GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 4, 2020

Ronda Pype
The Meadows at Canterbury-on-the-Lake
5601 Hatchery Road
Waterford, MI 48329

RE: License #: AH630380234
Investigation #: 2020A1019033

Dear Ms. Pype:

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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (248) 975-5053.

Sincerely,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630380234
Investigation #:	2020A1019033
Complaint Receipt Date:	02/13/2020
Investigation Initiation Date:	02/13/2020
Report Due Date:	04/14/2020
Licensee Name:	Canterbury Health Care, Inc.
Licensee Address:	5601 Hatchery Road Waterford, MI 48329
Licensee Telephone #:	(248) 674-9292
Administrator:	Jennifer Bishop
Authorized Representative:	Ronda Pype
Name of Facility:	The Meadows at Canterbury-on-the-Lake
Facility Address:	5601 Hatchery Road Waterford, MI 48329
Facility Telephone #:	(248) 674-9292
Original Issuance Date:	01/05/2018
License Status:	REGULAR
Effective Date:	07/05/2019
Expiration Date:	07/04/2020
Capacity:	32
Program Type:	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Care and safety concerns with some residents.	No
Concerns over Resident A's privacy.	Yes
Medication concern with Resident A's Risperidone.	No
Additional Findings	No

III. METHODOLOGY

02/13/2020	Special Investigation Intake 2020A1019033
02/13/2020	Special Investigation Initiated - Letter Emailed AR and administrator to obtain census
02/13/2020	Contact - Document Received Census received via email from administrator
02/25/2020	APS Referral Notified APS of the allegations via email referral template
02/25/2020	Inspection Completed On-site
02/25/2020	Inspection Completed BCAL Sub Compliance
03/04/2020	Exit Conference

The complainant identified some concerns that were not related to licensing rules and statutes for a home for the aged. Therefore, only specific items pertaining to homes for the aged provisions of care were considered for investigation. The following items were those that could be considered under the scope of licensing.

ALLEGATION:

Care and safety concerns with some residents.

INVESTIGATION:

On 2/13/20, the department received a complaint against the facility. The complaint read that they observed multiple wheelchair bound residents attempting to self-transfer in unlocked wheelchairs. The complaint did not list names of residents who were attempting to transfer themselves out of their wheelchairs. The complaint read that Resident A has unexplained weight gain and swelling in her legs and feet. The complaint also read that Resident A is not on any fall precautions but should be. Due to the anonymous nature of the complaint, I was unable to obtain any additional information.

On 2/25/20, I conducted an onsite inspection. I interviewed administrator Jennifer Bishop at the facility. Ms. Bishop stated that she did not have any knowledge of the allegations made by the complainant. Ms. Bishop stated that Resident A is independent with mobility and does not use any assistive devices and is not a fall risk. Ms. Bishop added that resident weights are recorded monthly and nursing staff will monitor if there is a significant change. Ms. Bishop advised that the facility nurse Cathy Wright would have the best insight into the allegations of weight gain and any swelling Resident A may have had but Ms. Wright was not working the day of my inspection.

On 2/25/20, I interviewed care staff Tierra Blackmon, Kelly Arnold and Germaine Lucien at the facility. The staff interviewed reported that several residents use wheelchairs and reported some can transfer on their own. Ms. Lucien stated that there is a resident who lacks safety awareness that will occasionally attempt to get up on his own unexpectedly, but reports that he is monitored closely and staff attempt to keep him in common areas so they are able to supervise him more. Staff interviewed denied any knowledge of recent weight gain, any sudden issues of swelling to Resident A's legs and feet and all reported that Resident A's weight is documented and reviewed monthly. Ms. Blackmon, Ms. Arnold and Ms. Lucien all report that Resident A ambulates independently without the use of any assistive devices and report they have not been advised to implement any specific fall precautions with the resident.

While onsite, I observed Resident A ambulating on her own without the use of any assistive devices. I observed her walking confidently with a steady gait.

While onsite, I observed six residents in wheelchairs. I observed staff providing assistance to all six of those residents. I did not observe any wheelchair bound residents attempt to get out of their wheelchair on their own.

While onsite, I obtained weight records for Resident A. In November 2019, staff documented that Resident A weighed 163 pounds. In December 2019, staff documented that Resident A weighed 166 pounds. In January 2020, staff documented that Resident A weighed 156.2 pounds. In February 2020, staff documented that Resident A weighed 158.2 pounds.

Nurse Cathy Wright was not present during my inspection but later attested via email that Resident A was admitted to the facility with “bilateral edema to her feet/legs. The Dr. is aware and has been monitoring. She was seen on 6-10-19, 9-30-19, 12-20-19, and she is being seen today by Laurie-Ann Mitchell NP.” Ms. Wright denied being aware of any weight issues with the resident.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(1) A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization, which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.
For Reference MCL 333.20201	**(e) A patient or resident is entitled to receive adequate and appropriate care, and to receive, from the appropriate individual within the health facility or agency, information about his or her medical condition, proposed course of treatment, and prospects for recovery, in terms that the patient or resident can understand, unless medically contraindicated as documented by the attending physician in the medical record.**

ANALYSIS:	Several residents in wheelchairs were observed during the onsite inspection. Staff provided assistance to all wheelchair bound residents and no residents were observed attempting to self-transfer. Staff interviewed all attested that Resident A walks independently and does not require any fall precaution measures at this time. Staff interviewed also denied knowledge of any issues with Resident A's weight or swelling in her legs and feet. Nurse Cathy Wright attested that Resident A was admitted to the facility with edema to her legs and feet and that she is being monitored for that by her physician. Review of documented weight logs reveal that Resident A's weight has had a slight fluctuation in recent months, with a two-pound increase from January to February 2020. Based on this information, the allegation is not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Concerns over Resident A's privacy.

INVESTIGATION:

The complaint read that resident's walk in and out of each other's rooms. The complaint reported that on one occasion, a male resident (resident's mane not provided) was found in Resident A's room with his pants undone.

Ms. Bishop stated that Resident A and Resident B have a close friendship and often sit together, hold hands and willingly go into each other's rooms to spend time together. Ms. Bishop stated that to her knowledge the contact between the two residents has been appropriate and Resident A's family is aware of the relationship.

On 2/25/20, I interviewed executive director Cory Cain at the facility. Mr. Cain stated that a few months ago, Resident A's family addressed their concern over the relationship between Residents A and B and even held a meeting to discuss the issue. Mr. Cain stated that the facility recently put a door alarm on Resident A's room that sends an alert notification to staff whenever her door is opened so they know to check on her at those times and also placed a stop sign on her door to deter other residents from entering. Mr. Cain stated that "[Resident A] seeks out the relationship just as much as [Resident B] does. We do try to redirect them but it is mutual."

Ms. Blackmon, Ms. Arnold and Ms. Lucien all confirmed that Resident A and B have a "friendship" and that they do go into each other's rooms frequently without

supervision. All three staff reported that Residents A and B often sit together during meals, sit by each other when watching television or movies and sometimes hold hands. The staff interviewed reported that they do not feel that the relationship is inappropriate, and they monitor the residents often.

A record review of this facility revealed an incident report involving Residents A and B from 12/18/219. The report read:

> Resident's family member came to visit and found both residents in [Resident A's] apartment. [Resident A] was not wearing pants. Both residents were standing by the resident's closet. When the daughter arrived [Resident B] left the room with the assistance of staff. [Resident A] and [Resident B] have had a friendship that has been developing over time. Families are aware of the friendship and would like the facilities assistance to ensure it is limited to handholding/smiliar [sic] comfort and affection and in public and common areas.

The corrective measures listed on the incident report read "Residents will be having silent alarms installed on their doors so that staff can ensure they are not spending time together in private areas. Redirection and support will be offered to assist residents in maintaining an appropriate relationship".

Review of Resident A's service plan read "[Resident A] enjoys socializing with [Resident B], usually sits next to him during meals and watching movies in the TV room. Staff to monitor the two and make sure they are not together alone in either of their own rooms, due to their diagnosis of dementia."

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 A's service plan instructs that she will not be alone with Resident B. Staff interviewed all attested that Residents A and B have a "friendship" and reciprocally go into each other's rooms without staff supervision. Attestations from staff reveal that facility staff have not followed Resident A's service plan instruction. While the staff actions are consistent with each resident right to privately associate with whom they wish, as defined in MCL 333.20201 (2)(k), the same action contradicts Resident A's plan. Based on this information, the allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Medication concern with Resident A's Risperidone.

INVESTIGATION:

The complaint read that Resident A is taking Risperidone for anxiety but that the resident does not need the medication and doesn't understand why she is taking it.

All staff interviewed (Ms. Bishop, Mr. Cain, Ms. Blackmon, Ms. Arnold and Ms. Lucien) reported that Resident A has anxiety related issues and believes the medication is helpful to Resident A in reducing her anxiety symptoms.

On 2/25/20, I interviewed Resident A at the facility. Resident A was unable to appropriately answer my questions and would only reply with "Thank you", "I don't know" or "I like that".

While onsite, I obtained a copy of Resident A's physician orders for Risperidone along with a copy of her medication administration records (MAR) for December-present. On 10/15/19, an order for Risperidone was initiated that read "Start Risperidone 0.25mg PO BID". On 12/3/19, another order was written that read "1. DC Risperdal 2. Risperdal (Risperidone) 0.25 PO QHS x 5 days then stop". On 1/21/20, another order was written that read "1. DC Risperdal 0.25mg 2. Start Risperdal 0.5mg PO QHS". Upon review of the records, it was determined that the resident is receiving the medication as prescribed.

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.
ANALYSIS:	Staff interviewed expressed that Resident A has anxiety and takes medication for that diagnosis. While the resident was unable to verbalize why she takes the medication, the facility was able to provide a current prescription for the medication. Review of Resident A's MAR reveals that staff are administering the medication as prescribed. Based on this information, the allegation is not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 3/4/20, I shared the findings of this report with authorized representative Ronda Pype.

IV. RECOMMENDATION

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

3/2/20

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

3/3/20

Russell B. Misiak Date
Area Manager