GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 10th, 2020

Rebecca Long
Sensations
511 E. Shepherd
Charlotte, MI 48813

RE: License #: AH230303551
Investigation #: 2020A1021034
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 #:	2020A1021034
Complaint Receipt Date:	02/25/2020
Investigation Initiation Date:	02/25/2020
Report Due Date:	04/26/2020
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?
Resident F is at risk of injury.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/25/2020	Special Investigation Intake 2020A1021034
02/25/2020	Special Investigation Initiated - On Site
02/28/2020	Inspection completed on site
03/10/2020	Exit Conference Exit Conference with authorized representative Rebecca Long

ALLEGATION:
Resident F is at risk of injury.

INVESTIGATION:
On 1/12/20, the licensing department received an incident report with narrative that read, “(Resident F) was attempting to sit on the side table in the park next to a resident she mistook for her husband. Resident in activities at this time and got up and moved before Crissta could get to her. She missed the end table and went to her bottom.” The corrective measures read, “3 day post fall, alarm and lap buddy, resident was in activities at this time in a park chair with the alarm. Resident presenting confusion more lately, will be attempting to get UA on resident. Continue to monitor and keep eye on resident in view.”

On 1/16/20, the licensing department received an incident report with narrative that read, “Resident was in the park. Another resident in the park, stated that (Resident F) was trying to move to another chair, and slid out of the chair and landed on her buttocks. She also stated/volunteered that Mary did not hit her head as she overheard me assessing (Resident F) and asking her questions. When I entered the Park, resident had been picked up and placed in her wheelhchair.” The corrective measures read, “monitor resident and complete 3 day post fall. Continue with alarm, lap buddy, keep within sight of staff. Began PT recently for strengthening. Checking with family today about possible seat belt for wheelchair and rails for her bed as well.”

On 1/17/20, the licensing department received an incident report that read, “Marketing hollered at me to come help in the park. I walked in and saw our activities staff on the floor with (Resident F), along with (Resident F’s visitor). (Resident F) was just sitting on her bottom on the floor. I helped her up into the chair. I put the alarm back under her, and asked what happened. I performed range of motion which she completed fine. I asked if she hit her head, she said no and I asked if she was in any pain she also said no.” The corrective measures stated, “with family’s consent we did get an order for a wheelchair with seat belt and bed rails today.”

On 1/21/20, the licensing department received an incident report that read, “resident was seated in the dining room, on her alarm pad. Alarm sounded, I was ambulating another resident to the dining room. Upon entering the dining room I observed a resident in the process of picking her up. I stepped in, and we sat her down in a chair. I was assessing resident post fall and felt a lump on the back of her head. I took vitals, called emergency services, her DPOA, Becky and Lisa.” The corrective measures read, “3 day post fall safety requirements, alarm, landing strip, lowering bed and process of new wheelchair and seat belt. Bed rails for the bed with Dr. and family consent coming. Resident presenting with UTI and on antibiotic at this time, still very impulsive. Dr in today and seen resident and is looking at Cat scan.”

On 1/23/20, I contacted authorized representative Rebecca Long by telephone regarding the use of seat belt and bed rails at the facility. Ms. Long reported the facility will ensure Resident F can remove the seat belt and that it will not be used as a restraint for Resident F. Ms. Long reported the facility will receive a physician order for the bed rails and for the seat belt. Ms. Long reported caregivers are keeping Resident F in eye view to prevent future falls. Ms. Long reported these measures will provide additional safety for Resident F and should decrease Resident F’s falls.

On 1/28/20, I received observation notes for Resident F. The observation notes read, “1/27/20: resident received her new wheelchair and seat belt today, upon inspection with the seat belt the resident is able to remove if needed. She is currently using both the seat belt and lapbuddy which she can remove both at this time. We want to make sure that she is able to do so but also distract her from the impulses to jump up and fall on her bottom. State needs to be sure that she can get out of this if she needs to and upon inspection she can. Continue to monitor resident and remember to ambulate the resident also if she is getting super antsy, toilet, exercise, etc. to help with distractions. She will have the bed/chair alarm on and in place.”

On 2/14/20, the licensing department received an incident report that read, “Pam a staff member called for me from down the hall stating that (Resident F) was sitting on the floor. I immediately headed to that end of the building and could then hear her alarm beeping. She was just sitting on the floor by her bed.” The corrective measures read, “resident presenting with 3 day post fall report, alarms, landing strip, lowered bed and rails, bolsters, continue with 2hr checks on resident. Continue to

monitor for any impulses adjust from there. Dr and state aware of incident at this time."

On 2/18/20, I contacted Ms. Long and Therese Fulgham for new corrective measures to ensure the safety of Resident F. The facility was unable to provide any new corrective measures for Resident F.

On 2/25/20, I conducted an on-site investigation at the facility. Ms. Long reported Resident F is doing better at the facility and falls have decreased. Ms. Long reported Resident F had a urinary tract infection that was making it difficult for her to sit still. Ms. Long reported the seat belt and bed rails are assisting in decreasing falls. Ms. Long reported Resident F does engage with other residents and spends time in the common areas which makes it easier for staff members to keep an eye on her. Ms. Long reported Resident F is very active and does not realize she cannot get up and ambulate and this contributes to the falls.

On 2/25/20, I interviewed caregiver Sara Suntken at the facility. Ms. Suntken reported caregivers try to stay with Resident F 1:1 but it is very difficult to do so with trying to provide care to the residents. Ms. Suntken reported the seat belt and lap buddy are helpful in preventing falls. Ms. Suntken reported Resident F can and has removed the lap buddy and seat belt.

On 2/25/20, I interviewed wellness center coordinator Sherri Rinard at the facility. Ms. Rinard reported safety measures are in place, bed alarm, chair alarm, landing strip, bed bolster, low bed, lap buddy, and seat belt, to prevent Resident F from falling. Ms. Rinard reported Resident F is typically in eyesight of caregivers as she is very active. Ms. Rinard reported the seat belt is used to distract Resident F from getting out of her wheelchair. Ms. Rinard reported Resident F can remove the seat belt. Ms. Rinard reported Resident F does not spend the entire day in the wheelchair and is often in a chair in the activity room.

On 2/25/20, I interviewed caregiver Samantha Mandyen at the facility. Ms. Mandyen reported the facility is working to prevent falls with Resident F but caregivers are limited because there are other residents to care for. Ms. Mandyen reported caregivers will try to keep Resident F in the common area but that does not mean Resident F is within eyesight of caregivers. Ms. Mandyen reported Resident F does not engage well with others and likes to be left alone. Ms. Mandyen reported Resident F has an alarm on wheelchair and bed, but caregivers cannot always respond to the alarm in time.

On 2/25/20, I interviewed caregiver Kelsey Weaver at the facility. Ms. Weaver reported Resident F does not like to sit still and is very active. Ms. Weaver reported Resident F's room is at the end of the hallway and is not near a common area. Ms. Weaver reported Resident F is to be checked on every 30 minutes while sleeping but that it is difficult to do because other residents require care. Ms. Weaver reported caregivers will try to keep Resident F within eyesight to prevent falls.

On 2/25/20, I observed Resident F's room. Resident F was sleeping in her bed with alarms placed, bed bolsters, and bed rails. Resident F's room was at the end of the hallway and was not located near a common area. If an alarm was to sound, it would be very difficult for caregivers to hear the alarm due to where Resident F's room was located.

On 2/28/20, the licensing department received an incident report that read, "alarm sounded and I observed resident sitting/scooting the hallway. Upon entering residents rooms, the bed alarm was sounding, bed rails were in the up position, bolster pillow was in place, bedside mat was on the floor next to the bed." The corrective measures read, "3 day post fall sheet started, alarm, bed rails and bolsters for end of bed, bed lowered to lowest position, landing strip next to bed. Dr and state made aware."

On 2/28/20, I attempted to interview Resident F at the facility to have her demonstrate the ability to remove the lab buddy. Resident F was seated in her wheelchair in the dining room. Resident F was unable to have a meaningful conversation with me due to her cognitive decline. My interactions with Resident F led me to question Resident F's ability to remove the lap buddy.

I reviewed the service plan for Resident F. The service plan read, "resident has a history of falling out of bed. Move nightstand away from headboard. Place landing strip on floor during periods of rest. Not during the day. During the day the landing strip is be placed behind or under the bed. make sure bed sensor is place during the night. A bed roll may be necessary if numerous falls out of bed. Lowering the bed to lowest setting is preferred. Bed with rails received. Include 2 hr checks. Fall Monitoring Device-Chair alarm, lap buddy, gait belt, keeping in eye shot of the resident, 1:1. Make sure the resident has a fall alarm device on and it is functioning and placed for proper use. The resident will be monitored at all times for ambulation and transferring. A personal device will be utilized to help with monitoring and meeting the residents need for ambulation. Resident received her new wheelchair and seat belt today. Upon inspection with the seat belt the resident is able to remove if need. She is currently using both the seatbelt and lap buddy which she can remove both at this time. We want to make sure that she is able to do so but also distract her from the impulses to jump up and fall on her bottom. Continue to monitor resident and remember to ambulate the resident also if she is getting super antsy, toilet, exercise, etc to help with distractions. She will also have the bed/chair alarm on and in place."

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: R 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:	The facility implemented safety precautions, such as lap buddy, seat belt, alarms, bed rails, and 1:1 supervision, to decrease Resident F's falls. Interviews with caregivers revealed these measures are not effective as Resident F continues to fall, and caregivers are unable to prevent Resident F from falls. The alarms the facility has implemented are reactive to Resident F and do not prevent Resident F from falling. In addition, Resident F is not provided 1:1 supervision at the facility. These interventions are not proactive but are reactive to Resident F's falls. The safety precautions the facility has implemented are not reasonable to ensure the safety of Resident F.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
Ms. Weaver reported the facility does not have enough staff to care for the residents. Ms. Weaver reported residents' needs are not met and they do not receive adequate care. Ms. Weaver reported residents do not receive showers on time, are not toileted accordingly, and residents' rooms are not tidied up like they should be. Ms. Weaver reported on first shift there are sometimes only two caregivers and a care coordinator to care for 23 residents. Ms. Weaver reported there are 11 residents that are a two person assist, 23 residents require assistance with dressing, 23 residents require assistance with toileting, two residents are exit seeking, and four residents have behavior issues.

Ms. Mandyen reported there is lack of staff at the facility. Ms. Mandyen reported the facility does not discipline workers for not coming into work as they cannot lose any additional workers. Ms. Mandyen reported there are nine residents that are a two person assist, 23 residents require assistance with dressing, 23 residents require assistance with toileting, two residents are exit seeking, and five residents have behavior issues. Ms. Mandyen reported sometimes there are only two caregivers and a care coordinator to care for 23 residents. Ms. Mandyen reported the shift supervisor will assist but they are primarily responsible for passing medications. Ms. Mandyen reported if a bed alarm or chair alarm is alarming it can be difficult to get to that resident if all caregivers are assisting a resident with a transfer which results in a resident falling at the facility. Ms. Mandyen reported the facility is usually short staffed at least twice a week.

Ms. Long reported the facility is currently hiring. Ms. Long reported there is a position open on second shift and a new caregiver started last week. Ms. Long reported on first shift there are three caregivers and a shift supervisor, second shift there are two caregivers and a shift supervisor, and third shift there is one caregiver and a shift supervisor. Ms. Long reported activity staff and culinary staff also assist with resident care.

On 2/25/20, I observed first shift caregivers at the facility. There were three caregivers and a shift supervisor, but one caregiver was to leave at 11:00 even though the shift ended at 3:00pm. Two caregivers were assisting a two person assist resident with toileting and there was another caregiver in a resident room providing care.

On 2/28/20, I interviewed wellness coordinator Lisa French at the facility. Ms. French reported there are four residents that are a two person assist, two residents that have catheters, one resident with behavior issues, three residents that require increased checks, and 23 residents require assistance with dressing and bathing.

On 2/28/20, I interviewed caregiver Ashley Ehl at the facility. Ms. Ehl reported the facility could have better staff. Ms. Ehl reported there are four residents that are a two person assist, two residents that are exit seeking, one resident with a catheter, four residents that require 1:1 feeding, three residents that require close to 1:1 supervision, and 23 residents require assistance with dressing and bathing.

On 2/28/20, I interviewed shift supervisor Tonya Lee at the facility. Ms. Lee reported she is responsible for providing medications and supervising the shift. Ms. Lee reported she does not provide resident care.

On 2/28/20, I observed the breakfast meal service at the facility. The facility has four small dining rooms. In three dining rooms, a caregiver was providing 1:1 feeding for a resident. A culinary staff member was also providing 1:1 feed to a resident. There were residents that were in the hallways and in their rooms. There were no

caregivers available to assist the residents that were not eating in one of the dining rooms.

I reviewed the staff schedule for 2/9-2/22. On 2/9, for first shift there were only two caregivers and a shift supervisor. On 2/10, for first shift there were only two caregivers and a shift supervisor. On 2/11, for first shift there were only two caregivers and a shift supervisor.

I reviewed the service plans for Resident B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, U, V, W, and Y. The service plans revealed four residents are a two person assist, four residents are exit seeking, six residents require assistance with eating, 13 residents require assistance with toileting, two residents have catheters, one resident requires 1:1 supervision, and 12 residents are incontinent.

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:	Interviews with staff, consideration of care needs as identified in their plans of care, along with schedule review, revealed a staffing protocol that seems incapable of ensuring care needs of the memory care residents are met. The facility has a cognitively impaired resident population that is subjected to potential harm due to the lack of available staff to ensure there is adequate staff to meet the needs of the residents as detailed in their service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
Ms. French reported the initial service plan is developed by the assessment that is completed prior to a resident moving into the facility. Ms. French reported all residents are put on a bed and chair alarm upon move in. Ms. French reported after one month the service plan is updated and then again at three months. Ms. French reported service plans are updated at least every six months or sooner if a change is required in the service plan. Ms. French reported the care coordinators will listen to input from caregivers. Ms. French reported all caregivers can access the service plans on the computer. Ms. French reported if there is a change in the service plan, an alert will notify the caregivers to review the service plan.

Ms. Ehl reported the service plans are not reflected of the actual care needs of the residents. Ms. Ehl reported concerns are brought to the care coordinators, but the concerns are not addressed. Ms. Ehl reported the care needs are higher than what is listed in the service plans. Ms. Ehl reported Resident O is a two person assist transfer.

Ms. Mandyen reported caregivers can access the service plans by looking at them on the computer but there is no time to review the service plans. Ms. Mandyen reported the service plans are not reflected of the current care needs of the residents. Ms. Mandyen reported Resident J, Resident O, Resident U, Resident T, and Resident Q are a two person assist.

Review of Resident J, O, Q, T, and U service plans revealed no mention that the residents were a two person assist.

Review of Resident B, C,D, E, F, G, H, I, K, L, M, N, P, Q, R, S, T, U, V, Y's service plan revealed the service plans had no direction of staff assistance required with dressing and showering

Review of Resident E, G, H, L, V's service plan read, "specific residents like to stay in their room all day, we want them to come out and join the rest of us down in activities, the specials, the hairdresser, the library. Something to try and get them involved with the groups. What are you doing to help get this resident involved and not hide in their room?"

Review of Resident F, M and N, P, U, V,'s service plan revealed the plan was inconsistent of how the resident ambulates, type of device used, and staff assistance required.

Review of Resident F's service plan mentioned Resident F had a concentrator but no direction on when this is to be used and staff assistance required.

Review of Resident J and L's service plan revealved the residents have compression stockings but there is no direction on when this is to be used and staff assistance required.

Review of Resident K's service plan revealed Resident K has incontinent supplies but does not provide additional information on what type of supplies, if Resident K can manage the supplies, and staff assistance required.

Review of Resident Q's service plan revealed Resident Q's communication is "independent" but then is outlined as "impaired communication."

Review of Resident W's service plan read, "ambulation-hands on assist/stand up lift for all transfers right now." In addition, the service plan read, "use gait belt for transfer as resident is getting weak on her legs."

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 staff members revealed service plans are not accurate of resident needs. Review of service plans revealed multiple inconsistencies, lack of direction, and limited information on the care needs of the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 2/14/20, the licensing department received an incident report that read, "Pam a staff member called for me from down the hall stating that (Resident F) was sitting on the floor. I immediately headed to that end of the building and could then hear her alarm beeping. She was just sitting on the floor by her bed." The corrective measures read, "resident presenting with 3 day post fall report, alarms, landing strip, lowered bed and rails, bolsters, continue with 2hr checks on resident. Continue to monitor for any impulses adjust from there. Dr and state aware of incident at this time."

On 2/18/20, I contacted Ms. Long and Therese Fulgham for new corrective measures to ensure the safety of Resident F. The facility was unable to provide any new corrective measures for Resident F.

On 2/28/20, the licensing department received an incident report that read, "alarm sounded and I observed resident sitting/scooting the hallway. Upon entering residents rooms, the bed alarm was sounding, bed rails were in the up position, bolster pillow was in place, bedside mat was on the floor next to the bed." The corrective measures read, "3 day post fall sheet started, alarm, bed rails and bolsters for end of bed, bed lowered to lowest position, landing strip next to bed. Dr and state made aware."

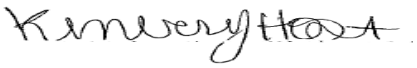
APPLICABLE RULE	
R 325.1941	**Reporting of incidents, accidents, elopement.**
	(1) The home shall complete a report of all reportable incidents, accidents, and elopements.

	The incident/accident report shall contain all of the following information: **(e) The corrective measures taken to prevent future incidents/accidents from occurring.**
ANALYSIS:	The facility submitted incident reports on 2/14 and 2/28 to the licensing department. The incident reports failed to include corrective measures to prevent future falls.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 3/10/20, I conducted an exit conference with authorized representative Rebecca Long.

IV. RECOMMENDATION

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



3/9/20

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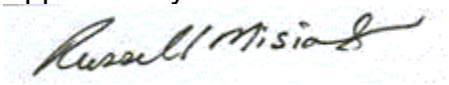
Kimberly Horst Date
Licensing Staff

Approved By:



3/9/20

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Russell B. Misiak Date
Area Manager