GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 2, 2022

Jeremiah Johnson
Bickford of Canton
5969 N Canton Center Rd
Canton, MI 48187

RE: License #: AH820395445
Investigation #: 2022A1027095
Bickford of Canton

Dear Mr. Johnson:

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 authorized representative and a date.

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) 241-1970.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820395445
Investigation #:	2022A1027095
Complaint Receipt Date:	09/13/2022
Investigation Initiation Date:	09/14/2022
Report Due Date:	11/13/2022
Licensee Name:	Bickford of Canton, LLC
Licensee Address:	Suite 301 13795 S Mur-Len Rd. Olathe, KS 66062
Licensee Telephone #:	(913) 782-3200
Administrator:	Denell Bruyere
Authorized Representative:	Jeremiah Johnson
Name of Facility:	Bickford of Canton
Facility Address:	5969 N Canton Center Rd Canton, MI 48187
Facility Telephone #:	(734) 656-5580
Original Issuance Date:	04/02/2020
License Status:	REGULAR
Effective Date:	10/02/2022
Expiration Date:	10/01/2023
Capacity:	78
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A lacked safety and protection after a fall.	Yes
Additional Findings	No

III. METHODOLOGY

09/13/2022	Special Investigation Intake 2022A1027095
09/14/2022	Special Investigation Initiated - Telephone Telephone interview conducted with complainant
10/26/2022	Inspection Completed On-site Ms. Bruyere to provide nurses notes, staff contacts, fall policy, and NP notes on 10/28/2022.
10/28/2022	Contact - Document Received Email received from Ms. Bruyere with documentation previously received (Resident A's face sheet and service plan), facility's fall policy, fall risk assessment and handwritten documentation of text messages related to fall
10/31/2022	Contact - Document Sent Email sent to Ms. Bruyere and Mr. Johnson requesting clarification regarding documentation sent, May/June progress notes and staff working third shift on 6/5/2022
10/31/2022	Contact - Document Received Email received from Ms. Bruyere with requested progress notes and clarification. Awaiting nurse practitioner note.
11/01/2022	Contact - Document Received Email received from Ms. Bruyere with clarification regarding staff on duty at time of incident
11/01/2022	Contact - Telephone call made Telephone interview conducted with Employee #2
11/01/2022	Contact - Telephone call made Telephone interview conducted with Kare agency staff
11/01/2022	Contact - Document Received Email received from Ms. Bruyere with physician progress note

11/02/2022	Inspection Completed – BCAL Sub. Compliance
11/28/2022	Exit Conference Conducted with authorized representative Jeremiah Johnson by voicemail

ALLEGATION:

Resident A lacked safety and protection after a fall.

INVESTIGATION:

On 9/13/2022, the department received a complaint through the online complaint system which read Resident A had fallen on 6/4/2022 while toileting with staff. The complaint read Resident A had hit his head and had obvious injuries including bleeding and swelling. The complaint read emergency medical services (EMS) was called on 6/6/2022 to take Resident A to the hospital at which at that time family was notified of the fall. The complaint read Resident A had admitted to the hospital with diagnosis of acute subarachnoid and parenchymal hemorrhages, comminuted right clavicle fracture, three right rib fractures, and a nasal bone fracture.

On 9/14/2022, I conducted a telephone interview with the complainant whose statements were consistent with the complaint. The complainant stated Resident A had two medical durable power of attorneys, in which one was notified of Resident A's fall on 6/6/2022 in route to the hospital. The complainant stated Resident A mainly utilized a wheelchair however could ambulate with a walker and staff assistance.

On 10/26/2022, I completed an on-site inspection at the facility. I interviewed administrator Denell Bruyere who stated she was training for her position at the time of Resident A's fall and did not recall details of the incident. Ms. Bruyere stated the staff member from the Kare agency had witnessed Resident A's fall no longer worked for the facility. Additionally, Ms. Bruyere stated the nurse at the time of Resident A's fall also no longer worked at the facility. Ms. Bruyere stated Resident A utilized the facility physician and his nurse practitioner, Laura Kremer.

While on-site, I interviewed Employee #1 who worked dayshift on 6/6/2022. Employee #1 stated Resident A's fall had occurred on third shift. Employee #1 stated she thought Resident A's fall occurred in his bathroom but was uncertain. Employee #1 stated Resident A had history of falls. Employee #1 stated she observed that Resident A had injured his head/face and ice was applied by previous staff. Employee #1 stated the policy for falls was to inform the facility nurse, the director, the resident's family, and the resident's physician.

Per email correspondence on 11/1/2022 with Ms. Bruyere, there were four staff on duty for third shift on 6/5/2022. The email read two Kare agency staff members no longer worked at the facility, however Employee #2 and #3 remained employed with the facility.

On 11/1/2022, I conducted a telephone interview with Employee #2 who stated she was the medication technician on duty and followed the facility's fall policy. Employee #2 stated she assessed Resident A after his fall. Employee #2 stated her, and the previous agency caregiver assisted Resident A to a standing position in which she was uncertain if he had gait belt on at that time. Employee #2 stated Resident A did not complain of pain at that time.

On 11/1/2022, I conducted a telephone interview with the Kare agency staff member by telephone who assisted and witnessed Resident A at the time of the fall. The Kare agency staff stated upon Resident A's transfer back to his wheelchair, he stated he was dizzy and fell, landing on his right shoulder. The Kare agency staff stated Resident A had a gait belt on. The Kare agency staff stated Resident A bumped his head and expressed that his shoulder was bothering him. The Kare agency staff stated Resident A did not lose consciousness and was able to communicate with her.

I reviewed Resident A's face sheet which read he admitted to the facility on 6/8/2020. The face sheet read to notify Relative A1 in case of emergency.

I reviewed Resident A's service plan dated 3/15/2022 which read consistent with statements from the complainant and staff interviews. The plan read in part read Resident A utilized a wheelchair and rolling walker in which he needed to be pushed in his wheelchair. The plan read Resident A was one person assist to transfer and to always use a gait belt. The plan read in part Resident A was blind in his left eye, had a pendant for safety in which he could not see if sitting in the chair and would need physical assistance for emergencies.

I reviewed the facility's incident report for Resident A's fall dated 6/6/2022 at 12:30 AM which in part read:

> "*Resident pivot transfers with SBA CNA was assisting [Resident A] in the bathroom transferring bac to his wc when his Rt leg gave out and he lost his balance. He bumped his Rt. Shoulder and forehead above his right eye. Ice was applied family and nurse were notified. VSS Resident A&O x3. At 5:32 AM nurse was notified that his right eye swollen and bruised. Rt shoulder bruising also noted. NP Laura saw him @ 1030 AM. Laura requested family be notified that he should go to ER for evaluation. RN spoke with his son. EMS called.*
>
> *Effect of the incident on the person who was involved: [Resident A] denied pain but said it aches. Bruising noted to RT shoulder and RT eye bruising and edema."*

The report read Dr. Sarafa was notified on 6/6/2022 at 1:54 AM by fax and Laura NP assessed Resident A on 6/6/2022 at 10:30AM. The report read Relative A1 was notified by telephone on 6/6/2022 at 2:00 AM. The report read EMS was called at 11:30 AM and arrived at 11:45 AM. The report read it was emailed to the department on 6/6/2022 at 5:30 PM.

Additionally, per email correspondence with Ms. Bruyere, a hand-written note was attached to the incident report which read:

> *"6/6/22 midnight text from [Employee #2] notifying of fall & bumped his head.*
>
> *5:23 AM text from [Employee #2] right upper eye swollen, ice applied, was told improving.*
>
> *10:18 AM [Previous facility nurse] texted Laura, NP to request to be seen."*

I reviewed the progress note dated 6/6/2022 and signed by the previous facility nurse which read:

> *"Resident observed on floor w/ c/o pain & open skin injury to head located above right eye, per med tech. Aid was transferring and resident lost balance. Vitals WNL. Wound cleansed, ice applied."*

I reviewed nurse practitioner Laura Kremer's notes dated 6/6/2022 which in part read:

> *"Chief Complaint*
>
> *Urgent request a facility for fall on 6/6/22 at midnight, write a bruise, facial swelling and abrasion. (Appt time: 1:30 PM) (Arrival time: 12:23 PM)*
>
> *HPI by problem:*
>
> *Seen a urgent request of facility for fall at midnight on 6/6/2022. Patient sustained right facial abrasion w/ sanguineous drainage and swelling, right periorbital ecchymosis, has known history of Eliquis use.*
>
> *Currently appears at baseline, A&Ox3, answers questions and follows instructions appropriately, pupil 1+/1+ equal and reactive. No changes in ocular movement.*
>
> *Spoke with son on phone call following visit, advised recommendations for hospital referral to rule out any internal bleeding as patient is high-risk with Eliquis. Son states understanding and is agreeable with plan of care."*

I reviewed the facility's fall policy which read:

KEY PROCEDURES
ASSESS SITUATION
SUMMON ASSISTANCE
AWAIT HELP
RE-ESTABLISH ORDER

ASSESS SITUATION:
The first step is to assess the situation: determine emergency action is needed. If the resident has painful areas or bumps, or if his/her limbs are in an unnatural position, encourage the resident to stay on the floor until the ambulance arrives. DO NOT MOVE THE RESIDENT.

SUMMON ASSISTANCE:
If other staff are present, use the call system, phone or call out to obtain additional assistance. If alone, after assessing the situation, leave the injured person long enough to call "9-1-1: to report an emergency. Return and remain with the injured resident, unless doing so put another resident at greater risk.

AWAIT HELP:
If the resident is unable to stand with minimal or no assistance, DO NOT attempt to assist the resident to his/her feet without assistance form another individual. If there is a question with regard to the resident's ability to get up without assistance, always call for help. If there is no other staff in the building, contact the Director for direction as to whom to call for assistance in moving the fallen resident. Do not, unless necessary, leave the resident alone until emergency assistance arrives.

RE-ESTABLISH ORDER:
Once help has arrived and situation is secured, calm the other residents, if necessary. Give appropriate information about the situation in brief and accurate terms. Complete an Incident Report and Fall Investigation Form following established procedures and contact appropriate supervisors.

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:	Review of facility documentation revealed Resident A had a history of falls and required staff assistance for transfers. Review of the incident report and facility documentation revealed Resident A's fall occurred on 6/6/2022, not 6/4/2022 as alleged. The report read Resident A had *bumped his Rt. Shoulder and forehead above his right eye a*nd complained of achiness after the fall while the nurse's progress note read Resident A complained of pain. The Kare staff member's interview revealed Resident A complained of discomfort. The facility's fall policy in part reads *If the resident has painful areas or bumps* to encourage the resident to remain on the floor until the ambulance arrived. Although staff sought medical attention, staff did not follow their fall policy. Based on this information, this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/28/2022, I shared the findings of this report with authorized representative Jeremiah Johnson by voicemail.

IV. RECOMMENDATION

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

11/02/2022

_____

Jessica Rogers Date
Licensing Staff

Approved By:

11/28/2022

_____

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