GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 21, 2022

Kelly Cornford
Union Court Assisted Living
302 Fulton St.
St. Charles, MI 48655

RE: License #: AH730301115
Investigation #: 2022A0585019
Union Court Assisted Living

Dear Ms. Cornford:

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. 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,

Brender L. Howard

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(313) 268-1788
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH730301115
Investigation #:	2022A0585019
Complaint Receipt Date:	12/29/2021
Investigation Initiation Date:	12/29/2021
Report Due Date:	02/28/2022
Licensee Name:	Union Court Assisted Living
Licensee Address:	302 Fulton St. St. Charles, MI 48655
Licensee Telephone #:	(989) 865-8100
Authorized Representative/Administrator:	Kelly Cornford
Name of Facility:	Union Court Assisted Living
Facility Address:	302 Fulton St. St. Charles, MI 48655
Facility Telephone #:	(989) 865-8100
Original Issuance Date:	11/19/2009
License Status:	REGULAR
Effective Date:	11/27/2021
Expiration Date:	11/26/2022
Capacity:	86
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A passed away after a fall in the bathroom and there are concerns that he was neglected during his stay at the facility.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/29/2021	Special Investigation Intake 2022A0585019
12/29/2021	Special Investigation Initiated - Letter Emailed the allegations to Adult Protective Services (APS).
12/29/2021	Contact - Telephone call made Attempts were made to contact complainant. No answer and a message were left to contact this writer.
01/04/2022	Contact - Telephone call received Telephone called received from complainant Cindy Smith regarding the allegations.
01/10/2022	Inspection Completed On-site Completed with observation, interview, and record review.
02/25/2022	Exit conference Conducted with authorized representative Kelly Cornford.

ALLEGATION:

Resident A passed away after a fall in the bathroom and there are concerns that he was neglected during his stay at the facility.

INVESTIGATION:

On 12/28/21, the department received the allegations from the complaint via the BCAL Online complaint website.

On 12/8/21, the allegations in this report were sent to centralized intake at Adult Protective Services (APS). APS determined they would not be investigating.

On 1/4/22, I interviewed complainant by telephone. The complainant stated that on the evening of October 25 or 26th, Resident A was put on the toilet by an aide who left the room. She stated that Resident A fell off the toilet and broke his hip. She stated that staff insists that he got himself out of bed and turned off the alarm. She stated that she does not believe that he is able to do that.

On 1/10/22, I conducted an onsite at the facility. During my onsite, administrator Kelly Cornford was not present. I interviewed manager Beth Shuler and Kris Fiting. Ms. Fiting stated that Resident A was able to turn himself in the bed. She stated that Resident A would unplug the alarm. She stated that staff did not leave him on the toilet, but they probably just walked away to give him his privacy.

On 1/10/22, during the onsite, I interviewed resident care coordinator Heather Keevan. She stated that Resident A had days that he would attempt to take himself to the bathroom. She stated that the last fall, he broke his hip. She stated that he would normally call for assistance and sometimes he would get aggressive.

On 1/21/22, I interviewed resident caregiver/medication technician Coleen Fath by telephone. She stated that Resident A took himself to the bathroom and while in there he fell. She said that during the time, he was able to walk. She stated that he was on hourly checks but did not remember the last time he was checked on.

Upon request, Ms. Fiting gave me copies of Resident A's service plan, Resident A's incident reports, hospice notes and staffing schedule.

A review of Resident A's incident reports, read,

On 10/23/21 at 5:30 am, Staff was standing next to the nurses' station and heard noise. I went down the hall and found resident on the floor next to his bed in front of his recliner. Small quarter size scape on middle of back. Sup notified. Hospice notified on 10/24/21 at 10:00 am.

.

On 10/24/21 at 4:10 pm, Staff was in another resident's room when a wheelchair alarm was going off. Came out to find resident laying on his left side with his feet touching the door. Resident had a small skin tear on left elbow. Hospice notified on 10/24/21 at 4:30 pm.

"On 10/25/21, when standing at med cart, staff heard a loud crash and found Resident A on the floor on right side with his walker, alarm did not go off, he had it unplugged. No signs or symptoms of injuries at this time, rubbing his right leg and shoulder, showing pain on his face when we stood him up to use the bathroom. Corrective measures: resident signs and symptoms of right thigh/hip pain – Hospice ordering x-ray. Hospice notified.

The service plan for Resident A read, “admitted to the facility on 3/18/19. Resident is ambulatory and uses a wheelchair which he needs help propelling. Resident completes all transfers 1-2 person assist. Resident has a chair and bed alarm due to transferring himself which resulted in falls. Resident is incontinent and wears depends on that hospice provides. Resident toilets and completes peri care with assistance. Resident is on a 2-hour toileting schedule.”

APPLICABLE RULE	
R 325.1931	**Admission and retention of residents.**
	(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.
R325.1901	**Definitions.**
	“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 supervisor, 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.
	“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 facility did not keep the resident safe as evident by the three falls that put the resident in more than minimum harm. There were no corrective measures put in place to help prevent this from happening. Therefore, this claim is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

Resident A's incident reports dated 10/23/2021 and 10/24/2021 was reviewed and was found to not be completed. The incident reports lacked corrective measures.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(1) The home shall complete a report of all reportable incidents, accidents, and elopements. **The incident/accident report shall contain all of the following information:** **(a) The name of the person or persons involved in the incident/accident.** **(b) The date, hour, location, and a narrative description of the facts about the incident/accident which indicates its cause, if known.** **(c) The effect of the incident/accident on the person who was involved, the extent of the injuries, if known, and if medical treatment was sought from a qualified health care professional.** **(d) Written documentation of the individuals notified of the incident/accident, along with the time and date.** **(e) The corrective measures taken to prevent future incidents/accidents from occurring.**
ANALYSIS:	Incident reports for Resident A was not fully complete. The report did not include correction measures to prevent future incidents/accidents from occurring. Therefore, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

The incidents for Resident A happened on 10/23/21, 10/24/21 and 10/25/21. The department received the reports during the onsite on 1/10/22.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.
ANALYSIS:	Facility did not report incidents to the department within 48 hours. Therefore, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 2/25/2022, I conducted an exit conference with licensee authorized representative Kelly Cornford by telephone.

IV. RECOMMENDATION

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

02/25/2022

Brender Howard Date
Licensing Staff

Approved By:

02/24/2022

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