GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 14, 2022

Jeffrey Floyd
Azpira Place Of Breton
4352 Breton Rd. SE
Kentwood, MI 49512

RE: License #: AH410391902
Investigation #: 2022A1021053
Azpira Place Of Breton

Dear Mr. Floyd:

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) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410391902
Investigation #:	2022A1021053
Complaint Receipt Date:	08/22/2022
Investigation Initiation Date:	08/23/2022
Report Due Date:	10/21/2022
Licensee Name:	Pathway Operations Kentwood, LLC
Licensee Address:	4352 Breton Road SE Kentwood, MI 49512
Licensee Telephone #:	(312) 837-0704
Administrator:	Selma Ibrahimovic
Authorized Representative:	Jeffrey Floyd
Name of Facility:	Azpira Place Of Breton
Facility Address:	4352 Breton Rd. SE Kentwood, MI 49512
Facility Telephone #:	(616) 288-4151
Original Issuance Date:	05/11/2018
License Status:	REGULAR
Effective Date:	11/11/2021
Expiration Date:	11/10/2022
Capacity:	103
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive medical attention.	Yes
Additional Findings	No

III. METHODOLOGY

08/22/2022	Special Investigation Intake 2022A1021053
08/23/2022	Special Investigation Initiated - Telephone called and left message with administrator
08/26/2022	Contact - Telephone call made interviewed administrator by telephone
08/30/20222	Contact-Documents Received Received Resident A service plan, MAR, and progress notes
08/30/2022	Contact-Telephone call made Interviewed Staff Person 2 (SP1)
08/30/2022	Contact- Telephone Call made Interviewed SP1
08/30/2022	Contact-Telephone call made Life EMS worker Rebecca Knepper
09/14/2022	Exit Conference

ALLEGATION:

Resident A did not receive medical attention.

INVESTIGATION:

On 8/22/2022, the licensing department received a complaint with allegations Resident A did not receive medical attention. The complainant alleged emergency medical services (EMS) were contacted because Resident A had a change in status.

The complainant alleged medical attention was not sought for hours and the facility delayed contacting EMS.

On 8/26/2022, I interviewed administrator Selma Ibrahimovic by telephone. Ms. Ibrahimovic reported on 8/22 around 5:30am the medication technician provided medications to Resident A and Resident A was at her baseline. Ms. Ibrahimovic reported around 6:30am Resident A pushed her call pendent for assistance. Ms. Ibrahimovic reported Resident A was standing near her chair and kept repeating herself. Ms. Ibrahimovic reported at this time Resident A was agitated and resistant to care. Ms. Ibrahimovic reported the medication technician told the oncoming caregivers about the change in mental status with Resident A. Ms. Ibrahimovic reported for the next two hours Resident A was confused and refused care. Ms. Ibrahimovic reported it was then decided to send Resident A to the hospital. Ms. Ibrahimovic reported Resident A's physician and family was notified of the transfer. Ms. Ibrahimovic reported Resident A was sent to the hospital at approximately 9:30-10:30am. Ms. Ibrahimovic reported when a resident has a change in status, the facility will implement increased checks to every 15-30 minutes. Ms. Ibrahimovic reported the caregiver was present in Resident A's room and continued to check on Resident A. Ms. Ibrahimovic reported Resident A was lowered to the ground by the caregiver but did not have a fall. Ms. Ibrahimovic reported the facility followed appropriate protocol and medical attention was provided to Resident A.

On 8/26/2022, I interviewed staff person three (SP3) by telephone. SP3 reported she was notified by the caregiver to evaluate Resident A. SP3 reported she observed Resident A to be combative, unable to make eye contact, and was not at baseline. SP3 reported the facility then contact Resident A's physician for direction and it was decided to send Resident A to the hospital for a medical evaluation. SP3 reported Resident A did not have a fall and was only lowered to the ground by the caregiver. SP3 reported Resident A did not have a change in status during the night and the change in status started on first shift, at approximately 7:30am. SP3 reported the facility acted appropriately to obtain medical attention for Resident A.

On 8/30/2022, I interviewed SP1 by telephone. SP1 reported she provided care to Resident A on third shift. SP1 reported she provided evening medications to Resident A at approximately 8:30pm. SP1 reported Resident A was at baseline through the evening and nighttime hours. SP1 reported she provided morning medications to Resident A at approximately 5:30am and Resident A was at baseline. SP1 reported at 6:30am she responded to Resident A's call pendent. SP1 reported Resident A kept repeating herself and was confused. SP1 reported she reported the change in status to the oncoming medication technician. SP1 reported Resident A did not fall and did not have a change in status during her shift.

On 8/30/2022, I interviewed SP2 by telephone. SP2 reported on 8/22 she provided care to Resident A. SP2 reported she was told by SP1 that Resident A had a change in status. SP2 reported she went into Resident A's room and Resident A was combative, kept repeating herself, and was not making any sense. SP2 reported she

was lowered to the ground by caregivers because she kept trying to walk without her walker. SP2 reported she called SP3 into the room to evaluate Resident A. SP2 reported the facility then called EMS for transfer to the hospital. SP2 reported she observed Resident A for a while before she asked SP3 for an evaluation.

On 8/30/22, I interviewed Life EMS worker Rebecca Knepper by telephone. Ms. Knepper reported Life EMS was contacted at approximately 11:00am for EMS transfer to the hospital for Resident A. Ms. Knepper reported when she arrived at the facility, Resident A was extremely combative, and it was difficult to get her into the ambulance. Ms. Knepper reported the facility reported Resident A had this change in status for at least 10 hours.

I reviewed the facility *Notification of Change* policy. The policy read,

> *"The staff must immediately inform the resident, consult with the physician, and notify the resident's responsible party when there is a significant change in the resident's care or condition related to:*
>
> 1. *An accident involving the resident which results in injury and has the potential for requiring physician intervention.*
>
> 2. *A significant change in the resident's physical, mental, or psychosocial status (deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications).*
> *Significant changes include but are not limited to:*
>
> *Falls with or without injury*
>
> *Accidents and injuries*
>
> *Abuse or suspected abuse, including resident-to-resident abuse*
>
> *Change in behavior*
>
> *Infection and initiation of antibiotics*
>
> *Abnormal lab values that require clinical monitoring and change in treatment and/or medications*
>
> *Pressure sores*
>
> *Significant weight loss/gain*
>
> *Elevated temperature*
>
> *New onset of, or uncontrolled, pain*
>
> *Vomiting, diarrhea, other GI disturbances*
>
> *Change in oral intake*
>
> *Bleeding*
>
> *Change in vital signs*
> *Leaving the building without authorization*

3. *A need to alter treatment significantly (discontinuation of an existing form of treatment or initiation of a new form of treatment, new medications, diagnostic tests).*
4. *A decision to refer to HHC should be the first plan of action. Transfers to the hospital or discharge should happen only if medically necessary.*

The staff will:

1. *Notify the physician and family member/responsible party of identified significant changes.*
2. *Document date, time, and party notified, and findings and details of the notification in the Resident Record.*
3. *Enter relevant information on the 24-Hour Report for follow-up as indicated."*

I reviewed facility service notes for Resident A. The service notes read,

"8/22/22: This writer was called to residents room by (SP2). Resident had noted AMS (altered mental status). Resident was yelling out "I have to go to the bathroom now." Resident continued yelling the same line even when in the bathroom. Resident was unable to answer any questions asked, make no eye contact. This nurse called provider, and emergency contact with a report of situation. This nurse called EMS to transport resident to ER for evaluation."

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(1) A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization, which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff.

	Patients or residents shall be treated in accordance with the policy.
For Reference: MCL 333.20201	**(2) (e) A patient or resident is entitled to receive adequate and appropriate care, and to receive from the appropriate individual within the health facility or agency, information about his or her medical condition, proposed course of treatment, and prospects for recovery, in terms that the patient or resident can understand, unless medically contraindicated as documented by the attending physician in the medical record.**
ANALYSIS:	Interviews with caregivers revealed Resident A exhibited altered mental status around 6:30am and EMS was not contacted until hours later. The facility did not comply with ensuring Resident A was provide adequate and appropriate care.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/7/22 and 9/12/22, I contacted authorized representative Jeffery Floyd to exit conference. Mr. Floyd did not respond and this report was emailed to him on 9/14/22.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

Kimberly Horst 8/31/22

Kimberly Horst Date
Licensing Staff

Approved By:

Andrea L. Moore 09/07/2022

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