GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 6, 2022

Todd Dockerty
The Reflections
14316 S. Helmer Rd.
Battle Creek, MI 49015

RE: License #: AH130403566
Investigation #: 2023A1010015
The Reflections

Dear Mr. Dockerty:

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.

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) 241-1970.

Sincerely,
Lauren Wohlfert

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa, NW Unit 13, 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH130403566
Investigation #:	2023A1010015
Complaint Receipt Date:	12/09/2022
Investigation Initiation Date:	12/13/2022
Report Due Date:	02/08/2023
Licensee Name:	Battle Creek Assisted Living Operator, LLC
Licensee Address:	111 W. Ferry St. #1 Berrien Springs, MI 49103
Licensee Telephone #:	(574) 261-1124
Administrator:	Jonathon Zima
Authorized Representative:	Todd Dockerty
Name of Facility:	The Reflections
Facility Address:	14316 S. Helmer Rd. Battle Creek, MI 49015
Facility Telephone #:	(269) 969-2500
Original Issuance Date:	12/09/2020
License Status:	REGULAR
Effective Date:	06/09/2022
Expiration Date:	06/08/2023
Capacity:	45
Program Type:	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility improperly discharged Resident D and did not provide him and his authorized representative with a less than 30-day discharge notice.	Yes
Staff did not administer Resident D's as needed Risperdal medication when he exhibited behaviors.	Yes
Additional Finding	Yes

III. METHODOLOGY

12/09/2022	Special Investigation Intake 2023A1010015
12/13/2022	Special Investigation Initiated - Telephone Message left for the complainant, a call back was requested
12/27/2022	Inspection Completed On-site
12/27/2022	Contact - Document Received Received resident service plan and MAR
01/06/2023	Exit conference

ALLEGATION:

The facility improperly discharged Resident D and did not provide him and his authorized representative with a less than 30-day discharge notice.

INVESTIGATION:

On 12/9/22, the Bureau received the allegations from Adult Protective Services (APS). The complaint was not assigned for APS investigation.

The complaint read, "On 12/8/22, Carolyn Reed (nursing director) petitioned to have [Resident D] taken to Bronson Battle Creek Hospital for evaluation and wanted him admitted after striking another resident at the facility whom he's engaged to. [Resident D] denied hitting the resident and said they were arguing. He seemed alert and oriented." The complaint also read, "The facility director, Carolyn Reed will not allow [Resident D] to return to the facility but offered to allow him to come back just for the night with his son. The facility did not assist [Resident D] with finding another

place to stay and has a poor 24-hour discharge plan." Resident D's responsible person did not receive a written less than 30-day discharge notice in accordance with licensing administrative rules.

On 12/13/2022, I left a voicemail message for the APS complainant. I did not receive a telephone call back.

On 12/27/22, I interviewed Ms. Reed virtually. Ms. Reed reported Resident D struck Resident E on 12/5/22. Ms. Reed stated after the incident, she attempted to get Resident D a psychological (psyche) evaluation. Ms. Reed reported it was determined Resident D would be transported to the emergency room (ER) on 12/8/22 for a psyche evaluation. Ms. Reed said Relative D1 was at the facility on 12/8/22 and she gave him a verbal less than 24-hour discharge notice for Resident D at that time. Ms. Reed reported Relative D1 and Resident D were not given a written less than 24 hour discharge notice.

Ms. Reed reported Resident D did not return to the facility after he was transported to the ER on 12/8/22. Ms. Reed stated Resident D's family found an alternative placement for Resident D in Portage after he was discharged from the hospital. Ms. Reed said she did not contact APS regarding Resident D's less than 24-hour discharge notice and Relative D1 was not informed of his right to file a complaint with licensing.

On 12/27/22, I interviewed administrator Jonathon Zima virtually. Mr. Zima's statements were consistent with Ms. Reed.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(16) A home that proposes to discharge a resident for any of the reasons listed in subrule (15) of this rule shall take all of the following steps before discharging the resident: **(a) The home shall notify the resident, the resident's authorized representative, if any, and the agency responsible for the resident's placement, if any, not less than 24 hours before discharge. The notice shall be verbal and issued in writing. The notice of discharge shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the home, if any.** **(iii) The location to which the resident will be discharged. (iv) The right of the resident to file a complaint with the department.**

	(b) The department and adult protective services shall be notified not less than 24 hours before discharge in the event of either of the following: **(i) A resident does not have an authorized representative or an agency responsible for the residents placement.** **(ii) The resident does not have a subsequent placement.** **(c) The notice to the department and adult protective services shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the home, if any.** **(iii) The location to which the resident will be discharged, if known.** **(d) If the department finds that the resident was improperly discharged, then the resident may return to the first available bed in the home that can meet the resident's needs as identified in the resident's service plan.** **(e) The resident shall not be discharged until a subsequent setting that meets the resident's immediate needs is located.**
ANALYSIS:	The interview with Ms. Reed revealed Resident D and his responsible person, Relative D1, were not provided with a written less than 24-hour discharge notice. Relative D1 was also not informed of the right to file a complaint with licensing. Resident D's family located an alternate placement for Resident D after he was discharged from the hospital.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff did not administer Resident D's as needed Risperdal medication when he exhibited behaviors.

INVESTIGATION:

On 12/9/22, the complaint read, "Reflections Clinical Services has not been giving [Resident D] his prescribed Risperdal for his dementia and behaviors. The medication was last given to [Resident D] last month. He's supposed to be taking the medication up to three times per day. It's not known why [Resident D] was not given the medication. There are concerns his aggressive behaviors are a result of him not being given the medication."

On 12/27/22, Ms. Reed reported Resident D is prescribed Risperdal as needed for agitation. Ms. Reed stated this medication was not administered to Resident D on 12/5/22, after he struck Resident E. Ms. Reed said she did not know why staff did not administer the medication as an intervention regarding his agitation. Ms. Reed stated staff are aware Resident D's as needed Risperdal is available to be administered as an intervention when he experiences agitation.

On 12/27/22, Mr. Zima provided me with a copy of Resident D's November and December medication administration records (MARs) via email for my review. The MARs read Resident D was prescribed "Risperidone 0.25 Mg Tablet Take 1 Tablet by Mouth Three Times Daily as Needed (behaviors)." The MARs read this medication was not administered in November or December.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	The interview with Ms. Reed, along with review of Resident D's MAR revealed he was prescribed as an as needed medication as an intervention when he experienced agitation. Resident D got into a physical altercation with Resident E on 12/5/22. Rather than administer Resident D's prescribed Risperdal, Resident D was sent to the ER a few days later to address his aggressive behavior.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 12/27/22, I received a copy of Resident D's service plan via email from Mr. Zima for my review. I observed Resident D's service plan did not outline his behaviors or any staff interventions. The plan did not outline Resident D's prescribed as needed Risperdal that can be used as an intervention when he experienced agitation and aggression.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	Review of Resident D's service plan revealed there were no instructions or interventions outlined for staff to use when Resident D exhibited aggressive behavior. The plan did not outline how Resident D's prescribed as needed Risperdal was to be used as an intervention when Resident D experienced agitation.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Todd Dockerty by telephone message on 1/6/22.

IV. RECOMMENDATION

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

12/29/2022

Lauren Wohlfert Date
Licensing Staff

Approved By:

01/04/2023

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