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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 10, 2022

Paul Carlson
Sojourner Aid OPCO, LLC
5364 Greenmeadow
Kalamazoo, MI 49009

RE: License #: AH390378211
Investigation #: 2022A1028070
Sojourner Place

Dear Mr. Carlson:

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

Sincerely,

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
Cell (616) 204-4300

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

I. IDENTIFYING INFORMATION

License #:	AH390378211
Investigation #:	2022A1028070
Complaint Receipt Date:	07/25/2022
Investigation Initiation Date:	07/26/2022
Report Due Date:	09/24/2022
Licensee Name:	Sojourner Aid OPCO, LLC
Licensee Address:	Ste. 3700 330 N. Wabash Chicago, IL 60611
Licensee Telephone #:	(312) 725-7000
Administrator:	Tawnee Stone
Authorized Representative:	Paul Carlson
Name of Facility:	Sojourner Place
Facility Address:	5364 Greenmeadow Kalamazoo, MI 49009
Facility Telephone #:	(269) 353-0416
Original Issuance Date:	04/24/2017
License **Status:**	REGULAR
Effective Date:	10/24/2021
Expiration Date:	10/23/2022
Capacity:	61
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A incurred several falls resulting injury and later death due to lack of staff neglect.	No
Additional Findings	Yes

III. METHODOLOGY

07/25/2022	Special Investigation Intake 2022A1028070
07/26/2022	Special Investigation Initiated - Letter
07/26/2022	APS Referral No APS referral, as resident is deceased as of March 2022.
08/01/2022	Inspection Completed On-site On-site inspection completed due to investigation.
08/01/2022	Contact - Face to Face Interviewed Admin/Tawnee Stone at the facility.
08/01/2022	Contact - Face to Face Interviewed Employee A at the facility.
08/01/2022	Contact - Face to Face 2022A1028070 - Interviewed Employee B at the facility.
08/01/2022	Contact - Document Received Received Resident A's record from Admin/Tawnee Stone.
08/22/2022	Contact – Telephone call made Interviewed Hospice staff member by telephone
10/10/2022	Exit Interview

ALLEGATION:

Resident A incurred several falls resulting injury and later death due to lack of staff neglect.

INVESTIGATION:

On 7/25/2022, the Bureau received the allegations anonymously from the online complaint system.

On 8/11/2022, I interviewed administrator, Tawnee Stone, at the facility who reported Resident A was admitted to the facility after a stay at the hospital due to a significant decline in function. Ms. Stone reported Resident A demonstrated significant behaviors at the hospital due to medication changes. Resident A was discharged from the hospital with hospice orders and was admitted to the facility with physician's order for symptom management of terminal illness on 3/1/2022. However, the hospital did not communicate that upon Resident A's discharge to the facility, Resident A was highly agitated, requiring medication intervention. The hospital also did not provide medications or orders for appropriate durable medical equipment (DME) for Resident A upon discharge to the facility. Ms. Stone reported Resident A entered the facility with some existing bruising as well and it was documented in the chart. Resident A was one to two person assist with all mobility and required assist with all care. Resident A could not appropriately make needs known. Ms. Stone reported with hospice's assistance, Resident A's medications were correctly ordered along with DME. However, Resident A's authorized representative did not want Resident A to receive morphine. Resident A's authorized representative also did not understand why Resident A was on a rotation schedule to prevent skin breakdown. Ms. Stone also reported Resident A's authorized representative required extensive education from facility staff and hospice staff about the disease process and end of life process for Resident A. Ms. Stone reported Resident A incurred two falls at the facility. The first fall occurred unwitnessed on 3/2/2022 with Resident A being found on the floor next to the wheelchair. No injuries were noted at this time and Resident A did not demonstrate any pain. The facility contacted hospice to assess and order DME to help prevent falls, and increased Resident A's monitoring as well. Resident A incurred a second fall on 3/4/2022 in the common area of the facility. Ms. Stone reported "[Resident A] attempted to stand from wheelchair without assistance and face planted hard on the floor." Hospice was contacted and Resident A's supervision was increased to 24-hour supervision. Ms. Stone reported it did not appear at first that Resident A was injured other than a skin tear on the forehead but the next day, facial bruising began to surface with the facility notifying hospice and the authorized representative immediately. The authorized representative did not want Resident A sent to the hospital for further assessment despite the facial bruising. Ms. Stone reported hospice saw Resident A everyday due to continued decline. Resident A passed away on 3/26/2022 due to terminal illness and end of life process. Ms. Stone provided me Resident A's service plan, physician orders, records notes, and hospice documentation for my review.

On 8/1/2022, I interviewed Employee A at the facility who reported Resident A was discharged from the hospital to facility without proper medications or DME. Resident

A entered the facility with significant agitation and with hospice's assistance, the correct medications to address agitation and decline in function and the correct DME was ordered. Employee A reported Resident A required assist with all care and could not make needs known. Resident A incurred two unwitnessed falls at the facility with the second fall resulting in facial bruising. Hospice and Resident A's authorized representative were notified of each fall with hospice assessing and the facility significantly increasing Resident A's supervision. Employee A reported the authorized representative refused to have Resident A sent out after each fall. Employee A also reported the authorized representative did not want Resident A to receive morphine at first, but later agreed to it. The authorized representative required extensive education from the facility and hospice staff to include the hospice social worker about the disease process and end of life process. Employee A reported the authorized representative "had hard a time accepting that [Resident A] was not going to improve or return to [their] normal baseline."

On 8/1/2022, I interviewed Employee B at the facility who reported [they] did not have a lot of interaction with Resident A but Resident A's authorized representative was "very unrealistic about the disease process" despite education from the facility, hospice, and the hospice social worker. Employee B reported knowledge that Resident A fell twice at the facility and incurred facial bruising from the second fall. Resident A was assessed by hospice after each fall and the facility increased Resident A's monitoring to 24-hour supervision. Employee B reported Resident A's authorized representative refused to have Resident A sent to the hospital after each fall.

On 8/1/2022, I completed an inspection of the facility due to the investigation. Residents observed were clean, well groomed, content and/or being assisted by facility staff. No concerns noted.

On 8/22/2022, I interviewed hospice staff member by telephone who reported Resident A entered the facility from the hospital. However, the hospital did not communicate to the facility or hospice staff that Resident A was highly agitated upon admittance. The hospital also did not provide medications or appropriate DME for Resident A upon discharge to the facility. The hospice staff member reported Resident A was total care and non-verbal despite staff attempting to use a communication board with Resident A. The hospice staff member reported Resident A fell twice upon entering the facility due to the demonstrated agitation in which the facility and hospice worked diligently to address. After each fall, the facility contacted hospice immediately to assess and get the correct DME ordered to help prevent further falls. The facility also increased Resident A's supervision after each fall with Resident A being placed on 24-hour supervision after the second fall in which Resident A incurred facial bruising. To their knowledge, other than the facial injuries from the second fall, Resident A did not incur any other injuries. The hospice staff member reported access to mobile x-ray machines and if further injury was suspected, then hospice would have completed x-rays of Resident A. The hospice staff member reported Resident A's authorized representative refused to send

Resident A to the hospital after each fall and required education on using morphine for Resident A because the authorized representative did not want it administered to Resident A initially. The authorized representative later agreed to use of morphine with Resident A. The hospice staff member reported the facility “went above and beyond with care” and followed all physician and hospice orders. The hospice staff member reported “the facility really did provide excellent care for [Resident A] until the end of life” and hospice had no concerns about the facility care for Resident A.

On 8/23/2022, I reviewed Resident A’s entire record which revealed the following:

- Resident A entered the facility on 3/1/2022 with hospice orders for progression in transition process of end of life.
- Hospice and Resident A’s authorized representative were notified of the two falls occurring on 3/2/22 and 3/4/22 through internal fall reports.
- Evidence of increased supervision after falls from 3/2/22 to 3/26/22.
- Evidence of DME ordered to prevent falls on 3/8/22.
- Evidence of consistent medication record updates and changes to address agitation, pain, and end of life process beginning 3/2/22 to 3/26/22.
- Evidence Resident A’s authorized representative refused transport to the hospital for evaluation after Resident A’s falls on 3/2/22 and 3/4/22.
- Evidence of education about the disease process and end of life process provided to Resident A’s authorized representative on from 3/1/22 to 3/26/22 by facility staff, hospice staff, and hospice social worker.

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:	It was alleged facility staff did not provide appropriate supervision and neglected Resident A resulting in Resident A sustaining significant injuries after two falls. It was also alleged the injuries sustained from the falls contributed to the end of life process. Interviews, on-site inspection, and review of documentation reveal facility staff provided care consistent with physician and hospice orders. Resident A was provided 24-hour supervision by facility staff after the second fall and Resident A did not incur any more falls at the facility. There is no evidence to support the allegation of neglect or abuse from facility staff. No violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

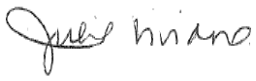
On 8/1/2022, Ms. Stone reported she did not submit incident reports for Resident A's two falls on 3/2/22 and 3/4/22 or death on 3/26/22. Internal reports were completed, and hospice and Resident A's authorized representative were notified but Ms. Stone reported she forgot to notify the department.

On 8/1/2022, Employee A reported "internal [facility] incident reports were completed, but I did not realize the department required to be notified".

APPLICABLE RULE	
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:	No incident reports about Resident A's falls on 3/2/22 and 3/4/22 were submitted to the department. The facility was also not notified of Resident A's death on 3/26/22. Therefore, the facility is in violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



8/22/2022

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Julie Viviano Date
Licensing Staff

Approved By:

10/05/2022

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