GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 21, 2021

Kelsey Hastings
Advantage Living Center-Redford Village
25330 6 Mile Road
Redford Charter Twp., MI 48240

RE: License #: AH820378377
Investigation #: 2021A1027023
Advantage Living Center-Redford Village

Dear Ms. Hastings:

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 licensee 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) 284-9727.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820378377
Investigation #:	2021A1027023
Complaint Receipt Date:	03/19/2021
Investigation Initiation Date:	03/22/2021
Report Due Date:	05/18/2021
Licensee Name:	Rhema-Redford Village Operating, LLC
Licensee Address:	Ste. 720 25800 Northwestern Hwy Southfield, MI 48075
Licensee Telephone #:	(248) 569-8400
Administrator:	Dolanda Scott
Authorized Representative:	Kelsey Hastings
Name of Facility:	Advantage Living Center-Redford Village
Facility Address:	25330 6 Mile Road Redford Charter Twp., MI 48240
Facility Telephone #:	(313) 531-6874
Original Issuance Date:	10/02/2015
License Status:	REGULAR
Effective Date:	04/01/2021
Expiration Date:	03/31/2022
Capacity:	56
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A had falls at the facility.	No
Additional Findings	Yes

III. METHODOLOGY

03/19/2021	Special Investigation Intake 2021A1027023
03/22/2021	Special Investigation Initiated - Letter Emailed K. Hastings to request documentation pertinent to investigation.
03/22/2021	Contact - Document Received Received requested documentation from administrator D. Scott
04/09/2021	Contact - Telephone call made Telephone interview conducted with complainant
04/15/2021	Contact - Document Sent Requested documentation from PACE
04/15/2021	Contact - Telephone call made Telephone interview conducted with resident assistant L. Henry
04/16/2021	Contact - Telephone call made Telephone interview conducted with resident assistant R. Henry
04/19/2021	Contact - Document Received Received requested documentation from PACE
04/22/2021	Contact – Telephone call made Telephone interview conducted with resident caregiver T. Howard
04/23/2021	Contact – Telephone call received Telephone interview conducted with midnight shift supervisor D. Wafer
04/23/2021	Inspection completed – BCAL Sub Compliance

04/30/2021	Exit Conference Conducted with authorized representative K. Hastings

ALLEGATION:

Resident A had falls at the facility.

INVESTIGATION:

On 3/19/21, the department received a complaint alleging Resident A had falls at the facility that were not reported to the guardian.

On 4/9/21, I conducted a telephone interview with the complainant. The complainant stated Resident A is a participate in Program of All-inclusive Care for the Elderly (PACE). The facility is contracted with PACE to provide respite care and intermittently provided care for Resident A in October 2020. The complainant stated Resident A is confined to her wheelchair and does not ambulate alone. The complainant alleged Resident A had fallen twice while in respite care at the facility, subsequently resulting in injuries to both of her knees. The complainant stated one injury was treated by the staff at PACE and the other at Henry Ford Hospital. The complainant stated Henry Ford Hospital stated the injury occurred from a fall. The complainant stated the facility nor PACE notified Resident A's guardian of the falls.

On 4/15/21, I conducted a telephone interview with resident assistant Loretta Henry. Ms. Henry stated the facility policy is to report falls to her supervisor and complete an incident report. Ms. Henry did not remember Resident A falling at the facility.

On 4/16/21, I conducted a telephone interview with resident assistant Rochelle Henry. Ms. Henry's statements were consistent with Ms. Loretta Henry.

On 4/22/21, I conducted a telephone interview with resident caregiver Tina Howard. Ms. Howard stated Resident A had bruising noted on her knees upon admission to the facility. Ms. Howard stated she did not recall Resident A falling at the facility.

On 4/23/21, I conducted a telephone interview with midnight shift supervisor Danielle Wafer. Ms. Wafer's statements were consistent with Ms. Howard.

Review of Resident A's facility admission assessment noted a scab on her left knee.

Review of Resident A's service plan was consistent with statements from the complainant.

I reviewed Resident A's PACE documentation. On 10/6/20, PACE nurse practitioner evaluated Resident A for concerns of bruising on her right knee. PACE nurse practitioner noted a "nickle-sized" bruise on the right knee, range of motion in all four extremities and no pain. On 10/12, a PACE physical therapist noted Resident A was able to actively participate with range of motion with no complaints. On 10/26, PACE nurse practitioner evaluated Resident A and noted both knees had abrasions, were freely moveable and Resident A denied pain. A PACE staff member reported to the nurse practitioner the abrasions were noted prior to the respite stay at the facility. On 10/26, PACE nurse case manager evaluated Resident A's left knee at her home and noted Resident A's left knee was painful and she was unable to extend it. Resident A was evaluated at Henry Ford Hospital and x-ray confirmed no fracture. On 10/27, the PACE nurse case manager noted she spoke with the facility administrator who stated Resident A had no reported falls or new injuries during her respite stay and abrasions on the knees were documented on admission to the facility.

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 facility staff along with review of facility and PACE documentation revealed falls were not documented in Resident A's records, thus it cannot be confirmed if fall(s) occurred at the facility while receiving respite care. Based on this information, this allegation cannot be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of Resident A's medication administration record (MAR) revealed the following medications were not initiated as given: Atorvastatin on 10/25/20, Lantus and Amitiza on 10/25 and 10/26. Accuchecks were not initialed, and a result was not written on the MAR on 10/25 and 10/26.

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:	Review of facility documentation revealed facility staff did not always initial when a medication was given. Facility staff did not mark any reason for the missed doses and the MARs were left blank, therefore it cannot be confirmed why the medication administration was not completed as scheduled.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 4/30/2021, I shared the findings of this report with licensee authorized representative K. Hastings. Ms. Hastings verbalized understanding of the citation.

IV. RECOMMENDATION

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

4/28/21

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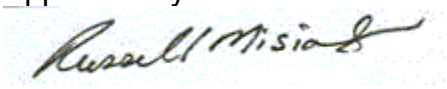
Jessica Rogers Date
Licensing Staff

Approved By:



4/28/21

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Russell B. Misiak Date
Area Manager