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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

David Benjamin
A&D Charitable Foundation Inc
3150 Enterprise Dr
Saginaw, MI 48603

March 25, 2024

RE: License #: AH730401359
Investigation #: 2024A1022019
Community Village

Dear David Benjamin:

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.

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

License #:	AH730401359
Investigation #:	2024A1022019
Complaint Receipt Date:	02/12/2024
Investigation Initiation Date:	02/21/2024
Report Due Date:	04/13/2024
Licensee Name:	A&D Charitable Foundation Inc
Licensee Address:	3150 Enterprise Dr Saginaw, MI 48603
Licensee Telephone #:	Unknown
Administrator:	Robin Rappley
Authorized Representative:	David Benjamin
Name of Facility:	Community Village
Facility Address:	3200 Hospital Rd Saginaw, MI 48603
Facility Telephone #:	(989) 792-5442
Original Issuance Date:	03/18/2020
License **Status:**	REGULAR
Effective Date:	09/18/2023
Expiration Date:	09/17/2024
Capacity:	90
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
The Resident of Concern (ROC) did not receive adequate care after a fall.	Yes
The Resident of Concern (ROC) did not receive adequate care after a fall because the staff were not trained to provide this type of care.	Yes

III. METHODOLOGY

02/12/2024	Special Investigation Intake 2024A1022019
02/21/2024	Special Investigation Initiated - On Site
02/21/2024	Inspection Completed On-site
02/21/2024	APS Referral
02/27/2024	Contact - Telephone call made Information exchanged with the facility via email.
03/25/2024	Exit Conference

ALLEGATION:

The Resident of Concern (ROC) did not receive adequate care after a fall.

INVESTIGATION:

On 02/12/2024, the Bureau of Community and Health Systems (BCHS) received an anonymous complaint that read in part, “On 1/30/24 a resident named [name of the Resident of Concern (ROC)] fell at 3:00am in her room. Staff found her screaming in

pain. They did not call to report the fall as they were afraid of being yelled at for waking them up in the night… Due to the poor medical training [name of the ROC] was not transported to the hospital until 7am when management came into work and assessed her. [Name of the ROC] then required emergency surgery.

On 02/21/2024, a referral was sent to Adult Protective Services.

On 02/21/2024, at the time of the onsite visit, I interviewed the administrator, the health care coordinator, and the manager of the resident care technicians (RCT). The administrator was asked to describe the steps staff were to take if they were faced with a resident emergency during "non-business hours," such as on weekends or in the middle of the night. In response, the administrator stated that the shift supervisor was to assess the resident and notify the on-call manager as well as the resident's family and health care provider. If the on-call manager was not available, the shift supervisor was to notify the administrator, as she was the back-up for the on-call managers.

When asked specifically about the ROC, the administrator stated that at the time of the incident, the ROC was fairly new to the facility, only having moved in on 01/04/2024 and not yet fully enrolled in the local PACE program. The administrator went on to explain that early in the morning of 01/30/2024, the ROC needed to use the toilet and fell when she attempted to transfer into her wheelchair. The overnight shift heard the ROC yelling out and found her on the floor. The administrator went on to say that the staff obtained the ROC's vitals and helped her back into bed, although the ROC was obviously in pain. While the ROC's spouse was notified, there was no notification to the on-call manager, the administrator or the ROC's health care provider.

According to the facility's incident report (IR), at 3:00 am on 01/30/2024, "Resident (ROC) was heard screaming in room, went to check her, she was on the floor next to her bed. Stated she was trying to get to in her wheelchair and slid out. Resident stated she was trying to go to the bathroom…911 (emergency services) called at 6:55 am…" The IR was signed as completed by RCT #1.

According to the RCT manager, on 1/30/2024, she called the facility about 6 am to inform them that she (the RCT manager) would not be in at her usual time. The RCT manager went on to explain that as part of this phone call, the 3rd shift supervisor advised her that the ROC had fallen, and that her spouse wanted the ROC to be transported to a hospital outside of their immediate geographical location. The RCT manager instructed the 3rd shift supervisor not to send the ROC out of their geographic location and that the day shift supervisor would be in to assess the ROC. According to the health care coordinator, she was notified when the first shift supervisor recognized that the ROC was seriously injured, and authorized transport to the facility's local emergency room. The health care coordinator went on to say that the ROC was diagnosed with a fractured hip but had subsequently developed additional complications and had not returned to the facility.

When the administrator, the health care coordinator, and the RCT manager of the resident care technicians were asked why none of the four caregivers, including the shift supervisor who were present on the 3rd shift notified the on-call manager or the administrator as required, they did not have an immediate answer. The administrator stated that she had heard it was because the staff were afraid of managements' response when called at a late hour but acknowledged that this was "hear-say." The administrator then clarified that at some point in the past, caregivers had been chastised for notification to the local on-call PACE manager late at night. The administrator went on to say that at some months prior to 01/30/2024, caregivers had been given a list of examples as to when to notify the on-call facility manager. The first item on the list was to call "right away" whenever a resident sustained a fall.

The RCT manager acknowledged that while she had "spoken" to the RCTs on the 3rd shift in a group meeting about the incident, she did not know the reason why the 3rd shift supervisor or other employees failed to notify the facility management that the ROC had been injured.

On 02/27/2024, via an email exchange, the administrator, the health care coordinator, and the RCT manager were asked to provide what they believed was the "probable reason" that none of the overnight shift caregivers notified their managers, even though they had been instructed to call "right away" when a resident fell. The health care coordinator replied, "I believe the probable reason to be the lack of formal education in assessment skills and critical thinking needed to determine if there is a significant injury. They looked for bleeding, bumps, swelling and lacerations. When none of that was present, they assumed there were no injuries and no need to call on call." The health care coordinator did not explain why caregivers did not see the ROC's expressions of pain as being a reason to suspect a significant injury.

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: 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.
ANALYSIS:	The facility has not determined why none of the four 3rd shift caregivers including the employee designated as the shift supervisor thought to inform the on-call manager or the administrator when the ROC expressed that she was in pain after falling. Because they did not determine the cause, they do not have the ability to implement measures to prevent recurrence.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The Resident of Concern (ROC) did not receive adequate care after a fall because the staff were not trained to provide this type of care.

INVESTIGATION:

According to the complaint received, “Staff is not medically trained enough to work the care needs of the residents that live in the 70+ facility. Of the residents in the care of community village more than half of them meet SNF level of care and are enrolled in PACE or waiver… Due to the high level of care and needed of the residents this facility needs more medical training.”

When the administrator was asked about training of caregivers, she acknowledged that the training curriculum had recently been changed. Previously, new RCTs “shadowed” RCTs who were experienced. The only classroom instruction involved the ability to pass medications. Now, all new RCTs have multiple days of classroom instruction on various topics as required by state rule. The administrator went on to say that all RCTs have ongoing in-service training, usually when some type of skill deficit becomes obvious, but sometimes on popular request. Any RCT can request skill update training.

Review of the employee orientation schedule revealed that although employees viewed training videos that included dealing with individuals with dementia, medication administration and the provision of assistance with activities of daily living, there was no training in how to deal with residents in emergency situations.

When the administrator was asked to provide the training records for the 3rd shift staff on duty when the ROC fell, she was unable to provide any training records for any of the caregivers, including RCT #2, whose date of hire was given as 01/09/2024.

The administrator provided an "Educational Opportunities" form, generated for RCT #1, dated 01/31/2024, indicating "On 01/30/2024, a resident fell trying to get to the bathroom (3 am)/ The on-call person was not notified. The resident laid in pain for 3 hours until 1st shift arrived and called on-call and 911…Expectations: call on-call person for resident falls." The form was signed by the administrator and by RCT #1. There was no explanation as to why there were no "Educational Opportunities" generated for any of the other three employees who were present for the shift, including the employee who had been designated the 3rd shift supervisor.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following: **(a) Reporting requirements and documentation.** **(b) First aid and/or medication, if any.** **(c) Personal care.** **(d) Resident rights and responsibilities.** **(e) Safety and fire prevention.** **(f) Containment of infectious disease and standard precautions.** **(g) Medication administration, if applicable.**
ANALYSIS:	The facility was unable to provide evidence that caregivers were adequately trained to perform their job responsibilities.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the authorized representative (AR) on 03/25/2024. When asked if there were any comments or concerns with the investigation, the AR stated that there were none.

IV. RECOMMENDATION

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

03/25/2024

Barbara Zabitz Date
Licensing Staff

Approved By:

03/25/2024

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