GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

Guy Geller
TV-MICH, LP
4500 Dobry Drive
Sterling Heights, MI 48314

April 28, 2023

RE: License #: AH500392805
Investigation #: 2022A1022019
Town Village Sterling Hgts - The Gem Memory Care

Dear Guy Geller:

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.

Please review the enclosed documentation for accuracy and contact me with any questions.

Sincerely,

Barbara P. Zabitz, R.D.N., M.Ed.
Health Care Surveyor
Health Facility Licensing, Permits, and Support Division
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Mobile Phone: 313-296-5731
Email: zabitzb@michigan.gov

enclosure

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

## I. IDENTIFYING INFORMATION

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|---|---|
| **License #:** | AH500392805 |
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| **Investigation #:** | 2022A1022019 |
| | |
| **Complaint Receipt Date:** | 08/12/2022 |
| | |
| **Investigation Initiation Date:** | 08/12/2022 |
| | |
| **Report Due Date:** | 10/11/2022 |
| | |
| **Licensee Name:** | TV-MICH, LP |
| | |
| **Licensee Address:** | 4500 Dobry Drive<br>Sterling Heights, MI 48314 |
| | |
| **Licensee Telephone #:** | (586) 200-4741 |
| | |
| **Administrator:** | Sheri Sepanak |
| | |
| **Authorized Representative:** | Guy Geller |
| | |
| **Name of Facility:** | Town Village Sterling Hgts - The Gem Memory Care |
| | |
| **Facility Address:** | 4500 Dobry Drive<br>Sterling Heights, MI 48314 |
| | |
| **Facility Telephone #:** | (586) 200-4741 |
| | |
| **Original Issuance Date:** | 06/15/2018 |
| | |
| License **Status:** | REGULAR |
| | |
| **Effective Date:** | 12/15/2021 |
| | |
| **Expiration Date:** | 12/14/2022 |
| | |
| **Capacity:** | 33 |
| | |
| **Program Type:** | AGED<br>ALZHEIMERS |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| The family of the Resident of Concern (ROC) found her with bruising on her head and left arm and no one in the facility was able to explain what had caused the injury. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 08/12/2022 | Special Investigation Intake<br>2022A1022019 |
| 08/12/2022 | Special Investigation Initiated - Telephone<br>Left message for complainant to call back |
| 08/19/2022 | Contact - Telephone call made<br>Complainant interviewed by phone. |
| 08/24/2022 | Inspection Completed On-site |
| 08/26/2022 | Contact - Document Received<br>Documents received by email from the RDCO |
| 12/15/2022 | Information received from the hospice provider via email. |
| 04/28/2023 | Exit Conference |
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**ALLEGATION:**

**The family of the Resident of Concern (ROC) found her with bruising on her head and left arm and no one in the facility was able to explain what had caused the injury.**

**INVESTIGATION:**

On 8/12/2022, the Bureau of Community and Health Systems received a complaint that read in part, “I (the complainant) also noticed a bruise on her (the ROC’s) forehead above her left eye, and a bruise on her left upper arm. I asked the med tech who was giving care to my mother at the time if she had noticed the new bruises and what they were from, as the family was not notified. She told me that she didn't notice either one.”

On 8/12/2022, I reviewed an incident report (IR) filed by the facility on 8/6/2022, describing an incident involving the ROC. According to the IR, “Residents family member visited resident at The Gem and noted that resident had a bruise on her forehead (left side). Bruising also noted to residents left arm upper arm. Cause of bruising is of unknown origin. Resident has bed bath on 8.7.22 with no reported bruising and or incidents from bath aide… Regional Director of Clinical Operations interviewed associates [name of caregiver #1] and [name of director of Life Enrichment] who stated no known bruising present during shifts on 8.6.22. Season Hospice notified on 8.6.22 of bruising. RDCO to investigate and observe all associates providing care for [name of ROC] to determine possible cause of bruising. Evaluation and plan of care to updated accordingly once investigation completed.

On 8/19/2022, I interviewed the complainant by phone. The complainant explained that the ROC had sustained a number of unexplained bruises over the past several months. On 4/5/2022, the ROC was found with a lump over her right eye and “black-eyes” on both eyes. The complainant stated that the explanation she received for the cause of the bruise and blackened eyes on 4/5/2022 was that the ROC must have rolled over during care and hit her head on the wall by her bed. The caregivers from then on were supposed to place an extra pillow the ROC’s bed by the wall. However, the complainant said, she never saw that extra pillow on the bed, even though she asked the caregivers about it. On 8/6/2022, the complainant found the ROC with a bruise over her left eye and another on her left upper arm. When she asked the medication technician on duty at that time about the bruising, the medication technician told the complainant that she had not noticed them. According to the complainant, she hadn’t been in to visit the ROC for at least a week and that bruise on her forehead had begun to turn a faint green and yellow color. The complainant went on to say that she could not understand why no one in the facility recognized that the ROC had been injured, as the ROC was not able to feed herself and was fed by staff. On 8/8/2022, the complainant found another bruise on the top of the

ROC's left hand. The complainant thought that bruise looked like a "thumb print." The complainant went on to say that the ROC was known to be resistive to care, and she thought that the care staff must "restrain her" when they provided care to her. According to the complainant, she had found alternate placement for the ROC and had moved her out of the facility.

On 8/19/2022, a referral from Adult Protective Services naming the ROC with essentially the same allegations as made by the complainant was received by the Bureau of Community and Health Systems.

On 8/24/2022, during the onsite visit, I interviewed the administrator. I also spoke with the corporate regional director of operations (RDCO) by phone. According to the administrator, the position of wellness director for the facility had been vacant for several weeks, going back to a time prior to the incident with the ROC. When the facility needed someone with clinical expertise, they were calling on the corporate RDCO or the wellness director of one of their corporate sister facilities, The administrator stated that when the ROC's daughter brought the ROC's bruising to her attention, it was the RDCO who handled the investigation and she had very little information about it. When contacted by phone, the RDCO stated that she did not have all the details of the investigation in her head at that time, but that she would send me her written investigation. I also asked the RDCO to identify which staff members she interviewed as part of her investigation.

At the time of the onsite visit, I asked the administrator if there were any caregivers at the facility who took care of the ROC in the timeframe of 8/4/2022 through 8/8/2022 and might remember something of the bruising. The administrator named caregiver #1, caregiver #2 and caregiver #3. I asked to interview these employees as well as the director of Life Enrichment, as her name was included on the IR.

Caregiver #1 was the medication passer at the time that the complainant found the bruising. Caregiver #1 stated that when the complainant pointed out the bruising, caregiver #1 saw a small bruise that looked as though it was in the process of healing. Caregiver #1 stated that she only administered medication to the ROC and never provided care to her and could not say what had caused the bruising.

Caregiver #2 stated that she remembered the ROC as being "fidgety" when receiving care. Caregiver #2 went on to say that when she was assigned to provide the ROC's care, she would always try to "distract" her to make the provision of care a bit easier. However, at the time the ROC was discovered to have this bruising, caregiver #2's assignment was to pass medications and she did not remember the ROC having any bruises.

Caregiver #3 stated that she had begun employment at the end of July 2022 and had provided care to the ROC only once during the entire time of her employment. Caregiver #3 stated she was not aware the ROC had sustained bruising.

The director of Life Enrichment stated that in her position, she would interact with residents including the ROC during activities and would help out in the dining room. She did not provide care. The director of Life Enrichment stated that she never looked at the ROC's arms and that the ROC frequently would "cover her face and put her head down, so it was difficult for me to see her face or forehead."

The director of Life Enrichment and caregiver #1 were named as information sources in the IR.

When the RDCO was asked to provide the details and outcome of her plan "to investigate and observe all associates providing care for [name of ROC] to determine possible cause of bruising," as indicated in the IR, on 8/26/2022, the RDCO sent the following via email. "Over the week of August 8th – August 12th, I spent time at The Gem (Memory Care unit) interviewing associates to determine a possible underlying cause of bruising of unknown origin on [name of the ROC]. While providing training for abuse and neglect and proper incident reporting, I interviewed multiple individuals who signed in for the education and who have direct interaction with [name of the ROC] to see if they had noted any bruising on [name of the ROC] and the consensus was that no bruising was noted. Many spoke about how [name of the ROC] fidgets and curls her hands and arms up, making it difficult to dress her. Some mentioned that the fidgeting seemed worse than it has been in the past and almost seemed to be a form of agitation. I reached out to hospice to discuss [name of the ROC]'s medications and the hospice nurse consulted with [name of the ROC]'s physician who made some medication changes based on her fidgeting/possible agitation. After my time spent interviewing associates, I was not able to come to any conclusion as to how the bruising may have occurred. At that time, I thought that perhaps the bruising may have happened while resident was being transferred. I determined that I should provide Hoyer training to make sure the Hoyer was being used properly by all associates. A Hoyer training session was then set up. I also observed [name of the ROC]'s room for any safety hazards that may have been obvious. I did not see anything that would be of concern pertaining to [name of the ROC]'s safety. I made sure pillows were in place along the wall side of the bed. I also posted two signs in her room for additional reminders to the associates. One sign reminded everyone to make sure two people are present for all transfers and the other sign was a reminder to make sure pillows were always in place along the wall side of the bed. Ultimately, the conclusion I came to was that I was not able to determine how the bruising occurred."

The RDCO did not provide any evidence or indication that she made observations of the care staff providing care to the ROC as she stated in the IR.

The ROC's hospice provider was asked if the ROC had been prescribed any medications that increased the ROC's risk for bruising. According to the hospice clinical manger who reviewed the ROC's hospice notes, there were not. The hospice clinical manager went on to say (via email), "On 8/9/2022 there is a note from RN

(hospice nurse #1) that notes bruising to L(left) forehead, L (left) upper arm, and R (right) forearm."

The RDCO named nine total employees that she remembered interviewing about the ROC's bruising, including caregiver #1, caregiver #2, and the Life Enrichment Director. Of the remaining six caregivers, only 1 of them provided care to the ROC between 8/4/2022 and 8/8/2022; although 1 other of the six would have administered medication to her.

When the RDCO was asked to provide details of interviews she conducted with staff who provided care to the ROC, the RDCO sent an email statement "I am the Regional Nurse and stepped in briefly to help when I learned of this situation with [name of the ROC] the week following the incident. Our Executive Director was out on vacation at the time so I did the best I could to determine the cause of [name of the ROC]'s bruising. I did interview as many people as possible. I was not able to get written statements from everyone. I believe whatever was given to you was what I had at the time. Unfortunately, due to the previous WD (Wellness Director)'s shortcomings, many of our systems in terms of assignments etc. were not completely accurate." The RDCO went on to acknowledge that there were no written statements taken from care staff; all interviews were verbal, and she kept no notes on the conversations.

According to the ROC's service plan initiated on 3/29/2022, The ROC required the physical assistance of the care staff for all of her activities of daily living (ADLs); required the use of a wheelchair; required the assistance of two persons for transfer from her wheelchair to her bed and back again; and was totally incontinent on a regular basis.

Review of the ROC's Charting Notes revealed the following:

On 8/7/2022, the RDCO documented, "Late entry—It was reported to this nurse that resident (the ROC) had bruising on her forehead and arm by ED (executive director/administrator) who received an email from resident's daughter. This nurse called to check in on resident's wellbeing. It was reported that the resident does in fact have bruising noted on her forehead and arm. This nurse requested vital signs which were reported WNL (within normal limits). Resident alert and at her usual baseline with no signs of distress. Incident report to Seasons hospice as well as state (State of Michigan)."

Also, on 8/7/2022, the RDCO documented, "Resident continues to have bruising on her head and arm which is from unknown origin. Resident has no s/s (signs and symptoms) distress noted. Alert as per usual baseline. This nurse made two attempts to call resident's daughter to follow up pertaining incident… This nurse assured resident's daughter that a complete investigation will be done and will get back with her pertaining to findings. This nurse called and spoke with two associates who were present with resident over Thursday and Friday of last week. No noted

bruising reported. This nurse saw resident on Thursday 8/4/22 and did not note any bruising. Call placed to APS hotline by this nurse on 8/7/22 at around 4 pm to report potential abuse/neglect. This nurse will continue investigation of incident upon arrival to community on 8/8/2022."

On 8/8/2022, the RDCO documented, "This nurse assessed resident today who was resting comfortably in her Broda (brand name) chair in dining room. Slight bruising noted on left forehead and left arm… "

Also, on 8/8/2022, the RDCO documented, "Late note entry, (for) 8/7/22. This nurse interviewed several associates who stated they did not see any bruising on resident over the weekend… Education provided to associates pertaining to proper reporting of resident incidents."

| **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:**<br><br>**(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.** |
| **For Reference: R325.1901** | **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.** |

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|---|---|
| **ANALYSIS:** | The facility did not protect the ROC as they did not have the systems in place to establish how the ROC sustained the injuries. The investigation conducted by the RDCO appears to have consisted of superficial questioning of random caregivers and associates available at the time (for example the Director of Life Enrichment) and not the in-depth investigation that she promised in the IR's section delineating "Corrective Measures Taken to Remedy and/or Prevent Recurrence." |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

I reviewed the findings of this investigation with the administrator on 4/28/2023. When asked if there were any comments or concerns with the investigation, the administrator said there were none.

## IV. RECOMMENDATION

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

4/28/2023

Barbara Zabitz Date
Licensing Staff

Approved By:

04/27/2023

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