GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 27, 2020

Rebecca Long
Sensations
511 E. Shepherd
Charlotte, MI 48813

RE: License #: AH230303551
Investigation #: 2020A1021031
Sensations

Dear Ms. Long:

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) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH230303551
Investigation #:	2020A1021031
Complaint Receipt Date:	02/14/2020
Investigation Initiation Date:	02/14/2020
Report Due Date:	04/15/2020
Licensee Name:	AWL Companies LLC
Licensee Address:	511 E.Shepherd Street Charlotte, MI 48813
Licensee Telephone #:	(520) 307-1196
Administrator/ Authorized Representative:	Rebecca Long
Name of Facility:	Sensations
Facility Address:	511 E. Shepherd Charlotte, MI 48813
Facility Telephone #:	(517) 543-8101
Original Issuance Date:	03/03/2011
License Status:	REGULAR
Effective Date:	04/16/2019
Expiration Date:	04/15/2020
Capacity:	39
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Facility cannot manage behaviors of Resident C.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/14/2020	Special Investigation Intake 2020A1021031
02/14/2020	Inspection Completed On-site
02/19/2020	Contact-Telephone Call Made Interviewed caregiver Tammi Hoag
02/27/2020	Exit Conference Exit conference with authorized representative Rebecca Long

ALLEGATION:
Facility cannot manage behaviors of Resident C.

INVESTIGATION:
On 1/6, 1/19,1/29, 2/2, and 2/7/20 the licensing department received incident reports of Resident C's behaviors.

On 1/6/20, the incident report narrative read, "Resident has become very aggressive with staff members as well as his roommate. Staff had to stand in between him and his roommate to make sure he did not make contact with him as he tried to hit and attack his roommate as well as staff hitting kicking punching all three staff members that were present at that time. We did try change of face with all of us to get him back to his room and is bed this was not working. Anytime we tried to redirect him or get him to comply with staff he would turn angry and aggressive towards us and roommate. Just trying to redirect him back into his room and over to bed and he begun swing at staff members and then tried to go after his roommate. He is also refusing his oxygen. I did pass him his 12am medications these did not seem to help the situation at all he still would not comply and if he tried to redirect him and get close to him be begun to scream and try to hit us again. We did have to stand between him and his roommate's bed to prevent him from having contact with the

roommate. The corrective measures noted in the incident report were Resident C was sent to inpatient psych for an evaluation.

On 1/19/20, the incident report read, “RSA Cassidy entered the Park and observed resident digging through the trash and eating yogurt from someone’s snack. RSA attempted to redirect resident and remove yogurt and trash from his hands. When RSA tried to take the spoon from resident, he punched her in the stomach. RSA called for help, while trying to remove the spoon out of his hand. Resident then punched RSA in the face. When I entered the park, I observed resident holding onto RSA’s forearm. I freed RSA’s arm and we did a change of face.”
The corrective measures in the incident report stated, “Resident was seen by his doctor here again. She is increasing Depakote sprinkles from 125mg 3x daily to 250mg 3x daily, but it requires a gradual step up. So his AM dose increases tomorrow but it will be the 27th before it’s fully doubled for all 3 doses. He has PRN Zyprexa. We have instructed staff to pass before behaviors start, in the meantime.”

On 1/29/20, the incident report read,

> “The resident was in his living unit at the time I arrived to do rounds. I had just went in and checked on everyone during rounds and this is when I seen his roommate in the hall. After helping his room mate I took him back to his room to lay down. (Resident D) was asleep during this time. Myself and another staff member were trying to redirect (Resident C) but he kept getting violent and hitting staff yelling out and not complying. This woke (Resident D) up at first he was a little upset said he just wanted to sleep and was trying to use the bathroom. (Resident C) was in the bathroom at this time. I worked on getting (Resident C) out and told (Resident D) I was sorry for waking him up. He was fine with me gave me a hug and said do not be it is not your fault. (Resident D) then used the bathroom and returned to his bed to lay down. (Resident D) was very angry when (Resident C) kept taking his pants off and then threw them at him and onto his bed. Tonya and I stepped in and tried to get them back on. He got away from us for a moment and went to (Resident D) bed and began to take his bedding and blankets from him. This is when (Resident D) jumped up out of the bed and tried to punch at (Resident C).

On 2/2/20, the incident report read,

> “(Resident D) came into the hall and asked me to “get him out of here.” (Resident C) had his roommates hat, and shirt on. I was attempting to help (Resident C) get the knot out of his shoe laces and was kicked at.”

The corrective measures read,

> “On 2/2 the roommates were both separated and put into different living spaces to help with his situation. We are continuing to monitor and keep them away from each other by taking them in different direction from the other resident at this time.”

On 2/7/20, the incident report read,

"male resident came into her room and would not leave and grabbed her arm and would not let go. Heard her yelling so I went into her room and helped loosed his hand from her arm."

The corrective measures read,

"resident who caused the issue has his family/DPOA meeting with hospice 2/8 here to possibly transition him to hospice if eligible. Recently got his Zyprexa scheduled instead of PRN, to try to keep steady supply in him. His trazodone was also increased Wednesday."

On 2/14/20, I interviewed supervisor Therese Fulgham at the facility. Ms. Fulgham reported Resident C has had multiple medication changes to manage the behaviors. Ms. Fulgham reported Resident C is unpredictable when and if he is going to have a behavior outburst. Ms. Fulgham reported Resident C wanders and has been known to take other resident's items. Ms. Fulgham reported the behaviors can be worse later in the day. Ms. Fulgham reported Resident C is now in a private room which appears to be helping with his behaviors. Ms. Fulgham reported sometimes caregivers can re-direct Resident C by changing caregivers. Ms. Fulgham reported if caregivers' sense Resident C is in a bad mood, caregivers will keep a closer eye on him to re-direct him from other residents.

On 2/14/20, I interviewed supervisor Lisa French at the facility. Ms. French reported Resident C signed onto hospice on 2/8. Ms. reported the physician attempted to increase Trazodone medication, but Resident C became too unsteady and the physician decreased the medication. Ms. French reported to manage the behaviors of Resident C, caregivers will keep a closer eye on him or attempt to get him to lay down to take a nap. Ms. French reported Resident C does not engage in activities or with other residents.

On 2/14/20, I interviewed caregiver Samantha Manyen at the facility. Ms. Manyen reported Resident C can become agitated and it is unpredictable when he is going to become agitated. Ms. Manyen reported it is difficult to re-direct Resident C. Ms. Manyen reported if Resident C becomes agitated the coordinator will be informed and a prn medication will be administered.

On 2/14/20, I interviewed resident services coordinator Tonya Lee at the facility. Ms. Lee reported Resident C has behavior issues at the facility and is unpredictable. Ms. Lee reported caregivers will attempt to re-direct Resident C by changing the caregiver that is attempting to provide care. Ms. Lee reported caregivers will let Resident C wander and do his own thing if he is safe and not hurting himself or others. Ms. Lee reported she has been hit by Resident C. Ms. Lee reported if Resident C is agitated, she will back off and give him space. Ms. Lee reported Resident C has had medication changes which seem to be helping decrease the behaviors.

On 2/14/20, I interviewed caregiver Carissa Collegrove at the facility. Ms. Collegrove reported Resident C can become aggressive with residents and caregivers and has

unpredictable behaviors. Ms. Collegrove reported Resident C goes into other residents' rooms and takes things. Ms. Collegrove reported caregivers will attempt to re-direct Resident C by changing the caregiver which is sometimes successful. Ms. Collegrove reported Resident E fears Resident C and does not like to leave her room because of Resident C.

On 2/14/20, I interviewed caregiver Kelsey Weaver at the facility. Ms. Weaver reported Resident C can be agitated towards caregivers and other residents. Ms. Weaver reported Resident C goes into other resident rooms and take items. Ms. Weaver reported some residents do not want to be around Resident C because of his behaviors. Ms. Weaver reported caregivers will give him space and leave him alone if he is agitated.

On 2/19/20, I interviewed caregiver Tammi Hoag by telephone. Ms. Hoag reported Resident C has punched and kicked her. Ms. Hoag reported Resident C will become frustrated and will become violent towards caregivers. Ms. Hoag reported caregivers will attempt to re-direct Resident C by changing caregivers that are providing care. Ms. Hoag reported Resident C medications have changed which appear to be helping with some of the behaviors. Ms. Hoag reported caregivers will attempt to provide food to Resident C for him to let go of the item that he should not have. Ms. Hoag reported Resident E does not feel safe around Resident C and caregivers will keep Resident C away from Resident E by using a wet floor sign to keep him away from Resident E's room. Ms. Hoag reported Resident C has been admitted to inpatient pysch in the past and his behaviors appear to be decreased and he is not as a big of a threat.

I reviewed the care plan for Resident D. The care plan read,

> "Resident is to be passed anxiety medication when resident starts exhibiting aggressing behavior (ie) slapping, hitting, kicking, biting, pulling hair, throwing objects, or the security of herself/himself or another is in jeopardy. If all other digressing methods have failed: redirection, reassurance, distraction, mirroring, change of face, stimulus control, environmental manipulation, therapeutic intervention…Pass the medication." The care plan revealed resident is at level care three and is "non redirectable, lack of communication."

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(8) A home shall not retain a resident if the resident has harmed himself or herself or others, or has demonstrated behaviors that pose a risk of serious harm to himself or herself or others, unless the home has the capacity to manage the resident's behavior.

ANALYSIS:	Resident C has demonstrated a pattern of violent behaviors towards caregivers and residents at the facility by hitting, kicking, punching, etc. Resident C's behaviors are incompatible with a home for the aged program designed to ensure an environment that is supportive of all resident's wellbeing. The facility has lacked the capacity to manage Resident C and therefore is not compliant with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

I reviewed the plan for Resident C. The plan read,

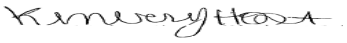
> "Resident is to be passed anxiety medication when resident starts exhibiting aggressing behavior (ie) slapping, hitting, kicking, biting, pulling hair, throwing objects, or the security of herself/himself or another is in jeopardy. If all other digressing methods have failed: redirection, reassurance, distraction, mirroring, change of face, stimulus control, environmental manipulation, therapeutic intervention…Pass the medication." The care plan revealed resident is at level care three and is "non redirectable, lack of communication."

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:	Resident C's service plan identifies behaviors of Resident C. However, it does not provide enough detail on how staff are to manage the behaviors and interventions to utilize when Resident C is exhibiting behaviors. Interviews with staff members revealed each staff member has a different technique for providing care to Resident C.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 2/27/20, I conducted an exit conference with authorized representative Rebecca Long by telephone. Ms. Long agreed with the findings in this report.

IV. RECOMMENDATION

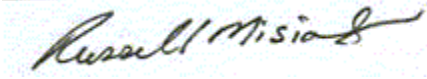
Upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.



2/25/20

Kimberly Horst Date
Licensing Staff

Approved By:



2/25/20

Russell B. Misiak Date
Area Manager