GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 29, 2021

Chelsea Rink
Mission Point Health Campus of Jackson
703 Robinson Rd.
Jackson, MI 49203-2538

RE: License #: AH380301277
Investigation #: 2022A0784001
Mission Point Health Campus of Jackson

Dear Ms. Rink:

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 responsible party 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.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH380301277
Investigation #:	2022A0784001
Complaint Receipt Date:	10/06/2021
Investigation Initiation Date:	10/07/2021
Report Due Date:	12/05/2021
Licensee Name:	Mission Point Health Campus of Jackson, LLC
Licensee Address:	30700 Telegraph Road Bingham Farms, MI 48205
Licensee Telephone #:	(502) 213-1710
Administrator:	Juliana Bright
Authorized Representative:	Chelsea Rink
Name of Facility:	Mission Point Health Campus of Jackson
Facility Address:	703 Robinson Rd. Jackson, MI 49203-2538
Facility Telephone #:	(517) 787-5140
Original Issuance Date:	10/25/2010
License Status:	REGULAR
Effective Date:	10/23/2020
Expiration Date:	10/22/2021
Capacity:	40
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was not provided adequate supervision	Yes
Additional Findings	No

III. METHODOLOGY

10/06/2021	Special Investigation Intake 2022A0784001
10/07/2021	Special Investigation Initiated - On Site
10/07/2021	Inspection Completed On-site
10/07/2021	Inspection Completed-BCAL Sub. Compliance
10/29/2021	Exit Conference – Telephone Conducted with authorized representative Chelsea Rink

ALLEGATION:

Resident A was not provided adequate supervision

INVESTIGATION:

On 10/6/21, the department received this online complaint.

According to the complaint, Resident A had an unwitnessed fall on the morning of 8/8/21. The fall resulted in a broken hip. Subsequently, Resident A was placed on hospice and ultimately passed away due to complications related to the fall. Resident A was supposed to have an increased level of care.

Review of the facility licensing file revealed a timely incident report was submitted regarding Resident A's fall on 8/8/21. The report indicated Resident A "fell in the living room resulting in fracture of R [right] hip". The report further indicated Resident A did not return to the facility. The report named associates Jennia Chropowicz, Kaci Willberding and Kimberely Presely as witnesses to the incident. Provided with the incident reporting were additional witness statements from Ms. Chropowicz, Ms. Willberding and Ms. Presely, provided on a *Witness Statement Form.* The

statement provided by Ms. Chropowicz, listed as a medication technician (med tech), indicated she was working in the assisted living when Ms. Presely retrieved her to evaluate Resident A who was found on the floor the couch in the common area. Ms. Chropowicz statement indicated Resident A was unable to move due to reported pain. Ms. Chropowicz statement indicated Ms. Wilberding, listed as an LPN, was also retrieved for help to conduct a secondary assessment and transfer Resident A back into her wheelchair. The statement provided by Ms. Wilberding was consistent with Ms. Chropowicz statement also indicating Resident A was sent to the hospital after contacting Resident A's family. The statement provided by Ms. Presley indicated she found Resident A on the floor after coming out of another residents room.

On 10/7/21, I interviewed administrator Juliana Bright at the facility. Ms. Bright stated she was not the administrator at the time of the fall but was aware of the incident. Ms. Bright stated she was of the understanding that the fall was unwitnessed due to staff working with other residents at the time and that Resident A did suffer a hip injury related to the fall. Ms. Bright stated Resident A was living in the facilities memory care at time. Ms. Bright stated Resident A did not return to the facility after 8/8/21.

On 10/7/21, I interviewed assisted living director Stacey Keast at the facility. Ms. Keast provided statements consistent with those of Ms. Bright. Ms. Keast stated that according to schedule and time clock punch times, associates Kimberly Presely and Nikki Robinson were working in the memory care the morning of 8/8/21. I reviewed the facilities schedule and time clock report for 8/8, provided by Ms. Keast, which confirmed statements provided by Ms. Keast. Ms. Keast stated Ms. Presely has since discontinued employment with the facility. Ms. Keast stated she could not recall Resident A's specific care needs, but that the facility determines provides four levels of care, one being the lowest and four being the highest, which she stated is determined by an assessment. Ms. Keast stated the assessment is also used to help create a service plan for each resident.

I reviewed Resident A's *Care Tracker Questions* document, provided by Ms. Keast, which Ms. Keast indicated was the assessment she previously referred to. The three-page document included several sections with titles relating to various needs and cares commonly referred to as activities of daily living (ADL's) such as *Mobility, Transfers and Bathing,* to name a few. Each section included subsections which had an attributed score, from 1 to 5 with 1 being the lowest and 5 being the highest. The last data line on page three is titled Total Points, indicating that all points from each section are added together to determine a "level of care". Handwritten notes on page three indicate the range of points which determine the level of care (LOC). The handwritten notes read "LOC 1 = 0 – 9.9, LOC 2 = 10 – 24.9, LOC 3 = 25 – 3939, LOC 4 = 40 and up". Resident A's assessment total added to 168. Notables are the subsections under the *Mobility* and *Transfers* sections. The *Mobility* section includes four sub-sections titled *Activity did not occur or independent*, R*equires escort or one-person physical assistance*, *Total dependence on staff to move about (Resident*

cannot self-propel wheelchair), and Two-person assistance, with scores of 0, 2, 3 and 4 respectively. The *Transfers* section includes four sub-sections titled *Actively did not occur or Independent, Supervision to/from bed to chair, Requires one-person physical assistance* and *Two-person assistance or total assistance or transfer to/from bed or chair* with scores of 0, 1, 3 and 5 respectively.

I reviewed Resident A's bill history, provided by Ms. Keast, which indicated Resident A was charged for a "Level of Care 4" from 7/1/21 to 7/31/31 as well as 8/1/21 to 8/7/21.

On 10/7/21, I interviewed associate Roxanne Ruth in the memory care at the facility. Ms. Ruth stated that while she was not working on the morning of 8/8/21, she had worked with Resident A frequently and was very familiar with her. Ms. Ruth stated Resident A was a known "busy body" who often did not sit still. Ms. Ruth stated Resident A was a "good walker". Ms. Ruth stated that although Resident A could walk well, staff were supposed to keep her "in view". Ms. Ruth stated Resident A did not have a history of frequent falling but that any resident who moves around a lot there is a generally higher risk for accidents.

On 10/7/21, I interviewed associate Nikki Robinson at the facility. Ms. Robinson confirmed she was working in the memory care on the morning of 8/8/21 with Ms. Presely. Ms. Robinson provided statements consistent with those of Ms. Ruth regarding Resident A's generally disposition. Ms. Robinson stated that based on her observations and work in the memory care, Resident A would not have been considered a high fall risk. Ms. Robinson stated she did not witness the fall as she was working with another resident inside a room. Ms. Robinson stated Resident A would often get up and move around on her own often wanting to "clean or make the table for dinner". Ms. Robinson stated that prior to the fall on 8/8, she did not have concerns about Resident A getting up on her or being unattended while staff were providing care to other residents in their rooms.

I reviewed internal facility incident reports provided by Ms. Keast. A report dated 7/7/21 indicated Resident A had a fall while "being assisted with ambulation to dinner. The report indicated she had reported pain in her right leg at the time and was able to be assisted to her wheelchair. Corrective measures noted on this report were to "provide one [person] assist with ambulation. Use a wheelchair when needed". A report dated 7/24/21 indicated Resident A was "observed lying on back in dining room. No injuries noted". Corrective measures noted on this report were to "monitor [Resident A] closely for self-transferring, intervene when observed".

I reviewed *Progress Notes* for Resident A for July and August of 2021, provided by Ms. Keast. Notes from 8/8/21 read consistently with reporting and statements provided by staff. Notes dated 7/7/21 were consistent with internal incident reporting from 7/7. Notes dated 7/8/21 read "Resident had a fall during evening on 7/7/21 while ambulating in room. Root cause is impaired balance and weakness. New

intervention is to provide 1 person assist with ambulation. Resident uses a wheelchair when needed. Care plan updated".

I reviewed Resident A's service plan provided by Ms. Keast. The plan includes several individual *Focus* sections each with a corresponding *Goal* and *Interventions/Tasks* section. Each of the individual sections, *Focus, Goal* and *Intervention/Tasks,* includes a "Date Initiated" and a "Revision on" date. A *Focus* section, on page 1, with an initiation date of 3/3/21 read "The resident has an ADL self-care performance deficit r/t cognitive impairment, inability to sequence tasks/steps, short attention span". The corresponding *Interventions/Tasks* section, with a revision date of 7/8/21, read, in part, "MOBILITY: Resident is a 1 person assist". A *Focus* section, on page 2, with a revision and initiation date of 6/8/21 read "The resident has had an actual fall with no injury r/t impaired mobility, cognitive deficits, poor safety awareness". The corresponding *Interventions/Tasks* section included several notes with a revision date of 6/8/21 with read, "Check on resident at frequent intervals to see if any assistance is needed and to offer reassurance to resident", "Ensure dining room and living room floors are free of food debris/clutter for safe environment", and "Monitor resident for proper footwear at all times". An additional note in this section, with a revision date of 7/8/21, read "Resident is 1 person assist with ambulation". A *Focus* section, on page 3, with a revision date of 6/8/21, read "the resident is at risk for falls r/t confusion, deconditioning, hx of falls, impaired mobility, incontinence, poor safety awareness, unaware of safety needs, wandering". The corresponding *Interventions/Tasks* section included several notes with a revision date of 6/8/21 which read, "Encourage participation in activities that will increase strength and mobility", "Encourage resident to stay in common areas to promote more supervision", "Provide resident with safe environment; clutter free; support/assistive devices are available and in good repair; the bed in low position at night; personal items and call device within reach; non-glare soft lighting at night, etc." and "Remind resident to rise and change positions slowly, e.g. arising from a chair, bed".

I reviewed a document titled *Office of the Medical Examiner*, provided by Ms. Keast, which indicated Resident A passed away on 9/2/21.

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: R 325.1901	Definitions
	(21) "Service plan" means a written statement prepared by the home in cooperation with a resident and/or the resident's authorized representative or agency responsible for a resident's placement, if any, and that identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical, social, and behavioral needs and well-being and the methods of providing the care and services while taking into account the preferences and competency of the resident.
ANALYSIS:	The complaint alleged Resident A suffered a broken hip related to an unwitnessed fall on 8/8/21 due to a lack of adequate and appropriate supervision. Review of facility incident reporting, which included additional witness statements, and interviews with the administrator and assisted living director confirmed the incident, and subsequent injury. Interviews with staff as well as review of internal facility incident reporting, staff progress notes related Resident A, Resident A's service plan and care assessment revealed contradictions regarding Resident A's supervision needs. For instance, staff indicated that while Resident A was a "busy body" who would often get up on her own and clean or attempt to prepare the dinner table, they did not feel she was a high fall risk person and felt comfortable with Resident A being in the common area of the memory care without direct supervision. Resident A's service plan and care assessment, as well as incident reporting and progress notes attributed to Resident A, clearly identified Resident A was a person who required assistance from staff with transfers and ambulation related to poor safety awareness, fall history and impaired mobility. Based on the evidence, it is reasonable to conclude that Resident A was not provided adequate supervision, as required by her plan, on 8/8 when she fell as staff working at the time were assisting other residents in their rooms.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/29/21, I discussed the findings of the investigation with authorized representative Chelsea Rink.

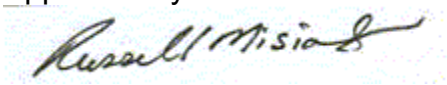
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan. It is recommended that the status of the license remain unchanged.

10/26/21

Aaron Clum — Date
Licensing Staff

Approved By:



10/28/21

Russell B. Misiak — Date
Area Manager