moore 05/02/2022

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