STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

December 22, 2021

Paul Carlson
Sojourner Aid OPCO, LLC
5364 Greenmeadow
Kalamazoo, MI 49009

RE: License #: Investigation #:	AH390378211 2022A1021008 Sojourner Place

Dear Mr. Carlson:

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 #:	AH390378211
Investigation #:	2022A1021008
Complaint Receipt Date:	11/18/2021
Investigation Initiation Date:	11/18/2021
Report Due Date:	1/18/2021
Licensee Name:	Sojourner Aid OPCO, LLC
Licensee Address:	Ste. 3700 330 N. Wabash Chicago, IL 60611
Licensee Telephone #:	(312) 725-7000
Administrator:	Tawnee Stone
Authorized Representative:	Paul Carlson
Name of Facility:	Sojourner Place
Facility Address:	5364 Greenmeadow Kalamazoo, MI 49009
Facility Telephone #:	(269) 353-0416
Original Issuance Date:	04/24/2017
License Status:	REGULAR
Effective Date:	10/24/2021
Expiration Date:	10/23/2022
Capacity:	61
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Staff Person 1 (SP1) verbally abuse to residents.	No
Resident B was not provided medical attention.	No
Service plans are not updated.	No
SP1 forged admission paperwork.	No
Residents are found soaked in urine.	No
Facility has insufficient staff.	No
SP1 writes orders for medications without a physician order.	Yes
SP1 has medications unsecured in her office.	Yes
Facility is unclean.	No
Additional Findings	No

III. METHODOLOGY

11/18/2021	Special Investigation Intake 2022A1021008
11/18/2021	Special Investigation Initiated - Letter referral sent to APS
11/23/2021	Inspection Completed On-site
12/03/2021	Contact-Document Received Received additional information on Resident B.
12/06/2021	Contact-Telephone call made Interviewed Kindred at Home manager Joshua Nordahl
12/22/2021	Exit Conference Exit Conference with authorized representative Paul Carlson

The complainant alleged Staff Person (SP1) does not observe residents take medication and a resident was not checked on properly. This complaint was investigated under special investigation 2021A1010047. The complainant identified

some concerns that were not related to home for the aged licensing rules and statutes. Therefore, only specific items pertaining to homes for the aged provisions of care were considered for investigation. The following items were those that could be considered under the scope of licensing.

ALLEGATION:

Staff Person 1 (SP1) verbally abuse to residents.

INVESTIGATION:

On 11/18/21, the licensing department received a complaint with allegations SP1 is verbally abusive to residents. The complainant alleged SP1 has thrown away personal belongings of Resident L. The complaint was anonymous and therefore I was unable to contact the complainant for additional information.

On 11/18/21, the allegations in this report were sent to centralized intake at Adult Protective Services (APS).

On 11/23/21, I interviewed Resident L at the facility. Resident L reported she enjoys living at the facility. Resident L reported the care staff treat her well. Resident L reported no concerns with caregivers at the facility.

On 11/23/21, I interviewed caregiver Logan Ledd at the facility. Mr. Ledd reported no concerns with how caregivers treat residents. Mr. Ledd reported residents are treated well at the facility.

On 11/23/21, I interviewed caregiver Austin Walker at the facility. Mr. Walker's statements were consistent with those made by Mr. Ledd.

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: **(a) Assume full legal responsibility for the overall conduct and operation of the home.**

ANALYSIS:	Interviews of multiple staff members and management revealed no concerns with the care SP1 provides to the resident and, therefore. I am unable to substantiate the allegations of the complainant.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident B was not provided medical attention.

INVESTIGATION:

The complainant alleged Resident B complained of stomach cramps, had no bowel movement for weeks, and passed away at the facility.

On 11/23/21, I interviewed administrator Tawnee Stone at the facility. Ms. Stone reported Resident B's family was moving Resident B to a different facility due to financial reasons. Ms. Stone reported Resident B then became upset and refused to eat. Ms. Stone reported caregivers tried different foods and approaches to get Resident B to eat. Ms. Stone reported Resident B had some bowel movements, but they were little due to her refusal to eat. Ms. Stone reported on the day the resident passed away, caregivers provided her a popsicle and left her sitting upright in her chair. Ms. Stone reported Resident B pressed her pendent and caregivers responded to Resident B's room. Ms. Stone reported when caregivers responded Resident B was hutched over in her wheelchair and had passed away. Ms. Stone reported Resident B did complain of some stomach pain, but it was contributed to her lack of eating.

I reviewed chart notes for Resident B. The chart notes read,

> *"6/15: over the past two weeks we have seen a change in her. She has the death of her brother in law, hospitalization of her sister and is moving to another facility due to financial problems. She has started refusing to bath & wash her hair, not calling for assistance when she vomits or has BM and is refusing to touch more than 10-15% of her meals. She has been spoken to multiple times by myself about dangers of not bathing & particularly not eating-very low blood sugars. Saturday she was at 49 and had to be given multiple things such as glucagon & Ensure to get BS up. She continues to eat almost nothing-Cheesecake for lunch on 6/14 and a biscuit for dinner. Ate 10% of oatmeal this morning. Spoke with her again and informed that Dr. has D/C all her insulin.*
> *6/15: Sent to ER last night w/ complaints of nausea and lower abdominal pain. Requested transport. Family states its up to her.*

6/16:Resident returned from ER which was sent to last evening around 2100. All appropriate persons were notified @ 2015-2025. New orders for Zofran and Miralax. Nausea and constipation were observed by ER. Also a CT scan was completed and showed "large lymph notes which need to be addressed by PCP. Faxed info to PCP.
6/16: 3:30pm assessed resident due to cough and voice issues. Temp 97.4. LSCTA-cough is loose, denies sore throat, nasal congestion. She was able to visit with this nurse and even recalled by 1st name. She stated she "feels better than I have for a while." Drank 720cc of chocolate nutrition shake and 240cc of water as well. In apt. out of bed in w/c at present.

I reviewed the incident report sent to the licensing department regarding the death of Resident B. The narrative read,

"On 6/17/21, (Resident B) had put her call light on at 2:16pm per call light system, she has been refusing food and throwing up r/t being nauseated she asked for something to nibble on, resident aid Shivam Gautam asked if a popsicle sounded good. (Resident B) stated it did Shivam Hautam also transferred her from her bed to her wheel chair before he left (Resident B)'s room. Shivam arrived back with the popsicle at 2:56pm and (Resident B) started to eat it. At approximately 3:05pm Austin Walker and Shivam Gautam went to check on (Resident B) and observed her slumped over in her wheelchair, vomit on her pants, and unable to arouse her. They immediately went to get the nurse Sindy Esseltine and Janet Verduzco. Sindy Esseltine checked for a pulse and heartbeat, when it had been determined that (Resident B) had passed the family, physician, and 911 were called. (Resident B) was sent to Borgess medical center for this on 6/15/2021 @9:30pm and returned on 6/16/21 @8:30am, with a diagnosis of nausea secondary to pain medication. (Resident B) was prescribed Zofran and Miralax. CT scan showed large lymph nodes however, no blockage of intestines was noted."

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: **(c) Assure the availability of emergency medical care required by a resident.**

ANALYSIS:	Resident B was observed to stop eating and had started to transition to end of life care. Resident B complained of stomach pain and was transported to the hospital that evening. There is lack of evidence to support the allegation the facility failed to provide medical attention to Resident B.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Service plans are not updated.

INVESTIGATION:

The complainant alleged service plans are not updated. The complainant did not provide a resident name.

Ms. Stone reported service plans are updated 30 days after admission and then every 90 days. Ms. Stone reported if there is no change in the service plan, she will contact the family to update them. Ms. Stone reported if there is a major change in the service plan, a care conference will be held. Ms. Stone reported she will update the service plan and notify the regional director of the changes. Ms. Stone reported service plans are updated appropriately.

I reviewed Resident D, E, F, G, and H's service plans. The service plans revealed there were changes noted on the service plan. All the service plans had been updated within the past year.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	Interviews with management and review of service plans revealed service plans are updated appropriately.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

SP1 forged admission paperwork.

INVESTIGATION:

The complainant alleged SP1 forged a nurse practitioner signature on admission paperwork, PPOC, so that a resident could move into the facility. The complainant did not provide a resident name or date when this occurred.

Ms. Stone reported she is responsible for the initial signing of the admission paperwork for new residents. Ms. Stone reported a regional director ensures the physician plan of care (PPOC) is completed with the admission assessment. Ms. Stone reported the PPOC must be signed by the physician as this document has the resident's medication orders on it. Ms. Stone reported SP1 does complete nursing assessments with new admissions but that is after they are moved in.

I reviewed Resident D, E, F, G, and H's admission paperwork. The paperwork revealed each resident had the PPOC signed by their corresponding physician.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(6) A home shall require an individual who, at the time of admission, is under the care of a licensed health care professional for ongoing treatments or prescription medications that require the home's intervention or oversight, to provide a written statement from that licensed health care professional completed within the 90-day period before the individual's admission to the home. The statement shall list those treatments or medications for the purpose of developing and implementing the resident's service plan. If this statement is not available at the time of an emergency admission, then the home shall require that the statement be obtained not later than 30 days after admission.
ANALYSIS:	Interview with administration revealed SP1 is not responsible for ensuring admission paperwork is completed. Review of multiple resident admission paperwork revealed the required paperwork was signed by their physician.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents are found soaked in urine.

INVESTIGATION:

The complainant alleged the facility has multiple residents with sores on their bottoms because they sit in soiled briefs. The complainant did not provide any resident names.

Mr. Ledd reported there are no issues with residents left sitting in urine. Mr. Ledd reported no residents have skin breakdown on their bottoms.

Mr. Walker reported Resident J prefers to sit in her recliner and is not good at pressure relief. Mr. Walker reported the resident has the beginnings of skin breakdown on her bottom, but it is not due to sitting in urine. Mr. Walker reported residents are not found sitting in soiled briefs.

Ms. Stone reported Resident J does have a sore on her bottom due to sitting in her chair. Ms. Stone reported the facility tried a pressure relief cushion, but Resident J did not like it. Ms. Stone reported Resident K has a foley catheter so she is not sitting in her urine. Ms. Stone reported Resident K has a sore on her calf due to fluid overload at the hospital. Ms. Stone reported there are no other residents with sores on their bottoms. Ms. Stone reported residents are not found sitting in urine.

While at the facility I observed multiple residents in their rooms and in the common areas. The residents I observed were in clean clothes and did not smell like urine.

I observed the infection control binder. The binder revealed no documentation on wounds within 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 caregivers revealed there are no residents with skin breakdown due to sitting in their urine. Observation of residents revealed the residents were in clean clothes and were not sitting in urine.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Facility has insufficient staff.

INVESTIGATION:

The complainant alleged the facility has lack of staff. The complainant alleged the facility will only have one caregiver to care for the residents and this happened on 11/15.

Mr. Ledd reported he always works with at least one additional caregiver. Mr. Ledd reported typically there are three caregivers in the facility for first shift but sometimes there are only two. Mr. Ledd reported the days are busy, but care tasks are completed. Mr. Ledd reported management will assist, if needed.

Mr. Walker's statements were consistent with those made by Mr. Ledd.

Resident L reported care staff treat her well at the facility. Resident L reported they assist with her needs quickly. Resident L reported no concerns with the facility.
Ms. Stone reported the facility is currently hiring for all shifts. Ms. Stone reported the facility is currently using agency staff to fill open shifts. Ms. Stone reported on first and second shift there are to be at least two caregivers but ideally three and on third shift there are to be two caregivers. Ms. Stoner reported when the schedule is developed, if there are open shifts, they are offered to agency staff and then to facility staff. Ms. Stone reported on the schedule it is noted if a caregiver has a "bubble shift" which means that caregiver will be mandated to stay over their shift to fill an open shift. Ms. Stone reported there is always two caregivers on the floor. Ms. Stone reported on 11/15, for first shift there was one call in which resulted in two caregivers that worked the entire shift and an agency staff worker that came in at 10:45am. Ms. Stone reported on second shift, reported the "bubble" worker called in and the other worker was late. Ms. Stone reported this resulted in the first shift caregiver staying over. Ms. Stone reported there was 15 minutes between shift changes that there was only one caregiver on the floor. Ms. Stone reported residents receive good care and there is sufficient staff at the facility.

I reviewed the staff schedule for 11/07-11/20. The schedule revealed there was at a minimum two caregivers on each shift. The schedule revealed when there was a call

in, the facility mandated a caregiver to stay over or found an agency staff worker. The schedule revealed their staffing ratios were consistent with statements made by Ms. Stone.

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:	On 11/15, on second shift there was 15 minutes where there was only one caregiver on the floor. However, this was a rare occurrence and was fixed in a timely manner. Review of staff schedules and attestations from staff revealed the facility is operating at their desired staffing levels. Employees reported they are fully meeting the needs of the residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

SP1 writes orders for medications without a physician order.

INVESTIGATION:

The complainant alleged SP1 writes orders for medications without a physician order. The complainant alleged the resident has a PRN narcotic medication and SP1 made it a scheduled medication. The complainant did not provide a resident name for this allegation.

Ms. Stone reported a resident had an order for PRN Ativan and it was to be changed to a scheduled medication. Ms. Stone reported the facility nurse obtained a verbal order from the home care company for the change and then received the written order.

Ms. Verduzco reported Resident P is on hospice services. Ms. Verduzco reported Resident P had a PRN narcotic medication and she kept falling. Ms. Verduzco reported hospice recommended for the PRN to be changed to schedule. Ms. Verduzco reported this occurred on a Friday, 10/27. Ms. Verduzco reported she received the verbal order and then the written order on Monday.

On 12/6/21, I interviewed Kindred at Home manager Joshua Nordahl by telephone. Mr. Nordahl reported Resident P is on service with their company. Mr. Nordahl reported Resident P has an order for PRN Ativan. Mr. Nordahl reported there was a discussion with the facility regarding administering the medication if the resident was exhibiting symptoms that required the medication. Mr. Nordahl reported the medication was not to be scheduled.

I reviewed the October medication administration record (MAR) for Resident P. The MAR revealed Resident P had an order for Ativan with instruction to administer 0.5mg by mouth every six hours for agitation. There was a note under the instructions that read,

> *"10/27: changed now routine if awake & agitated. If asleep-do not awaken to give."*

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 Resident P's MAR revealed there was a change noted on her MAR. This change did not have a corresponding physician order.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

SP1 has medications unsecured in her office.

INVESTIGATION:

The complainant alleged a resident passed away and SP1 left the resident's medications unsecured in her office.

Ms. Stone reported a resident was on hospice and the hospice company brought in pre-filled liquid morphine syringes. Ms. Stone reported the resident passed away, the drug buster was filled, and SP1 put the medication in her office. Ms. Stone reported she was notified by the facility physician that there were unsecured medications in the nurse office. Ms. Stone reported she spoke with SP1, and the drugs were then moved to a secure location. Ms. Stone reported this was an isolated incident and has not occurred since then.

SP1 reported a resident was on liquid morphine and the hospice company brought 120 pre-filled syringes. SP1 reported the resident passed away and she moved the medication to her office. SP1 reported the medication was locked but it was not double locked. SP1 reported she contacted the hospice company to dispose of the medication, but it did take a while for the hospice company to come. SP1 reported since this incident she has not moved any resident medications.

I inspected the nurse office. I did not observe any resident medications in the nurse office.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(6) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a licensed health care professional or a pharmacist.
ANALYSIS:	SP1 moved a resident's medication to her office until the hospice company could dispose of the medication. SP1 did not properly dispose of the medication that was no longer needed by the resident.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Facility is unclean.

INVESTIGATION:

The complainant alleged residents complain about rooms not being cleaned.

Mr. Ledd reported resident rooms are kept clean and tidy. Mr. Ledd reported he has never heard anyone complain about rooms being dirty.

Resident A reported things are going well at the facility. Resident A reported her room is kept clean by care staff.

Ms. Stone reported the facility recently hired a new housekeeper. Ms. Stone reported the activities director has been assisting with cleaning the facility. Ms. Stone reported caregivers at the facility has worked together to ensure the facility is clean.

I observed the common areas of the facility including the living area, dining area, hallways, and bathrooms. The common areas of the facility were clean as observed by the floors were vacuumed, there was no litter on the floor, and the facility smelt clean.

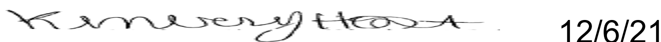
I observed multiple resident rooms and bathrooms. The rooms were tidy and clean. The bathrooms were also clean.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	The facility was without a housekeeper but had various other staff members completing housekeeping tasks. The facility has recently hired a new housekeeper. While at the facility, I did not observe any cleanliness issues and therefore there is lack of evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 12/22/21, I conducted an exit conference with authorized representative Paul Carlson by telephone.

IV. RECOMMENDATION

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



12/6/21

Kimberly Horst Date
Licensing Staff

Approved By:

12/6/21

Russell B. Misiak Date
Area Manager