GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 6, 2023

Leigh McLeod
The Meadows at Canterbury-on-the-Lake
5601 Hatchery Road
Waterford, MI 48329

RE: License #: AH630380234
Investigation #: 2023A0784021
The Meadows at Canterbury-on-the-Lake

Dear Ms. McLeod:

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.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AH630380234 |
| | |
| **Investigation #:** | 2023A0784021 |
| | |
| **Complaint Receipt Date:** | 12/08/2022 |
| | |
| **Investigation Initiation Date:** | 12/09/2022 |
| | |
| **Report Due Date:** | 02/06/2023 |
| | |
| **Licensee Name:** | Canterbury Health Care, Inc. |
| | |
| **Licensee Address:** | 5601 Hatchery Road<br>Waterford, MI 48329 |
| | |
| **Licensee Telephone #:** | (248) 674-9292 |
| | |
| **Administrator:** | Deandre Schultz |
| | |
| **Authorized Representative:** | Leigh McLeod |
| | |
| **Name of Facility:** | The Meadows at Canterbury-on-the-Lake |
| | |
| **Facility Address:** | 5601 Hatchery Road<br>Waterford, MI 48329 |
| | |
| **Facility Telephone #:** | (248) 674-9292 |
| | |
| **Original Issuance Date:** | 01/05/2018 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 07/05/2022 |
| | |
| **Expiration Date:** | 07/04/2023 |
| | |
| **Capacity:** | 32 |
| | |
| **Program Type:** | ALZHEIMERS |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A was provided inadequate protection and supervision | Yes |
| Additional Findings | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 12/08/2022 | Special Investigation Intake<br>2023A0784021 |
| 12/09/2022 | Special Investigation Initiated - On Site |
| 12/09/2022 | Inspection Completed On-site |
| 12/13/2022 | Contact - Document Received<br>Investigative documents received via email from administrator Deandrea Schultz |
| 02/06/2023 | Exit Conference – Telephone<br>Message left with Ms. Schultz regarding the outcome of the investigation |

**ALLEGATION:**

**Resident A was provided inadequate protection and supervision**

**INVESTIGATION:**

On 12/08/2022, the department received an incident report from the facility indicating Resident A had fallen out of bed, sometime before 6am on 12/07/2022, and ultimately sustained a broken nose and contusion above her right eye. The report further indicated the facility investigated the possibility of physical abuse due to a staff member concern and determined no evidence of abuse due to a lack of evidence of such and no witnesses to the fall or injury. The facility reportedly submitted a report to police regarding the abuse concern. Under a section titled *Explain What Corrective Measures Taken to Remedy and/or Prevent Recurrence*, the report read, in part, “Upon return from the hospital all orders will be followed up on and a follow up report will be sent with findings. Resident will be on increased safety checks”.

On 12/09/2022, I interviewed administrator Deandra Schultz at the facility. Ms. Schultz stated that on the morning of 12/07/2022, at approximately 6am, she

received a call from Associate 1 who reported Resident A had fallen from her bed and was observed to have sustained an injury to her right eye. Ms. Shultz stated Associate 1 reported that Associate 2 had discovered Resident A laying on her floor after the fall shortly before 6am, after what appeared to be a fall, and retrieved him to help transfer Resident A from the floor to her wheelchair. Ms. Schultz stated that she had received a separate concern from Associate 3, the team lead during that same shift, who saw Resident A's injury and felt it looked like Resident A had been hit in the eye. Ms. Schultz stated Associate 3 did not witness any abuse. Ms. Schultz stated she pursued interviews with Associate 1 and Associate 2 regarding the events of the morning of 12/07/2022 after Associate 3 suggested possible abuse. Ms. Shultz stated she has not had any concerns of abuse regarding Associate 1 and that Associate 2 stated she had not witnessed any such treatment. Ms. Schultz stated, however, that when interviewed, Associate 2 provided a different account of events on the morning of 12/07/2022. Ms. Schultz stated Associate 2 reported she did not discover Resident A on her floor and had not helped Associate 1 assist Resident A off the floor. Ms. Schultz stated Associate 2 reported she had gone into Resident A's room at approximately 5:35am that morning to administer Resident A medications and observed her sitting in her chair and noticed she had a black eye. Ms. Schultz stated Associate 2 reported that she asked Associate 1 if he knew what happened and he reportedly said not and that she asked Resident A if she remembered what happened and that she said no. Ms. Schultz stated Resident A is physically unable to pick herself up off the floor so she would have had to be helped off the floor by someone. Ms. Schultz stated her belief that, based on Associate 2's statements, Associate 1 discovered Resident A on the floor after having fallen and assisted her into her wheelchair by himself. Ms. Schultz stated Associate 1 is aware that while resident A generally requires one staff member for transfers, any resident that is discovered to have fallen requires two staff to assist that resident off the floor. Ms. Schultz stated Associate 1 has been given at least two previous written corrective actions due to not following appropriate safety protocols. Ms. Schultz stated Associate 1, who was assigned to Resident A that morning for care, was also aware, per Resident A's service plan, that Resident A requires at least two-hour checks. Ms. Schultz stated staff are supposed to document if they completed their safety checks for residents and that Associate 1 had not done so for the shift. Ms. Schultz stated this has been common for Associate 1. Ms. Schultz stated that due to the lack of documentation and conflicting statements, she could not be certain when Resident A had last been checked on that morning or what exactly happened with Resident A. Ms. Schultz stated that it also appears, based on Associate 2's statements that she discovered Resident A sitting in her chair with the injuries at around 5:35am, Associate 1 may have known about Resident A's injuries prior to this time and did not respond in an adequate amount of time to report the situation to

her and to contact EMS. Ms. Schultz stated Resident A was ultimately sent to the hospital and diagnosed with a broken nose and a contusion above her right eye.

I reviewed Resident A's service plan, provided by Ms. Schultz, which was consistent with her statements regarding Resident A's transfer needs.

I reviewed written statements from Associate 1 and 2 which were consistent with the description of their statements provided by Ms. Schultz.

I reviewed *Corrective Action Notice* documentation for Associate 1, provided by Ms. Schultz. The first notice, dated 11/10/2022, indicated a *Company Policy Violation* of "failure to report resident injury in a timely and appropriate fashion". The second notice, dated 11/26/2022, indicated a *Company Policy Violation of* "failure to follow resident safety procedures".

| **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.** |
| **For Reference: R 325.1901** | **Definitions** |
| | **(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.** |

| | |
|---|---|
| **ANALYSIS:** | The department received an incident report from the facility indicating Resident A had suffered injuries from a fall with a reported suspicion that Associate 1 may have subjected her to physical abuse. While evidence is not supportive of physical abuse, based on Ms. Schultz statements, conflicting statements from staff, Resident A's service plan, previous documented corrective actions against Associate 1 and confirmed injuries to Resident A, it is reasonable to conclude that Associate 1 did not provide adequate supervision for Resident A's safety and protection. Due to the findings, the facility is not in compliance with this rule. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

Upon request, Ms. Schultz was unable to provide documentation showing Associate 1 had conducted the facility required two-hour safety checks for residents, and specifically for Resident A. Ms. Schultz stated it was common for Associate 1 not to fill out these observation documents.

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1942** | **Resident records.** |
| | **(3) The resident record shall include at least all of the following:**<br>**(f) Health information, as required by MCL 333.20175(1), and other health information needed to meet the resident's service plan.** |
| **333.20175** | **Maintaining record for each patient** |

| | |
|---|---|
| | **(1) A health facility or agency shall keep and maintain a record for each patient, including a full and complete record of tests and examinations performed, observations made, treatments provided, and in the case of a hospital, the purpose of hospitalization. Unless a longer retention period is otherwise required under federal or state laws or regulations or by generally accepted standards of medical practice, a health facility or agency shall keep and retain each record for a minimum of 7 years from the date of service to which the record pertains. A health facility or agency shall maintain the records in such a manner as to protect their integrity, to ensure their confidentiality and proper use, and to ensure their accessibility and availability to each patient or his or her authorized representative as required by law. A health facility or agency may destroy a record that is less than 7 years old only if both of the following are satisfied** |
| **ANALYSIS:** | During the investigation, it was revealed that facility staff are supposed to document two-hour safety checks completed for residents during each shift and that Associate 1 did not do so for Resident A during his shift the evening of 12/06/2022 and the morning of 12/07/20220. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

Aaron L Clum 2/03/2023

_____

Aaron Clum Date
Licensing Staff

Approved By:

Andrea L Moore 02/06/2023

_____

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