GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 5, 2019

Patricia Hindman
Cherry Blossom Manor Inc.
611 E Main Street Suite B
Hart, MI 49420

RE: License #: AH640236763
Investigation #: 2020A1010012
Cherry Blossom Manor Inc.

Dear Ms. Hindman:

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 (616) 356-0183.

Sincerely,
Lauren Wohlfert

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 #:	AH640236763
Investigation #:	2020A1010012
Complaint Receipt Date:	11/18/2019
Investigation Initiation Date:	11/20/2019
Report Due Date:	01/18/2019
Licensee Name:	Cherry Blossom Manor Inc.
Licensee Address:	611 E Main St. Ste. B Hart, MI 49420
Licensee Telephone #:	Unknown
Authorized Representative/ Administrator:	Patricia Hindman
Name of Facility:	Cherry Blossom Manor Inc.
Facility Address:	Suite B 611 E Main Street Hart, MI 49420
Facility Telephone #:	(231) 873-5377
Original Issuance Date:	09/01/1999
License Status:	REGULAR
Effective Date:	09/19/2019
Expiration Date:	09/18/2020
Capacity:	39
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident E did not receive medical treatment for her fall outside.	No
The facility did not report her leaving unsupervised and the injury suffered.	Yes
Resident E was on the floor all night on 11/16 because staff could not get her up. Resident E was not properly cared for while she was at the facility.	No
Additional Findings	Yes

III. METHODOLOGY

11/18/2019	Special Investigation Intake 2020A1010012
11/20/2019	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
11/20/2019	APS Referral APS referral emailed to Centralized Intake
11/25/2019	Contact - Telephone call made Voicemail left for the complainant, a call back was requested
11/25/2019	Inspection Completed On-site
11/25/2019	Contact - Document Received Received Resident E service plan, staff notes, and incident report
11/25/2019	Contact - Telephone call received Voicemail received from the complainant
12/03/2019	Contact – Telephone call made Interviewed the complainant by telephone
12/03/2019	Contact – Telephone call made Interviewed Relative E1 by telephone
12/04/2019	Exit Conference Completed with administrator/authorized representative Trish Hindman

ALLEGATION:

- **Resident E did not receive medical treatment for her fall outside.**
- **The facility did not report her leaving unsupervised and the injury suffered.**

INVESTIGATION:

On 11/18/19, the Bureau received the allegations from the online complaint system. The complainant read on 11/17, Resident E was observed with a "yellow fading bruise around her right eye and redness under her left eye." Relative E1 reported Resident E eloped from the facility and fell outside. Relative E1 stated this caused the injuries on Resident E's face. Resident E did not receive medical treatment after the incident.

On 11/20/19, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 11/25/2019, I interviewed administrator/authorized representative Trish Hindman at the facility. Ms. Hindman reported Resident E did exit the facility during lunch at approximately 12:30 pm on 11/3. Ms. Hindman stated Resident E was outside for approximately ten minutes before noticed she was not in the dining room. Ms. Hindman said Resident E was in the parking lot near the County Council on Aging building when she fell and hit her head. Ms. Hindman explained Relative E1 was contacted after the incident and arrived at the facility shortly after. Ms. Hindman said Emergency Medical Services (EMS) were also contacted and responded. Ms. Hindman said EMS staff recommended Resident E go to the hospital to be evaluated. Ms. Hindman reported Relative E1 did not want to send Resident E to the hospital after the incident, therefore she did not go.

Ms. Hindman reported Resident E's physician was notified of the incident the following morning on 11/4. Ms. Hindman provided me with a copy of Resident E's incident report for my review. Ms. Hindman said the incident report was not sent to licensing staff. The report was dated 11/3. The *Location* section of the report read, "Outside of building, stepped off the curb in front of the Oceana County Council on Aging and fell." The *People Who Were Contacted* section of the report read Relative E1 was contacted at 12:45 pm. The report read Resident E's physician was not notified. The report read Resident E had a "Hematoma" on the left side of her head.

The *Range of motion on all extremities performed?* section read, "Resident able to move all body parts without any pain." The *Mental status performed?* Section of the plan read, "Completed by ambulance personnel." The *Resident sent to ER?* Section of the plan read, "Ambulance personnel did not feel it was needed." The report read

staff monitored Resident E and took her vitals at 1:00 pm, 1:30 pm, 2:30 pm, 3:30 pm, and 4:30 pm on 11/3. The report was completed by Ms. Hindman.

Ms. Hindman stated an appointment with Resident E's physician was scheduled for 11/6 to follow up regarding the incident on 11/3.

On 11/25/19, I interviewed resident care aide Denice Cram at the facility. Ms. Cram reported Resident E was exit seeking prior to the incident on 11/3. Ms. Cram stated Resident E was easily redirected when she was exit seeking. Ms. Cram said she did not work on 11/3 when Resident E eloped and fell. Ms. Cram reported she did not have any firsthand information regarding the incident.

On 11/25/19, I interviewed resident care aide Dawn Keller at the facility. Ms. Keller reported she was present during the incident on 11/3. Ms. Keller stated Resident E likely exited out of the facility's main entrance while staff were in the dining room assisting other residents during the lunch hour. Ms. Keller explained when she realized Resident E was not present in the dining room, she looked outside and saw a group of people gathered near the Council on Aging building across the parking lot. Ms. Keller stated she knew the people were likely gathered around Resident E so she went outside. Ms. Keller reported Resident E fell and the bystanders gathered around her helped her get up and sat her down. Ms. Keller said one of the bystanders contacted an ambulance and the police.

Ms. Keller said she observed a "bump" on Resident E's head. Ms. Keller reported she called Ms. Hindman after the incident and Ms. Hindman arrived at the facility. Ms. Keller stated Ms. Hindman called Relative E1 to inform her of the incident. Ms. Keller reported Relative E1 did not want Resident E sent to the hospital after the incident. Ms. Keller said staff gave Resident E Tylenol and checked her vitals every half hour after the incident. Ms. Keller reported she did not hear Resident E complain about being in pain after the incident. Ms. Keller stated Resident E did have a black and blue eye the following day.

On 11/25/19, I was unable to interview Resident E because she no longer resided at the facility.

On 12/2/19, I reviewed the facility file. I confirmed I did not receive Resident E's incident report dated 11/3.

On 12/3/19, I interviewed the complainant by telephone. The complainant reported she observed Resident E on 11/17 and she had a bruise on her right eye. The complainant stated she asked Relative E1 how Resident E got the injuries. The complainant explained Relative E1 informed her about the incident on 11/3. The complainant said Relative E1 reported staff at the facility evaluated Resident E and told her she was ok, therefore Resident E did not receive medical treatment.

On 12/3/19, I interviewed Relative E1 by telephone. Relative E1's statements were consistent with Ms. Hindman and Ms. Keller. Ms. Keller reported the EMS staff evaluated Resident E and said she "was fine."

Relative E1 reported Ms. Hindman maintained good communication with her and Resident E's physician while Resident E resided at the facility. Relative E1 denied concerns regarding the care Resident E received while she lived at the facility.

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: **(c) Assure the availability of emergency medical care required by a resident.**
ANALYSIS:	While the facility was not the initiator of the call to emergency first responders, Resident E did receive assessment by emergency responders. That assessment along with Relative E1 direction led to Resident E remaining at the facility under the medical care of her physician. The facility reasonably complied with this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(1) The home shall complete a report of all reportable incidents, accidents, and elopements. The incident/accident report shall contain all of the following information: **(a) The name of the person or persons involved in the incident/accident.** **(b) The date, hour, location, and a narrative description of the facts about the incident/accident which indicates its cause, if known.** **(c) The effect of the incident/accident on the person who was involved, the extent of the injuries, if known, and if medical treatment was sought from a qualified health care professional.** **(e) The corrective measures taken to prevent future incidents/accidents from occurring.**

ANALYSIS:	Review of Resident E's incident report dated 11/3 revealed the report did not include a detailed narrative regarding Resident E's elopement from the facility and subsequent fall. The report did not include the names of the staff involved in the incident or what corrective measures were taken to prevent future incidents from occurring. The facility was not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident/accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician
ANALYSIS:	The interview with Ms. Hindman, along with review of the facility file, revealed Resident E's elopement and fall on 11/3 were not reported to licensing. Ms. Hindman reported Resident E's physician was not notified of the incident until the morning after on 11/4. The facility was not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident E was on the floor all night on 11/16 because staff could not get her up. Resident E was not properly cared for while she was at the facility.

INVESTIGATION:

On 11/18/19, the complaint read, on 11/16 Resident E "was on the floor all night long because staff at Cherry Blossom could not get [Resident E] off the floor." Staff did not call EMS. Resident E was admitted to the hospital with Rhabdomyolysis on 11/17 as a result.

On 11/25/19, Ms. Hindman reported Resident E did not spend the entire night on the floor on 11/16. Ms. Hindman explained Resident E kept laying herself on the floor on 11/16 after staff got her up with a gait belt and back in bed multiple times. Ms. Hindman explained Resident E did not fall out of bed, she lowered herself onto the

floor to sleep. Ms. Hindman stated staff would not knowingly leave a resident on the floor.

Ms. Hindman explained Resident E experienced behavioral changes and became increasingly combative towards staff. Ms. Hindman reported Resident E was admitted to the hospital on 10/30/19 and had medication changes to address her increased aggression. Ms. Hindman stated Resident E had a urinary tract infection (UTI) and finished her antibiotics on 11/4. Ms. Hindman reported Resident E's gait changed and she started to lean and "shuffle" her feet after her medications were changed. Ms. Hindman reported she communicated the changes to Resident E's physician.

Ms. Hindman reported she arrived at the facility on 11/16 to monitor Resident E due to her change in condition. Ms. Hindman stated she observed Resident E had difficulty walking long distances as her gait became "shuffled." Ms. Hindman said she contacted Relative E1, however Relative E1 did not want to send Resident E to the hospital to be evaluated. Ms. Hindman reported Relative E1 requested staff continue to monitor Resident E over the weekend and send her to her physician the following Monday.

Ms. Hindman provided me with a copy pf Resident E's staff notes for my review. A note dated 11/15 read, "Call placed into Hart Family Medical regarding concerns of her not comprehending, appearing to be unable to walk/off balance. Spoke with Lindsey, she will communicate with Jen Tate, PA as Dr. Rudy Ochs is out of office until Dec. 2nd. Repeat urinalysis order requested. Previous antibiotic treatment completed on 11/4/19." Another note dated 11/15 read, "Pam from Hart Family Medical called re: [Resident E]. Dr. Jen Tate stated that because of [Resident E's] change in behavior she wants her evaluated at the ER. Will call family to notify them of Dr.'s recommendation. Spoke with [Relative E1] regarding return call from physician's office and instruction to send to ER for evaluation. [Relative E1] stated that [Resident E] appeared to be doing better when she was here earlier today. [Resident E] has been up and walking and needing redirection as before. [Relative E1] stated she would rather we monitor her throughout the weekend for any other changes cognitively or behavior wise and then determine if ER is needed."

Notes dated 11/16 read, "Put self on floor then pulled blankets on floor would not get up off floor. Refused to get up from the floor we used a gait belt to get her up and in a wheelchair with 2 assist. Very combative wouldn't stand up for us to clean her up. Fed her lunch she was unable to feed herself."

Ms. Hindman provided me with a copy of Resident E's service plan for my review. The *Behavior Patterns* section of the plan did not have any behaviors or staff interventions identified.

On 11/25/19, Ms. Cram reported she did work on 11/16. Ms. Cram's statements were consistent with Ms. Hindman and Resident E's staff notes. Ms. Cram stated

she observed Resident E laid herself on the floor in her room multiple times after staff got her up with a gait belt and put her in bed. Ms. Cram said staff did not leave Resident E on the floor.

On 11/25/19 Ms. Keller's statements were consistent with Ms. Hindman, Ms. Cram, and Resident E's staff notes.

On 12/3/19, the complainant reported Resident E was on the floor all night on 11/16. The complainant stated Ms. Hindman said Resident E was on the floor all night "because staff could not get her up." The complainant reported this led to Resident E's admission to the hospital on 11/17 for Rhabdomyolysis.

On 12/3/19, Relative E1 stated staff at the facility communicated Resident E's behavioral changes. Relative E1 reported she was aware Resident E lowered herself to lay on the floor in her room multiple times on 11/16 after staff got her up and back in bed. Relative E1 denied concerns regarding the care Resident E received while she was in the facility. The complainant explained Ms. Hindman went to the facility to monitor Resident E on 11/16 when she had behavioral issues and a change with her gait. The complainant said Resident E received "great care" and was "happy" while she lived at the facility.

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 with Ms. Hindman, Ms. Cram, Ms. Keller, along with review of Resident E's staff notes revealed Resident E lowered herself to lay on the floor in her room multiple times after staff got her up and back in her bed. There is insufficient evidence to suggest staff knowingly left Resident E on the floor.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITONAL FINDING:

INVESTIGATION:

On 11/25/19, Ms. Hindman provided me with a copy of Resident E's service plan for my review. I observed the *Behavioral Pattern* section of the plan did not address Resident E's reported behavioral changes or how staff were to intervene. The service plan did not address Resident E's reported wandering behavior that increased prior to her elopement on 11/3.

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:	Review of Resident E's service plan revealed her behavioral changes and staff interventions were not adequately outlined.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this reported with licensee authorized representative Trish Hindman at the facility on 12/4. Ms. Hindman agreed with the findings.

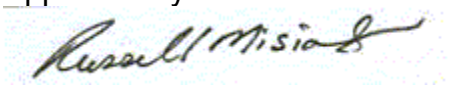
IV. RECOMMENDATION

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

12/3/19

Lauren Wohlfert Date
Licensing Staff

Approved By:



12/5/19

Russell B. Misiak Date
Area Manager