GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 22, 2022

Paul Buchholz
Summit Park Assisted Living Center
2100 Park Rd.
Jackson, MI 49203

RE: License #: AH380236900
Investigation #: 2022A1027065
Summit Park Assisted Living Center

Dear Mr. Buchholz:

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 authorized representative 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) 241-1970.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH380236900
Investigation #:	2022A1027065
Complaint Receipt Date:	06/06/2022
Investigation Initiation Date:	06/06/2022
Report Due Date:	08/06/2022
Licensee Name:	Ganton Retirement Centers, Inc.
Licensee Address:	7925 Spring Arbor Rd. Spring Arbor, MI 49283
Licensee Telephone #:	(517) 750-0500
Authorized Representative/ Administrator:	Paul Buchholz
Name of Facility:	Summit Park Assisted Living Center
Facility Address:	2100 Park Rd. Jackson, MI 49203
Facility Telephone #:	(517) 782-8888
Original Issuance Date:	01/01/2000
License Status:	REGULAR
Effective Date:	09/03/2021
Expiration Date:	09/02/2022
Capacity:	83
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was treated roughly by staff.	No
Additional Findings	Yes

III. METHODOLOGY

06/06/2022	Special Investigation Intake 2022A1027065
06/06/2022	Special Investigation Initiated - Letter Email sent to Adult Protective Services worker to provide notification her intake was assigned for investigation
06/10/2022	Inspection Completed On-site
06/10/2022	Contact - Telephone call made Telephone interview conducted with Employee #1
06/10/2022	Contact - Telephone call made Telephone interview conducted with Employee #3
06/10/2022	Contact - Telephone call made Telephone interview conducted with Employee #2
06/14/2022	Contact - Telephone call received Voicemail received from director of resident care Belinda Gregorio
06/14/2022	Contact - Telephone call made Telephone interview conducted with director of resident care Belinda Gregorio
06/14/2022	Inspection Completed-BCAL Sub. Compliance
09/06/2022	Exit Conference Conducted with authorized representative Paul Buchholz by telephone

ALLEGATION:

Resident A was treated roughly by staff.

INVESTIGATION:

On 6/6/2022, the department was forwarded a complaint from Adult Protective Services (APS) which read on 6/2/2022, Resident A was “dragged” out of her bed roughly by three staff, Employee #1, Employee #2, and a third staff’s name was unknown. The complaint read there was skin breakdown on Resident A’s right wrist.

On 6/10/2022, I conducted an on-site inspection at the facility. I interviewed facility nurse Employee #4 who stated Resident A had resided with the facility since 2019 and had issues with sleeping at night since prior to her admission. Employee #4 stated Resident A frequently gets angry with third shift staff because she will sleep for an hour then wake up requesting to get ready for the day during the night, as well as make telephone calls to her male friend. Employee #4 stated she had communicated Resident A’s sleeping issues with her health care provider Thome PACE (Program of All-inclusive Care for the Elderly) in which they had adjusted her medications. Employee #4 reviewed Resident A’s Thome PACE records from 2017 in which their records reviewed her sleeping issues at that time. Employee #4 stated Resident A visits Thome PACE three times weekly and had voiced her concerns regarding her experience with third shift staff on 6/2/2022.

While on-site, I conducted an interview with Resident A whose statements were consistent with the complaint. Resident A stated she remembered screaming and thought it was around 2:00 or 3:00 AM when staff came to her room, got her out of bed and into the wheelchair. Resident A stated Employee #1, #3 and could not remember the third staff all came to her room. Resident A stated this was the first time this type of incident had occurred with staff. Resident A showed a bandage on her right wrist and lifted it in which I observed an inch and a half thin half circular cut. Resident A stated the cut happened during the incident but was uncertain of how. I observed Resident A’s bilateral lower and upper arms along with her face and neck which did not reveal any other abrasions, cuts, or bruises. Resident A stated she was not afraid of staff. Resident A stated, “I love it here.” Additionally, Resident A stated she had always had problems with sleeping throughout the night.

On 6/10/2022, I conducted a telephone interview with Employee #1 whose statements were consistent with Employee #4. Employee #1 stated Resident A’s routine on third shift would be to sleep for a few hours, then request to get ready for the next day throughout the night. Employee #1 stated on 6/2/2022, Resident A had requested to get out of bed to use the bathroom then did not want to leave the bathroom. Employee #1 stated Resident A yelled and pounded her fists on the wall. Employee #1 stated Resident A had a history of falls and “I was trying to get her in a

safe place.” Employee #1 stated she had contacted Resident A’s physician through Thome PACE that night regarding Resident A’s behaviors. Employee #1 stated she had not observed nor knew what caused the wound on Resident A’s right wrist but thought it could have been from her watch.

On 6/10/2022, I conducted a telephone interview with Employee #2 whose statements were consistent with Employee #4 and #1. Employee #2 stated Resident A requested to get up at 4:00 AM, so she was usually the first resident dressed and in her wheelchair in the morning. Employee #2 stated Resident A had fallen asleep on the toilet, so she is a standby assist when using the bathroom. Employee #2 stated on 6/2/2022, once Resident A was amendable to returning to bed for her safety, she as well as Employee #3 and Employee #1, assisted her back to bed. Employee #2 stated after Resident A returned to bed, then she went to check on her and discovered dried blood around her watch on her left arm, as well as blood coming from her right wrist. Employee #2 stated she nor the other staff observed the blood while assisting her back to bed. Employee #2 stated Resident A had stated the staff caused the cut on right wrist, so she apologized to Resident A, cleaned the wound area, and bandaged it.

On 6/10/2022, I conducted a telephone interview with Employee #3 whose statements were consistent with previous staff interviews. Employee #3 stated Resident A attempted to ambulate independently without staff assistance in which she had fallen in the past. Employee #3 stated Resident A worried about being late for breakfast and her Thome PACE appointments. Employee #3 stated some interventions she has tried with Resident A was showing her the clock and explaining time, redirection, and providing affirmations that staff will wake her up at 4:00 AM.

On 6/14/2022, I conducted a telephone interview with director of nursing Belinda Gregorio who statements were consistent with previous staff interviews. Ms. Gregorio stated Resident A would call Thome PACE or her male friend frequently during the night so third shift staff try to intervene. Ms. Gregorio stated Resident A accused third shift staff of being “mean” prior because they have tried to intervene.

I reviewed Resident A’s service plan which read she admitted to the facility on 1/14/2019. The plan read she had a history of a cerebrovascular accident (CVA) with left side left paresis, vascular dementia with behaviors, and falls. The plan read under vascular dementia with behaviors to monitor for change in cognitive status and report to physician as needed, explain all care before providing it, encourage routine daily decision making and to coach through process as needed, maintain as well as establish consistency in daily routine, and invite, encourage and remind resident of activities. The plan read under falls to use a two-wheel walker with one person assist and a gait belt for short distances, use wheelchair for long distances.

I reviewed Resident A’s chart notes from 5/18/2022 through 6/10/2022 which read Resident A pushed her call pendent on third shift during the night hours to request

staff assist her to get ready for the day on 5/18/2022, 5/19/2022, 5/23/2022, 5/29/2022, 5/30/2022, 6/2/2022, 6/4/2022, 6/5/2022, 6/8/2022, and 6/10/2022. The notes read Resident A yelled at staff, would sometimes decline to the leave her bathroom to return to bed and would “bang” on the walls, as well as intermittently ambulate to the bathroom without assistance. The note dated 6/2/2022 read consistent with staff interviews.

I reviewed Resident A’s medication administration records (MARs) which read consistent with statements from Employee #4.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(l) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician or physician's assistant. In case of a chemical restraint, a physician shall be consulted within 24 hours after the commencement of the chemical restraint.**

ANALYSIS:	Staff interviews, along with review of facility documentation, revealed Resident A had history of falls, dementia with behaviors, and inability to sleep throughout the night. Facility staff had communicated Resident A's sleeping patterns and dementia related behaviors to her licensed health care professional, as well as described interventions for staff in her plan of care. Interview with Resident A, as well as observations, revealed there was insufficient evidence to support staff treated Resident A roughly. Based on this information, this allegation cannot be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 6/10/2022, at the on-site inspection of the facility, I observed Resident A's bed in which there was a bedside assist device located on the right side of her bed. The device was not attached to the bedframe but rather slid between the mattress and bedframe and was held in place by the weight of the occupant and mattress. The device was made of curved metal tubing and presented with a gap approximately 12 inches wide and 18 inches from the top of the mattress. The gap was large enough to became entangled or in the event the occupant's body pushes the device away from the mattress, it becomes an entrapment zone with risk of suffocation.

On 6/14/2022, I conducted a telephone interview with Ms. Gregorio who stated she had discussed the danger of the device with Resident A but had not removed the device from the bed.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**

For Reference: **R 325.1901**	**Definitions**
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and wellbeing 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 supervision 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.
ANALYSIS:	Given the observations listed above and lack of an organized program the facility has not provided reasonable protective measures to ensure Resident A's well-being and safety with the use of a bedside assistive device.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Resident A's service plan was dated 1/14/2019. The plan read it was updated on 1/20/2020.

On 6/14/2022, I conducted a telephone interview with Ms. Gregorio who stated her nursing staff were working to update residents service plans.

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 annually and thus was not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this report with authorized representative Paul Buchholz by telephone.

IV. RECOMMENDATION

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

6/24/2022

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Jessica Rogers Date
Licensing Staff

Approved By:

09/02/2022

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