GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 4, 2021

Paul Buchholz
Legacy Assisted Living
5025 Ann Arbor Rd.
Jackson, MI 49201

RE: License #: AH380299010
Investigation #: 2021A1027039
Legacy Assisted Living

Dear Mr. Buchholz:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed by the facility authorized representative and dated.

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. 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 #:	AH380299010
Investigation #:	2021A1027039
Complaint Receipt Date:	07/06/2021
Investigation Initiation Date:	07/06/2021
Report Due Date:	09/05/2021
Licensee Name:	Ganton Retirement Centers, Inc.
Licensee Address:	7925 Spring Arbor Rd. Spring Arbor, MI 49283
Licensee Telephone #:	(517) 750-0500
Administrator/ Authorized Representative:	Paul Buchholz
Name of Facility:	Legacy Assisted Living
Facility Address:	5025 Ann Arbor Rd. Jackson, MI 49201
Facility Telephone #:	(517) 764-2000
Original Issuance Date:	05/12/2009
License Status:	REGULAR
Effective Date:	08/20/2020
Expiration Date:	08/19/2021
Capacity:	113
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A lacked protection.	Yes
Additional Findings	No

III. METHODOLOGY

07/06/2021	Special Investigation Intake 2021A1027039
07/06/2021	Special Investigation Initiated - Letter Email sent to AR/admin P. Buchholz requesting documentation
07/07/2021	Contact - Document Received Requested documentation received by email.
07/12/2021	Inspection Completed On-site Staff and resident interviews conducted, and documentation obtained
07/12/2021	Contact - Telephone call made Telephone interview conducted with resident aide Breonna Filas
07/12/2021	Contact - Telephone call made Voicemail left with resident aide Heather Rutan
07/12/2021	Contact - Telephone call made Voicemail left with complainant
08/04/2021	Contact - Telephone call made Voicemail left with resident aide Heather Rutan
08/04/2021	Inspection Completed-BCAL Sub. Compliance
08/09/2021	APS Referral Adult Protective Services (APS) referral sent via email
08/10/2021	Contact – Telephone call received Telephone interview conducted with resident aide Heather Rutan
08/19/2021	Exit Conference

	Conducted with authorized representative P. Buchholz

ALLEGATION:

Resident A lacked protection.

INVESTIGATION:

On 7/6/21, the department received a complaint alleging Resident A had bruising in the shape of handprint on her arm.

On 7/12/21, I conducted an on-site inspection at the facility. I interviewed facility director of nursing Marianne Clay. Ms. Clay stated she was contacted by facility caregiver Kay Delamarter regarding bilaterally bruising on Resident A's arms. Ms. Clay stated she observed Resident A's arms and that they did not appear to be bruises, but multiple areas of pooled blood between Resident A's layers of skin. Ms. Clay stated she asked Resident A about the areas. Ms. Clay stated Resident A stated caregivers Breonna Filas and Heather Rutan grabbed her arms while assisting her. Ms. Clay stated Resident A is a one person assist with a history of Parkinson's disease. Ms. Clay stated she interviewed both third shift caregivers Ms. Filas and Ms. Rutan who had stated they both assisted Resident A that night due to Resident A's unsteadiness. Ms. Clay stated both third shift caregivers stated they assisted Resident A by putting their arms underneath hers to lift her to a standing position along with using a gait belt. Ms. Clay stated both caregivers were re-educated to assist residents utilizing a gait belt. Ms. Clay stated Resident A is not on blood thinners, so when she spoke with Resident A's physician, he was planning to investigate why the areas developed. I interviewed Resident A. Resident A stated two employees on third shift, Ms. Rutan and she could not remember the other caregiver's name, came to assist her to the bathroom in the middle night. Resident A stated they assisted her from a lying position in her bed to a sitting, then standing position. Resident A stated the caregivers assisted her by grabbing her arms. Resident A stated she informed both employees that they were hurting her. Resident A stated she did not remember having a gait belt on during the transfer to the bathroom. I observed Resident A's arm. The left arm had three areas nickel in size that were dark purple around the edge with lighter centers appeared to be bruising. I interviewed charge aide Kay Delamarter. Ms. Delamarter stated she observed the discolored areas on Resident A's upper arms. Ms. Delamarter also asked Resident A what happened. Ms. Delamarter stated Resident A stated the third shift caregivers assisted her to the bathroom by picking her up by her arms. Ms. Delamarter stated Resident A stated that it hurt when they picked her up. Ms. Delamarter stated the policy is to place a gait belt on anyone requiring assistance with ambulation and both caregivers stated Resident A had a gait belt on. I interviewed Resident B and Resident C, both who require staff assistance, regarding staff care at the facility and they reported no concerns.

On 7/12/21, I conducted a telephone interview with resident caregiver Breonna Filas. Ms. Filas stated her and her coworker both assisted Resident A to the bathroom by holding under her armpits and walking alongside her without the gait belt. Ms. Filas stated Resident A does not like using the gait belt because it hurts her. Ms. Filas stated Resident A ambulates fast and loses her balance, so both caregivers were there to support her. Ms. Filas stated she noticed the reddened areas Resident A's arms but thought they were normal age spots.

On 8/6/21, I conducted a telephone interview with resident caregiver Heather Rutan. Ms. Rutan statements were consistent with Ms. Filas. Ms. Rutan stated her, and Ms. Filas usually work together throughout the night to answer call lights. Ms. Rutan stated Resident A pressed her pendant, shortly afterward her and Ms. Filas answered the call light and assisted Resident A to bathroom. Ms. Rutan stated upon assisting Resident A out of the bathroom, she complained of pain on her left arm when Ms. Filas touched it. Ms. Rutan stated Ms. Filas had observed a yellowish colored bruise at that time. Ms. Rutan stated she did not observe bruising on Resident A's arms. Ms. Rutan stated they did not use a gait belt since both caregivers assisted.

I reviewed Resident A's service plan which read consistent with staff interviews. Resident A's service plan read one person assist with a gait belt while walking and with transfers.

I reviewed the training records for Ms. Filas and Ms. Rutan. The training records read Ms. Filas and Ms. Rutan were trained on "assisting ambulation/gait belt."

I reviewed the facility's policy on transferring residents. The policy read "a gait belt must be always used when assisting a resident with a transfer and or ambulation."

I reviewed the Resident A's nurses' notes from 5/15/21 through 7/7/21. The note on 7/5/21 read consistent with statements from Ms. Delamarter. A note from 7/7 read Resident A had two bruised areas noted her upper left outside arm, a bruise on her upper left arm above her elbow, a bruise on the left inside arm, as well as two areas of bruising on her right arm. The nurses' notes documented Resident A's refusal of medications, but there was not documentation of her refusal to wear a gait belt for transfers.

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.
For Reference: R325.1901	**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:	Staff and resident interviews, along with review of facility documentation revealed Resident A requires one person assist with a gait belt and walker with transfers due to difficulty walking from Parkinson's disease. Although it cannot be determined the cause of the bruise like areas, staff did not follow Resident A's service plan nor the facility's transfer policy. Based on this information, this allegation has been substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 8/19/2021, I shared the findings of this report with facility authorized representative Paul Buchholz. Mr. Buchholz verbalized understanding of the findings.

IV. RECOMMENDATION

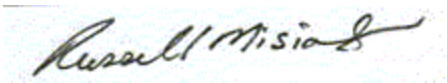
Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

8/11/21

Jessica Rogers
Licensing Staff

Date

Approved By:



8/19/21

Russell B. Misiak Date
Area Manager