GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 31, 2022

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

RE: License #: AH390236863
Investigation #: 2022A1028023
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 within 15 days on or by 2/12/2022 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. 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) 356-0100.

Sincerely,
Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AH390236863
Investigation #:	2022A1028023
Complaint Receipt Date:	12/28/2021
Investigation Initiation Date:	12/29/2021
Report Due Date:	01/27/2022
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:	03/31/2021
Expiration Date:	03/30/2022
Capacity:	215
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The facility issued Resident A an improper discharge notice.	Yes
Mediation was found on Resident A's floor.	Yes

III. METHODOLOGY

12/28/2021	Special Investigation Intake 2022A1028023
12/29/2021	Special Investigation Initiated – Letter APS referral emailed to Centralized Intake
12/29/2021	APS Referral APS referral emailed to Centralized Intake
12/29/2021	Contact - Telephone call made Interviewed the complainant by telephone
01/03/2022	Inspection Completed On-site I completed onsite inspection
01/03/2022	Contact - Document Received 2022A1028023 - Received Resident A's admission contract, service plan, current account notice, and record notes from Compliance Director, David Murray
01/03/2022	Contact - Face to Face Interviewed staff Employee A at the facility
01/06/2022	Contact - Face to Face 2022A1028023 - Interviewed CEO, David Bos and Director of case work and compliance, David Murray with Long-Term-Care State Licensing Section manager, Andrea Moore, present via Teams
01/06/2022	Exit Interview

ALLEGATION:

The facility issued Resident A an improper discharge notice.

INVESTIGATION:

On 12/28/21, the Bureau received the allegations from the online complaint system.

On 12/29/21, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 1/3/22, I completed an onsite inspection of the facility. Resident A was asleep in [their] room in the recliner. Resident A was clean and groomed and Resident A's room was clean as well.

On 1/3/22, facility director of case work and compliance, David Murray provided me copies of the facility discharge notice for Resident A, facility discharge policy, Resident A's service plan and record with notes, and Resident A's current account statement for my review.

On 1/6/22, I interviewed facility CEO, David Bos, and Mr. Murray via virtual meeting. Long-Term-Care State Licensing Section manager, Andrea Moore was present during the virtual meeting as well. Mr. Bos reported the facility is discharging Resident A due to being unable to meet Resident A's needs and the expectations of Resident A's family.

On 1/24/22, I reviewed Resident A's discharge notice. The discharge notice was dated 12/7/21 and provides the following as reason for discharge:
This 30-Day Discharge Notice is necessary for the following reason:
"Per R325.1922(11)(C)-(15) subsection (B) For His or Her welfare or that of the other residents.

Note of prior actions taken by Park Village Pines to attempt to solve this situation:
Unsuccessful attempts to meet the level of care that said resident needs.

Attached are the following documents:
- *Resident's observation history*

Further review of the facility discharge notice reveals the following: R325.1922(11)(C) was given as reason for Resident A's discharge from the facility. However, this specific rule actually states *"In accordance with MCL 333.20201(3)(e), a home's discharge policy shall specify that a home for the aged resident may be transferred or discharged for any of the following reasons:*
(c) For nonpayment of his or her stay.

I reviewed Resident A's most recent account statement and Resident A is current with all payment and account information. Resident A's account is not outstanding.

Rule R325.1922(15)(B) was also provided by the facility as an additional reason for Resident A's discharge. However, this specific rule actually states *"A home may discharge a resident before 30-day notice if the home has determined and documented that either, both, of the following exist:*
(b). A substantial risk or an occurrence of the destruction of property.

Upon review of all documentation, there is no evidence or any incident reports that Resident A has been a substantial risk or participated in the destruction of property.

Additional review of documentation reveals the facility includes Resident A's observation history as additional support for Resident A's discharge. However, Resident A's observation history is not attached to the discharge notice and review of Resident A's record with record notes demonstrates no evidence of the facility being unable to meet Resident A's needs appropriately. When interviewed, Mr. Bos confirmed Resident A receives additional home health services five days a week, so Resident A needs are met appropriately. There is no evidence and/or no documented history of behaviors or incidents pertaining to Resident A either. Review of the facility department file also reveals no reported incidents from the facility to the department concerning Resident A.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(11) In accordance with MCL 333.20201(3)(e), a home's discharge policy shall specify that a home for the aged resident may be transferred or discharged for any of the following reasons: **(a) Medical reasons.** **(b) His or her welfare or that of other residents.** **(c) For nonpayment of his or her stay.** **(d) Transfer or discharge sought by resident or authorized representative.**

ANALYSIS:	On 12/7/21, the facility issued a discharge for Resident A stating the following reasons: • R325.1922(11)(C) - For nonpayment of his or her stay. • R325.1922 (15)(B) - A substantial risk or an occurrence of the destruction of property. However, the reasons provided by the facility in Resident A's discharge do not align with the state statutes for discharge. There is also no evidence the facility has been unsuccessful at meeting Resident A's needs, that Resident A's account is not current, or that Resident A engaged in behaviors and the destruction of property. The facility has issued Resident A an improper discharge notice.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Mediation was found on Resident A's floor.

INVESTIGATION:

On 12/29/21, I interviewed the complaint by telephone. The complainant reported medications were found on Resident A's floor during a routine visit in December 2021. The complainant reported it was brought to the attention of the facility immediately. The complainant reported "it appears the medication was spit out" by Resident A. The complainant reported this is not the first time medication has been found on Resident A's floor during routine visits. The complainant is unsure if the service plan was updated and the complainant provided me photographic evidence of medications that were found on Resident A's floor.

On 1/3/21, Employee A was interviewed at the facility. Employee A reported medication was found on Resident A's floor in December 2021, and it was brought to [their] attention immediately by family. Employee A reported care staff are to remain in the room to make sure a resident swallows the medication once it is administered. Employee A reported "sometimes residents will pocket the meds in the back of their mouth and sometimes we can't see them when we check to make sure they swallowed the meds". Employee A reported Resident A does not have a history of refusing or pocketing medications, "but the pill turned in by the family that day, looked like it had been spit out". Employee A reported Resident A's care plan was updated to ensure Resident A does not continue to pocket or spit out medications.

On 1/3/22, Mr. Murray provided me a copy of Resident A's medication administration record for December 2021.

On 1/24/22, I reviewed Resident A's medication record which revealed no medication errors or refusals of medication from Resident A for December 2021.

I also reviewed Resident A's service plan and there is no evidence medication administration was updated for Resident A to ensure Resident A does not continue to pocket or spit out medications.

Review of the facility department file revealed the medication administration error was not reported to the department either.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.
ANALYSIS:	Medication was found on Resident A's floor during a routine family visit in December 2021. Resident A does not have a history of pocketing or spitting out medications. Employee A reported due to the incident, Resident A's service plan was updated to ensure Resident does not continue to pocket or spit out medications. However, there is no evidence Resident A's service plan was updated. Facility care staff did not administer Resident A's medication appropriately or ensure Resident A appropriately took the medications in accordance with the service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Julie Viviano

1/25/2022

Julie Viviano Date
Licensing Staff

Approved By:

01/25/2022

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Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section