GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 20, 2020

Rochelle Lyons
Springvale Assisted Living
4276 Kroger Street
Swartz Creek, MI 48473

RE: License #: AH250382043
Investigation #: 2020A0784016
Springvale Assisted Living

Dear Ms. Lyons:

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 responsible party 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 (810) 787-7031.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
4809 Clio Road
Flint, MI 48504
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH250382043
Investigation #:	2020A0784016
Complaint Receipt Date:	12/13/2019
Investigation Initiation Date:	12/13/2019
Report Due Date:	02/11/2020
Licensee Name:	Springvale Assisted Living, LLC
Licensee Address:	3196 Kraft Se, Suite 200 Grand Rapids, MI 49512
Licensee Telephone #:	(616) 464-1564
Administrator:	Bethany Frechette
Authorized Representative:	Rochelle Lyons
Name of Facility:	Springvale Assisted Living
Facility Address:	4276 Kroger Street Swartz Creek, MI 48473
Facility Telephone #:	(810) 230-6644
Original Issuance Date:	08/15/2017
License Status:	REGULAR
Effective Date:	02/15/2019
Expiration Date:	02/14/2020
Capacity:	73
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Staff did not seek adequate medical attention for Resident A	No
Resident A was not administered ordered medication	Yes
Additional Findings	Yes

III. METHODOLOGY

12/13/2019	Special Investigation Intake 2020A0784016
12/13/2019	Special Investigation Initiated - Telephone Interview conducted with the Complainant
12/13/2019	APS Referral
01/09/2020	Inspection Completed On-site
01/09/2020	Inspection Completed-BCAL Sub. Compliance
02/12/2020	Contact - Telephone call made Interview conducted with associate Jordan Howe
02/12/2020	Contact - Telephone call made interview conducted with associate Sherri Fallis
02/12/2020	Contact - Telephone call made Interview conducted with associate Katee Maste
02/20/2020	Exit Conference – Telephone Conducted with authorized representative Rochelle Lyons

ALLEGATION:

Staff did not seek adequate medical attention for Resident A

INVESTIGATION:

On 12/13/19, the department received this online complaint. I made a referral to adult protective services (APS).

According to the complaint, Resident A suffered a fall on 11/17/19 while staff were attempting to have her stand and clean her. Resident A reported she had extreme pain in her knee at the time of the fall and staff did not seek emergency medical care. Resident A passed away on the morning of 11/19/19.

Review of the facility licensing file revealed a timely report was submitted in relation to the events surrounding the complaint. Under a section titled *Explain What Happened/Describe Injury*, the report reads "During the 1st shift (6am-2:30pm), employee Courtney [Biggs] observed and reported to hospice that the resident had a swollen and bruised knee and wanted pain medication. Hospice arrived at 2:10pm and observed the right knee. Hospice nurse ordered a mobile x-ray of the right knee. Resident was in bed per her preference. Resident has a diagnosis of dementia and as under hospice care. It was discovered that resident was lowered to the floor on 11/16/19 by employee while employee was assisting with peri-care. Per resident, she stated my legs are week and my knee will buckle". Under a section titled *Action taken by Staff/Treatment Given*, the report reads "Upon discover of the swollen knee Hospice was contacted for instruction. Hospice shower aide came at 11:00am, assisted [Resident A] with bed bath. Resident's hospice nurse arrived at 2:10pm. [Resident A's] right knee evaluated, and x-ray ordered by hospice. PRN [as needed] pain medication was given to resident. Hospice nurse dispensed pain medication to resident upon arrival. Resident's representative notified by phone. Physician notified by phone. Hospice RN notified by phone". The report indicates the x-ray revealed Resident A was found to have a "positive acute distal right femur fracture". The report further indicates Resident A passed away on 11/19/19 at "6:24am due to hypertensive hear per hospice".

On 12/13/19, I interviewed the Complainant by telephone. Complainant stated that on the morning of 11/18/19, Resident A was observed to have a swollen and bruised knee and reported being in "extreme" pain. Complainant stated Resident A reported that she had a fall on a previous morning, "either Saturday or Sunday" (11/16/19 or 11/17/19). Complainant stated that according to Resident A, staff were trying to help Resident A stand while providing peri-care after Resident A had used the restroom when her "knee gave out" and she fell. Complainant stated Resident A reported she had told staff, at the time of the incident, that she was in extreme pain and wanted staff to seek emergency medical services (EMS). Complainant stated Resident A reported staff told her they could not contact EMS because she was on hospice and that hospice needed to be contacted first. Complainant stated hospice was not contacted at the time. Complainant stated hospice was contacted at approximately 7am on the morning of 11/18 due to Resident A's bruised and swollen knee and reported pain. Complainant stated a message was left with the hospice operator explaining Resident A's injury and reported pain. Complainant stated that a hospice "shower aide" came to the facility that morning and provided Resident A with a bed bath and that Resident A was reporting high levels of pain. Complainant stated Resident A was asked several times on 11/18 if she wanted someone to contact EMS and that Resident A reported she did not despite being in a lot of pain.

Complainant stated Resident A's hospice nurse arrived at the facility at approximately 2pm that day. Complainant stated a mobile x-ray completed on Resident A on the evening of 11/18 at which time it was discovered she had a fractured bone in her leg. Complainant stated Resident A passed away on the morning of 11/19/19.

On 1/9/20, I interviewed administrator Bethany Frechette at the facility. Ms. Frechette stated that on the morning of 11/18/19, care associate Courtney Briggs, who she stated no longer works with the facility, informed her that Resident A was complaining of pain in her knew and had some swelling as well. Ms. Frechette stated Ms. Briggs stated she had contacted a hospice representative to report the pain and was awaiting a response for further guidance. Ms. Frechette stated Ms. Briggs reported that she administered Resident A PRN Tylenol to help with the pain. Ms. Frechette stated Ms. Briggs did not report that Resident A needed emergency care or that Resident A was in such a high level of pain Resident A would have needed emergency care. Ms. Frechette stated that had that been the case, she would have assured Resident A received such care at that time. Ms. Frechette stated she received no indication from staff working with Resident A on 11/16/19 or 11/17/19 that Resident A was reporting an abnormal amount of pain or more specifically, pain in her knee. Ms. Frechette stated she did not receive any other reporting regarding Resident A until approximately 2pm when she stated Ms. Briggs informed her that the hospice nurse had not arrived at the facility and that Resident A was "in a lot of pain". Ms. Frechette stated she contacted a hospice supervisor to see when the hospice nurse would be at the facility as Resident A did not have any PRN morphine to help with the elevated pain. Ms. Frechette stated the hospice nurse arrived shortly after, approximately 2:15pm. Ms. Frechette stated the hospice nurse was not aware that Resident A did not have morphine available to her and so went to the pharmacy to retrieve it and was able to administer the morphine to Resident A by approximately 3pm. Ms. Frechette stated that the hospice nurse also ordered a mobile x-ray for Resident A due to the reported pain and observed swelling. Ms. Frechette stated the mobile x-ray representative arrived at approximately 8:30pm that evening to conduct the x-ray. Ms. Frechette stated that in the meantime Resident A was resting "comfortably" in bed while staff kept her knee elevated. Ms. Frechette stated the x-ray results were received several hours later and called in to the hospice on-call nurse at approximately 2:22am. Ms. Frechette stated the results showed Resident A had a knee fracture. Ms. Frechette stated she received reporting from staff on the early morning of 11/19/19 that Resident A had passed away at approximately 5am. Ms. Frechette stated that Resident A's authorized representative visited the facility on the evening of 11/18, at approximately 6pm, and reported that Resident A told that her knee pain was related to something that happened while staff were assisting her with using the restroom. Ms. Frechette stated spoke with associate Jordan Howe who she stated was assigned to work with Resident A over the previous two days, 11/16 and 11/17, regarding the authorized representatives reporting. Ms. Frechette stated Ms. Howe reported that on the morning of 11/16, she was assisting Resident A with using the restroom. Ms. Frechette stated Ms. Howe reported that after going to the bathroom, Ms. Howe

attempted to conduct peri-care on Resident A. Ms. Frechette stated Ms. Howe reported Resident A was holding a grab bar next to the toilet while Ms. Howe used one are to help hold her up and the other to perform the peri-care. Ms. Frechette stated Ms. Howe reported that during the attempted peri-care, Resident A reported her knees were “buckling”. Ms. Frechette stated Ms. Howe reported that she as able to slowly lower Resident A to the floor, without incident, while waiting for a staff member to help her with getting Resident A transferred back to her wheelchair. Ms. Frechette stated Ms. Howe reported Resident A had not complained of pain in her knee. Ms. Frechette stated she could not be certain that Resident A being lowered to the floor was the source of the injury to Resident A’s knee, but that nothing else had been reported that might have related to Resident A ultimately being found to have a fracture in her knee. Ms. Frechette stated staff notes from the evening of 11/17 did indicate that Resident A was administered PRN pain medication after reporting knee pain but that the notes did not indicate the need for emergency services or care beyond general pain medication.

On 1/9/20, I interviewed associate Shaniqua Raines at the facility. Ms. Raines reported she was working on the morning of 11/16/19. Ms. Raines stated she helped Ms. Howe transfer Resident A from her bed to her wheelchair and from her wheelchair to the toilet that morning as Resident A required two people and a Hoyer lift for transfers. Ms. Raines stated she then left to help another resident while Ms. Howe assisted Resident A with using the restroom. Ms. Raines stated she did not witness Resident A either falling or being lowered to the floor. Ms. Raines stated she had not received any reports of Resident A complaining of pain in her knee on that day the next day, 11/17/19, which she stated she also worked.

I reviewed a document titled *RADIOLOGY REPORT* dated 11/18/19 and attributed to Resident A. Under a section of the report titled Conclusion, the report reads “Acute distal femur fracture”. I conducted a google search and according to oamortho.com, a “distal femur fracture refers to a fracture of the femur just about the knee joint”.

I reviewed staff schedules for 11/16/19, 11/17/19 and 11/18/19, provided by Ms. Frechette. According to the schedule, associates Jordan Howe and Katee Maste were assigned to work with Resident A on first and second shift of 11/16 and 11/17 respectively. The schedule further revealed that associate Sheri Fallis was in training on the morning of 11/18/19 while shadowing Ms. Biggs who was assigned to Resident A.

On 2/12/20, I interviewed associate Jordan Howe by telephone. Ms. Howe provided statements consistent with those of Ms. Frechette as it pertains to assisting Resident A to the restroom on the morning of 11/16/19. Ms. Howe added that once she lowered Resident A to the floor, she contacted another associate who helped her transfer Resident A back into her wheelchair with the Hoyer lift and then back into her bed. Ms. Howe stated she did not report this circumstance because Resident A did not fall and did not report any injuries or present with injuries. Ms. Howe stated

she was worked the evening of 11/16 and the morning of 11/17/19 as well and was assigned to work with Resident A. Ms. Howe stated Resident A did not complain of pain in her knee and did not present with knee swelling. Ms. Howe stated she would have noticed any swelling as Resident A wore shorts most of the weekend due to having to use the restroom often. Ms. Howe stated she would have contacted Resident A's hospice nurse and pursued emergency care if necessary, had Resident A reported severe pain or presented with injuries.

On 2/12/20, I interviewed associate Sherri Fallis by telephone. Ms. Fallis confirmed she was in training and "shadowing" Ms. Biggs on the morning of 11/18/19. Ms. Fallis stated Resident A was reporting pain "somewhere in her leg". Ms. Fallis stated Ms. Biggs reported having called Resident A's physician. Ms. Fallis stated she was not aware of any reporting that happened other than the reporting to the physician as reported by Ms. Biggs.

On 2/12/20, I interviewed associate Katee Maste. Ms. Maste confirmed having worked with Resident A on 11/16/19 and 11/17/19. Ms. Maste stated Resident A did report having pain in her knee on the afternoon and evening of 11/17. Ms. Maste stated Resident A requested PRN Tylenol for the pain, and it was administered to her. Ms. Maste stated Resident A did not present with pain in a way that would have caused her concern enough to contact emergency services. Ms. Maste stated she did not observe Resident A to have an injury to her knee. Ms. Maste stated Resident A appeared to be comfortable with the medications provided to her at that time.

I reviewed facility *Charting Notes* which were consistent with statements made by Ms. Maste. The notes indicate that on 11/17/19, "[Resident A] c/o [complained] of knee pain. Administered PRN Tylenol 2 tabs 325mg each at 3:27pm and again at 7:23pm".

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:	The complaint alleged staff did not seek adequate medical care for Resident A after she suffered an alleged fall on 11/16/19 and allegedly reported severe pain. The investigation revealed that due to Resident A's reporting of pain and observed swelling on 11/18/19, further medical attention was sought, and Resident A was found to have a fracture on or around her knee. While Resident A was found to have an injury, it is not clear, upon interviews with staff and review of documentation, that Resident A suffered a fall related to the injury or that staff should have pursued more medical attention sooner. Based on the findings there is insufficient evidence to support a finding.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was not administered ordered medication

INVESTIGATION:

Complainant stated that on 11/18/19 Resident A had requested morphine due to increased pain in her knee. Complainant stated Resident A had a PRN prescription for morphine, but it was not available when Resident A initially requested it.

When interviewed, Ms. Frechette confirmed Resident A did have an order for morphine which was not available to Resident A upon initial request on 11/18/19. Ms. Frechette stated Resident A's hospice nurse was able to obtain a new prescription for morphine on the afternoon of 11/18 and administer the medication to Resident A that afternoon.

I reviewed Resident A's *Physician's Orders*. Listed among Resident A's medications was "MORPHINE SULFATE" with 10/31/19 indicated as the original order date.

I reviewed Resident A's medical administration record (MAR) for November of 2019 which listed "MORPHINE SULFATE" as consistent with the *Physician's Order* as prescribed. Further review of the MAR provided no indication that Resident A's morphine was administered on 11/18/19.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
For Reference: 325.1901	**Definitions**
	(14) "Medication management" means assistance with the administration of a resident's medication as prescribed by a licensed health care professional.
ANALYSIS:	The complaint alleged Resident A did not receive her prescribed PRN morphine as ordered by her physician. Interviews and document review revealed that on 11/18/19, the facility did not have Resident A's medication available when request. While it was reported that Resident A did receive morphine in the evening, after being retrieved by the hospice nurse, the MAR provides no indication that Resident A received the medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

When interviewed, Ms. Frechette stated Resident A's morphine was prescribed to her through hospice when resident started on the hospice program. Ms. Frechette stated Resident A had been on hospice for approximately two or three weeks prior to her passing. Ms. Frechette stated hospice generally provides their hospice patients a "care pack" which she stated the morphine was a part of. Ms. Frechette stated the care pack, and thus the morphine, was never delivered. Ms. Frechette stated it is the primary responsibility of the facilities care coordinator to ensure medications are received as ordered. Ms. Frechette stated this follow up was not done to ensure Resident A's morphine was available when she needed it.

When interviewed, Ms. Raines provided statements consistent with those of Ms. Frechette.

When interviewed Ms. Howe provided statements consistent with those of Ms. Frechette.

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: 325.1901	**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:	Review of Resident A's Physician's Orders and MAR as well as interviews with the administrator and staff revealed that reasonable action was not conducted to ensure Resident A's medications were available when needed. Based on the findings, the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

When interviewed, Ms. Frechette stated that Ms. Howe reported that after Resident A was done using the restroom, Resident A held the grab bar next to her toilet while Ms. Howe held under Resident A's other arm and attempted to perform peri-care. Ms. Frechette stated Ms. Howe reported Resident A said her knees were getting weak while providing the care, so she slowly lowered Resident A to the floor and summoned help to transfer Resident A. Ms. Frechette stated Ms. Howe reported using a Hoyer for the transfers. I reviewed Resident A's service plan while present with Ms. Frechette. Under a section of the plan titled Transferring, the plan read "Transfers with sit to stand, one-person assist required". Ms. Frechette stated that due to Resident A's recent decline, staff have had to conduct her transfers with a Hoyer and two people.

When interviewed, Ms. Howe provided statements consistent with those of Ms. Frechette. Ms. Howe stated she attempted to provide the peri-care without the Hoyer lift because Resident A told her she did not want to use it as the straps that are used for her arms were uncomfortable.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
For Reference: 325.1901	**Definitions**
	(21) "Service plan" means a written statement prepared by the home in cooperation with a resident and/or the resident's authorized representative or agency responsible for a resident's placement, if any, and that identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical, social, and behavioral needs and well-being and the methods of providing the care and services while taking into account the preferences and competency of the resident.

ANALYSIS:	Resident A had a decline in health that precipitated a change in the number of staff needed and the use of assistive devices during her care routine. Resident A's plan was never updated to include this change and methods for staff to follow to ensure her safety during provision of care.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 325.1921	**(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: 325.1901	**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:	Ms. Howe made an independent decision to solely provide care to Resident A despite knowledge of both Resident A's decline of health status and recent use of Hoyer device with two employees for safety. Not only did this place herself at risk of injury during the provision of care, her decision to complete the task herself injured Resident A. Ms. Howe did not take reasonable action protecting Resident A from harm.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

2/18/20

Aaron Clum — Date
Licensing Staff

Approved By:

2/18/20

Russell B. Misiak — Date
Area Manager