STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

September 26, 2022

Nicole Swart
Clark Retirement Home
1551 Franklin Street, SE
Grand Rapids, MI 49506-8203

RE: License #: AH410236767
Investigation #: 2022A1010054
Clark Retirement Home

Dear Mrs. Swart:

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) 241-1970.

Sincerely,

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa NW Unit 13, 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410236767
Investigation #:	2022A1010054
Complaint Receipt Date:	07/05/2022
Investigation Initiation Date:	07/05/2022
Report Due Date:	09/04/2022
Licensee Name:	Clark Retirement Community Inc.
Licensee Address:	1551 Franklin SE Grand Rapids, MI 49506
Licensee Telephone #:	(616) 278-6543
Authorized Representative/ Administrator:	Nicole Swart
Name of Facility:	Clark Retirement Home
Facility Address:	1551 Franklin Street, SE Grand Rapids, MI 49506-8203
Facility Telephone #:	(616) 452-1568
Original Issuance Date:	12/25/1957
License Status:	REGULAR
Effective Date:	08/21/2021
Expiration Date:	08/20/2022
Capacity:	107
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was found deceased with her chin resting on her nightstand, right hand resting on her bedrail, and her left hand resting on her oxygen concentrator. Her cause of death was asphyxia by neck compression.	No
Additional Findings	Yes

III. METHODOLOGY

07/05/2022	Special Investigation Intake 2022A1010054
07/05/2022	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
07/05/2022	APS Referral APS referral emailed to Centralized Intake
07/06/2022	Inspection Completed On-site
07/06/2022	Contact - Document Received Received resident service plan and staff notes
07/18/2022	Contact – Document received Received Resident A's autopsy report from the Kent Co. medical examiner's office
09/26/2022	Exit Conference Completed with licensee authorized representative Nicole Swart

ALLEGATION:

Resident A was found deceased with her chin resting on her nightstand, right hand resting on her bedrail, and her left hand resting on her oxygen concentrator. Her cause of death was asphyxia by neck compression.

INVESTIGATION:

On 6/8/22, I received an incident report regarding Resident A’s death. The report read, “Resident experienced a fall on 5/12/2022 sometime between the staff’s last observation around 4:15 am and upon finding resident in her room at approximately 6:25 am in front of her nightstand with her chin resting on her nightstand, right hand resting on the bedrail and left hand resting on her oxygen concentrator. Resident

was unresponsive and had no pulse. Faith hospice was notified, and the deceased resident assisted to her bed. Because of the nature of how the resident was found by staff hospice notified the Medical Examiner. Family, MD, SOM notified of death of resident.

Upon receipt of the Certificate of Death the cause states asphyxia by neck compression related to an accident."

The report read the staff person who found Resident A was interviewed by the facility's administrator Nicole Swart. The report read, "It was verified that L.E reported to work on 5-12-2022 around 6am. L.E was scheduled to work on the fourth-floor assisted living. She reported "counting off" with another LCP (G.R). After this, she began making her rounds. Resident B.H is serviced by hospice and likes to be up and have eaten before they arrive for her shower. L.E reported that she entered resident's room at approximately 6:25am. Upon opening resident's door, L.E. observed the lights were on and resident was positioned parallel next to her bed with her head near the head of the bed with her facing towards the floor. Resident's left arm was out straight, like a T, and her hand was resting on her oxygen concentrator. Resident's right arm was also out and resting on her bed rail. When asked to clarify if resident's arm was entangled in her bedrail, L.E. indicated no, that her arm entered the area through the outside and it was just setting in there. Resident was in a back-up position with stomach and legs not touching the ground. Resident was supported by the tops of her feet. Resident's chin was noted to be resting on her nightstand with point of contact on resident's neck."

The report read Resident A "was wearing her nightgown and her brief. Her brief was partially down as if she was trying to use her commode and there was a smear of BM on the edge of her bed. Resident's bottom was covered by her nightgown. Resident's feet were bare. Staff member indicated resident's legs were warm to the touch. Her feet were cold."

On 6/9/22, I emailed director of nursing Heather Holm to inquire whether law enforcement responded. Ms. Holm reported law enforcement did not respond to the incident.

On 7/6/22, I interviewed Ms. Swart at the facility. Ms. Swart reported Resident A was checked on at 2:00 am and at 4:00 am on 5/12/22. Ms. Swart said Resident A was last observed by an agency staff person at approximately 4:00 am on 5/12/22. Ms. Swart stated it is the facility's policy and procedure for staff to check on residents every two hours during third shift. Ms. Swart stated at that time, the agency staff person who checked on Resident A at 4:00 am observed her sitting up on the edge of her bed with her light on. Ms. Swart said the agency staff person did not speak to or interact with Resident A at the time, she "peeked in" on her and left the room.

Ms. Swart explained Resident A was able to ambulate herself with the use of a four wheeled walker. Ms. Swart reported Resident A was supposed to use her call

pendant to summon staff for assistance anytime she had to use the bathroom. Ms. Swart stated Resident A was often not compliant with this. Ms. Swart reported it appeared Resident A attempted to toilet herself on 5/12/22. Ms. Swart stated Resident A may have had a medical incident that caused her to fall and not be able to get back up.

Ms. Swart reported staff person Lashandra Everett found Resident A on 5/12/22 at approximately 6:25 am. Ms. Swart stated Ms. Everett found Resident A unresponsive, she had her chin resting on her nightstand, her left arm was resting on her oxygen concentrator, and her right arm was resting on her mattress between her bed rails. Ms. Swart clarified Resident A's right arm was not trapped within the bedrails. Ms. Swart stated Ms. Everett explained it looked as if Resident A was "floating," as she was on the top, or dorsal region, of her feet, her knees were not touching the ground.

Ms. Swart reported the medical examiner did do an autopsy, however the facility had not received the results. Ms. Swart stated the facility's in-house physician was attempting to get the autopsy results from the medical examiner's office, however they have not been received to date.

Ms. Swart reported Resident A received hospice services through Faith Hospice. Ms. Swart stated Resident A had several comorbidities and was obese. Ms. Swart stated Resident A was pronounce dead at 7:25 am on 5/12/22.

On 7/6/22, I interviewed Ms. Holm at the facility. Ms. Holm reported she interviewed agency staff person Laken Antcliff regarding the incident. Ms. Holm stated Ms. Antcliff is an agency staff person. Ms. Holm stated Ms. Antcliff told her she last checked on Resident A at approximately 4:00 am on 5/12/22. Ms. Holm's statements regarding Ms. Antcliff "peeking in" on Resident A were consistent with Ms. Swart.

Ms. Holm said staff do no document when they check on residents every two hours during third shift. Ms. Holm's statements were consistent with Ms. Swart. Ms. Holm reported staff were following Resident A's hospice service plan. Ms. Holm provided me with a copy of Resident A's hospice *Skilled Nursing Care Plan* for my review. The document read, "Encourage patient to use bedside commode. Keep personal items within reach." The *ADL'S/IADL'S* section of the document read, "Activity – Ambulate patient using assistive device 4WW; patient independent."

Ms. Holm provided me with a copy of Resident A's death certificate for my review. The *ENTER the chain of events - diabetes, injuries or complications – that directly cause the death* section of the certificate read, "asphyxia by neck compression." The *MANNER OF DEATH* section of the certificate read, "Accident." The *DESCRIBE HOW INJURY OCCURRED* section read, "deceased fell onto nightstand and couldn't get up."

Ms. Holm provided me with a copy of Resident A's *Interdisciplinary Notes* for my review. A note dated 5/12/22 at 12:31 pm read, "This writer received a phone call at 0625 from the oncoming lead carepartner, stating that something was wrong with [Resident A] and requested help immediately. Upon entering the room, this writer witnessed the resident kneeling next to her bed, with her head resting on her nightstand. She was unresponsive and did not have a pulse. This writer immediately called management, as my coworker was reaching out to hospice. When RN with Faith Hospice arrived, she requested my assistance in transferring the resident back to bed, which I did. I then left for the day, as I worked the midnight shift and my shift was over. This writer last checked on resident approximately 0200 and she was asleep in bed." This note was written by staff person Megan Springfield.

On 7/6/22, I interviewed Ms. Everette at the facility. Ms. Everette's statements were consistent with Ms. Swart, Ms. Holm, and Resident A's incident report. Ms. Everette demonstrated the position Resident A's body was in when she entered her room at approximately 6:25 am on 5/12/22. Ms. Everette stated Resident A's four wheeled walker was behind Resident A's body and her commode was behind the walker.

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.**
ANALYSIS:	The interviews with staff, along with review of Resident A's incident report and death certificate, revealed she fell onto her nightstand and died from asphyxiation. Staff reported Resident A was checked on at 2:00 am and at 4:00 am on 5/12/22 before the incident. Staff reported Resident A often had to be redirected to use her pendant to summon staff assistance to toilet because she was non-compliant with doing so. There is insufficient evidence to suggest staff did not follow the facility's policy and procedure to check on Resident A every two hours overnight on 5/12/22.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 7/6/22, Ms. Holm reported staff were following the Faith Hospice service plan for Resident A. Ms. Holm provided me with a copy of Resident A's service plan that was dated 2/14/20. Ms. Holm stated this was the most updated service plan the facility completed for Resident A.

The *Toileting* section of the plan read, "Resident is independent with toileting needs." The *Wellness* section of the plan read, "Wellness Check: every 2 hours to provide toileting ques/reminders, incontinence care and offer refreshments."

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.
FOR REFERENCE: **R 325.1901**	**Definitions.**
	(21) "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 interview with Ms. Holm, along with review of Resident A's service plan, revealed the plan was not updated annually in accordance with this rule. Resident A's service plan was dated 2/14/20.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	The interviews with staff revealed Resident A required assistance toileting and was reminded several times to use her pendant to summon staff for assistance. Resident A's outdated service plan read she was "independent with toileting needs." Resident A's plan did not outline her need to summon for staff assistance with toileting.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Nicole Swart by telephone on 9/26/22.

IV. RECOMMENDATION

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

07/19/2022

Lauren Wohlfert　　Date
Licensing Staff

Approved By:

09/26/2022

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