GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 19th, 2023

Connie Clauson
Bishop Hills L.L.C.
3196 Kraft Ave SE
Grand Rapids, MI 49512

RE: License #: AH410236738
Investigation #: 2024A1021010
Bishop Hills Elder Care

Dear Mrs. Clauson:

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) 284-9730.

Sincerely,

Kimberly Horst

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410236738
Investigation #:	2024A1021010
Complaint Receipt Date:	10/26/2023
Investigation Initiation Date:	10/27/2023
Report Due Date:	12/25/2023
Licensee Name:	Bishop Hills L.L.C.
Licensee Address:	4951 11 Mile Rd. NE Rockford, MI 49341
Licensee Telephone #:	(616) 719-5100
Administrator:	Debra Smith
Authorized Representative:	Connie Clauson
Name of Facility:	Bishop Hills Elder Care
Facility Address:	4951 11 Mile Road, NE Rockford, MI 49341
Facility Telephone #:	(616) 866-8227
Original Issuance Date:	02/29/1996
License Status:	REGULAR
Effective Date:	11/06/2022
Expiration Date:	11/05/2023
Capacity:	47
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident B fell out of bed and laid on the floor for hours.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/26/2023	Special Investigation Intake 2024A1021010
10/27/2023	Special Investigation Initiated - Telephone left message with complainant
10/30/2023	Inspection Completed On-site
11/06/2023	Contact-Telephone call made Interviewed SP3
11/06/2023	Contact-Telephone call made Interviewed SP4
11/07/2023	Contact-Document Received Received Resident B's documents
12/11/2023	Exit Conference
12/15/2023	Contact-Documents Received Received additional documents that revealed Resident B was checked on more frequently than previously known.
12/19/2023	Contact-Document Sent Report sent to Authorized Representative and Administrator

ALLEGATION:

Resident B provided inconsistent care.

INVESTIGATION:

On 10/26/2023, the licensing department received a complaint with allegations on 10/17/2023 at 12:00am, Resident B fell out of bed and laid on the floor until 5:00am.

On 10/27/2023, I interviewed the complainant by telephone. The complainant alleged this information was provided by Resident B. The complainant alleged Resident B was sitting in his recliner chair, leaned over to get a blanket, and fell out of his chair. The complainant alleged Resident B yelled for help, but no one heard him. The complainant alleged the facility has heated floors, and Resident B fell asleep on the floor. The complainant alleged Resident B was found at 5:00am. The complainant alleged Resident B's service plan now reflects for hourly checks and for a baby monitor to be placed at the care station to alert caregivers when Resident B requires assistance.

On 10/30/2023, I interviewed administrator Debra Smith at the facility. Ms. Smith reported Resident B has been a resident since 11/08/2021. Ms. Smith reported Resident B does not like to call for help or request assistance. Ms. Smith reported on the night of 10/17/2023, Resident B was observed to be in his chair around midnight watching television. Ms. Smith reported Resident B will occasionally stay up late watching television. Ms. Smith reported Resident B is independent to get out of his chair and transfer to his bed. Ms. Smith reported the emergency call button is over his bed and Resident B refuses for the call light button to be moved. Ms. Smith reported on 10/17/2023, staff person 3 (SP3) and SP4 worked at the facility. Ms. Smith reported SP3 is a seasoned worker and SP4 is an as needed worker. Ms. Smith reported Resident B was not on set checks during the nighttime hours. Ms. Smith reported around 5:00am, SP3 questioned SP4 on Resident B and that is when Resident B was found on the floor. Ms. Smith reported since this incident occurred, Resident B is now on hourly safety checks. Ms. Smith reported Resident B will also have a baby monitor to alert staff when Resident B requires assistance.

On 10/30/2023, Resident B was not at the facility and therefore I was unable to interview him.

On 11/06/2023, I interviewed SP4 by telephone. SP4 reported she observed Resident B to be in his chair at approximately 12:00am. SP4 reported she provided after that observation she provided care to other residents located near Resident B's room and heard no calls for help. SP4 reported at approximately 4:50am, SP3 questioned if she had checked Resident B's room for dirty linen. SP4 reported she and SP3 then went to Resident B's room and found Resident B on the floor. SP4 reported she never heard any calls from help from Resident B's room.

On 11/06/2023, I interviewed SP3 by telephone. SP3 reported she worked the evening Resident B fell but she was not assigned to Resident B's hallway. SP3 reported she observed Resident B to be in his recliner chair around 12:00am watching television. SP3 reported it is common for Resident B to stay up late in his recliner chair. SP3 reported around 4:50am she spoke with SP4 if she had checked on Resident B. SP3 reported SP4 reported she had not checked on Resident B and

that is when they found Resident B on the floor. SP3 reported Resident B was not on hourly safety checks. SP3 reported Resident B is now on hourly checks and there is a baby monitor at the desk to alert staff if Resident B requires assistance.

I reviewed Resident B's service plan that was active at the time of the fall. The service plan revealed Resident B was not on set checks but is now on hourly checks for safety. The service plan omitted all information on the usage of a baby monitor.

I reviewed *Baruch Senior Ministries Resident Care Monitor Log* for 10:00pm-6:00am for 10/20-11/05. The log revealed the following day Resident A was not check on hourly:

10/24: 11:00p-5:00am

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:	Interviews conducted and review of documentation revealed Resident B had a fall on 10/07/2023 and was on the floor for an unknown number of hours. Following the fall, Resident A's plan of care was updated to include the usage of a baby monitor and hourly safety checks. Review of documentation revealed Resident A's service plan did not include information on the baby monitor and review of *Baruch Senior Ministries Resident Care Monitor Log* revealed times in which Resident A was not checked on hourly.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Inspection of Resident B's room revealed Resident B had a trapeze attached to the head of his bed.

Review of Resident B's service plan omitted all information pertaining to the use of this device.

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.**
For Reference: R 325.1901	**Definitions.**
	(p) "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 service plan for Resident B lacked information about the devices related to purpose of use, staff responsibility to ensure devices were safe, and ongoing maintenance schedules. For instance, instruction regarding whether the resident could summon staff independently for help or require monitoring on a predetermined frequency was not defined. In addition, it lacked what staff were responsible for, and what methods were to be used in determining if the device posed a risk. The facility was unable to provide policy on the use of bedside assistive devices.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

12/19/2023

Kimberly Horst — Date
Licensing Staff

Approved By:

12/19/2023

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