GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 20, 2022

Rochelle Lyons
Senior Living Boulder Creek, LLC
7927 Nemco Way, Ste 200
Brighton, MI 48116

RE: License #: AH410406207
Investigation #: 2022A1028077
Boulder Creek Assisted Living & Memory Care

Dear Ms. Lyons:

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 #:	AH410406207
Investigation #:	2022A1028077
Complaint Receipt Date:	08/25/2022
Investigation Initiation Date:	08/25/2022
Report Due Date:	09/24/2022
Licensee Name:	Senior Living Boulder Creek, LLC
Licensee Address:	7927 Nemco Way, Ste 200 Brighton, MI 48116
Licensee Telephone #:	(616) 464-1564
Administrator:	Mallory Hollomon
Authorized Representative:	Rochelle Lyons
Name of Facility:	Boulder Creek Assisted Living & Memory Care
Facility Address:	6070 Northland Drive Rockford, MI 49341
Facility Telephone #:	(616) 866-2911
Original Issuance Date:	08/10/2021
License Status:	REGULAR
Effective Date:	02/10/2022
Expiration Date:	02/09/2023
Capacity:	108
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff did not provide Resident A care in a timely manner in accordance with the service plan.	Yes
Staff did not administer medications in accordance with physician orders.	No
Additional Findings	No

III. METHODOLOGY

08/25/2022	Special Investigation Intake 2022A1028077
08/25/2022	Special Investigation Initiated - Letter
08/25/2022	APS Referral APS referral made to Centralized Intake.
09/14/2022	Inspection Completed On-site Onsite inspection completed due to this investigation.
09/14/2022	Contact - Face to Face Interviewed Admin/Mallory Hollomon at the facility.
09/14/2022	Contact - Face to Face Interviewed Employee A at the facility.
09/14/2022	Contact - Face to Face Interviewed Employee B at the facility.
09/14/2022	Contact - Face to Face Interviewed Employee C at the facility.
09/14/2022	Contact - Document Received 2022A1028077 - Received Resident A's service plan, admission contract, MAR, call light log, and incident report from Admin/Mallory Hollomon.
10/20/2022	Exit – Left voicemail with SIR findings for Admin/Mallory Hollomon. No phone number provided for AR/Rochelle Lyons. Report sent to Admin/Mallory Hollomon and AR/Rochelle Lyons via email.

ALLEGATION:

Staff did not provide Resident A care in a timely manner in accordance with the service plan.

INVESTIGATION:

On 8/25/2022, the Bureau received the allegations from the online complaint system.

On 8/25/2022, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 9/14/2022, I interviewed the facility administrator, Mallory Holloman, at the facility who reported Resident A was at the facility for a short period. Resident A had Parkinson's Disease and staff provided care in accordance with the service plan. Ms. Holloman reported Resident A had a call light assigned to [them] on the day of admission but it was discovered it was not functioning properly. A new call light pendant was ordered, and Resident A was placed on hourly checks the first night to ensure appropriate care. Ms. Holloman also reported the maintenance person drove to another facility to obtain a good working call light pendant until Resident A's new call light pendant arrived. Ms. Hollomon reported Resident A utilized the call light well and call lights were typically answered within 15 minutes or less. However, Ms. Hollomon reported sometimes staff would forget to reset the call light resulting in the call light response time appearing longer than it was. Ms. Hollomon reported Resident A's level of care varied from day to day due to the progression of Parkinson's Disease. Ms. Hollomon reported staff carefully followed Resident A's service plan for all care. Resident A did not have any falls at the facility and did not make any complaints to staff or herself about care. Ms. Hollomon reported to her knowledge there were no issues with assisting Resident A with dressing, bathing, toileting, grooming, or mobility. Resident A is no longer at the facility and returned home under the care of the authorized representative. Ms. Hollomon provided me a copy of Resident A's service plan and call light log for my review.

On 9/14/2022, I interviewed Employee A at the facility who reported Resident A did not have a working call light due to it malfunctioning but was placed on hourly checks the first night of admission. Employee A reported a replacement call light was obtained for Resident A by the next morning and Resident A was consistent in using it. Employee A reported all call light are answered within 15 minutes and had no knowledge of Resident A's call light not being answered for 30 minutes, but staff have forgotten to reset call lights resulting in longer response times being recorded by the call light system. Employee A reported Resident A had Parkinson's Disease and the level of care varied each day due to the progression of the disease. Resident A's service plan was reviewed regularly, and staff followed it carefully. Employee A

reported to [their] knowledge there were no issues with providing Resident A care and no complaints from Resident A. Resident A did not incur any falls while at the facility either.

On 9/14/2022, I interviewed Employee B at the facility who reported Resident A's care varied each day due to the progression of Parkinson's disease. Resident A's service plan was carefully followed and reviewed often to ensure appropriate care levels. Employee B reported to [their] knowledge there were no issues with staff assisting Resident A with dressing, grooming, bathing, or toileting. Employee B confirmed Resident A did not have a working call light the first night at the facility but was placed on hourly checks. A replacement call light was obtained for Resident A by the next day and Resident A was consistent with use of the call light. Employee B reported no knowledge of any call light not being answered and no knowledge that Resident A's call light took 30 minutes to answer. However, Employee B reported "sometimes we forget to reset the call light, so the time is still recording in the system, So, it looks like it took longer to answer the resident than it actually did". Employee B reported all lights are supposed to be answered within 15 minutes or less.

On 9/14/2022, I interviewed Employee C at the facility whose statements are consistent with Ms. Hollomon's, Employee A's, and Employee B's statements.

On 9/20/2022, I reviewed Resident A's service plan which revealed the following:

- Resident A had some confusion requiring occasional prompting.
- Communicates independently and able to follow directions.
- Has good safety awareness and may be on campus grounds unsupervised,
- Does not wander and requires baseline monitoring at each shift, mid-day, and one per mid third shift.
- Does not exhibit behaviors.
- Requires assistance with grooming, upper and lower body dressing.
- Requires two-person assist with bathing and toileting.
- Ambulates with two-person assist, unable to climb stairs.
- Transfers with Hoyer lift or Sit to Stand with two-person assist.
- Staff provides all medication administration.
- No fall history.

I also reviewed the call light log for Resident A which revealed the following:

- Five call light response times exceeded 15 minutes.
- Eight call light response times exceeded 20 minutes.
- Two call light response times exceeded 25 minutes.
- Four call light response times exceeded 30 minutes.
- Two call light response times exceeded 40 minutes.
- Two call light response times exceeded 50 minutes.

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:	It was alleged Resident A was provided assist with toileting and other care while at the facility. Interviews with staff, onsite inspection, and review of documentation reveal evidence staff provided care in accordance with the service plan. It was also alleged that Resident A's call lights were not answered in 15 minutes or less. Interviews and review of the call light log reveal 23 call light response times that were greater than 15 minutes. It cannot be determined if this is the actual response time or if the call light pendant was not reset by staff. However, due to the significant number of call light response times exceeding 15 minutes, the facility is in violation of providing Resident A care in a timely manner.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff did not administer medications in accordance with physician orders.

INVESTIGATION:

On 9/14/2022, Ms. Hollomon reported the facility was provided Resident A's medications by the hospital and Resident A's authorized representative upon admittance to the facility. Ms. Hollomon reported there was some confusion however with the medications due to Resident A's authorized continuing to refill prescriptions for Resident A at the facility. Ms. Hollomon reported the authorized representative signed the admission contract in agreement the facility would handle all Resident A's medication administration to include the refilling of prescriptions. Resident A's service plan also stipulates the facility is managing all Resident A's medications. Ms. Hollomon reported several emergency care conferences with education took place with the authorized representative about medication administration to include the refilling of prescriptions for Resident A, but the authorized representative continued to refill the prescriptions outside of the facility for Resident A. The authorized representative did not inform staff [they] were bringing medications to Resident A. On 7/24/2022, Resident A informed staff the authorized representative had brought medication into the facility to administer to [them]. Resident A provided the staff member the medication the authorized representative had brought into the facility

despite education and warnings from Ms. Hollomon and staff. Resident A's physician was contacted immediately, and the licensing department was notified as well. Ms. Hollomon reported education was immediately provided again to the authorized representative that all medications are to be administered by the facility only in accordance with physician orders. Resident A is not to self-administer and [the authorized representative] is not to refill prescriptions or bring any medication into the facility for Resident A. Ms. Hollomon reported the authorized representative finally agreed to abide by the facility policy and procedures. However, facility staff were alerted to continue to monitor Resident A for any adverse symptoms and to check-in with Resident A more frequently during visits with the authorized representative.

On 9/14/2022, Employee A reported Resident A's authorized representative was provided education on multiple occasions about not refilling Resident A's medications outside the facility and bringing those medications to Resident A for self-administration. Resident A was not to self-administer any medication while at the facility. Employee A reported knowledge that Resident A turned over medication to staff the authorized representative had brought into the facility for Resident A to self-administer. Employee A reported several emergency care conferences took place to educate the authorized representative about the dangers of Resident A self-administering. Employee A reported Resident A's family were also involved in the care conferences and were supportive of the facility managing all medication to include prescription refilling, but the authorized representative was not initially cooperative. Due to the incident that occurred on 7/12/2022, visits between Resident A and the authorized representative were monitored closely to prevent any further self-administering of medication. The facility also monitored Resident A closely and continued to be in consistent communication with Resident A's physician. Employee A reported the authorized representative finally agreed to abide by the facility medication administration policy and procedures after the emergency care conference on 7/12/2022.

On 9/14/2022, Employee B reported knowledge that "[Resident A] turned over a bag of medication the [authorized representative] had brought into the facility despite being told several times not to do that". Employee B reported the facility handles all medication administration to include the refilling of prescriptions through the facility's long term care pharmacy. Resident A's authorized representative was provided education on multiple occasions about refilling prescriptions outside the facility and to not bring the medications into the facility. Employee B reported due to incident in July 2022, an emergency care conference was held with the authorized representative and Resident A's family to provide education again that the facility handles all medication administration in accordance with the physician orders. Resident A's family agreed and the authorized representative finally agreed to abide by the facility medication administration policy and procedures. Employee B reported the facility was in consistent communication with Resident A's physician, monitored Resident A for any adverse symptoms, and staff completed frequent check-ins with

Resident A when the authorized representative visited to ensure no medication was being administered to Resident A by the authorized representative.

On 9/14/2022, Employee C's statements are consistent with Ms. Hollomon's, Employee A's, and Employee B's statements.

On 9/20/2022, I reviewed Resident A's admission contract which revealed Resident A's authorized representative signed and dated the contract on 7/12/2022 in agreement the facility would handle all of Resident A's medication administration to include the refilling of prescriptions through the facility's long term care pharmacy.

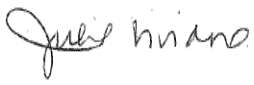
I reviewed Resident A's service plan which revealed that staff provides all medication administration.

I also reviewed Resident A's physician orders and medication administration record (MAR) which revealed staff provided medication administration in accordance with the physician orders.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.
ANALYSIS:	It was alleged staff did not provide Resident A medication administration in accordance with physician orders. There is evidence to support Resident A's authorized representative violated Resident A's admission contract and service plan by providing medications to Resident A to self-administer, despite the facility providing the authorized representative education and advisement not to. The facility took good measures to protect and to ensure Resident A's medication was administered in accordance with physician orders. There is no evidence to support the allegation the facility did not provide Resident A appropriate medication administration. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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



9/20/2022

Julie Viviano Date
Licensing Staff

Approved By:

10/06/2022

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