GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 18, 2022

Janet Antin
Jewish Apartments & Services
15100 W. Ten Mile Rd.
Oak Park, MI 48237

RE: License #: AL630276749
Investigation #: 2022A0605029
Jewish Apt. & Ser. Coville III

Dear Ms. Antin:

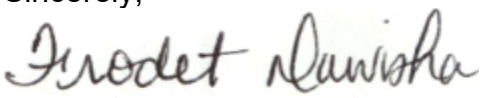
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630276749
Investigation #:	2022A0605029
Complaint Receipt Date:	03/25/2022
Investigation Initiation Date:	03/28/2022
Report Due Date:	05/24/2022
Licensee Name:	Jewish Apartments & Services
Licensee Address:	15100 W. Ten Mile Rd. Oak Park, MI 48237
Licensee Telephone #:	(248) 967-4240
Administrator/Licensee Designee:	Janet Antin
Name of Facility:	Jewish Apt. & Ser. Coville III
Facility Address:	15100 W. Ten Mile Road Oak Park, MI 48237
Facility Telephone #:	(248) 967-4240
Original Issuance Date:	11/10/2005
License Status:	REGULAR
Effective Date:	01/19/2021
Expiration Date:	01/18/2023
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A fell resulting in a fractured right hip. Direct care staff (DCS) at Coville III did not know Resident A had fallen.	Yes

III. METHODOLOGY

03/25/2022	Special Investigation Intake 2022A0605029
03/28/2022	Special Investigation Initiated - Letter I emailed Adult Protective Services (APS) worker Tameia Kelly.
03/28/2022	APS Referral APS made referral.
03/29/2022	Inspection Completed On-site I conducted an unannounced on-site investigation. I interviewed direct care staff (DCS) Jannina Abraham, Patricia Williams and Carmen Leonard. I also interviewed Resident B, Resident D, and Resident C regarding the allegations. I spoke with the licensee designee Janet Antin via telephone.
03/29/2022	Contact - Telephone call made I interviewed APS Tameia Kelly and Relative A regarding the allegations.
05/05/2022	Contact - Telephone call made Message left for registered nurse (RN) Fran Carlisi-Cordle.
05/05/2022	Contact - Telephone call made I interviewed DCS Serita Hartley who is employed by Irving Professional Staffing Agency regarding the allegations. I left message for ATC Agency to speak with their licensed practical nurse (LPN) Verlillian.
05/05/2022	Contact - Document Sent I emailed licensee designee Janet Antin requesting Resident A's assessment plan.

05/05/2022	Contact - Document Received RN Fran Carlisi-Cordle emailed Resident A's care plan, but not the assessment plan completed annually. I emailed the RN back requesting Resident A's assessment plan.
05/09/2022	Contact - Telephone call received I interviewed the RN regarding the allegations.
05/10/2022	Contact - Telephone call made I interviewed the midnight RN with ATC Health Care Verlillian Dauherty regarding the allegations.
05/10/2022	Contact - Document Received RN emailed me Resident A's assessment plan.
05/13/2022	Contact - Document Received RN emailed Coville III fall policy.
05/17/2022	Exit Conference Discussed findings with licensee designee Janet Antin.

ALLEGATION:

Resident A fell resulting in a fractured right hip. Direct care staff (DCS) at Coville III did not know Resident A had fallen.

INVESTIGATION:

On 03/25/2022, intake #186075 was referred by Adult Protective Services (APS) regarding Resident A had a right hip fracture and staff at Coville III did not know how Resident A sustained the injury.

On 03/29/2022, I conducted an unannounced on-site investigation. Initially staff was very reluctant to speak with me or allow me to speak with residents until the licensee designee Janet Antin was contacted. I spoke with Ms. Antin, identifying myself and advising her of the complaint. Ms. Antin stated Resident A had an unwitnessed fall that staff were unaware of as the midnight shift staff found Resident A on the floor near Resident A’s bedroom door. Resident A was not on the floor for more than five minutes when the midnight staff found Resident A on the floor and picked Resident A up from the floor and placed Resident A on the bed. The next morning Resident A was still complaining of leg pain, so Resident A was taken to the hospital. Later, it was determined by the hospital that Resident A had a fractured right hip. Ms. Antin then reviewed the video camera surveillance and learned that Resident A had an unwitnessed fall. Ms. Antin contacted staff and advised staff to permit me to conduct my investigation. There are a total of eight residents at this facility. I interviewed direct care

staff (DCS) Jannina Abraham, Patricia Williams, and medication technician Carmen Leonard. I also interviewed Resident B, Resident D, and Resident C regarding the allegations.

I interviewed DCS Jannina Abraham who has been with this corporation for six months. Ms. Abraham stated she works all shifts and heard that Resident A fell and was hospitalized. Ms. Abraham stated she does not know what happened as she was not working the midnight shift on 03/23/2022. Ms. Abraham stated that there are two DCS per shift, a medication passer, and a caregiver. She stated she is unable to provide me with any other details.

I interviewed DCS Patricia Williams who has been with this corporation for eight years. Ms. Williams works the morning shifts; therefore, she too was not present on 03/23/2022. Ms. Williams stated she does not know how Resident A fell, but that Resident A fell and had to be hospitalized. Ms. Williams stated when she arrived on 03/24/2022, she did not see any notes in the staff communication log regarding Resident A's fall nor did she see an incident report (IR) regarding the fall. Ms. Williams stated staff are to review the log at the beginning of their shifts to see if there is anything staff must know about the residents. I requested to review the communication log, but Ms. Williams stated she is unable to locate it.

I interviewed the medication technician Carmen Leonard who has been working for this corporation for seven months. Ms. Leonard works the morning shift. She stated that Resident A fell on 03/23/2022 during the midnight shift. Ms. Leonard arrived the next day, 03/24/2022 at 7AM. As she was doing her rounds, visiting each residents' rooms, she went into Resident A's room to check on her. Resident A was complaining of her leg hurting. Ms. Leonard asked Resident A, "What happened?" Resident A stated, "I fell." Ms. Leonard contacted RN Fran Carlisi-Cordle who arrived at Resident A's bedroom and began assessing Resident A. Resident A continued to complain of leg pain; therefore, Resident A was transported to the hospital. Ms. Leonard stated when she looked at Resident A's leg, it looked normal, no bruising, but that Resident A was having difficulty walking. Ms. Leonard stated later that day, she learned that Resident A's femur was fractured.

I interviewed Resident B who was lying in bed in his bedroom. Resident B did not say much other than he likes it here and has never fallen nor has he witnessed anyone else fall.

I interviewed Resident C who has been residing here for seven years. Resident C stated she has not fallen, nor has she witnessed anyone fall. Resident C stated the staff is "attentive to her needs," and when she calls for staff, staff come to her to assist. She stated, "I'm very pleased." Resident C stated she knows Resident A but did not know that Resident A fell. She has never seen Resident A fall. Resident C then stated, "If I'm not happy here, I would be out of here."

I interviewed Resident D who stated that “it’s fine here,” and that “staff is ok.” Resident D stated that Resident A is her “meal partner.” She stated she does not know how Resident A fell, but prior to the fall, the staff brought Resident A in a wheelchair instead of Resident A using her walker to ambulate. Resident D stated she never saw Resident A in a wheelchair and did not ask Resident A nor staff why Resident A was in a wheelchair.

On 03/29/2022, I reviewed an incident report (IR) dated 03/24/2022 at 1:40AM which indicated that Resident A reported she had fallen, but there were no reports received from staff that Resident A was found on the floor. Resident A was sent to Beaumont Hospital the next day at 2PM. Resident A sustained a fractured right hip. Additional information was documented stating that the Director of Nursing, registered nurse (RN) Fran Carlisi-Cordle conducted their own investigation and contacted Irving Professional Staffing Agency who confirmed from DCS Serita Hartley that Resident A had fallen, and the RN was informed that Ms. Hartley informed the on-call nurse that Resident A was found on the floor. The RN spoke with the on-call nurse, Verlillian Dauherty who stated that Ms. Hartley never informed her that Resident A was found on the floor and was adamant that she was never informed by the midnight staff.

On 03/29/2022, APS Tamekia Kelly returned my call. Resident A is at the hospital. Ms. Kelly interviewed Relative A regarding the group home. Resident A has been at Coville III for one year. Staff have been attentive to Resident A. Relative A stated there was “footage,” about Resident A falling. Resident A sustained a right hip fracture due to falling. Ms. Kelly stated her complaint was received as “physical abuse,” due to staff at Coville III did not know how Resident A sustained the injuries. Ms. Kelly stated Coville III reported Resident A did not have any falls which is not consistent with the hip fracture. Ms. Kelly made a referral to the Oak Park Police Department regarding this incident. Ms. Kelly stated she made attempts to interview Resident A at Beaumont Hospital but was unsuccessful as Resident A did not remember anything about her fall.

On 03/29/2022, I contacted Relative A regarding the allegations. Relative A was called by the licensee designee Janet Antin when Relative A was already at the hospital with Resident A. Relative A was told that the morning of 03/24/2022, Resident A complained about her side and hip hurting. The RN called Relative A for permission to send Resident A to the hospital, so Relative A agreed. Relative A called Ms. Antin after learning that Resident A had a fracture asking Ms. Antin how Resident A had a sustained the fractured hip. Ms. Antin told Relative A that “according to the video, Resident A fell, and someone picked her up.” Ms. Antin stated the person who found Resident A on the floor called someone else to help get Resident A up. Relative A stated, “No one new Resident A fell until the video was reviewed.” Relative A stated that Resident A woke up around 12AM and fell out of bed. Resident A uses a walker only but does have a wheelchair in her room which sometimes is used when Resident A is tired.

On 05/05/2022, I contacted DCS Serita Hartley via telephone. Ms. Hartley works for Irving Professional Staffing Agency. Ms. Hartley stated she has only worked at Coville III twice and one of those times was the midnight shift 10PM-7AM on 03/24/2022. Ms. Hartley stated when she arrived to begin her shift, she was informed by the previous shift which residents she needed to "pay close attention to," and that she was responsible for laundry and to check all the residents every two hours. Ms. Hartley stated Resident A was not one of the residents she was advised that needed her to pay close attention to. Ms. Hartley stated around 1AM, she conducted her walk around and found Resident A on the floor near Resident A's walker. Ms. Hartley helped Resident A up off the floor onto the chair and called the on-call nurse. The on-call nurse that was in the building was contacted and came up to Resident A's bedroom. Ms. Hartley told the nurse that Ms. Hartley found Resident A on the floor. The nurse checked Resident A and found no bruising, but Resident A was complaining of pain. Ms. Hartley does not know the nurse's name. She stated the nurse gave Resident A something for pain and then left. Ms. Hartley stated she does not know how Resident A was on the floor; therefore, she did not know if Resident A had fallen or how Resident A ended up on the floor. Ms. Hartley stated that the nurse contacted someone else in the building, (name unknown) and that person told the nurse that "Resident A has a tendency of getting up in the middle of the night." Ms. Hartley stated, "If I knew that, I would have made sure to check on Resident A frequently instead of every two hours. No one told me about Resident A." Ms. Hartley stated there is no assessment plan or staff communication log that she refers to when she works her shift. She stated she does what the previous staff tells her and that the staff only showed her the laundry room and only gave her the names of the residents that needed assistance to the bathroom.

On 05/09/2022, I interviewed the Director of Nursing registered nurse (RN) Fran Carlisi-Cordle via telephone regarding the allegations. The RN stated after reviewing the video surveillance at Coville III, on 03/23/2022, Resident A got out of bed, walked to the door with her walker and then fell. Not long after, the midnight staff found Resident A and helped Resident A up. On 03/24/2022, after RN arrived at Coville III, the medication technician, Carmen Leonard asked the RN to check Resident A who was complaining of leg pain. The RN arrived at Resident A's room and asked Ms. Leonard if anything happened to Resident A. Ms. Leonard replied, "I don't know." The RN then asked Resident A, "When did you fall?" Resident A stated, "I did not fall." The RN proceeded to examine Resident A. As the RN was squeezing Resident A's right leg, Resident A was "flinching." Resident A was unable to stand; therefore, the RN called Relative A to request approval to send Resident A to the hospital, which Relative A agreed. The RN stated the midnight staff was supposed to document in the staff communication log the incident and then complete an IR, which neither was done. The RN stated that all staff know that they must conduct rounds for all residents, not only the ones that are pointed out to staff. The RN stated according to the on-call nurse, Verlillian Dauherty, the midnight staff never informed the on-call nurse that the staff found Resident A on the floor. The RN stated, "there was very poor communication," regarding Resident A's incident between staff.

On 05/10/2022, I interviewed the on-call nurse Verlillian Dauherty via telephone regarding the allegations. The on-call nurse works for ATC Health Care which is an outside agency. She works the midnight shift, 11PM-7AM when she fills in. On 03/23/2022, there were two caregivers plus the on-call nurse. Around 3-4AM, the on-call nurse received a call from the midnight staff, Serita Hartley. Ms. Hartley informed the on-call nurse that “Resident A was in pain.” The on-call nurse stated, “I’ll come up and give her Tylenol.” The on-call nurse arrived at Resident A’s bedroom. As the on-call nurse was moving Resident A’s leg, Resident A was complaining of pain. The on-call nurse asked Ms. Hartley, “What was Resident A doing?” Ms. Hartley told the on-call nurse, “standing by the bed.” The on-call nurse asked Resident A, “Did you fall?” Resident A did not respond. The on-call nurse stated if Resident A would have fallen, Resident A would require assistance to get up off the floor. The on-call nurse administered the Tylenol and Resident A went to sleep. On 03/24/2022, the on-call nurse received a telephone call from the RN advising her that Resident A had fallen according to the video surveillance and that the midnight staff, Serita Hartley picked Resident A up off the floor and put Resident A in the chair. The on-call nurse advised the RN that “elders fall all the time, but that Ms. Hartley never once told me that Resident A was on the floor. If she would have told me then I would have followed protocol.” She stated that the protocol is to call the doctor, the designated representative and to document the incident. The on-call nurse stated when she begins her shift, she receives information for the medication technician as to what needs to be done or followed up on. She stated, “there’s also a book (staff communication log) somewhere.” The on-call nurse stated that whenever she worked the midnight shift, Resident A would be asleep.

Note: The incident was never documented by the on-call nurse nor DCS Serita Hartley.

On 05/13/2022, I reviewed Coville III policy on falls and it stated that the staff must contact the on-call nurse on staff if a fall occurs and that the on-call nurse will assess the resident, which is what the midnight staff, Serita Hartley did after finding Resident A on the floor. There is no policy on unwitnessed falls.

On 05/17/2022, I conducted the exit conference via telephone with licensee designee Janet Antin with my findings. Ms. Antin stated both the DCS Serita Hartley, and the on-call nurse Verlillian Dauherty will no longer be working for this corporation. Ms. Antin stated that the on-call nurse should have contacted the RN, Fran Carlisi-Cordle after Resident A complained of leg pain for further instructions if the on-call nurse did not know what to do next. However, Ms. Antin stated that both the DCS and the on-call nurse made frequent bed checks (according to video surveillance) afterwards of Resident A to ensure Resident A’s safety and well-being. Ms. Antin stated she will be reviewing fall protocol with staff in addition to submitting a report after a fall occurs or after finding a resident on the floor. Ms. Antin stated she will submit a corrective action plan.

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 my investigation and information gathered, staff at Coville III did not seek immediate medical care for Resident A on 03/24/2022 after she had fallen. DCS Serita Hartley with Irving Professional Staffing Agency was working the midnight shift when she found Resident A on the floor. Resident A complained of leg pain to Ms. Hartley. Ms. Hartley then contacted the on-call nurse, Verlillian Dauherty with ATC Health Care advising the on-call nurse that Resident A was found on the floor and is complaining of leg pain. The on-call nurse assessed Resident A and administered Tylenol. The on-call nurse stated that Ms. Hartley never informed her that Resident A was found on the floor. The next morning, Resident A continued to complain of leg pain. The RN, Fran Carlisi-Cordle assessed Resident A and when Resident A's right leg was touched, Resident A flinched. Resident A was then transported to the hospital. At the hospital, it was determined that Resident A had a fractured right hip. The on-call nurse stated if she would have known that Resident A was found on the floor, she would have followed protocol. The on-call nurse stated that protocol was to call the on-call manager and Resident A's designated representative. The on-call nurse did not state that she would have sought immediate medical care.
CONCLUSION:	**VIOLATION ESTABLISHED**

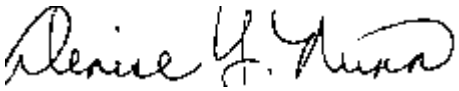
IV. RECOMMENDATION

Contingent upon receiving an acceptable corrective action plan, I recommend no modification to the status of the license.

05/17/2022

Frodet Dawisha — Date
Licensing Consultant

Approved By:



05/18/2022

Denise Y. Nunn — Date
Area Manager