GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 1, 2022

Tami McKellar
AH Kentwood Subtenant LLC
6755 Telegraph Road Suite
Bloomfield Hills, MI 48301

| | |
|---|---|
| RE: License #: | AL410397696 |
| Investigation #: | 2022A0356026 |
| | AHSL Kentwood Fieldstone |

Dear Ms. McKellar:

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 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

## I. IDENTIFYING INFORMATION

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| **License #:** | AL410397696 |
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| **Investigation #:** | 2022A0356026 |
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| **Complaint Receipt Date:** | 06/06/2022 |
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| **Investigation Initiation Date:** | 06/07/2022 |
| | |
| **Report Due Date:** | 08/05/2022 |
| | |
| **Licensee Name:** | AH Kentwood Subtenant LLC |
| | |
| **Licensee Address:** | One SeaGate, Suite 1500<br>Toledo, OH 43604 |
| | |
| **Licensee Telephone #:** | (248) 203-1800 |
| | |
| **Administrator:** | Tami McKellar |
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| **Licensee Designee:** | Tami McKellar |
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| **Name of Facility:** | AHSL Kentwood Fieldstone |
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| **Facility Address:** | 5980 Eastern Ave SE.<br>Kentwood, MI 49508 |
| | |
| **Facility Telephone #:** | (616) 455-1357 |
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| **Original Issuance Date:** | 01/22/2019 |
| | |
| **License Status:** | REGULAR |
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| **Effective Date:** | 07/22/2021 |
| | |
| **Expiration Date:** | 07/21/2023 |
| | |
| **Capacity:** | 20 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Staff at the facility did not notify Relative #1 of Resident A's hospitalization. | Yes |
| Staff at the facility did not contact emergency medical services for Resident A in a timely manner. | Yes |

## III. METHODOLOGY

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| 06/06/2022 | Special Investigation Intake<br>2022A0356026 |
| 06/07/2022 | Special Investigation Initiated - Telephone<br>Relative #1. |
| 06/09/2022 | Inspection Completed On-site |
| 06/09/2022 | Contact - Face to Face<br>DCW Tatiana Lopez<br>Katrina Aleck, clinical specialist, nurse, Kayla Meek, VP Resident Care, Laura Kelling, Exec. Director, AH Wyoming, support staff & Jennifer Schuchard, Regional Wellness Director. |
| 07/11/2022 | Contact - Telephone call received<br>Relative #1. |
| 07/12/2022 | Contact - Document Received<br>Facility documents for Resident A. |
| 07/20/2022 | Contact - Telephone call made<br>DCW, Tatiana Lopez. |
| 07/25/2022 | Contact-Telephone call made<br>Called main number for this facility, no answer.<br>Called main number for facility, opted for the office & left message for DCW, Linda Guyton to call. |
| 07/25/2022 | Contact-Document Sent<br>Email sent to Katrina Aleck. |
| 07/26/2022 | Contact-Telephone call made<br>DCW, Joseph Nelson, Linda Guyton, RN Mischelle Peel. |

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| 07/27/2022 | Contact-Telephone call made<br>Tami McKellar, former Licensee Designee. |
| 08/01/2022 | Exit Conference-Katrina Aleck, acting Licensee Designee. |

**ALLEGATION: Staff at the facility did not notify Relative #1 of Resident A's hospitalization.**

**INVESTIGATION:** On 06/06/2022, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaint. The complainant reported on 04/21/2022 at 4:01a.m., Metro Hospital Emergency Room staff called Relative #1 requesting information about Resident A. The complainant reported Relative #1 never received a call or any contact at all by the facility that Resident A had been sent to the hospital.

On 06/07/2022, I interviewed Relative #1 via telephone. Relative #1 stated she is Resident A's DPOA (durable power of attorney including medical decision making) and when she arrived at Metro ER just after 4:00a.m. on 04/21/2022, she was told Resident A arrived with difficulty breathing via EMS (Emergency Medical Services) and had no medical history that arrived with him from the facility to the ER. Relative #1 stated after Resident A was admitted, she went home to retrieve all the info the hospital required, returned to the hospital, and gave them the information they needed. Relative #1 stated she made three attempts to call the facility with no response. Relative #1 stated she never received a telephone call or any type of contact from anyone at the facility to notify her that Resident A had been transported to the hospital. Any and all attempts she and the hospital made to contact staff at the facility failed, no one answered the phone. Relative #1 stated she later discovered that Resident A had fallen at the facility as well as had difficulty breathing. Relative #1 stated staff at the facility have historically called her about everything, including scratches that Resident A received, so she found it out of the ordinary that no one called to inform her that Resident A had been sent to the hospital. Relative #1 stated she requested the Incident Report (IR) from 04/21/2022 and the IR documented that Relative #1 had been notified of Resident A's hospitalization when in fact, she never was.

On 06/09/2022, I conducted an inspection at the facility and interviewed Katrina Aleck (Regional Nurse/Clinical Specialist), Jennifer Schuchard (Regional Wellness Director), Kayla Meek (Vice President of Residential Care) and Laura Kelling ( Executive Director of American House Wyoming). in the office. Ms. Aleck stated Resident A was sent to the hospital at 10:00a.m. and Relative #1 was notified the same day at 2:00p.m. Ms. Aleck stated they sent Resident A's face sheet with identifying information, and the list of medications. Ms. Aleck stated staff Michelle Peel, Director of Nursing and Joseph Nelson, DCW/Med Tech would have sent the documents with Resident A to the hospital. Unfortunately, Ms. Aleck stated, neither Ms. Peel nor Mr. Nelson work at the facility any longer. Ms. Aleck stated sometimes EMS keeps the documents and they do not make it into the ER (emergency room)

which could have happened as it often does however, Ms. Aleck stated the hospital had to have had Resident A's face sheet if they contacted Relative #1 because they would not have known who to contact had they not had information on Resident A. Nonetheless, Ms. Aleck stated staff at the facility ended up getting ahold of Relative #1 that day. Ms. Schuchard, Ms. Meek, and Ms. Kelling supported the information Ms. Aleck provided.

On 07/11/2022, I interviewed Relative #1 via telephone. Relative #1 stated she received a telephone call at 4:01a.m. from the hospital and reiterated that no one from the facility ever called to notify her of Resident A's hospitalization. Relative #1 stated she eventually spoke to Mr. Nelson at the facility who stated he sent Resident A's face sheet to the hospital and when she contacted Mr. Nelson the first time, he said he did not have her number to call her. Relative #1 stated the second time she contacted Mr. Nelson, he told her he called her number and left her a voicemail, which, Relative #1 stated, he did not. Relative #1 stated she has had the same telephone number for 26 years and the number the facility has on record is correct. Relative #1 stated Resident A knew her name and knew to tell staff at the hospital to call her and that is how she was contacted by the hospital. Relative #1 stated she requested the IR concerning this incident from (former) Licensee Designee, Tami McKellar and met with Ms. McKellar on 04/27/2022 after making an appointment to see her. Relative #1 stated this is when she received a copy of the incident report and staff notes. Relative #1 stated she informed Ms. McKellar that the IR and staff notes were not accurate, and the dates and times did not match but Ms. McKellar said that was all she had. Relative #1 stated the information on the IR does not match the correct date or time of the incident, and the IR documented that she (Relative #1) had been contacted on 04/20/2022 which is prior to Resident A ever being hospitalized and there is no time documented as to when she was allegedly notified. Relative #1 stated she never received a call or any notification by way of an IR from the facility until she requested and received the IR almost a week after the incident occurred.

On 07/12/2022, I received and reviewed the IR dated 04/21/2022, written by Mischelle Peel, RN (registered nurse), DON (director of nursing) and signed by Ms. Peel. The IR documented that Relative #1 was notified on '*4/20/22'* and that the incident occurred on '*04/20/2022 at 1:30a.m*' but there is no time documented on the IR as to when Relative #1 was notified. The actual incident occurred on 04/21/2022 and therefore, the date of the incident documented on the IR is not correct. The IR also documented the Licensing Consultant, Anthony Mullins was notified but there is no date or time documenting when Mr. Mullins was notified of Resident A's hospitalization. The IR documented the following information, *'Resident reported having a hard time breathing. Vital signs and oxygen saturation obtained and were within normal limits. Resident has a history of COPD and stated he felt short of breath and wanted to go to the hospital. EMS called and transported resident in stable condition to Metro Hospital ER, (Relative #1) notified, MD notified.'*

On 07/12/2022, I received and reviewed the University of Michigan Health-West Hospital (formerly known as Metro Hospital) Emergency Department notes. On 04/21/2022 at 10:09a.m. Cassie McAlister, RN (nurse case manager) documented, *'This CM attempted to place call to American House x3 to speak with staff and wellness director. No answer and no option to leave voicemail for wellness director. Per daughter, patient resides in Fieldstone manor which is the memory care unit for American House. He was transitioned from assisted living to the memory care unit within American House about a little over a year ago (Nov. 2020).'*

On 07/12/2022, I received and reviewed the AMR/EMS (American Medical Response/Emergency Medical Service) notes dated 04/21/2022, that documented the following information, *'Staff stated they cannot print out PT HX (history) but PT has dementia and asthma.'*

On 07/20/2022, I interviewed DCW Tatiana Lopez via telephone. Ms. Lopez stated she knows Resident A went out via EMS early in the morning on 04/21/2022 but she does not have information regarding who was contacted or when in regard to Resident A's hospitalization. Ms. Lopez stated she works in the Cobblestone facility located on the same campus as Resident A's facility. Ms. Lopez explained Resident A had been a resident at Cobblestone prior to moving to his current building and she had a good working relationship with Relative #1. Ms. Lopez stated Relative #1 contacted her (Ms. Lopez) because she stated she was having trouble contacting staff and communicating with staff at Resident A's building, Fieldstone.

On 07/26/2022, I interviewed DCW Joseph Nelson via telephone. Mr. Nelson stated he still works at this facility and never ended his employment there as reported. Mr. Nelson stated Resident A was sent to the hospital in the middle of the night on 04/21/2022 so a date of 04/20/2022 is not correct on the IR. Mr. Nelson stated he placed three or four telephone calls to Relative #1 in the middle of the night, could have been 2-2:30a.m. possibly as late as 3:00a.m. on 04/21/200 and left messages updating her and informing her that Resident A was being sent to the hospital. Mr. Nelson stated he figured she did not answer because it was in the middle of the night, and she was sleeping. Mr. Nelson stated he used the telephone number on file at the facility for Relative #1 and suggested this number could have been an old number for Relative #1 and possibly, his messages were not received by her. Mr. Nelson stated he was aware that Relative #1 reported she never received any notification of Resident A's hospitalization but that he did attempt to reach her.

On 07/26/2022, I interviewed Mischelle Peel, RN and (former) Director of Nursing via telephone. Ms. Peel stated the incident date on the IR is wrong and should not be 04/20/2022, it should have been documented as 04/21/2022, the incident occurred in the middle of the night and the staff that filled the IR out, must have put the wrong date on as to when the incident occurred. Also, the person who fills the IR out is typically the person who notifies all the pertinent people, family, licensing, and doctor. Ms. Peel stated Ms. Lopez may have been the person that filled out or initiated the completion of the IR. Ms. Peel's signature date on the IR is 04/21/2022

and Ms. Peel stated that date is correct, but Ms. Peel stated, she did not complete the IR. Ms. Peel stated Relative #1 reported she never received a call to inform her of Resident A's hospitalization from staff at the facility, and most likely, facility staff did not call Relative #1. Ms. Peel stated Relative #1 probably received the notification call from the hospital. Ms. Peel stated typically when a resident is sent to the hospital, staff call to inform her, and she was never called or informed by staff at the facility of Resident A's hospitalization. Ms. Peel stated Mr. Nelson was having trouble printing out Resident A's face sheet and MAR so he did not send any information with EMS when Resident A went to the hospital. Ms. Peel stated she asked Ms. Lopez to fax Resident A's information to the hospital but the information was faxed to the wrong hospital, it went to Spectrum rather than Metro, because that is where she (Ms. Peel) was told Resident A went. Ms. Peel reported, eventually, Resident A's information made it to the correct hospital, so they had identifying information on Resident A and Relative #1's telephone number.

On 07/27/2022, I interviewed Tami McKellar, former Licensee Designee via telephone. Ms. McKellar stated Mr. Nelson informed her that he tried to call Relative #1 and Relative #1 reported that no one including Mr. Nelson contacted her about Resident A's hospitalization. Ms. McKellar stated staff at the facility did not notify her of Resident A's hospitalization, she was informed the following day and stated most likely, staff did not contact Relative #1.

On 08/01/2022, I conducted an Exit Conference via telephone with Katrina Aleck, acting Licensee Designee. Ms. Aleck stated she understands the information, analysis, and conclusion of this applicable rule and will submit an acceptable corrective action plan.

| **APPLICABLE RULE** | |
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| **R 400.15311** | **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:<br>(b) Any accident or illness that requires hospitalization. |
| **ANALYSIS:** | The complainant reported Relative #1 never received a call or any contact at all by the facility that Resident A was sent to the hospital.<br><br>Relative #1 stated she never received a telephone call or any type of contact from anyone at the facility to notify her that Resident A had been transported to the hospital. Relative #1 |

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| | reported she has had the same telephone number for 26 years and the facility had the correct number to contact her.<br><br>Ms. Aleck stated Resident A was sent out to the hospital at 10:00a.m. and Relative #1 was notified the same day at 2:00p.m<br><br>The IR documented that Relative #1 was notified on '4/20/22' with no time of when the notification took place. In addition, the date of the incident occurred on 04/21/2022, not 04/20/2022.<br><br>University of Michigan Health-West Hospital Emergency Department notes document staff at the hospital attempted to call this facility three times and there was no answer and no way to leave a message.<br><br>Ms. Lopez stated Relative #1 contacted her because she was having trouble contacting staff and communicating with staff at the facility.<br><br>Mr. Nelson stated he called Relative #1 and left messages informing her of Resident A's hospitalization.<br><br>Ms. Peel & Ms. McKellar stated staff did not call them to inform them of Resident A's hospitalization and likely did not contact Relative #1.<br><br>Based on investigative findings, there is a preponderance of evidence to show that staff at the facility did not make a reasonable attempt to contact Relative #1 by telephone to inform her of Resident A's hospitalization. In addition, Relative #1 received the Incident Report detailing Resident A's accident and hospitalization six days after the incident occurred when she requested and picked it up from the Licensee Designee. Therefore, a violation of this applicable rule is established. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION: Staff at the facility did not contact emergency medical services for Resident A in a timely manner.**

**INVESTIGATION:** On 06/06/2022, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaint. The complainant reported Resident A suffered a massive heart attack in his room at the facility and died at the hospital of aspiration pneumonia and severe sepsis. The complainant reported once facility documentation was requested and received, a review of the IR and daily notes

showed the timeline of events did not match. The date of the incident and when an ambulance was called for Resident A do not match or make sense.

On 06/07/2022, I interviewed Relative #1 via telephone. Relative #1 stated Resident A died in the hospital on 04/24/2022 from a heart attack that occurred while he was at the facility. Relative #1 stated staff at the facility always called her about everything that happened with Resident A but this time, she was not aware of anything happening to Resident A until she received a telephone call from hospital staff informing her that Resident A was admitted. Relative #1 stated finally, around 10:00a.m. on 04/21/2022, she (Relative #1) reached a DCW (direct care worker) at the facility, Linda Guyton via telephone and Ms. Guyton stated Resident A "had not fallen on her watch" which Relative #1 stated was an odd thing to say when she never asked if Resident A had fallen. Relative #1 stated she then spoke to DCW, Joseph Nelson who informed her that Resident A had fallen a few times throughout the day, and that he found Resident A in the bathroom on the floor. Relative #1 stated Resident A was transported to the hospital where he later died from aspiration pneumonia and sepsis after suffering a massive heart attack in his bathroom at the facility. Relative #1 stated after Resident A died, she requested the IR and facility notes from Ms. McKellar, the former Licensee Designee of this facility. Relative #1 stated once she received and reviewed the IR and daily notes along with hospital and EMS information, nothing adds up. The time of the incident documented on the IR is wrong and the notes staff wrote documenting Resident A's illness do not match the time when EMS was dispatched to the facility. Relative #1 stated none of the information seems to be accurate.

On 06/09/2022, I conducted an inspection at the facility and interviewed Ms. Aleck, Ms. Schuchard, Ms. Meek, and Ms. Kelling in the office. Ms. Aleck stated EMS was contacted immediately upon Resident A having difficulty breathing. Ms. Schuchard, Ms. Meek, and Ms. Kelling supported the information Ms. Aleck provided.

On 07/12/2022, I received and reviewed the IR dated 04/21/2022, written by Mischelle Peel, RN (registered nurse), DON (director of nursing) and signed by Ms. Peel. The IR documented that Relative #1 was notified on *'4/20/22' and that the incident occurred on '04/20/2022 at 1:30a.m.'* The IR documented the following information, *'Resident reported having a hard time breathing. Vital signs and oxygen saturation obtained and were within normal limits. Resident has a history of COPD and stated he felt short of breath and wanted to go to the hospital. EMS called and transported resident in stable condition to Metro Hospital ER, (Relative #1) notified, MD notified.'*

On 07/12/2022, I received and reviewed the Kentwood Fieldstone Observations. I reviewed the following notes:

- Nurse notes dated 04/20/2022, written by DCW Ms. Guyton at 2:33p.m. The notes document, *'(Resident A) took scheduled medication, ate well for lunch, slept in for breakfast, given a PRN Xanax for up agitation, loud outbursts of help me, I'm scared, in bedroom at this time.'*

- Nurse notes dated 04/21/2022, written by DCW Mr. Nelson at 9:48a.m. The notes document, *'(Resident A) was having a hard time getting air so I give him meds to help him and he was ok onto around 11:45 (no a.m. or p.m. documented) this is when he was find on the restroom floor have a hardtime gettin air so I call EMS and he was sent out to the hospital.'*
- Nurse notes dated 04/21/2022, written by Tatiana Lopez at 2:36p.m. The notes document, *'Cobblestone MC (Ms. Lopez) spoke with (Relative #1) and she states resident has been admitted into Metro Hospital with pneumonia in right lung and irregular heart rate. Hospital staff is attempting to stabilize resident. (Relative #1) is very upset with the lack of communication with administrative staff. MC (Ms. Lopez) asked that WD contact (Relative #1) directly.'*
- Nurse notes dated 04/22/2022, written by Ms. Lopez at 8:34p.m. The notes document, *'Cobblestone MC spoke with (Relative #1) and resident has been placed onto Hospice and is going to stay at Metro Hospital until passing. Resident suffered a heart attack during the night and irreversible damage was done to his heart. Resident has also become septic from pneumonia and is now only on comfort meds.'*
- Nurse notes dated 04/26/2022, written by Ms. Lopez at 6:39p.m. The notes document, *'Cobblestone MC spoke with (Relative #1) and she informed staff that resident had passed away on Sunday night at Metro Hospital while on Hospice. Remedi Pharmacy and Dr. Elami were both notified of passing.'*

On 07/12/2022, I received and reviewed the University of Michigan Health-West Hospital Emergency Department notes that included the AMR (American Medical Response/ambulance) patient care report. The report is dated 04/21/2022 and documented the call for emergency medical services as follows:

- Received: 02:23:31 (2:23a.m. on 04/21/2022)
- Dispatched: 02:23:39 (2:23a.m. on 04/21/2022)
- Enroute: 02:23:43 (2:23a.m. on 04/21/2022)
- At scene: 02:35:10 (2:35a.m. on 04/21/2022)
- At pt (patient) side: 02:37:00 (2:37a.m. on 04/21/2022)
- Transport: 02:54:42 (2:54a.m. on 04/21/2022)
- Arrival: 03:08:38 (3:08a.m. on 04/21/2022)
- Care transfer: 03:15:30 (3:15a.m. on 04/21/2022)

The AMR/EMS noted the following information, *'Diff breathing, per fire on scene they found PT on the floor in the bathroom having difficulty breathing, fire stated PT has wheezing throughout and is very diminished. Fire stated staff gave PT a neb (nebulizer) treatment and then found PT in the bathroom, fire stated PT is currently on his second neb, fire stated PTs room SPO2 was 75%. Fire stated after starting the second neb LS are more wheezing and less diminished. Staff stated they cannot print out PT HX (history) but PT has dementia and asthma, PT is going to Metro to be evaluated. PT sitting on the floor in the bathroom, PT alert to self, PT is at baseline, skin mottled. Primary impression, respiratory dyspnea'*

On 07/12/2022, I received and reviewed the University of Michigan Health-West Hospital Emergency Department notes. The notes are dated 04/21/2022, 5:52a.m., signed by Dr. William Punch, DO, *'patient found at the facility after mechanical fall with increased oxygen requirements, concern for aspiration pneumonia vs pneumonitis. Also found to have increasing troponin (sepsis) during the course of his admission. Cardiology consulted for assistance, appreciate their help. Lactic acidosis resolving on broad spectrum antibiotics coverage.'*

On 07/20/2022, I interviewed DCW Tatiana Lopez via telephone. Ms. Lopez stated she works in another building on this campus and knows Resident A went to the hospital early in the morning but is not aware of the dates and times of the reports.

On 07/26/2022, I interviewed DCW Joseph Nelson via telephone. Mr. Nelson stated he works from 6:30p.m.-7:00a.m. and is not in the building during daytime hours. Mr. Nelson explained the 9:48a.m. staff note dated 04/21/2022 was entered into the system at 9:48a.m. on 04/21/2022 because the system was "messed up" and did not work correctly, so, he had to go back into the facility and resubmit the nursing notes from his previous shift on 04/20/2022-04/21/2022. Mr. Nelson explained the 11:45 time in the notes describing Resident A's symptoms is 11:45p.m. on 04/20/2022 before EMS was called. Mr. Nelson stated on 04/20/2022 at 7:30p.m. just after coming on to his shift at 6:30p.m., he gave Resident A a breathing treatment, Resident A laid in bed and was "ok" and "around midnight" is when Resident A experienced more breathing problems so at that time, EMS was called. Mr. Nelson stated EMS was called due to Resident A's difficulty breathing, not due to a heart attack and EMS was called immediately upon him (Mr. Nelson) finding Resident A on the floor in the bathroom. Mr. Nelson stated he did not call EMS, his co-worker Dee (Orr) called and "it was late at night" and unsure of the actual time EMS was called. Mr. Nelson confirmed that he found Resident A on the floor in the bathroom in his room and stated Resident A had apparently gotten up and went to the bathroom unassisted by staff. Mr. Nelson stated, as the staff notes depict, Resident A's O2 saturation score was low and that is why EMS was called and he was immediately sent to the ER. Mr. Nelson stated Resident A was breathing, talking, responding and there was no indication or discussion at that time or when EMS arrived as to Resident A suffering a heart attack. Mr. Nelson stated he is not able to explain why there is a gap of time between finding Resident A on the floor in his bathroom and calling EMS.

On 07/26/2022, I interviewed Mischelle Peel, RN and (former) Director of Nursing via telephone. Ms. Peel stated Resident A was sent to ER in the "middle of the night" and she is not aware of the actual time Resident A went to ER, but she instructed Mr. Nelson to come into the facility on the morning of 04/21/2022 to document the staff notes regarding the events on the evening of 04/20/2022-04/21/2022 because they were having trouble with their system and the internet at that time and he was unable to log the notes on the evening of 04/20/2022 and into the early morning hours of 04/21/2022. Ms. Peel stated that is why the time of 9:48a.m. on 04/21/2022 is documented on the staff notes. Ms. Peel stated she was not aware that EMS was

called at 2:23a.m. on 04/21/2022 when Mr. Nelson documented he found Resident A on the floor in his bathroom having trouble breathing at 11:45p.m. on 04/20/2022 and questioned the gap in time.

On 07/27/2022, I interviewed Tami McKellar, (former) Licensee Designee via telephone. Ms. McKellar stated she was not aware that EMS was called at 2:23a.m. on 04/21/2022 when Mr. Nelson documented he found Resident A on the floor in his bathroom having trouble breathing at 11:45p.m. on 04/20/2022 and also questioned the gap in time.

On 08/01/2022, I conducted an Exit Conference via telephone with Katrina Aleck, acting Licensee Designee. Ms. Aleck stated she understands the information, analysis, and conclusion of this applicable rule and will submit an acceptable corrective action plan.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.15310** | **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:** | The complainant reported the date of the incident and when an ambulance was called for Resident A do not match or make sense.<br><br>Relative #1 stated the time of the incident documented on the IR is wrong and the notes staff wrote documenting Resident A's illness do not match the time when EMS was dispatched to the facility.<br><br>Ms. Aleck stated EMS was contacted immediately upon Resident A having difficulty breathing.<br><br>The IR indicates the incident occurred on 04/20/2022 at 1:30 a.m. at that EMS was called at that time.<br><br>Notes dated 04/21/2022 written by DCW Mr. Nelson document Mr. Nelson discovered Resident A on the bathroom floor at 11:45p.m., having a hard time breathing and that EMS was called at that time.<br><br>The EMS report dated 04/21/2022 documented the called for medical services was received at 02:23:31 (2:23a.m. on 04/21/2022) |

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| | Dr. Punch documented notes on 04/21/2022 at 5:52a.m., stating Resident A had a *'mechanical fall with increased oxygen requirements with concern for aspiration pneumonia vs pneumonitis. Also found to have increasing troponin (sepsis).'*<br><br>Ms. Lopez, Ms. Peel and Ms. McKellar stated they were unaware of a lapse of time between Resident A's breathing issues and staff's call to EMS.<br><br>Mr. Nelson is unable to explain the gap of time between discovering Resident A on the floor of the bathroom at 11:45p.m. on 04/20/2022 and the call to EMS for medical assistance at 2:23a.m. on 04/22/2022.<br><br>Based on investigative findings, there is a preponderance of evidence to show that upon discovering the adverse change in Resident A's physical condition at 11:45p.m. on 04/20/2022, staff did not obtain timely care by not calling EMS until 2:23a.m. on 04/21/2022. Therefore, a violation of this applicable rule is established. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

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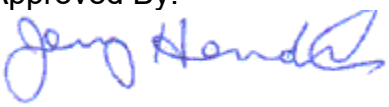
| Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged. |

08/01/2022

_____

Elizabeth Elliott — Date
Licensing Consultant

Approved By:



08/01/2022

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Jerry Hendrick — Date
Area Manager