GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 9, 2022

Guy Geller
TV-MICH, LP
4500 Dobry Drive
Sterling Heights, MI 48314

RE: License #: AH500392805
Investigation #: 2022A1019047
Town Village Sterling Hgts - The Gem Memory Care

Dear Mr. Geller:

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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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.

Sincerely,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500392805
Investigation #:	2022A1019047
Complaint Receipt Date:	04/22/2022
Investigation Initiation Date:	04/22/2022
Report Due Date:	06/22/2022
Licensee Name:	TV-MICH, LP
Licensee Address:	4500 Dobry Drive Sterling Heights, MI 48314
Licensee Telephone #:	(586) 200-4741
Administrator:	Sheri Sepanak
Authorized Representative:	Guy Geller
Name of Facility:	Town Village Sterling Hgts - The Gem Memory Care
Facility Address:	4500 Dobry Drive Sterling Heights, MI 48314
Facility Telephone #:	(586) 200-4741
Original Issuance Date:	06/15/2018
License Status:	REGULAR
Effective Date:	12/15/2021
Expiration Date:	12/14/2022
Capacity:	33
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A received inadequate care.	No
Additional Findings	Yes

III. METHODOLOGY

04/22/2022	Special Investigation Intake 2022A1019047
04/22/2022	Special Investigation Initiated - Letter Notified APS of the allegations via email referral template.
04/22/2022	APS Referral
05/06/2022	Contact - Telephone call made Called complainant to conduct interview, complainant's phone would not accept this writer's call; a recording came up that this was an unrecognized number and the call was being screened. Unable to leave message.
05/12/2022	Contact - Telephone call made Second attempt to reach complainant by telephone, unable to leave message.
05/12/2022	Inspection Completed On-site
05/12/2022	Inspection Completed BCAL Sub. Compliance
06/09/2022	Exit Conference

ALLEGATION:

Resident A received inadequate care.

INVESTIGATION:

On 4/22/22, the department received a complaint regarding the care Resident A received while at the facility. The complaint alleged that Resident A was improperly supervised which led to multiple falls and hospitalization.

On 5/12/22, I conducted an onsite inspection. Administrator Sheri Sepanak was not present, Employee A was interviewed in her absence. Employee A reported that Resident A resided at the facility from 11/11/21-11/20/21. Employee A stated that shortly upon move in, it was evident that Resident A had more significant care needs than what was described by his family members prior to move in. Employee A stated that on 11/15/22, the reassessment was completed, and Resident A went from a care level 4 to a care level 6, meaning that he required more hands on care and assistance from staff. Employee A stated that Resident A was a fall risk and required staff supervision with mobility and transfers and received hourly safety checks during waking hours. Employee A stated that Resident A had cognitive deficits that made it difficult for him to communicate and make his needs known. Employee A acknowledged that Resident A did fall while at the facility and stated that she initially thought was exacerbated by Resident A adjusting to the new surroundings and trying to get acclimated. Employee A stated that it was mutually agreed upon that Resident A ultimately required a higher level of care than what the facility could provide, and he was moved out. Employee A stated that Resident A's family was upset with this and felt the facility did not care for him in the way that they had expected.

While onsite, Employee A provided me with Resident A's move in assessment along with the reassessment completed on 11/15/21. I observed that increased care needs were documented in the following areas: mobility, transfers, toileting and nighttime care. Prior to move in, Resident A's family indicated that he was independent with mobility and transfers but needed some prompting and reminding to use walker. During the reassessment, Resident A was deemed to need a wheelchair escort for mobility and staff assistance with transferring. Prior to move in, Resident A was listed as being "occasionally incontinent" however Employee A stated that he was completely incontinent and required staff assistance with all toileting needs. Employee A stated that upon move in, Resident A's family requested that he be checked on once throughout the night but Employee A stated that he required multiple checks throughout the night, as the resident would attempt to get up and ambulate on his own and didn't have the cognitive awareness to understand that he wasn't capable of doing so.

While onsite, Employee A provided me with progress notes and incident reports for Resident A. Facility staff documented that Resident A fell on 11/12/21, 11/15/21 and 11/16/21 and went to the hospital following his last fall. The incident report and progress note for the fall on 11/12/21 read "During rounds resident was heard yelling and upon arrival he was observed laying on the floor in front of his chair. Resident unable to verbalized what occurred. Resident has no visible injuries POA and physician notified." The incident report for the fall on 11/15/21 read "As morning shift arrived to provide care resident was observed laying on the floor with his brief off and fecal matter on the floor. Resident unable to state what occurred. Resident has small skin tear to his left arm and elbow. First aide [sic] applied. Responsible party and Physician notified." The progress note for this fall read "During rounds resident observed lying on the floor nude. Resident unable to verbalize what occurred." The

incident report for the fall on 11/16/21 read “At approx. 1:15 am care staff went in to do rounds and resident was observed laying on the floor in front of his recliner. 911 called and resident sent to Troy Beaumont for evaluation. Resident returned to community with no new orders. Residents wife accompanied him to the ER and return with resident. Physician notified.” Employee A also provided me with Resident A's hospital discharge paperwork. The documentation from Troy Beaumont hospital read in part:

> Patient presents for fall at his nursing facility. X-trays were obtained of his shoulder and pelvis without evidence of fractures. After discussion with his wife, he is otherwise in his usual state of health and is safe for transport back to his facility.
>
> Final Impression:
>
> 1. Mechanical fall
> 2. Hand abrasion

No new orders, follow up or after care instructions were noted on the documentation from the hospital.

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:	Resident A’s initial service plan was developed based on the report of his family members (wife and daughter). Employee A stated that within a few days, Resident A’s care level needed be increased which was reflected in his revised service plan. While Resident A did have three falls, there is no evidence to suggest that the care he received was not consistent with what his service plan outlined.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Employee A reported that Resident A ambulated by wheelchair with the assistance of staff. Employee A state that Resident A moved into the facility using a walker but has since switched over to using the wheelchair for mobility. Resident A's service plan did not mention the use of a wheelchair, and therefore lacked pertinent information on the type of assistance staff needed to provide to him for ambulation.

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:	Resident A's service plan was not updated to include the use of his wheelchair.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Resident A fell on 11/12/21, 11/15/21 and 11/16/21. Resident A was hospitalized following the last fall. The facility did not report any of the incidents to the department.

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:	Resident A sustained three falls within a few days, with one fall resulting in hospitalization. The department was not notified of Resident A's falls or hospitalization.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/9/22, I shared the findings of this report with management company director Brian Storey at the request of authorized representative Guy Geller.

IV. RECOMMENDATION

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

05/23/2022

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

06/07/2022

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