GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 11, 2023

Matthew Brawner
Premier Operating Lapeer AL, LLC
1442 Suncrest Drive
Lapeer, MI 48446

RE: License #:	AL440383805
Investigation #:	2024A0872005
	The Pines of Lapeer

Dear Matthew Brawner:

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 that I am not available, and you need to speak to someone immediately, please contact the local office at (517) 643-7960.

Sincerely,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL440383805
Investigation #:	2024A0872005
Complaint Receipt Date:	10/20/2023
Investigation Initiation Date:	10/23/2023
Report Due Date:	12/19/2023
Licensee Name:	Premier Operating Lapeer AL, LLC
Licensee Address:	6th Floor 299 Park Ave New York, NY 10171
Licensee Telephone #:	(810) 423-8003
Administrator:	Matthew Brawner
Licensee Designee:	Mark Walker
Name of Facility:	The Pines of Lapeer
Facility Address:	1442 Suncrest Drive Lapeer, MI 48446
Facility Telephone #:	(810) 423-8003
Original Issuance Date:	05/19/2017
License Status:	REGULAR
Effective Date:	11/19/2021
Expiration Date:	11/18/2023
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A had an Xray on her left arm which revealed a fracture. The cause of the fracture is unknown.	Yes

III. METHODOLOGY

10/20/2023	Special Investigation Intake 2024A0872005
10/23/2023	Special Investigation Initiated - Letter I exchanged emails with Relative A1
10/23/2023	Contact – Document Sent I emailed the administrator requesting information about this complaint
10/25/2023	Inspection Completed On-site Unannounced
10/25/2023	Contact - Document Received I received documentation from the administrator
11/22/2023	Contact - Document Sent I emailed the administrator requesting additional information related to this complaint
11/27/2023	Contact - Document Received Additional AFC information received
12/05/2023	Contact - Telephone call made I interviewed staff Claudia Brock
12/05/2023	Contact - Telephone call made I interviewed staff Hannah Lucas
12/05/2023	Contact - Telephone call made I interviewed staff James Herd
12/05/2023	Contact – Telephone call made I spoke to Relative A1 about my investigation

12/11/2023	Contact – Document Received I reviewed an Incident/Accident Report regarding this investigation
12/11/2023	Exit Conference I conducted an exit conference with the administrator, Matthew Brawner
12/11/2023	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: Resident A had an Xray on her left arm which revealed a fracture. The cause of the fracture is unknown.

INVESTIGATION: On 10/25/23, I conducted an unannounced onsite inspection of The Pines of Lapeer, and I interviewed staff Jennifer Blackmer. Staff Blackmer said that she has worked at The Pines of Lapeer AFC since March 2023, and she typically works 1st shift. I reviewed the allegations with Staff Blackmer, and she confirmed that Resident A resided at this facility for approximately one month and she provided personal care, protection, and supervision to her.

Staff Blackmer said that on 09/28/23, she and staff Claudia Brock were working together. She said that she assisted Resident A to the bathroom on several occasions and she always transferred her the way she was taught. Resident A would sit up in bed, use her arms to steady herself on her wheelchair, and Staff Blackmer would then lift Resident A by the waist to get her into her wheelchair and to the bathroom. According to Staff Blackmer, she was told that Resident A had broken her left arm several years ago and surgery was not done so she often suffered pain in her arm. Therefore, Resident A had a limb alert band on her left arm and all staff were told not to transfer her using her left arm, not to take her blood pressure on that arm, and not to put too much pressure on that arm.

Staff Blackmer said that Resident A complained of pain in her left arm on a regular basis and family told staff that Resident A suffers from chronic pain in her left arm because of the break she suffered years ago. Staff Blackmer told me that she recalls Resident A complaining of pain on 09/28/23, but she did not suffer any known incidents or accidents, and Staff Blackmer did not see any swelling or bruising in her arm, so she did not feel Resident A required outside medical attention. Staff Blackmer told me that until Resident A's decline shortly before her death, she was a 1-person assist.

On 10/26/23, I reviewed Adult Foster Care documentation related to Resident A. She was admitted to The Pines of Lapeer on 08/11/23. She began receiving services from Harmony Care Hospice on 03/14/23 and her primary care physician was Dr. Amanda Chmielewski. According to her hospice records, Resident A was diagnosed with multiple sclerosis, dementia, epilepsy, spinal stenosis, cervical spinal degenerative and arthritis, COPD, eye-macular degeneration, left arm fracture (from 40-years ago), osteoporosis, and breast cancer. According to Resident A's Health Care Appraisal dated 09/25/23,

she uses a walker and wheelchair for mobility, she experiences weakness, she is frail, and she has a left upper arm abnormality.

According to Resident A's Assessment Plan dated 07/27/23, she requires a 1-2 person assist with toileting and bed changes and hospice staff will assist AFC facility staff with bathing Resident A. She also requires assistance with grooming, dressing, and personal hygiene and Resident A's food needs to be cut up. Resident A's Assessment Plan was updated on 10/17/23 and stated, "Resident had a catheter put in and is now bed bound."

I reviewed Resident A's hospice notes from October 2023. According to the note dated 10/02/23, registered nurse (RN) Patricia Howell provided care to Resident A on this date. According to RN Howell's narrative, Resident A was in bed and "states she is very tired, complaining of a break in her left arm. (She) states she was transferred by facility staff last Thursday, and now her arm has a separation. L Humerus has an obvious indentation, and a crunching noise is made during movement. Staff reports that (she) is sleeping all the time and asking for morphine frequently. (She is) choking on grapes and thin liquids. Staff re-educated to give soft foods and thickened water." A bedside commode was requested.

According to the hospice note dated 10/04/23, RN Tyler Goodrich provided care to Resident A on this date. According to RN Goodrich's narrative, Resident A was lying in bed, she was awake and alert. Facility staff Claudia (Brock) was present during the visit and Resident A did not appear to be in distress. RN Goodrich noted a "1x1 area of redness to coccyx" so staff was educated on turning Resident A to "off load pressure" and to use barrier cream on the coccyx area. RN Goodrich noted that the x-ray technician was present when he left the facility.

I reviewed a radiology report from TridentCare dated 10/04/23. According to the report, Resident A was diagnosed with "proximal to mid shaft fracture with malalignment." The fracture was noted as being "acute to subacute humeral shaft fracture." The report was signed by Nicolaus J. Kuehn, MD.

According to the hospice note dated 10/05/23, RN Howell provided care to Resident A on that date. According to RN Howell's narrative, Resident A was in bed, awake and alert during this visit. She "refuses to wear arm sling, she states the pain is occasional." Staff was instructed on safe transfers. RN Howell also noted, "bedside commode found 3 rooms down."

On 11/01/23, I received a copy of Resident A's death certificate which was certified by Angela Yurk, MD. Resident A died on 10/22/23 at the age of 80-years old. According to this document, her manner of death was natural, and her cause of death was multiple sclerosis and chronic obstructive pulmonary disease. Both conditions were listed as existing for years and breast cancer and Alzheimer's Disease were listed as other significant conditions.

During the course of this investigation, I received several emails from Relative A1. She said that she had several issues with staff while Resident A resided at The Pines of Lapeer. Relative A1 said that staff told her that they were understaffed and not trained properly.

Relative A1 said that approximately 40 years ago, Resident A fractured her left arm. Relative A1 said that because of this fracture, Resident A did have permanent deformity in her left arm as well as chronic pain. Approximately one year ago, family consulted with an orthopedic surgeon because Resident A was complaining of increased pain. The orthopedic surgeon recommended no surgery because the fracture would heal on its own.

According to Relative A1, on 09/28/23, she walked into Resident A's room and found her crying, in bed, holding her left arm. When asked, Resident A1 told her that staff Jenn (Blackmer) "hurt her left arm when taking her to the bathroom." Relative A1 found staff Claudia Brock and asked if she knew what happened. Staff Brock denied knowing what was wrong and said that Staff Blackmer had taken Resident A to the bathroom. Relative A1 and Staff Brock again asked Resident A what happened, and she said that Staff Blackmer was "a little rough with her and hurt her left arm and she was too upset to talk." Relative A1 said that Staff Brock told her that she contacted the Resident Care Director (RCD), Allie Brode and told her what happened. RCD Brode told Staff Brock to contact Resident A's hospice nurse and notify her of the incident. Relative A1 said that in addition to Resident A's complaint of pain, she also had bruising to her left arm.

On 10/02/23, one of Resident A's hospice nurses came to complete a routine check with Resident A. The hospice nurse ordered an x-ray due to Resident A verbally expressing pain in her left arm. On 10/04/23, Resident A's arm was x-rayed and on 10/05/23, hospice nurse Howell told Relative A1 that the x-ray revealed a new fracture. Relative A1 said that RN Howell told her that they never received a call from the facility regarding Resident A's arm hurting. Relative A1 and Resident A chose not to take Resident A to the hospital for a cast due to her declining medical condition.

Relative A1 stated that on 10/16/23, Resident A was having trouble breathing so Relative A2 called staff and asked for a PRN. One of the staff, James Herd, began taking Resident A's blood pressure on her left arm. Relative A2 told Staff Herd not to use her left arm but Staff Herd told him that he had to because Resident A was sleeping on it. Staff Herd continued to take Resident A's blood pressure while Resident A screamed and yelled from the pain. Relative A1 sent me a picture of Resident A's left arm which clearly showed a pink bracelet with the words ***LIMB ALERT*** on it.

On 11/27/23, I reviewed staff notes regarding Resident A who resided in Room #18. On 09/27/23, staff noted "poor breathing, morphine." On 09/28/23, staff Jennifer Blackmer worked 6a-6p and staff Claudia Brock worked 7am-3pm and noted "lots of pain in arm (left) shower aides here (Kim)." Staff James Herd worked 6p-6a and Sarah (last name unknown) worked 3p-11p and noted "poor breathing/covid tested (neg)."

On 09/29/23, staff Marissa Bohl worked 11p-7a and Kourtney Bowman worked 6p-11p and noted “good day/no problems.” Staff Heather Sagady worked 6a-6p and Hannah Lucas worked 7a-3p and noted “having trouble breathing in the am.” Staff also noted that Resident A’s nurse was there to see her. Staff James Herd worked 6p-6a and Chris Newton worked 11p-7a and noted “good mood, slept well.”

On 09/30/23, Staff Blackmer and Staff Newton worked 6a-6p and noted “daughter here, ok day, but meds are hospital.” On 10/01/23, Staff Sagady worked 6a-6p and Staff Blackmer 7a-3p and did not note anything. Staff Sarah worked 3p-11p and Staff Bohl worked 6p-6a and noted “daughter here to visit, ok day.”

On 10/02/23, Staff Blackmer worked 6a-6p and Staff Brock worked 7a-3p and noted “hospice nurse came, sometime today x-ray on left arm, needs to be rotated and make sure creams on her butt and heels.” Staff Sarah worked 3p-11p and Staff Herd worked 6p-6a and noted “lots of sleeping today.”

On 10/03/23, Staff Blackmer worked 9a-6p and Staff Brock worked 6a-6p and noted “asked for morphine (hospice allowed) because her breath.” Another note dated 10/03/23 noted that Staff Blackmer worked 6a-6p and Staff Sagady worked 7a-3p and noted “lots of pain in left arm, PRN morphine, am had a shower. Fracture to left upper arm she is a two assist please do not move her alone. She is refusing splint so no cast will be done. (She) will be receiving a bedside commode. Please use this instead of toilet. Also (she) needs thick-it in all liquids.”

On 10/04/23, Staff Brock worked 6a-6p and Staff Sarah worked 7a-3p and noted “nurse here to see her. X-ray here. Has sore on her butt, needs lotion to heal.” Staff Herd and Staff Newton worked 6p-6a and noted “great night, no complaints, keeps ending up in same position after turns.”

On 10/05/23, Staff Herd worked 11p-7a, Staff Sarah worked 3p-11p and Staff Newton worked 6p-6a and noted “use commode for toileting, 2 assist at all times. Gave morphine for breathing.”

On 10/06/23, Staff Brock worked 6a-6p and Staff Sagady worked 7a-3p and noted “daughter here, hospice nurse here. Please pay attention, medication changes for (her) as of today. Discontinued norco. Will give scheduled morphine 2 syringes of 0.25ml every 6 hours. Morphine prn every hour of 0.25ml as needed for shortness of breath or pain. Changed Ativan to 0.5mg every 8 hours.”

On 10/07/23, Staff Herd worked 6p-6a and Staff Newton worked 11p-7a and noted “social, toileted twice.” On 10/08/23, Staff Bowman worked 6p-6a and noted “been in bed/good night/no problems.” Staff Newton worked 11p-7a and noted “toileted twice, slept all night.”

On 12/05/23, I interviewed staff Claudia Brock via telephone. Staff Brock said that she has worked at this facility for almost two years, and she always works 1st shift. She

confirmed that while Resident A resided at this facility, she provided care to her. Staff Brock said that she is aware that Resident A broke her arm several years ago and it was still very sensitive. She confirmed that Resident A wore a ***LIMB ALERT*** bracelet and staff was instructed to not use that arm when providing care to her. She said that Resident A often complained of pain in her arm and if you even brushed against her arm, she would say, "ouch." Staff Brock said that she called hospice on numerous occasions to notify them if Resident A was having a lot of pain on any particular day and would follow their instructions.

I asked Staff Brock if Resident A ever complained that someone hurt her and she said that she recalls that on one occasion, when she went into Resident A's room, she had "a look" on her face so she asked her what was wrong. Resident A told her that "somebody came in here and moved me and hurt my arm." Staff Brock said that she asked Resident A who moved her, but Resident A would not say. I asked Staff Brock who she was working with that day, and she said staff Jennifer Blackmer. Staff Brock told me that Resident A never told her that Staff Blackmer or any of the other staff deliberately harmed her.

On 12/05/23, I interviewed staff Heather Lucas via telephone. Staff Lucas said that she has worked at this facility for over a year, and she typically works 1st shift. Staff Lucas confirmed that she provided care to Resident A while she resided at The Pines of Lapeer. Staff Lucas confirmed that Resident A had a ***LIMB ALERT*** bracelet on her arm due to a previous break and staff was told to be very careful with that arm. She said that when transferring Resident A, she would lift her under both armpits and assist her. Staff Lucas told me that Resident A often complained of pain in her arm whenever staff transferred her or repositioned her in any way.

I asked Staff Lucas if she was aware that Resident A sustained a new fracture while at this facility and she said that she had "heard that." I asked her if she knew what happened and she said that she only heard what other staff were saying. When asked, she told me that she heard that staff Jennifer Blackmer was too rough with her when moving her and that is how Resident A sustained the new fracture. Staff Lucas told me that Resident A never told her that any of the staff deliberately harmed her in any way and she never saw any of the staff be physically inappropriate with Resident A.

On 12/05/23, I interviewed staff James Herd via telephone. Staff Herd said that he has worked at this facility for almost 16 years, and he always works 3rd shift. Staff Herd confirmed that he provided care to Resident A while she resided at The Pines of Lapeer. He also confirmed that she had a ***LIMB ALERT*** bracelet on her left arm due to a previous break and staff were instructed to be very careful when transferring her. I asked Staff Herd how he transferred Resident A and he said that he would lift her under both her armpits to transfer her. He said that she often complained of pain in that arm but said that she never told him that any of the staff was rough with her or that any of the staff deliberately harmed her.

Staff Herd confirmed that on 10/16/23, Resident A was experiencing a lot of pain. He said that he went into her room to take her blood pressure and since she was laying on her right arm and it was under her pillow, he decided that it would cause her more pain to move her so he "carefully lifted her wrist and slid the cuff up her arm to just under her elbow." Staff Herd said that Relative A2 was in the room when this occurred and he asked Staff Herd, "Was that her bad arm?" and when Staff Herd confirmed that it was, Relative A2 said, "Well we won't be doing that anymore." Staff Herd told me that although Resident A was in pain, she was not screaming or yelling while he was taking her blood pressure because if she would have, he would have stopped what he was doing. I asked Staff Herd if he was aware that Resident A sustained a new fracture while a resident of this facility and he said that he heard that from a coworker that he feels is "unreliable", but he was never told about the new fracture by management or Resident A's family.

On 12/11/23, I conducted an exit conference with the administrator, Matthew Brawner. I discussed the results of my investigation and explained which rule violation I am substantiating. Admin Brawner asked how I could substantiate since there is no evidence that Resident A fell and no definite explanation for the new fracture. I explained that since Resident A did receive a new fracture while a resident of The Pines of Lapeer, staff failed to provide her with protection and safety as defined in the rule.

On 12/11/23, I reviewed an Incident/Accident Report (IR) dated 10/02/23 completed by staff Jenn Blackmer and Claudia Brock. According to the IR, "Resident complained of pain in her left arm, to her hospice nurse. Hospice nurse ordered Xray of her left arm." No corrective measures taken were listed on the report.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
ANALYSIS:	**(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.**
	Resident A broke her left arm 40+ years ago. As a result, she experienced chronic pain, and often complained about her arm hurting. On 09/28/23, Relative A1 found Resident A, crying in bed, holding her left arm. When asked, Resident A1 told her that staff Jenn (Blackmer) "hurt her left arm when taking her to the bathroom." Staff Jennifer Blackmer confirmed that she provided care to Resident A on 09/28/23 and Resident A complained of pain in her left arm. However, Staff Blackmer said that there was not an

	incident or accident that took place on that date and therefore, she did not know that Resident A's complaint had to do with a new injury. Staff Claudia Brock said that she typically works 1st shift, and she often works with Staff Jennifer Blackmer. Staff Brock said that on one occasion, Resident A1 had "a look" on her face and when Staff Brock asked her what was wrong, Resident A said, "Somebody came in here and moved me and hurt my arm." Staff Brock said that she asked Resident A who moved her, but Resident A would not say. I asked Staff Brock who she was working with that day, and she said staff Jennifer Blackmer. According to Hospice RN Howell's narrative, on 10/02/23, Resident A was in bed and "states she is very tired, complaining of a break in her left arm. (She) states she was transferred by facility staff last Thursday, and now her arm has a separation. L Humerus has an obvious indentation, and a crunching noise is made during movement." RN Howell ordered an Xray. I reviewed a radiology report from TridentCare dated 10/04/23. According to the report, Resident A was diagnosed with "proximal to mid shaft fracture with malalignment." The fracture was noted as being "acute to subacute humeral shaft fracture." The report was signed by Nicolaus J. Kuehn, MD. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

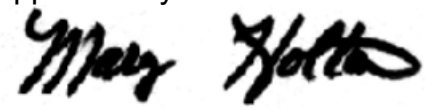
IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.

December 11, 2023

Susan Hutchinson Licensing Consultant	Date

Approved By:



12/11/2023

Mary E. Holton Area Manager	Date