GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 16, 2023

Paul Barber
Directors Hall
600 Golden Drive
Kalamazoo, MI 49001

RE: License #: AH390236775
Investigation #: 2023A1028083
Directors Hall

Dear Paul Barber:

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

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

I. IDENTIFYING INFORMATION

License #:	AH390236775
Investigation #:	2023A1028083
Complaint Receipt Date:	09/13/2023
Investigation Initiation Date:	09/18/2023
Report Due Date:	11/18/2023
Licensee Name:	Heritage Community of Kalamazoo
Licensee Address:	2400 Portage St. Kalamazoo, MI 49001
Licensee Telephone #:	(269) 343-5345
Administrator:	Amy Beach
Authorized Representative:	Paul Barber
Name of Facility:	Directors Hall
Facility Address:	600 Golden Drive Kalamazoo, MI 49001
Facility Telephone #:	(269) 349-8694
Original Issuance Date:	03/01/1974
License Status:	REGULAR
Effective Date:	08/14/2023
Expiration Date:	08/13/2024
Capacity:	89
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was neglected due to improper care at the facility.	Yes
Additional Findings	No

III. METHODOLOGY

09/13/2023	Special Investigation Intake 2023A1028083
09/18/2023	Special Investigation Initiated - Letter
09/18/2023	APS Referral No APS referral. APS initially made referral to HFA. Resident is deceased.
09/27/2023	Contact - Face to Face Interviewed Admin/Amy Beach at the facility.
09/27/2023	Contact - Face to Face Interviewed Employee A at the facility.
09/27/2023	Contact - Document Received Received Resident A's record from Admin/Amy Beach.

ALLEGATION:

Resident A was neglected due to improper care at the facility.

INVESTIGATION:

On 9/14/2023, the Bureau received the allegations from the online complaint system.

On 9/18/2023, no Adult Protective Services (APS) referral made due to resident being deceased.

On 9/18/2023, I interviewed facility administrator, Amy Beach, at the facility who reported Resident A was admitted to the facility in April 2023 with a history of falls and resided in the memory care unit. Resident A was diagnosed with dementia and multiple other conditions. Resident A also had a high fall risk assessment in place

with the facility and physician monitoring. Resident A had multiple falls at the facility due to decline in health and multiple medication changes. Ms. Beach reported Resident A was part of the Senior Care Partners program which also monitored Resident A at the facility. Ms. Beach reported Resident A's authorized representative and physician were contacted each time Resident A fell and/or an incident occurred. On 8/14/2023, Resident A was sent to the hospital due to multiple falls resulting in bruising, and allegedly due to a dresser falling on Resident A. Ms. Beach provided me Resident A's record for my review.

On 9/18/2023, I interviewed Employee A at the facility who confirmed Resident A had multiple falls with bruising at the facility. Resident A was a high fall risk and had dementia which impaired Resident A's safety awareness. Resident A was monitored by the facility, physician, and Senior Care Partners due to history of falls and decline in health. Employee A reported the physician and Senior Care Partners were contacted multiple times due to Resident A's decline in health, impaired safety awareness, and multiple falls at the facility resulting in bruising. Employee A reported a psych evaluation was also requested by the facility because it became increasingly difficult to keep Resident A safe at the facility due to dementia and impaired safety awareness. Employee A reported the facility provided 1:1 care because of the increase in falls. Employee A also reported Resident A had multiple medication changes throughout [their] stay at the facility and this contributed to Resident A's impaired safety awareness, confusion, and multiple falls. Employee A reported knowledge of an incident in which Resident A was found on the floor and it appeared the dresser might have fallen on Resident A, but it could not be substantiated. Resident A was sent to the hospital on 8/14/2023 due to multiple falls and demonstrating a decline in health.

On 9/18/2023, I reviewed Resident A's record which revealed the following:

- Resident A was admitted to the facility on 4/11/2023 and was discharged on 8/18/2023.
- Had a diagnosis of dementia with behavioral disturbance, along with other multiple co-morbidities.
- Physician Lack of Capacity Determination in place due to dementia diagnosis and dated 1/11/2023.
- Required cuing, redirection, and short simple sentences due to disorientation.
- Required set-up with cuing and/or assistance with toileting, grooming, dressing, and bathing.
- Could complete transfers and ambulation without assistive device but required hand-held assistance occasionally.
- Had raised toilet seat, shower chair, and grab bars and could be transported by wheelchair if necessary.
- Facility managed all medications.
- Facility managed all laundry, meals, and housekeeping.
- Undated health care appraisal completed by Senior Care Partner nurse practitioner documenting Resident A is *chronically ill appearing and demented with limited insight and judgement.*

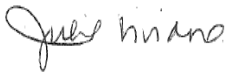
- High Fall Risk Assessment in place and dated beginning 5/19/2023 to 8/8/2023.
- Surgical history with most recent surgery on 5/23/2023 pertaining to the left wrist fracture and internal fixation.
- X-Ray of right finger completed on 8/8/2023 due to fall with injury. Findings were *acute non-displaced transverse fracture near the distal tuft of the second distal phalanx. Additional comminuted fracture fragments measuring between 3mm to 6mm. The tip of the distal tuft.*
- X-Ray completed of right shoulder completed on 8/9/2023 due to fall and complaints of pain. *No findings of acute fracture.*
- Chest, abdomen, and pelvis CT scan with contrast completed on 8/9/2023 with findings of *a healing fracture of the sternum with sclerosis. There was a healing fracture of the left fourth, fifth, and sixth rib. There were superior endplate compression deformities of C7 and Tl, chronic.*
- Spine Cervical CT scan completed 8/9/2023 with findings resulting *no new fracture. Mild C7 and T1 superior endplate compression fractures are redemonstrated. Mild degenerative changes. Moderate posterior disc osteophyte complex at C6 level bilaterally narrow central canal. Multilevel facet arthropathy.*
- Brain CT scan completed on 8/8/2023 without contrast with findings of *no evidence of acute infarct. Arterial calcification is noted. No intracranial hemorrhage, no intracranial mass, no hydrocephalus. Moderate white matter hypoattenuation most commonly represents chronic microvascular ischemic disease. Moderate cerebral and cerebellar atrophy.*
- On 6/3/2023, fall documented in hallway with Resident hitting head and resulting in bloody nose. Supervisor and physician notified. Vitals stable and staff continued to monitor.
- On 6/5/2023, Resident A not eating much and requiring encouragement from staff.
- Brusing on Resident A documented on 7/5/2023, 7/8/2023, 8/2/2023, and 8/13/2023.
- Bump on left eyebrow documented on 8/8/2023.
- Cut finger on 8/8/2023. Resident A refused to allow facility to assess it.
- On 8/8/2023, refused medication and two bumps noted on right side of head. Sent to hospital for assessment.
- Behavioral and/or emotional disturbances occurring on 5/13/2023, 5/17/2023, 5/27/2023, 6/4/2023, 6/5/2023, 6/10/2023, 6/23/2023, 6/28/2023, 8/2/2023, 8/5/2023, 8/9/2023, 8/10/2023, 8/11/2023, 8/13/2023, and 8/14/2023.
- Documented falls on 6/3/2023, 8/10/2023, multiple falls on 8/13/2023, and 8/14/2023.
- On 8/13/2023, Resident A marked a fall risk in chart notes and *needs eyes 24/7.*
- Resident A sent to hospital on 8/14/2023 and discharged from facility 8/18/2023.

- Evidence of communication with physician and Resident A's authorized representative from 4/26/2023 to 8/14/202 concerning Resident A's falls, behaviors, medications, and/or injuries.

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:	It was alleged Resident A was neglected due to improper care at the facility. Interviews, evidence, and on-site investigation revealed while Resident A was a high fall risk, there were not appropriate interventions in place for facility staff to provide appropriate supervision and assistance for Resident A's safety. A fall was documented on 6/3/2023 resulting in Resident A hitting [their] head and a bloody nose, but it could not be determined if Resident A was sent to the hospital for evaluation due to potential head injury. On 8/14/2023, Resident A had multiple falls with one of the falls resulting in a dresser being tipped over and potentially falling on Resident A. It could not be substantiated if the dresser fell on Resident A because the facility staff did not document the incident appropriately or in a timely manner. There was also no evidence of interventions in Resident A's care plan or evidence of assistive devices such as a winged mattress or fall mat being utilized with Resident A despite Resident A being documented as a high fall risk. Also, one to one care was not documented as being provided until 8/13/2023, after multiple falls with bruising and injury. Resident A was sent to the hospital on 8/14/2023 for multiple falls and due to a demonstrated decline. The facility did not provide appropriate supervision or assistance for the protection and safety of Resident A. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



10/16/2023

Julie Viviano Date
Licensing Staff

Approved By:

10/30/2023

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