GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

Robert Kornfeld
The Orchards at Canterbury Village
5601 Hatchery Road
Waterford, MI 48329

November 27, 2024

RE: License #: AH630380234
Investigation #: 2025A1022001
The Orchards at Canterbury Village

Dear Robert Kornfeld:

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 #:	AH630380234
Investigation #:	2025A1022001
Complaint Receipt Date:	10/10/2024
Investigation Initiation Date:	10/10/2024
Report Due Date:	12/09/2024
Licensee Name:	Canterbury Village MI Opco LLC
Licensee Address:	362 E Kennedy Blvd Lakewood, MI 08701
Licensee Telephone #:	Unknown
Administrator:	Leigh Mcleod
Authorized Representative:	Robert Kornfeld
Name of Facility:	The Orchards at Canterbury Village
Facility Address:	5601 Hatchery Road Waterford, MI 48329
Facility Telephone #:	(248) 674-9292
Original Issuance Date:	01/05/2018
License **Status:**	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	32
Program Type:	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Residents do not receive appropriate incontinence care.	No
Caregivers did not respond timely when residents activated their call lights.	Yes
Food is served cold and is unappetizing.	No

III. METHODOLOGY

10/10/2024	Special Investigation Intake 2025A1022001
10/10/2024	Special Investigation Initiated - Telephone Complainant interviewed by phone.
10/18/2024	Inspection Completed On-site
11/25/2024	Contact - Document Received Information exchanged with the facility via email.
11/27/2024	Exit Conference

ALLEGATION:

Residents do not receive appropriate incontinence care.

INVESTIGATION:

On 10/10/2024, the Bureau of Community and Health Systems (BCHS) received a complaint alleging that the care residents received was inadequate, especially when it came to incontinence care.

On 10/18/2024, at the time of the onsite visit, I interviewed the on-call manager, as the administrator was out of the building for training. The on-call manager arranged 3 opportunities for me to make continence observations.

Resident A was seated in the common area of the facility. Caregiver #1 transported her in her wheelchair back into her room and helped her onto the toilet. Her incontinence brief was dry, but there was wetness on her pants, as if she had just voided. There was no dampness evident on the seat of the wheelchair. According to

her service plan, Resident A required full assistance of a caregiver to complete all of her activities of daily living (ADLs) and was incontinent of both urine and feces.

Resident B was also seated in the common area of the facility. When approached by caregiver #2, Resident B rose to her feet and used a walker to ambulate to her room. Caregiver #2 assisted her onto the toilet, but she was clean and dry. According to her service plan, Resident B needed a moderate level of assistance from caregivers to complete her ADLs. There were a number of activities she was able to complete with cueing and supervision only, including toilet use.

Resident C was independently walking around the unit, when approached by caregiver #2. Resident C allowed caregiver #2 to take her into her bathroom, but once there, she indicated that she did not need to use the toilet. Resident C allowed caregiver #2 to expose her incontinence brief to reveal that it was clean and dry. According to her service plan, Resident C was independent for mobility, and transfer, and could independently use the toilet. Occasionally, she needed reminders and cuing for completion of tasks.

Caregiver #2 then disclosed to me that just before I began my observations, she and caregiver #1 had completed their mid-morning continence checks.

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:	There was no evidence that residents received inadequate incontinence care.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Caregivers did not respond timely when residents activated their call lights.

INVESTIGATION:

On 10/10/2024, when I interviewed the complainant, the complainant described lengthy wait times when residents activated their call buttons. The complainant went on to say that when caregivers were questioned about responding to residents call lights, she was told that the caregiver did not have a beeper and therefore did not know that a resident had pressed their call light. The complainant went on to say that the facility did not have enough caregivers to provide good care to residents.

At the time of the onsite visit, when asked about facility scheduling, the on-call manager stated that the caregivers worked three 8-hour shifts daily with either a medication tech or preferably a licensed nurse working two 12-hour shifts. For both the morning and the afternoon 8-hour shifts, the facility staffed 2 caregivers for each shift, and just 1 caregiver for the overnight shift. Review of the facility' staffing schedule for 09/22/2024 through 09/28/2024 indicated that the number of caregivers and the number of nurse/med tech conformed to the on-call manager's description.

When the on-call manager was asked how the call light system worked, she stated that when a call light was activated, a signal comes to 2 mobile phones assigned to the unit. One phone stayed with the medication cart and one phone was assigned to whichever caregiver was providing care for Hall One. The on-call manager went on to explain that most of the residents did not have enough cognitive ability to use the call light. There was only one resident, Resident F, who used a pendent to request help from caregivers.

Review of the call light response log for September 2024 confirmed that few of the residents used their call lights to summon assistance. However, residents who did use their call light regularly waited more than 20 minutes for caregivers to answer the light. Resident D waited more than 20 minutes on 4 occasions in September, including on 09/23/2024, when the call light was first activated on 12:34 am, but was not turned off until 7:39 am, 7 hours later. Resident E waited more than 20 minutes on 5 occasions in September, including a 90-minute wait on 09/13/2024. Resident F who used a pendent, waited more than 20 minutes on 3 occasions in September, including a 2-hour wait on 09/16/2024.

On 11/25/2024, via an email exchange with the administrator, when the administrator was asked to describe the facility's expectation for answering call lights and to explain the lengthy call light response from caregivers, she responded, "Our goal (for answering call lights) is to have the care partners answer the call lights as soon as possible. I am not sure what happened with these particular incidents of the call lights being on (for an extended time). However, I have started an education today with the staff to ensure that the lights are a priority and being answered in an appropriate time frame."

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable

	of providing for resident needs consistent with the resident service plans.
ANALYSIS:	Based on the facility's call light response log, residents had excessively lengthy wait times for their call lights to be answered by the caregiver.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Food is served cold and is unappetizing.

INVESTIGATION:

When interviewed, the complainant expressed her dissatisfaction with the meals served at the facility. The complainant stated that for the most part, hot food was not hot, and the food was "awful."

At the time of the onsite visit, the noon meal was observed. Most of the residents living on the unit were seated at tables in front of the serving area. Food service employees brought the food in bulk from the main kitchen, plated the individual food servings on dishes that were presented to residents as they were ready. The meal at the time of the onsite visit consisted of a beef barley soup, fried fish fillets served on buns with a slice a cheese, stewed tomatoes, and a side of potato chips. Residents were served ice cream for dessert. The meal had an appropriate appearance. The hot foods when tasted were of an appropriate temperature and acceptable in flavor. The ice cream was still in a frozen form and appropriately cold to taste.

APPLICABLE RULE	
R 325.1952	**Meals and special diets.**
	(5) A home shall prepare and serve meals in an appetizing manner.
ANALYSIS:	Based on observation, there was no evidence that the food was unappetizing.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

I reviewed the findings of this investigation with the administrator on 11/27/2024. When asked if there were any comments or concerns with the investigation, the administrator stated that there were none.

IV. RECOMMENDATION

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

11/27/2024

_____

Barbara Zabitz Date
Licensing Staff

Approved By:

11/27/2024

_____

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