GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 24, 2022

Louis Andriotti, Jr.
IP Vista Springs Timber Ridge Opco, LLC
Ste 110
2610 Horizon Dr. SE
Grand Rapids, MI 49546

RE: License #: AL190383348
Investigation #: 2022A0466038
Vista Springs Rediscovery at Timber Ridge

Dear Mr. Andriotti, Jr.:

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 (517) 284-9727.

Sincerely,

Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL190383348
Investigation #:	2022A0466038
Complaint Receipt Date:	04/28/2022
Investigation Initiation Date:	04/29/2022
Report Due Date:	06/27/2022
Licensee Name:	IP Vista Springs Timber Ridge Opco, LLC
Licensee Address:	Ste 110 2610 Horizon Dr. SE Grand Rapids, MI 49546
Licensee Telephone #:	(303) 929-0896
Administrator:	Louis Andriotti, Jr.
Licensee Designee:	Louis Andriotti, Jr.
Name of Facility:	Vista Springs Rediscovery at Timber Ridge
Facility Address:	16260 Park Lake Road East Lansing, MI 48823
Facility Telephone #:	(303) 929-0893
Original Issuance Date:	11/14/2016
License Status:	REGULAR
Effective Date:	05/14/2021
Expiration Date:	05/13/2023
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION:

	Violation Established?
Resident A had a change in medical condition and did not receive medical attention timely.	Yes
Staff at the facility would not provide the information/number to report allegations to the State of Michigan.	No
Relative A1 requested documents from the facility on behalf of Resident A but never received the documents.	No
Additional Findings	Yes

III. METHODOLOGY

04/28/2022	Special Investigation Intake- 2022A0466038.
04/28/2022	Contact - Telephone call made to Complainant, message left.
04/29/2022	Contact - Document Received Relative A1 interviewed.
04/29/2022	Special Investigation Initiated - On Site.
04/29/2022	Contact - Document Received, Complainant.
05/02/2022	Contact - Document Received, Complainant.
05/09/2022	Contact - Document Received from Jenny Bishop, managing partner.
05/23/2022	Contact - Document Received, Complainant.
05/24/2022	Contact - Document Received, Complainant.
06/15/2022	Contact – Document Sent to Complainant.
06/16/2022	Contact- Telephone call made to DCW Fatmata Swaray, interviewed.
06/16/2022	Contact- Telephone call made to DCW Kiara Brown-Rios, interviewed.
06/16/2022	Contact- Telephone call made to Relative A2, interviewed.

06/16/2022	Contact- Telephone call made to DCW Clementine Cummings, message left.
06/16/2022	Contact- Telephone call made to Jennie Bishop, interviewed.
06/16/2022	Contact - Document Received from Relative A1.
06/16/2022	Contact- Telephone call received from Relative A1 and Relative A3.
06/16/2022	Contact- Telephone call made to Jennifer Slater, interviewed.
06/24/2022	Exit Conference with Louis Andriotti, Jr.

ALLEGATION: Resident A had a change in medical condition and did not receive medical attention timely.

INVESTIGATION:
On 04/28/2022, Complainant reported Resident A had a previous fall while at the facility and broke his neck. Complainant reported that although Resident A was still recovering from the broken neck, Resident A had another fall while at the facility but was not taken to the hospital for 17 hours. Complainant reported this fall was not reported to Resident A's family. Complainant reported Resident A is now on life support and family is on the way to remove life support.

On 04/29/2022, I interviewed Relative A1 who reported Resident A moved into the facility in early March 2022 and has had two fall which were reported to Relative A1. Relative A1 reported facility direct care staff members waited 17 hours after the most recent fall before seeking medical attention for Resident A even though he was still recovering from a broken neck resulting from the first fall. Relative A1 believes that if medical attention were sought sooner maybe Resident A's condition and prognoses would not be as bad. Relative A1 reported Resident A is in the intensive care unit (ICU) and is not expected to live.

On 04/29/2022, I conducted an unannounced investigation and I interviewed Katelyne Dobson from human resources who reported Resident A was admitted to the facility on 03/02/2022. Ms. Dobson reported that any incident reports (IRs) that had been completed would be in Jenny Bishop's office. Ms. Dobson reported Ms. Bishop's office was locked and that I would be unable to review the IRs until Ms. Bishop returned.

On 04/26/2022, I reviewed Resident A's resident record which contained a *Health Care Appraisal* dated 03/03/2022 which documented that Resident A had "weakness in the upper and lower extremities, decrease in mobility" and an uses a "walker and gait belt. Alert with confusion." Resident A's *Health Care Appraisal* documented in

the “mental/physical status limitations “alert with confusion.” In the “susceptibility to hyper/hyperthermia and related limitations” section it stated, “decrease in mobility.”

Resident A’s record contained an *Assessment Plan for Adult Foster Care (AFC) Residents* which was dated 03/02/2022 and signed by Relative A2. In the “walking/mobility” section of the report it documented “Assis x1 with standby with ambulatory needs. Resident has rolling walker and wheelchair with foot pedals (PRN). Assist x1with cueing and reminders for orientation of the building.” In the “special equipment” section of the report it documented “Wheelchair, rolling walker, foot pedals as needed.”

Resident A’s record contained a *ALC-ALZ Service/Functional Evaluation* dated 03/03/2022 which documented in the “fall prevention” section “Resident has a history of falls, VSWP to monitor with potential causes of falls. Provide standby assist.”

Resident A’s record contained an *After Visit Summary* dated 3/17/2022-3/30/2022 which documented in the “Problems addressed during admission” section of the report, “(Principal) fall, closed fracture of C6 vertebra, closed fracture of bilateral C6-C7 facets, S/PC5-7 ACDF (3/20/2022), coronary artery disease (CAD), history of cerebrovascular accident (CBR), platelet inhibition due to Plavix, pacemaker, resolved closed fracture of seventh cervical vertebra, resolved long term use of antithrombotic/antiplatelets, delirium of mixed origin, dementia, aspire long use, 81mg.” This *After Visit Summary* dated 3/17/2022-3/30/2022 was issued after Resident A’s first fall and discharge from the hospital directly to an inpatient rehabilitation facility.

Resident A’s record contained another *Discharge Summary* that was dated 03/30/2022. In the “indication for admission” section of the report it stated “”84-year-old male that presented after a fall.” In the “hospital course” section of the report it stated: “patient sustained C6 fracture as well as bilateral C6 and C7 facet fractures. Dr. Qawash performed C5-C7anterior cervical fixation on 3/20/2022. Patient is to wear a Miami J collar at all times.”

Resident A’s record also contained a Durable Power of Attorney (DPOA) paperwork that appointed Relative A2 as Resident A’s DPOA. This document was signed by Resident A, Relative A2 and a notary on 04/05/2018. Resident A’s record contained a Do Not Resuscitate Order dated 03/02/2022, signed by Relative A2 who is Resident A’s DPOA. There were no other documents designating authority to any other individual to act on behalf of Resident A.

On 04/29/2022, I interviewed direct care worker (DCW) Salamatu Swaray who reported Resident A had fallen at the facility. DCW Salamatu Swaray reported she witnessed one of Resident A’s recent falls however she could not recall the date. DCW Salamatu Swaray reported she was not working when Resident A fell and broke his neck previously. DCW Salamatu Swaray reported she witnessed Resident A’s most recent fall (April 18, 2022). DCW Salamatu Swaray reported that she went

into Resident A's room to say goodbye before she left for the day and she saw Resident A stand up with his recliner behind him. DCW Salamatu Swaray reported Resident A started to fall and she ran towards him but it was too late, she could not catch him and he fell. DCW Salamatu Swaray reported Resident A fell on his side but she cannot remember which side. DCW Salamatu Swaray reported Resident A's elbow was bleeding a little and there was blood on the floor. DCW Salamatu Swaray reported she yelled for help and DCW Fatmata Swaray, DCW Clementine Cummings, DCW Kiara Brown-Rios and DCW Jessica Kalka all "came running." DCW Salamatu Swaray reported Resident A was fine and was trying to get up by himself. DCW Salamatu Swaray reported she did not see Resident A hit his head but reported "everything happened so fast she cannot remember any more details." DCW Salamatu Swaray reported DCW Fatmata Swaray was no longer on shift either as they were both off duty at that time. DCW Salamatu Swaray reported she told DCW Kalka what happened. DCW Salamatu Swaray reported she did not complete an IR as the medication technician writes them even if they did not witness the incident and gives them to the nurse. DCW Salamatu Swaray reported she came back to work the next day at 7am and Resident A was still at the facility. DCW Salamatu Swaray reported she could not remember who worked third shift but that it was reported to her Resident A slept through the night. DCW Salamatu Swaray reported Resident A was up for breakfast, but he was not talking like he usually does and he did not eat much, probably only about 25% of his meal. DCW Salamatu Swaray reported Resident A seemed off baseline. DCW Salamatu Swaray reported she went to the medication technician on duty and they called Relative A1. DCW Salamatu Swaray reported Relative A1 reported he would come to the facility. DCW Salamatu Swaray reported in the meantime the facility doctor and nurse saw Resident A and made the determination that he needed to be seen at the hospital. DCW Salamatu Swaray reported Resident A was not receiving hospice care at the time of the second fall in April 2022.

On 04/29/2022, Relative A1 provided a Designation of Health Care Surrogate document dated 04/05/2018 and signed by Resident A, Relative A1 and a notary. This document was not in Resident A's file at the facility.

On 05/09/2022, Jenny Bishop provided an IR for Resident A dated 3/16/2022 and written Jennifer Slater. This incident report was not signed by the person completing the report nor the licensee designee. In the "explain what happened" section of the report it stated, "Staff noted resident entering another resident's room. Resident had noted laceration on elbow. Resident only was noted wearing a brief. Resident unable to say how he obtained skin tear. Resident sent in for further evaluation to Sparrow Hospital. In the "action taken by staff" section of the report it stated, "Staff assisted resident back to room and cleaned area. Staff noted laceration may need stiches. Staff notified residents DPOA and physician. Resident sent to Sparrow Hospital for further evaluation. Resident required anterior C5-C7 fixation. Resident to be transferred to sub-acute rehab after hospitalization. In the "corrective measures" section of the report it stated, "Resident to be evaluated by sub-acute

rehab in regard to unsteady gai and unstable balance. Resident to be re-assessed upon admission and care plan to be updated upon completion of assessment."

On 05/09/2022, Jenny Bishop provided an IR for Resident A dated 4/18/2022 and written by Jennifer Slater. This incident report was not signed by the person completing the report nor the licensee designee. In the "explain what happened" section of the report it stated, "Staff notices resident's bed alarm sounding and responded to room. Resident was in the process of getting up without assistance. Staff was unable to get to resident prior to him falling. In the "action taken by staff" section of the report it stated, "Staff reported that resident stated he had no pain. Staff cleaned and dressed skin tear on left arm." In the "corrective measures" section of the report it stated, "Resident to be placed on 2-hour checks to anticipate needs. Care plan updated to reflect this change."

On 05/09/2022, Jenny Bishop provided an IR for Resident A dated 4/18/2022 and written by Jennifer Slater. This incident report was not signed by the person completing the report nor the licensee designee. In the "explain what happened" section of the report it stated, "Resident seen by Dr. Phillip Eisenberg, doctor noted that resident had increased bruising on left eye and altered mental status. Doctor requested that resident be sent to hospital for further evaluation." In the "action taken by staff" section of the report it stated, "Staff notified family of doctor request. Staff assisted in preparing resident to be transferred to Sparrow Hospital." In the "corrective measures" section of the report it stated, "Staff to follow discharge plan from hospital and care plan to be updated to meet resident's needs."

On 06/16/2022, I interviewed managing partner Jenny Bishop who reported when Resident A fell on 04/18/2022 it was noted Resident A had a small laceration on his shoulder but no head injury noted. Ms. Bishop reported that the next day DCWs noticed a bruise on Resident A's eye area. Ms. Bishop reported the facility physician was contacted, he came out to see Resident A and sent Resident A to the hospital. Ms. Bishop reported Resident A was hospitalized for a brain bleed which required surgery due to the swelling. Ms. Bishop reported Resident A was on life support and passed away. Ms. Bishop reported the changes in Resident A's condition were not noticed until the following morning so that when the facility doctor saw Resident A.

On 06/16/2022, I interviewed Relative A2 who reported he was not notified of Resident A's second fall on 04/18/2022 until the next day (04/19/2022). Relative A2 reported that he immediately went to the facility to see Resident A2 and reported that Resident A was sitting at the table awake and alert but less conversational then normal. Relative A2 reported that he was concerned about Resident A and wanted him sent to the hospital. Relative A2 reported the facility doctor had recommended Resident A go to Sparrow Hospital. Relative A2 reported Resident A was fully dressed and wearing his neck brace. Relative A2 reported facility direct care staff members stated Resident A had fallen the previous evening and that he had been fine thought out the night. Relative A2 reported Resident A had been diagnosed with vascular dementia and that he does at times have sleep disturbances. Relative

A2 reported the hospital diagnosed Resident A with a subdermal hematoma which required them to cut Resident A's skull to relieve pressure. Relative A2 reported Resident A was in neurology intensive care unit where he eventually passed away. Relative A2 reported Resident A's cause of death was from a fall.

On 06/16/2022, I interviewed Fatmata Swaray who reported her shift had ended and she had returned to the facility off duty on 04/18/2022 to pick up her sister. DCW Fatmata Swaray reported that when she arrived at 7pm, she entered the building and heard a loud boom. DCW Fatmata Swaray reported that she checked on Resident A and he was already getting up off the floor from his knees. DCW Fatmata Swaray reported Resident A was assisted in getting up. DCW Fatmata Swaray reported she observed purple bruising on Resident A's forehead and he was wearing his neck brace. DCW Fatmata Swaray reported Resident A did not have any bleeding but he had 2 layers of clothing on and she did not assess his skin. DCW Fatmata Swaray reported that when she arrived at work the next morning, she knew something was wrong with Resident A so she asked the medication technician to call Relative A2. DCW Fatmata Swaray reported she dressed Resident A and got him ready to go to the hospital. DCW Fatmata Swaray reported that Resident A was weak, looked tired and did not eat anything for breakfast. DCW Fatmata Swaray reported that based on the condition Resident A was in, he should have been sent out to the hospital earlier. DCW Fatmata Swaray reported midnight shift direct care staff members did not say how Resident A did overnight when she arrived at work. DCW Fatmata Swaray reported based on the bruising on Resident A's head and the knot that developed, Resident A had to have hit his head during the fall. DCW Fatmata Swaray reported when a resident falls the nurse is contacted by the medication technician. DCW Fatmata Swaray reported that anytime a resident hits their head they are supposed to be sent to the hospital.

On 06/16/2022, I interviewed DCW Kiara Brown-Rios who reported that she worked on 04/18/2022 from 3pm-11 pm with DCW Jessica Kalka. DCW Brown-Rios reported she was taking care of other residents when Resident A fell. DCW Brown-Rios reported DCW Kalka was the one checking on Resident A throughout that shift. DCW Brown-Rios reported she did not see Resident A with her own eyes anytime throughout her shift. DCW Brown-Rios reported she heard DCW Kalka did not report Resident A's fall to anyone on 4/18/2022. DCW Brown-Rios reported DCW Kalka told her that Resident A had swelling around his head/face. DCW Brown-Rios reported Resident A was still wearing his neck brace as he was recovering from a broken neck. DCW Brown-Rios reported that when a resident hits their head, they typically send the resident to the hospital or keep them in a common area to keep an eye on the resident. DCW Brown-Rios reported Resident A stayed in his room as he can be aggressive and he does not like to be in the common areas. DCW Brown-Rios reported DCW Salamatu Swaray told her that they did not see Resident A hit his head nor did he have any marks or bruises. DCW Brown-Rios reported reporting Resident A's fall was not her responsibility as she is not a medication technician, nor did she witness it, so she did not report it despite hearing about the fall.

On 06/16/2022, I interviewed licensed practical nurse (LPN) Jennifer Slater who reported the facility policy is anytime a resident has a fall and there is a potential for a head injury, the resident is sent to the hospital. LPN Slater reported that she did not have any documentation to support that she was contacted by any facility direct care staff member on 4/18/2022 when Resident A fell. LPN Slater reported there are also other nurses on call however she did not see any note Resident A's record that direct care staff members contacted a nurse. LPN Slater reported that if she had been contacted, she would have directed DCWs to call an ambulance for Resident A because it was noted Resident A had a medium skin tear and three bruises. LPN Slater reported bruising was noted on Resident A's left arm and by his eyebrow. LPN Slater reported Resident A has had multiple falls and he has aggressive behaviors. LPN Slater reported Resident A saw the facility doctor the following morning and then was sent to the ER. LPN Slater confirmed she does write the IRs that are completed from the notes that are written by the DCWs.

On 06/16/2022, I interviewed Relative A1 and Relative A3 who reported Resident A's death certificate documented Resident A fell at 7:00 PM on 4/18/2022 "from a standing position" while on two anticoagulants, aspirin and Plavix, and while still wearing a c-collar for a broken neck. Relative A1 and Relative A3 reported Resident A was not taken to the hospital until 17 hours later (sometime on 04/19/2022) where he was treated for a subdermal hematoma which required surgery and then Resident A was admitted to the ICU. Relative A1 reported Resident A had been prescribed anticoagulants, aspirin and Plavix. Relative A1 reported this was another reason why Resident A should have been provided medical care the same day as the fall due to the medications potentially affecting his body's ability to manage any bleeding injury .

On 06/16/2022, I reviewed Resident A's death certificate which documented Resident A died on 05/01/2022 due to a subdural hematoma. Additionally, the death certificate stated "other significant conditions hypertensive and atherosclerotic cardiovascular disease. C6 vertebral fractures s/p surgical fixation." In the "manner of death" section it stated "accident." In the "describe how injury occurred" it stated, "fell from standing height."

I attempted to call DCW Jessica Kalka via the phone number provided by the facility but the phone number was not working. On 06/16/2022, Ms. Bishop reported the phone number she has for DCW Kalka was recently working however is no longer in service. As of the writing of this report, DCW Kalka has not contacted me nor has the facility provided me with her work schedule nor a working telephone number.

On 06/16/2022, I reviewed Resident A's April 2022 medication administration record (MAR) which documented that Resident A was prescribed two anticoagulants, aspirin and Plavix, which were administered to Resident A while he was at the facility. Resident A was prescribed "aspirin EC 81mg tablet. Take 1 by mouth every evening." Resident A was prescribed "Clopidogrel 75 mg, (Plavix 75mg) take 1

tablet by mouth daily." Resident A was also prescribed "acetaminophen 500 mg tablet (Tylenol) take 1 tablet by mouth every eight hours as needed (max 3gms apap/24hrs)."

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:	On 04/18/2022 around 7PM, Resident A sustained a fall while standing from his recliner. According to direct care worker interviews and the completed IR, Resident A sustained a wound on his elbow but did not complain of any other injuries or pain and was wearing his neck brace at the time of the fall. Resident A was not taken to the ER or evaluated by a physician at the time of the fall on 04/18/2022 despite recovering from a fractured neck. My review of Resident A's record did not find any other documented medical treatments or evaluations taken to determine if further care was needed until mid-morning on 04/19/2022. On 04/19/2022 direct care staff members determined Resident A was not at his baseline as he was not talking normally and was not eating. EMS was called after the facility doctor examined Resident A and stated he needed to be transported to Sparrow Hospital. At the hospital, Resident A was diagnosed with a subdural hematoma which required surgery and Resident A was admitted to the intensive care unit. Resident A later passed away and his death certificate documented that Resident A died on 05/01/2022 due to a subdural hematoma. In the "manner of death" section it stated "accident." In the "describe how injury occurred" it stated, "fell from standing height." Resident A's Health Care Appraisal and *ALC-ALZ Service/Functional Evaluation* both documented Resident A had decrease in mobility, history of falls, confusion, and direct care staff needed to "provide stand by assist" for mobility and monitor Resident A given his potential for falls. Further, LPN Slater noted it was the policy of the facility to send residents to the ER for evaluation after a fall and that had she been contacted she would have directed staff members to send Resident A to the ER for evaluation immediately due to Resident A recovering from a neck fracture. Based on the above information, the facility did not obtain medical treatment for Resident A until the day after he fell even though Resident A was already recovering from a fractured neck at the time of the fall therefore a violation has been established. Further, Resident A was diagnosed with dementia and was not a reliable historian as to his pain level or potential injury at the time of the fall or hours after the fall. Resident A was prescribed anticoagulants, aspirin and Plavix, which may have affected his body's ability to recover from a fall but only a medical evaluation would have been

	able to determine any negative effects. Lastly, it was unable to be determined if Resident A hit his head during the fall on 04/18/2022, so a medical evaluation would have ruled out any further injury to his recovering neck fracture or any additional or new injuries.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff at the facility would not provide the information/number to report allegations to the State of Michigan.

INVESTIGATION:
On 04/28/2022, Complainant reported staff at the facility would not provide the information/number to report allegations to the State of Michigan.

On 04/29/2022, Relative A1 and Relative A3 reported they asked Jenny Bishop to provide them with the process for filing a complaint to the State of Michigan and she would not provide them with how that process worked.

On 06/17/2022, I interviewed Jenny Bishop who reported that Relative A1 and/ or Relative A3 never asked her what the process was to file complaint in the State of Michigan and that is why she never provided them with that information.

On 06/17/2022, I interviewed Nurse Slater who reported that she has never had direct contact with Relative A1 and/or Relative A3.

APPLICABLE RULE	
R 400.15304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(f) The right to voice grievances and present recommendations pertaining to the policies, services, and house rules of the home without fear of retaliation.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**

ANALYSIS:	Complainant, Relative A1 and Relative A3 reported staff at the facility would not provide/give them information/phone numbers to report allegations to the State of Michigan. Jenny Bishop denied that Relative A1 and/or Relative A3 asked her for information/phone numbers to report allegations to the State of Michigan therefore there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Relative A1 requested documents from the facility on behalf of Resident A but never received the documents.

INVESTIGATION:
On 04/28/2022, Complainant reported that since 04/24/2022, he has been trying to obtain an IR from when Resident A fell on 03/18/2022 and was transported to the hospital on 03/19/2022. Complainant reported that follow up emails were sent on 04/26/2022 and 04/27/2022 without a response.

On 04/29/2022, I reviewed Resident A's record which contained admission documents signed by Relative A2. There were no documents designating Relative A1 as a designated representative by Resident A in Resident A's record.

On 05/23/2022, Relative A1 reported contacting the facility multiple times trying to get a copy of all medical records for Resident A (both as Medical Surrogate and as "heir.") Relative A1 reported he provided the facility with legal paperwork where he was named as a medical surrogate. Relative A1 reported after Resident A passed away, under the Michigan Medical Records Access Act (MCL Section 333.26265) the facility has to release Resident A's records. Relative A1 reported that so far, the facility refused to provide this information. Relative A1 reported the facility's response (to the Michigan Medical Records Access Act request) continues to be that the information will be provided to the DPOA who is not Relative A1. Relative A1 reported that since Resident A passed, he no longer has a DPOA.

On 06/16/2022, Relative A1 reported that the facility refuses to give him any information about Resident An even though he has quoted Michigan State statute that gives legal heirs the right to his records. Relative A1 reported that he is one of Resident A's sons and entitled to this information.

On 06/16/2022, I interviewed Ms. Bishop who reported she has received several written requests from Relative A1 for Resident A's records. Ms. Bishop reported Relative A2 is Resident A's DPOA. Ms. Bishop reported facility lawyers are reviewing Relative A1's request and will provide her direction. Ms. Bishop reported Relative A2 is who they consider Resident A's designated representative. Ms. Bishop reported Relative A2 has not requested any of Resident A's records.

APPLICABLE RULE	
R 400.15302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(8) At the time of discharge, a licensee shall provide copies of resident records to the resident and his or her designated representative when requested, and as determined appropriate, by the resident or his or her designated representative. A fee that is charged for copies of resident records shall not be more than the cost to the licensee of making the copies available.
ANALYSIS:	Since 04/24/2022, Relative A1 has asked in writing for documents that are contained in Resident A's record. The facility has yet to dispense those documents to Relative A1 because the facility has Relative A2 as Resident A's designed representative and therefore a violation has been not established.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 04/29/2022, I conducted an unannounced investigation and I interviewed Ms. Dobson who reported that any IRs that had been completed would be in Ms. Bishop's office. Ms. Dobson reported that Ms. Bishop's office was locked and that I would not be able to review any IRs until Ms. Bishop returned.

On 04/29/2022, I reviewed Resident A's record in its entirety and there were no IRs in the record.

APPLICABLE RULE	
R 400.14316	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A

	resident record shall include, at a minimum, all of the following information: **(a) Identifying information, including, at a minimum, all of the following:** **(h) Incident reports and accident records.**
ANALYSIS:	On 04/29/2022, I conducted an unannounced investigation and I was unable to review any IRs that had been completed regarding Resident A as they were in Ms. Bishop's office which was locked. The IRs were not provided as requested at the time of the unannounced investigation. Additionally, I reviewed Resident A's record in its entirety and there were no IRs in the record as required therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 06/24/2022, I conducted an exit conference with licensee designee Lou Andriotti who voiced understanding regarding the rule violations cited.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan I recommend no change in the status of the license.

06/24/2022

_____

Julie Elkins Date
Licensing Consultant

Approved By:

06/24/2022

_____

Dawn N. Timm Date
Area Manager