GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 3, 2024

Tim Stoll
The Villa
307 N Franks Ave.
Sturgis, MI 49091

RE: License #: AH750236918
Investigation #: 2023A1010088
The Villa

Dear Licensee:

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) 241-1970.

Sincerely,

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 260-7781

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH750236918
Investigation #:	2023A1010088
Complaint Receipt Date:	09/19/2023
Investigation Initiation Date:	09/20/2023
Report Due Date:	11/19/2023
Licensee Name:	Thurston Woods Village Inc.
Licensee Address:	307 N. Franks Ave. Sturgis, MI 49091
Licensee Telephone #:	(269) 651-7841
Administrator/Authorized Representative:	Tim Stoll
Name of Facility:	The Villa
Facility Address:	307 N Franks Ave. Sturgis, MI 49091
Facility Telephone #:	(269) 651-7841
Original Issuance Date:	09/23/1999
License Status:	REGULAR
Effective Date:	02/23/2023
Expiration Date:	02/22/2024
Capacity:	100
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident D was left soiled for 3 days before staff changed her, resulting in a stage 1 pressure ulcer.	Yes

III. METHODOLOGY

09/19/2023	Special Investigation Intake 2023A1010088
09/20/2023	APS Referral
09/20/2023	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
09/25/2023	Inspection Completed On-site
09/25/2023	Contact - Document Received Received Resident D's service plan and hospice observation notes
10/10/2023	Contact – Telephone call made Interviewed Witness 1 (W1) by telephone
01/03/2023	Exit Conference

ALLEGATION:

Resident D was left soiled for 3 days before staff changed her, resulting in a stage I pressure ulcer.

INVESTIGATION:

On 9/19/23, the Bureau received the allegations from the online complaint system. The complaint read, “Resident is on hospice and mainly bed ridden but is alert and oriented, she can communicate her needs but needs assistance with transfers. Resident was left to sit in her feces for 3 days before being changed, resulting in a stage 1 pressure ulcer. Resident told staff members and her hospice nurse [Witness 1] about this situation.”

On 9/20/23, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 9/25/23, I interviewed director of nursing Fanesse Barton at the facility. Ms. Barton reported Resident D did not go three days without staff changing her soiled brief. Ms. Barton stated Resident D can make her needs known, however she does experience intermittent confusion. Ms. Barton said Resident D is currently on hospice and is ordered by hospice to be checked on and changed every two hours. Ms. Barton reported Resident D has a history of refusing to allow staff to reposition her in bed and change her soiled brief.

Ms. Barton said Resident D does have a stage II wound that is being treated by hospice staff. Ms. Barton stated Resident D also has a catheter that is maintained by hospice staff. Ms. Barton reported Resident D's care needs are met consistent with her service plan. Ms. Barton provided me with a copy of Resident D's service plan for my review. The *Continence Action Plan* section read, "Incontinent of bowels. Comments – Has a foley cath and uses attends (sic)."

Ms. Barton provided me with a copy of Resident D's *Progress Notes* for my review. A note written by Ms. Barton dated 9/20/23 read, "[Resident D] continues with Hospice care provided by Centrica. Spoke with [Relative D1]. He is aware that resident has an open area on her bottom which is managed by hospice and that at times [Resident D] continues to refuse care. Also spoke to [Relative D1] regarding hospice aide reporting that resident had stated that she hadn't been changed in 3 days. Hospice aide stated that she knew that resident was confused at times and that it didn't appear that she hadn't been changed in 3 days. [Relative D1] stated that he knows [Resident D] has confusion at times, that he knows that wasn't factual (that she hasn't received care or been changed in 3 days), and that he has no concerns about her care or the frequency of."

A note written by Ms. Barton dated 9/21/23 read, "Spoke with hospice nurse Nicole regarding wound care. Nicole stated that just this week it opened, and she is doing treatment of Zinc and Optifoam and changing it a couple of times a week or if soiled. Nicole stated that she is aware that [Resident D] is confused at times and refuses care at times, that she typically doesn't refuse her, however she knows that she refuses for her hospice aide and facility staff. Nicole stated that she has no concerns with the care that she receives."

Ms. Barton provided me with a copy of Resident D's hospice staff *Communications* notes for my review. The hospice notes dated 8/14/23, 8/15/23, 8/17/23, 8/21/23, 8/31/23, and 9/21/23 read Resident D refused care from her hospice aide. The note dated 8/15/23 also read, "Client does not was hospice visits tomorrow." A hospice communication note dated 9/15/23 read, "Brief change, pericare, stage I R Buttock. Please turn every 2 hrs. check brief every 2 hrs."

On 9/25/23, I interviewed administrator Tim Stoll at the facility. Mr. Stoll's statements were consistent with Ms. Barton. Mr. Still reported last week, he spoke with Resident D regarding her statement of not being changed for three days. Mr. Stoll stated he asked Resident D if she used her pendant to summon staff assistance when she

allegedly hadn't been changed for three days. Mr. Stoll said Resident D denied using her pendant to summon staff for assistance. Mr. Stoll explained he encouraged Resident D to use her pendant anytime she felt she needed staff assistance.

On 9/25/23, I interviewed Staff Person 1 (SP1) at the facility. SP1's statements were consistent with Ms. Barton. SP1 reported facility staff received instruction from hospice to reposition Resident D in bed every two hours on 9/15/23. SP1's statements were consistent with Resident D's hospice staff's *Communications* notes. SP1 reported Resident D also has a history of refusing her medications.

On 9/25/23, I attempted to interview Resident D at the facility. I observed Resident D asleep in her bed. Resident D did not want to wake to speak to me. I was unable to interview Resident D as a result. I observed Resident D was well groomed and I did not detect any foul odors.

On 10/10/23, I interviewed Centrica hospice nurse Witness 1 (W1) by telephone. W1's statements were consistent with Ms. Barton and SP1. W1 reported Resident D did tell her she wasn't changed for three days, however W1 has never observed Resident D soiled. W1 said she informed Ms. Barton and staff at the facility about Resident D's comment about not being changed for three days.

W1 reported Resident D did have a Stage I wound on her buttocks, however it has healed. W1 stated because Resident D's wound healed, it appears staff are repositioning her in bed every two hours. W1 stated staff at the facility provide care to Resident D "as best as she will allow them to." W1 said Resident D also had a history of refusing care from her hospice aides.

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:	The interviews with Ms. Barton, SP1, W1, along with review of Resident D's staff *Progress Notes* and hospice staff's *Communications* notes revealed Resident D has a history of refusing care. On 9/25/23, I observed Resident D was well groomed and I did not detect any foul odors. There is insufficient evidence to suggest Resident D was left soiled for three days. Review of Resident D's service plan revealed how often Resident D is to be re-positioned in bed was not outlined. There was also no instruction for staff regarding how to intervene when Resident D refused care. Resident D's service plan did not adequately address her care needs.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Tim Stoll by telephone on 1/3/24.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

10/10/2023

Lauren Wohlfert — Date
Licensing Staff

Approved By:

12/20/2023

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