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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 14, 2022

Rochelle Lyons
Senior Living Boulder Creek, LLC
7927 Nemco Way, Ste 200
Brighton, MI 48116

RE: License #: AH410406207
Investigation #: 2022A1028086
Boulder Creek Assisted Living & Memory Care

Dear Ms. Lyons:

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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
Cell (616) 204-4300

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

I. IDENTIFYING INFORMATION

License #:	AH410406207
Investigation #:	2022A1028086
Complaint Receipt Date:	09/22/2022
Investigation Initiation Date:	09/27/2022
Report Due Date:	11/22/2022
Licensee Name:	Senior Living Boulder Creek, LLC
Licensee Address:	7927 Nemco Way, Ste 200 Brighton, MI 48116
Licensee Telephone #:	(616) 464-1564
Administrator:	Mallory Hollomon
Authorized Representative:	Rochelle Lyons
Name of Facility:	Boulder Creek Assisted Living & Memory Care
Facility Address:	6070 Northland Drive Rockford, MI 49341
Facility Telephone #:	(616) 866-2911
Original Issuance Date:	08/10/2021
License Status:	REGULAR
Effective Date:	02/10/2022
Expiration Date:	02/09/2023
Capacity:	108
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A's service plan does not reflect appropriate care levels.	Yes
Resident A and Resident B did not receive medications in a timely manner.	No
The facility is short staffed.	No
Additional Findings	No

III. METHODOLOGY

09/22/2022	Special Investigation Intake 2022A1028086
09/27/2022	Special Investigation Initiated - Letter
09/27/2022	APS Referral APS referral made to Centralized Intake.
10/24/2022	Contact - Face to Face Interviewed Admin/Mallory Holloman at the facility.
10/24/2022	Contact - Face to Face Interviewed Employee A at the facility.
10/24/2022	Contact - Face to Face Interviewed Employee B at the facility.
10/24/2022	Contact - Face to Face Interviewed Resident A at the facility.
10/24/2022	Contact - Face to Face Interviewed Resident B at the facility.
10/24/2022	Contact - Document Received Received Resident A's and Resident B's MAR, Resident A's service plan with record notes, and staff working schedules for September 2022 to October 2022 from Admin/Mallory Hollomon.

11/14/2022	Exit - Left voicemail with SIR findings for AR/Rochelle Lyons. Report sent to Admin/Mallory Hollomon and AR/Rochelle Lyons via email.

ALLEGATION:

Resident A's service plan does not reflect appropriate care levels.

INVESTIGATION:

On 9/22/2022, the Bureau received the allegations from the online complaint system.

On 9/27/2022, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 10/24/2022, I interviewed the facility administrator, Mallory Holloman, at the facility, who reported Resident A incurred a fall resulting in injury. Ms. Hollomon reported the fall was reported to Resident A's hospice physician, the authorized representative, and the department. Ms. Hollomon reported staff wrapped Resident A's wrist to support it until hospice could arrive to assess Resident A. Ms. Hollomon reported Resident A has very thin skin and is prone to skin tears as well. Resident A's skin integrity is monitored by hospice and facility staff. A care conference was also completed with hospice and Resident A's authorized representative to reassess medications and the service plan, to ensure appropriate care, and to consider a possible long term care placement.

On 10/24/2022, I interviewed Employee A at the facility who reported Resident A incurred a fall that resulted in injury. Employee A reported Resident A was not compliant with use of call light and would get up unassisted. Resident A's hospice physician, the authorized representative, and the department were notified of the fall. Employee A reported Resident A's wrist was carefully wrapped to support it until hospice arrived to assess the injury. Employee A Resident A has very thin skin and staff are aware of this when providing care. Hospice and/or facility staff monitor Resident A's skin integrity daily. Employee A reported Resident A's service plan was also recently updated to reflect medication changes and to ensure appropriate care.

On 10/24/2022, I interviewed Employee B at the facility whose statements are consistent with Ms. Hollomon's statements and Employee A's statements.

On 10/24/2022, I attempted to interview Resident A, but Resident A was unable to participate in interview due to demonstrating some confusion. Resident A was observed lying in bed with a right wrist splint and clean bandages on the lower extremities.

On 10/25/2022, I reviewed Resident A's service plan which revealed the following:

- Resident A demonstrates occasional confusion and has some difficultly requiring reorientation from staff.
- Does not wander.
- Is cooperative with care and staff to report any change.
- Requires assistance with grooming, upper and lower body dressing, bathing, and toileting.
- Has incurred three falls with the most recent 3 days ago (no date given).
- Can ambulate with use of walker but requires reminders to use.
- Can transfer and reposition self independently.
- Staff provide assistance with medication administration to include oxygen but resident is able to administer topical treatments.
- Service is last dated 6/9/2022.

I reviewed Resident A's record notes which revealed the following:

- On 8/19/2022, Resident A was found on floor.
- Possible fall on 9/3/2022 with skin tears to legs and left arm but Resident A unable to state what happened.
- On 9/4/2022, Resident A had huge skin tear on upper right arm, left leg, and right leg due to fall.
- On 9/9/2022, Resident A was observed on living room floor and not oriented to time or place.
- On 9/14/2022, Resident A was observed sitting on floor in the hallway floor outside of apartment in a crossed leg position. No injury or new skin tears noted. Documented in record notes Resident A *sitting in crossed leg position would be a natural position for [Resident A] due to [Resident A] "once [being] very much into yoga".*
- On 9/15/2022, Resident A demonstrated unsteadiness throughout the evening and third shift. Staff provided increased monitoring.
- On 9/15/2022 at 9:48 pm, Resident A observed on floor with oxygen cord tangled around neck.
- On 9/16/2022, Resident A observed on floor with walker out of reach and a sheet covering face. Resident A reported to be on the floor *"because [they] were praying".* Skin tear on right knee was uncovered and open with staff providing assistance.
- On 9/16/2022, Hospice nurse requested *staff notify hospice about any observations of resident being on the floor, even if evidence and/or resident statements indicate resident put [self] on the floor.*
- On 9/18/2022, Resident A observed sitting on floor and stated [they] fell out of bed and hit head on side table. Hospice notified.
- On 9/19/2022, Resident A observed sitting on floor outside of bathroom. Skin tear noted on right arm and right wrist was misshapen. Staff assisted Resident A while facility administrator and hospice were notified. Hospice assessed Resident A at the facility revealing Resident A incurred a dislocated left wrist.

- On 9/20/2022, Resident A was observed sitting on floor and incurred *various new skin tears.* Staff assisted resident with skin tears and back to bed. Alarm pad placed in bed. Splint to be delivered today. Resident A's transfer increased to two person assist. New hospice company to assess Resident A and place Resident A into their care.
- On 9/25/2022, Resident A observed on floor near bed. Resident A holding injured wrist with hospice recommending Resident A be sent to hospital. Resident A had multiple skin tears on left hand.
- On 9/26/2022, Resident A returned from hospital with new orders for skin tears and morphine.
- On 9/30/2022, Resident A demonstrated some confusion.
- On 10/3/2022, Resident A's bed alarm alerted staff to room. Resident A found on knees in front of bed attempting to get back into bed. No injuries or new skin tears noted. Family and hospice notified.
- On 10/6/02022, Resident A demonstrating restlessness and confusion. Bed alarm sounded three times with staff assisting resident.
- On 10/10/2022, the bed alarm sounded, and Resident A was found to have removed the arm splint and was out of bed ambulating in bedroom without walker. Staff assisted resident back to bed and placed splint back on Resident A. Staff remined Resident A to keep splint on for healing.

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.**

ANALYSIS:	On 9/19/2022, Resident A incurred a fall with injury. It was alleged Resident A's service plan was not updated to reflect appropriate care levels due to increased falls and confusion. Interviews, on-site inspection, and review of documentation reveal there is evidence of consistent communication with hospice and Resident A's authorized representative concerning each incident and Resident A's care. However, when reviewing Resident A's service plan, it does not address Resident A's skin integrity issues. Also, Resident A is still classified as independent with transfers and ambulation using an assistive device, despite Resident A's recent and significant fall history resulting in multiple skin tears and a dislocated right wrist. The service plan has not been updated since 6/9/2022 to reflect increased levels of care, protection, supervision, and/or assistance needed due to Resident A's increased fall history with injuries and ongoing demonstrated confusion. Therefore, the facility is in violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A and Resident B did not receive medications in a timely manner.

INVESTIGATION:

On 10/24/2022, Ms. Hollomon reported there was a medication administration error recently, but it did not involve Resident A or Resident B. Ms. Hollomon reported the medication administration error was immediately addressed with staff, the resident, resident's physician, and resident's families, and the licensing department was notified of the error as well. Ms. Hollomon reported no knowledge of Resident A or Resident B not receiving medications in timely manner or not in accordance with physician orders. Ms. Hollomon provided me a copy of Resident A and Resident B's medication administration record (MAR) from September 2022 to October 2022 for my review.

On 10/24/2022, Employee A reported there was a recent medication error but reported [they] did not work the shift this occurred. Employee A reported the medication administration error was immediately addressed. Employee A reported no knowledge of Resident A or Resident B not receiving medications.

On 10/24/2022, Employee B reported [they] did not work the shift the medication error occurred and that it was addressed immediately. Employee B reported no knowledge of Resident A or Resident B not receiving medications on time.

On 10/24/2022, Resident C requested to speak with me during my on-site investigation. Resident C expressed concerns about medications for Resident A and Resident B being administered late on second and third shifts. However, Resident C reported [their] medications have not been late because [they] “know to ask for them.”

On 10/31/2022, I reviewed Resident A’s MAR for September 2022 which revealed appropriate and correct medication administration. I reviewed Resident A’s MAR for October 2022 which also revealed appropriate and correct medication administration.

I reviewed Resident B’s MAR for September 2022 which revealed appropriate and correct medication administration. I reviewed Resident B’s MAR for October 2022 which also revealed appropriate and correct medication administration.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.
ANALYSIS:	It was alleged Resident A’s and Resident B’s were not administered in a timely manner. While a recent medication administration error occurred at the facility, it did not involve Resident A or Resident B. The medication administration error was also immediately and appropriately addressed by the facility at the time it occurred. Interviews, on-site inspection, and review of documentation reveal there is no evidence to support this allegation and that Resident A’s and Resident B’s medications are correctly administered by the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility is short staffed.

INVESTIGATION:

On 10/24/2022, Ms. Hollomon reported the facility continues to experience call-ins but the facility has adjusted staff to prevent any short shifts. Ms. Hollomon reported when call-ins occur management and shifts supervisors will stay, agency is utilized, and on-call and float staff are utilized as well. Ms. Hollomon provided me a copy of the working staff schedules for September 2022 and October 2022.

On 10/24/2022, Employee A reported call-ins do occur at the facility, but float staff, on-call staff, and agency staff are utilized to prevent shift shortages. Employee A reported the facility is also actively hiriing.

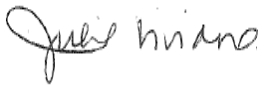
On 10/24/2022, Employee B's statements are consistent with Ms. Hollomon's statements and Employee B's statements.

On 11/1/2022, I reviewed the working staff schedules for September 2022 and October 2022 which revealed several call-ins across September 2022 and October 2022, but appropriate facility staff and agency coverage to prevent shift shortages.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plan.
ANALYSIS:	Interviews, on-site inspection, and review of working staff schedules reveal that while call-ins occur at the facility, appropriate actions are taken by management, facility staff and agency staff to ensure resident care and to prevent shift shortages. There is no evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, I recommend the status of this license remain unchanged.



11/2/2022

Julie Viviano Date
Licensing Staff

Approved By:

11/02/2022

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