GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 16, 2022

Michele White
The Village of Westland, A Senior Living Community
32001 Cherry Hill Road
Westland, MI 48186-7902

RE: License #: AL820244670
Investigation #: 2022A0101029
Ivy Cottage

Dear Ms. White:

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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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 (313) 456-0380.

Sincerely,

Edith Richardson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-1934

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL820244670
Investigation #:	2022A0101029
Complaint Receipt Date:	07/13/2022
Investigation Initiation Date:	07/15/2022
Report Due Date:	09/11/2022
Licensee Name:	The Village of Westland, A Senior Living Community
Licensee Address:	32001 Cherry Hill Road Westland, MI 48186-7902
Licensee Telephone #:	(734) 728-5222
Administrator:	Michele White
Licensee Designee:	Michele White
Name of Facility:	Ivy Cottage
Facility Address:	32151 Cherry Hill Road Westland, MI 48186
Facility Telephone #:	(734) 762-8885
Original Issuance Date:	06/19/2002
License **Status:**	REGULAR
Effective Date:	02/21/2021
Expiration Date:	02/20/2023
Capacity:	20
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A fell and broke her neck. Resident A did not receive medical care until six days later.	Yes

III. METHODOLOGY

07/13/2022	Special Investigation Intake 2022A0101029 Referral received from APS and ORR
07/15/2022	Special Investigation Initiated - On Site
08/04/2022	Contact – Phone call made Relative 1
08/04/2022	Inspection Completed-BCAL Sub. Compliance
08/10/2022	Document received
08/11/2022	Contact – Phone call made Direct Care Staff (DCS) Olaoluwa Adenike, Aisha Baugh, Muna Paye, Rajmonda, Frahheri and Regina Jones
08/11/2022	Contact – Phone call made Relative 1
08/11/2022	Contact – Phone call made Nurse Manager, Jan Smith
08/12/2022	Contact – Phone call made DCS Regina Jones
08/12/2022	Exit Conference with Michelle White

ALLEGATION: Resident A fell and broke her neck. Resident A did not receive medical care until six days later.

INVESTIGATION: Resident A was an eighty-eight-year-old female with a history of frequent falls. According to Resident A's PACE (a Program of All-inclusive Care for the Elderly) assessment plan, Resident A used a wheelchair. Resident A was able to propel her wheelchair with her feet. Resident A was also able to stand and pivot. On 03/17/2022, the Activities Coordinator Marie Yax found Resident A on her bedroom floor. Ms. Yax is no longer an employee of the facility.

On 08/04/2022, I interviewed direct care staffs (DCS) Erica Skip, Melissa Thorn-Monroe, and the nurse Leslie Vaden. According to Ms. Skip, Ms. Thorn-Monroe and Ms. Vaden, they all had to assist with getting Resident A off the floor. Resident A was taken into the dining area so staff could closely monitor her. According to Ms. Vaden, Resident A "showed no signs of distress" and Resident A stated she was okay. However, the incident report states, "Skin tear observed on right elbow, right index finger, right knee, and left index finger. Bruise also observed on the forehead and top of head."

According to Ms. Skip and Ms. Thorn-Monroe, later that evening Resident A had bruising on her face, she did not eat and appeared to be in a daze. Ms. Vaden stated prior to leaving her shift on 03/17/2022, she contacted Resident A's health care provider PACE and was told PACE would be out to assess. Ms. Vaden stated PACE is responsible for assessing their clients' medical needs.

Ms. Vaden stated when she returned to work on 03/19/2022, Resident A wanted to stay in bed and wanted to be left alone. According to Ms. Vaden Resident A showed no signs of pain.

Ms. Skip stated she did not seek medical care for Resident A because she is not allowed to do that. Ms. Skip stated she was unaware of the adult foster care licensing rules and the statue. Ms. Thorn-Monroe stated she should have obtained medical care for Resident A.

On 08/04/2022, I spoke with Terina Clark an employee of PACE. Ms. Clark stated if a participant is experiencing a medical emergency the caregiver/staff should call 911. Pace is not a hospital.

On 03/20/2022, Relative 1 took photos of Resident A. The photos show that Resident A's face had significant bruising and her facial expressions suggested she was in agony.

On 08/04/2022, I reviewed Resident A's progress notes written by Leslie Vaden, the nurse. The progress notes show a steady decline in her health. On 03/17/2022, Resident A stopped eating. On 03/20/2022, "resident not eating, and drinking a little in last 24 hours. Staff was trying [sic] feed apple sauce and give water to resident this afternoon and she spit most of it out even when daughter tried to give it to her." On 03/22/2022, "resident had to be fed an [sic] cued to eat and swallowed and resident still not eating. Resident was more confused and needed complete assistance for everything." On 03/23/2022, resident is complaining of an [sic] headache and screaming when touched."

According to Resident A's medical records. When she arrived at the hospital on 03/23/2022, Resident A had "traumatic ecchymosis"' of the face. Resident A was unable to sit up independently. Resident A was also diagnosed with "multiple comorbidities" meaning you have one or more conditions beside the one you are

being treated for and advanced age.

On 04/01/2022, Resident A was placed in Beaumont Hospice Care. On 04/10/2022, Resident A passed away. The death certificate indicates manner of death "accident." The death certificate also states, "The chain of events, diseases, injuries, or complications that cause the death" were "Fall C2 – C3 fracture, Alzheimer's Dementia and Dysphagia."

On 08/11/2022, I spoke with DCS Olaoluwa Adenike (Nickie). Ms. Adenike provided Resident A's personal care on 03/18/2022, and 03/19/2022. Ms. Adenike stated she noticed that Resident A was in pain, she was just lying-in bed. Ms. Adenike stated she reported it to the nurse, Ms. Vaden. Ms. Vaden told Ms. Adenike she called PACE.

On 08/11/2022, I spoke with DCS Aisha Baugh. Ms. Baugh stated on 03/20/2022, she worked in Ivy Cottage, but she was not assigned to Resident A. Ms. Baugh stated she did not notice any bruising on Resident A. Ms. Baugh stated Resident A did not want to get out of bed.

I spoke with DCS Muna Paye on 08/11/2022. Ms. Paye stated on 03/22/2022, she worked in Ivy Cottage, but she was not assigned to Resident A. Ms. Paye stated she had just returned from a mini vacation and assumed everything was okay with Resident A. Ms. Paye believed everything was okay because staff are to follow the guidelines for a fall. She explained if you find a resident on the floor, you are to stay with the resident and pull the call light for backup. You are to immediately call the nurse and the nurse completes an assessment.

On 08/11/2022, I spoke with DCS Rajmonda Frasheri. Ms. Frasheri stated on 03/20/2022, she worked in Ivy Cottage. Resident A was not assigned to Ms. Frasheri. Ms. Frasheri stated Resident A was badly bruised. Ms. Frasheri stated in her country she was a nurse but here she is a DCS. Therefore, she cannot call 911, only the nurse can. Ms. Frasheri was not familiar with the adult foster care licensing rules and the statue.

On 08/11/2022, I spoke with Relative 1. Relative 1 stated after seeing her mother on 03/20/2022, she did not request her mother be sent to the hospital because she trusted their knowledge. Relative 1 also stated she did not receive a written report within 48 hours after the fall and did not receive one when Resident A was sent to the hospital.

On 08/11/2022, I spoke with Jan Smith. Ms. Smith is the Manager of the nurses. Ms. Smith stated she did not become aware of Resident A's condition until 03/23/2022. At that time, she immediately had Resident A transported to the hospital. However, I spoke to Ms. Smith again on 09/13/2022. I asked Ms. Smith what nurse was on duty on 03/18/2022. Ms. Smith stated she was the nurse on duty on 03/18/2022, and again on 03/21/2022. Ms. Smith stated she assisted Resident A

with medications. According to Ms. Smith, Resident A was “fine.” They got her up and she ate breakfast. Noteworthy, there are no progress notes on Resident A the days Ms. Smith worked.

I spoke with DCS Regina Jones on 08/12/2022. Ms. Jones provided personal care to Resident A on 03/18/2022, and 03/19/2022. Ms. Jones stated when she saw Resident A on 03/18/2022, she said, “Oh my God,” because Resident A’s face was badly bruised. Ms. Jones stated she did not take further action because she had read the progress notes and saw that Resident A had been assessed by the nurse. Ms. Jones stated she does not recall any more details because it was so long ago.

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 03/17/2022, Resident A was found lying on her bedroom floor. According to the incident report she sustained the following visual injuries skin tear observed on right elbow, right index finger, right knee, and left index finger. Bruise also observed on the forehead and top of head.” According to DCS Ms. Skip and Ms. Thorn-Monroe, later that evening Resident A had bruising on her face, and she did not eat. For the next six days there was a sudden adverse change in her physical condition. Resident A stayed in bed, did not eat, and wanted to be left alone. She was no longer propelling her wheelchair. Nor was she standing and pivoting. When she arrived at the hospital on 03/23/2022, Resident A had “traumatic ecchymosis” of the face. Resident A was unable to sit up independently. Therefore it is concluded Resident A had an accident on 03/17/2022, and for the next six days there was a sudden adverse change in her physical condition and the group home did not obtain needed care immediately.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING(s):

INVESTIGATION: On 08/05/2022, I requested verification from the licensee designee that the staff have been reviewing the licensing statute and administrative rules. I observed that several of the staff was unaware in case of an accident or sudden adverse change in a resident's physical condition or adjustment, the group

home shall obtain needed care immediately, not just the nurse.

On 08/09/2022, I received an email from Jason Lovelly the Human Resource Manager indicating “in the nurse’s office a manual is kept that contains the Licensing Rules for Adult Foster Care Group Home Technical Assistance Handbook.” However, they do not have verification that the staff have been reviewing the licensing statute and administrative rules.

APPLICABLE RULE	
R400.15207	**Required personnel policies.**
	(2) The written policies and procedures identified in subrule (1) of this rule shall be given to employees and volunteers at the time of appointment. A verification of receipt of the policies and procedures shall be maintained in the personnel records.
ANALYSIS:	According to Jason Lovelly the Human Resource Manager, the licensee does not have verification that the staff have been reviewing the licensing statute and administrative rules.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 08/04/2022, I spoke with Relative 1. Relative 1 stated she was aware that her mother had fallen twice at Ivy Cottage. I asked Relative 1 if she had received incident reports regarding the falls, she stated no. I asked Relative 1 if she knew the date of the first fall. She stated she would check with her husband to determine the date of the first fall. Relative 1 stated her husband received a phone call therefore it should be in his phone call log. I asked Relative 1 if she received any written incident reports regarding her mother falling. Relative 1 stated no.

On 08/04/2022, I conducted an onsite investigation. I reviewed the incident reports on Relative 1. Relative A was found lying on the floor 3 times. On the incident report under the section titled “Person (s) Notified designated person/guardian” it indicates Relative 1’s husband name and a telephone number.

On 08/04/2022, I interviewed Jan Smith the Nurses Manager. Ms. Smith stated the phone number under the section titled Person (s) Notified indicates they received a phone call. Ms. Smith stated she was unaware that written notification was required.

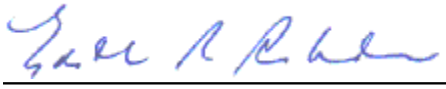
On 08/11/2022, I spoke with Relative 1. Relative 1 stated she did not receive a written report within 48 hours after her mother fell and she did not receive one when Resident A was sent to the hospital.

On 03/24/2022, the Department received notification of Resident A’s fall on 03/17/2022. The report also indicates the date care was given as 03/23/2022.

APPLICABLE RULE	
R400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: (a) The death of a resident. (b) Any accident or illness that requires hospitalization. (c) Incidents that involve any of the following: (i) Displays of serious hostility. (ii) Hospitalization. (iii) Attempts at self-inflicted harm or harm to others. (iv) Instances of destruction to property.
ANALYSIS:	The licensee did not provide the designated representative/Relative 1 with a written report within 48 hours of her fall and hospitalization. According to Relative 1, she did not receive a written report within 48 hours after her mother fell and she did not receive one when Resident A was sent to the hospital. On 08/04/2022, I interview Ms. Smith. Ms. Smith stated that she was unaware that written notification was a requirement.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon submission of an acceptable corrective action plan, I recommend the status of the license be modified to a provisional license.

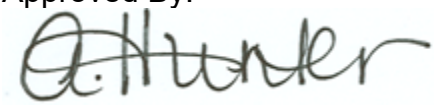


09/16/2022

Edith Richardson
Licensing Consultant

Date

Approved By:



09/16/2022

Ardra Hunter
Area Manager

Date