GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 6, 2020

Melissa Peebles
Park Village Pines
2920 Crystal Lane
Kalamazoo, MI 49009

RE: License #: AH390236863
Investigation #: 2021A1010002
Park Village Pines

Dear Ms. Peebles:

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
350 Ottawa, N.W. Unit 13, 7th Floor
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 #:	AH390236863
Investigation #:	2021A1010002
Complaint Receipt Date:	10/08/2020
Investigation Initiation Date:	10/09/2020
Report Due Date:	12/07/2020
Licensee Name:	The Kalamazoo Area Christian Retirement Assoc Inc
Licensee Address:	2920 Crystal Lane Kalamazoo, MI 49009
Licensee Telephone #:	(269) 372-1928
Authorized Representative/ Administrator:	Melissa Peebles
Name of Facility:	Park Village Pines
Facility Address:	2920 Crystal Lane Kalamazoo, MI 49009
Facility Telephone #:	(269) 372-1928
Original Issuance Date:	03/01/1975
License Status:	REGULAR
Effective Date:	03/31/2020
Expiration Date:	03/30/2021
Capacity:	215
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A fell and was injured on 9/20 when staff did not provide care consistent with her service plan.	Yes

III. METHODOLOGY

10/08/2020	Special Investigation Intake 2021A1010002
10/09/2020	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
10/09/2020	APS Referral APS referral emailed to Centralized Intake
10/12/2020	Contact - Telephone call made A message was left for the complainant, a call back was requested
10/12/2020	Inspection Completed On-site
10/12/2020	Contact - Document Received Received resident service plan, incident report, and email correspondence
10/13/2020	Contact – Telephone call received Interviewed the complainant by telephone
10/27/2020	Contact – Telephone call received Interviewed Relative A1 by telephone
11/06/2020	Exit Conference Completed with licensee authorized representative Melissa Peebles

ALLEGATION:

Resident A fell and was injured on 9/20 when staff did not provide care consistent with her service plan.

INVESTIGATION:

On 10/8/20, the Bureau received the allegations from the online complaint system. The complaint read, "[Resident A] sustained an injury and resulted in death due to the staff at PVP neglecting to follow the care plan in her medical record. Resident fell and broke her arm and cut her head in her room at Park Village Pines (PVP) in Kalamazoo. The fall occurred 3:45 pm Sunday 9-20-20. Attendant notified [Relative A1] that resident had again fallen out of her chair. Resident was taken to Bronson Hospital around 5:30pm and a cast was placed on her arm. Hospice later explained resident had days to live due to the fall. There were instructions on how to use the chair placed in residents care plan and staff were instructed not to leave the resident in the chair while it was plugged in and if it was not reclined back, and to put the remote control of the chair on the floor. A note was also posted on the wall near the chair for a staff reminder regarding the use of the chair."

On 10/9/20, I emailed an Adult Protective Services (APS) complaint to Centralized Intake.

On 10/12/20, I interviewed administrator Melissa Peebles at the facility. Ms. Peebles reported Resident A had a recliner chair in her room that reclined and lifted to a standing position. This chair was also known as a "lift recliner." Ms. Peebles stated approximately one year ago, Resident A had her first fall out of the chair. Ms. Peebles explained at that time, she was in discussion with Relative A1 regarding removing the chair from Resident A's room due to concerns regarding her safety.

Ms. Peebles said Relative A1 was adamant that the chair remained in Resident A's room because "it was more comfortable" for Resident A. Ms. Peebles reported she agreed to allow the chair to remain in Resident A's room, however her service plan was updated with instruction for staff to put the chair in the recline position, unplug it, and place the remote in the side pocket on the chair when Resident A was in it.

Ms. Peebles provided me with email correspondence between herself and Relative A1 for my review. I observed the email correspondence was consistent with Ms. Peebles' statements.

Ms. Peebles said when Resident A was reclined in her chair on 9/20, she "must have grabbed" the chair's remote while her chair was still plugged causing her to fall. Ms. Peebles stated an incident report was faxed to licensing staff person Elizabeth Gregory-Weil.

Ms. Peebles reported prior to Resident A's fall out of her chair on 9/20, she was placed on hospice on 9/16. Ms. Peebles stated Resident A declined prior to her fall on 9/20, however she was able to make her needs known. Ms. Peebles said Resident A used a wheelchair to ambulate and required the use of a hoyer lift for transfers.

Ms. Peebles provided me with a copy of the incident report and fax confirmation page for my review. The fax confirmation page read the incident report was successfully transmitted to Ms. Gregory-Weil on 9/22.

The *Explain What Happened/Describe Inury (if any)* section of the report dated 9/20 read, “Observed Resident face down with head towards door with coagulated blood next to resident left side of head. Immediately rolled resident over to examine and to communicate. Resident stated in pain all over. When asked what happened, resident stated she tried to get up. Blood observed on residents face, inside residents right nostril, and on bump near left center of residents forehead by hairline slightly bleeding. Resident denied tasting blood in mouth. Resident denies losing consciousness.”

The *Action Taken by Staff/Treatment Given: Include Vitals* section of the plan read, “Pulse, pulse ox, temperature obtained. Called 911 right away due to bump on residents head and bleeding from bump. Observed slight bruise on residents right knee. Could not obtain B/P and respirations as resident stated in pain and trying to check mental status of resident. Resident alert as usual self. Called son. Called Hospice. Called Sam Bare. P70 POX 94% T97.7.”

The *Corrective Measures Taken to Remedy and/or Prevent Recurrence: Clinical Staff* section of the report read, “Turned around with a note placed on chair ‘not to be used.’ Resident is unable to properly use the chair remoted. Hospice is monitoring daily as well as the staff at the facility. Neuro checks were completed.” The *Physician’s Diagnosis of Injury, Illness, or Cause of Death if known* section of the report read, “L Humerus fx, contusion on on [sic] head.”

Ms. Peebles provided me with a copy of Resident A’s service plan for my review. The *FYI Reclining Chair* section of the plan read, “Whenever Resident is in her reclining chair, the chair must always be in the reclined position. Before leaving Resident’s room, ensure her remote to her recliner is in the side pocket of chair, and chair is unplugged with cord under or behind chair ***WHENVER RESIDENT IS IN HER CHAIR***. This is for the safety of the Resident. Resident may get her remote confused with the call light if she has access to it.”

On 10/12/20, I interviewed resident care aide Brittney Hinton at the facility. Ms. Hinton reported she worked second shift on 9/20. Ms. Hinton explained she arrived for her shift at 2:00 pm on 9/20. Ms. Hinton reported when she completed rounds, she walked past Resident A’s room twice and observed her reclined in her chair in her room. Ms. Hinton stated when she walked past Resident A’s room for the third time, she observed Resident A on the floor. Ms. Hinton reported she observed Resident A’s recliner was no longer in the recline position, it was in the standing position.

Ms. Hinton reported the only way the chair could have changed to the standing position was if Resident A got a hold of the remote and accidently changed the

setting. Ms. Hinton stated the remote to the chair was not supposed to be within Resident A's reach when she was placed in the recline position in the chair by staff. Ms. Hinton said the staff person who placed Resident A in her chair also forgot to unplug it. Ms. Hinton reported she did not know what staff person placed Resident A in her chair on 9/20.

On 10/12/20, I was unable to interview Resident A because she is deceased.

On 10/13/20, I interviewed the complainant by telephone. The complainant's statements were consistent with the written complaint the bureau received.

On 10/27/20, I Relative A1 by telephone. Relative A1 reported he received Resident A's death certificate. Relative A1 stated Resident A's death certificate read her cause of death was the fracture she received when she fell out of her chair.

Relative A1 explained Resident A did not have the strength to push the buttons on her recliner remote control. Relative A1 reported it was likely Resident A sat on the remote because it was not properly placed on the floor and out of reach the day she fell. Relative A1 said Resident A's chair was also plugged in despite instruction in her service plan for staff to unplug the chair and put the remote out of reach. Relative A1 reported Resident A experienced confusion and was unable to walk for the past five years.

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:	The interviews with Ms. Hinton, along with review of Resident A's incident report and service plan, revealed staff did not follow the instruction outlined in her service plan regarding her recliner chair. Resident A fell out of her recliner chair on 9/20 when staff did not unplug it and ensure the remote was out of her reach.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Melissa Peebles at the facility on 11/5.

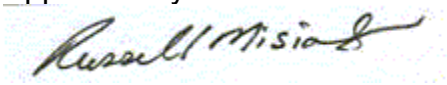
IV. RECOMMENDATION

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

10/14/20

Lauren Wohlfert Date
Licensing Staff

Approved By:



11/5/20

Russell B. Misiak Date
Area Manager