GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 17, 2022

Jeffery Felton
Birchwood Gardens LLC
5277 Jackson Rd Ste D
Ann Arbor, MI 48103

RE: License #: AS810396721
Investigation #: 2022A0575015
Birchwood Gardens

Dear Mr. Felton:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On May 11, 2022, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9720.

Sincerely,

Jeffrey J. Bozsik, Licensing Consultant
Bureau of Community and Health Systems
22 Center Street
Ypsilanti, MI 48198
(734) 417-4277

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

I. IDENTIFYING INFORMATION

License #:	AS810396721
Investigation #:	2022A0575015
Complaint Receipt Date:	05/03/2022
Investigation Initiation Date:	05/04/2022
Report Due Date:	06/02/2022
Licensee Name:	Birchwood Gardens LLC
Licensee Address:	5277 Jackson Rd Ste D Ann Arbor, MI 48103
Licensee Telephone #:	(734) 663-8862
Administrator:	Jeffery Felton
Licensee Designee:	Jeffery Felton
Name of Facility:	Birchwood Gardens
Facility Address:	5272 West Liberty Rd Ann Arbor, MI 48103
Facility Telephone #:	(734) 663-8862
Original Issuance Date:	01/15/2019
License **Status:**	REGULAR
Effective Date:	07/15/2021
Expiration Date:	07/14/2023
Capacity:	6
Program Type:	PH; ALZHEIMERS; AGED; TBI

II. ALLEGATION(S)

	Violation Established?
Resident A suffered bruises and abrasions using a Sit to Stand.	Yes
Resident A's change in health status not attended to.	No
Resident A's injuries not reported to family.	No
Resident A was given a medication that was not prescribed.	No

III. METHODOLOGY

05/03/2022	Special Investigation Intake 2022A0575015
05/04/2022	Special Investigation Initiated - Telephone
05/04/2022 05/05/2022	Contact - Telephone call made- complainant Contact- Telephone call made-Kay Holcomb, overnight staff
05/09/2022	Contact - Telephone call made-Karen Westphal, Promedica hospice nurse
05/09/2022	APS Referral-submitted by licensee
05/11/2022	Inspection Completed On-site—interview with Erika Whiting, nurse administrator; Others present: (a) Jeff Felton, licensee designee; (b) Devon Bailey, home manager; and (c) Kay Holcomb-overnight staff
05/11/2022	Inspection Completed-BCAL Sub. Compliance
05/11/2022	Corrective Action Plan Requested and Due on 05/11/2022
05/11/2022	Corrective Action Plan Approved
05/11/2022	Exit conference-with Jeff Felton, licensee designee

ALLEGATION:

Resident A suffered bruises and abrasions using a "Sit to Stand" device.

INVESTIGATION:

Resident A was not interviewed. He resided at this facility from 3/30/2022 until 4/17/2022 when he passed away at age 97.

On 5/9/2022, I contacted the Arbor Hospice nurse but the nurse refused to discuss the care Resident A received from their agency.

On 5/4/2022, I interviewed the complainant, who stated Resident A was 97 years old when he died on 4/17/2022. She stated he was receiving hospice care, had Alzheimer's, was a "no code", and his death certificate listed the cause of death as Sick Sinus Syndrome. She stated he fell twice, once in early April and on 4/7/22 and had bruises on his arms, the front of his shins, a bruised left eye, and abrasions on the left side of his head above his left ear.

On 5/5/2022, I interviewed Kay Holcomb, overnight staff. She stated she is the only staff on the overnight shift, and she stated Resident A didn't fall on her shift. She stated he slipped out of the gait belt when she was attempting to use the Sit to Stand transferring device. She stated the device is supposed to be used to do a 1-person transfer, but that Resident A was dead weight and so was difficult to transfer. Finally, she stated Resident A had bruises on his arms and legs when he arrived at the facility.

On 5/9/2022, I interviewed Karen Westphal, Promedica hospice nurse. She stated Promedica provided hospice care from 3/31/2022 until early April 2022. She stated that due to Resident A's advanced age, his skin was very thin, and he bruised very easily. She stated he couldn't stand, bear weight, or walk, but that his wife wanted him moved around the facility to different positions. He used a Sit to Stand device for transferring, but she stated one direct care staff could not perform a 1-person transfer. She stated his bruising was caused by swinging when the gait belt was used to transfer him. Finally, she stated that when an individual receives hospice care, unless there's a broken bone, for example, then there is no hospital visit if there's nothing to fix.

On 5/11/2022, I interviewed Erika Whiting, nurse administrator, who provided Resident A's assessment plan. It is dated 3/31/2022 and listed Resident A as a 1-person max assist for walking/mobility. She stated that after the incident where Resident A was bruised, they adjusted his care plan to be a 2-person assist.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be always attended to in accordance with the provisions of the act.
ANALYSIS:	Although Resident A's advanced age certainly contributed to him easily bruising and inability to bear weight, the hospice nurse recognized he was not a 1-person transfer. That the overnight staff was the only staff on duty and attempted a 1-person transfer using the Sit to Stand device, at least contributed to Resident A's bruises. Therefore, Resident A's protection and safety was not always attended to.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A's change in health status not attended to

INVESTIGATION:

As part of my interview with Karen Wesphal, hospice nurse, on 5/9/2022, she stated that when an individual receives hospice care they are not sent to the hospital if there's nothing to fix, in this case, bruises from using the Sit to Stand device.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.

ANALYSIS:	Although Resident A sustained bruises, in part, probably from attempting to use the Sit to Stand device, the hospice nurse made the medical decision that Resident A did not need to be transported to a hospital for examination and evaluation, which is part of receiving hospice care that he was prescribed/enrolled in.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's injuries not reported to family

INVESTIGATION:

During my interview with the complainant on 5/4/2022, she alleged that Resident A's injuries were not reported to the family although she did send me emails in which Resident A's bruises were discussed after the fact, with Erika Whiting, the facility nurse administrator.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(b) Any accident or illness that requires hospitalization.**
ANALYSIS:	Per this rule, the licensee was not required to send incident reports to the family that addressed Resident A's bruises/injuries. Resident A was not hospitalized per his hospice care plan prior to his death and so the licensee was not required to notify the family at the time of the injury.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was given a medication that was not prescribed

INVESTIGATION:

As part of my 5/11/2022 interview with Erika Whiting, nurse administrator, she provided the medication record for Resident A. It showed he was prescribed Ativan .5 mg, PRN. And Erika stated Resident A was given a PRN dose at least once.

As part of my 5/9/2022 interview with Karen Westphal, hospice nurse, she stated Resident A was prescribed Ativan because he was agitated at night from "terminal restlessness", which happens when a person's organs are failing. She stated the complainant did not want Resident A sedated with any medication.

On 5/11/22, I conducted an exit conference with Jeff Felton, licensee designee and Erika Whiting, nurse administrator. They weren't pleased with the above established rule violation because they had implemented a corrective action plan after Resident A's fall and injuries and before the complaint was filed.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist.
ANALYSIS:	Since the hospice nurse made a medical decision to prescribe a PRN dose of Ativan to address Resident A's overnight agitation, then when he did receive a PRN dose of Ativan, it was from a prescription.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

An acceptable corrective action plan was received; therefore, I recommend no change in the status of the license.

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Jeffrey J. Bozsik Date: 5/12/22
Licensing Consultant

Approved By:

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Ardra Hunter Date: 5/17/22
Area Manager