GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 24, 2022

Anne Kesler
Country Woods Assisted Living, LLC
8504 Doe Pass
Lansing, MI 48917

RE: License #: AM230388695
Investigation #: 2022A0783052
Country Woods Assisted Living

Dear Ms. Kesler:

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) 284-9730.

Sincerely,

Leslie Herrguth, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 256-2181

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AM230388695 |
| | |
| **Investigation #:** | 2022A0783052 |
| | |
| **Complaint Receipt Date:** | 07/05/2022 |
| | |
| **Investigation Initiation Date:** | 07/07/2022 |
| | |
| **Report Due Date:** | 09/03/2022 |
| | |
| **Licensee Name:** | Country Woods Assisted Living, LLC |
| | |
| **Licensee Address:** | 8504 Doe Pass<br>Lansing, MI 48917 |
| | |
| **Licensee Telephone #:** | (517) 224-8300 |
| | |
| **Administrator:** | Anne Kesler |
| | |
| **Licensee Designee:** | Anne Kesler |
| | |
| **Name of Facility:** | Country Woods Assisted Living |
| | |
| **Facility Address:** | 7021 Hartel Road<br>Potterville, MI 48876 |
| | |
| **Facility Telephone #:** | (517) 224-8300 |
| | |
| **Original Issuance Date:** | 08/27/2019 |
| | |
| License **Status:** | REGULAR |
| | |
| **Effective Date:** | 02/27/2022 |
| | |
| **Expiration Date:** | 02/26/2024 |
| | |
| **Capacity:** | 12 |
| | |
| **Program Type:** | AGED<br>ALZHEIMERS |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Licensee designee Anne Kesler refused to accept Resident A back at the facility upon discharge from the hospital. | No |
| Additional Findings | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 07/05/2022 | Special Investigation Intake - 2022A0783052 |
| 07/07/2022 | Special Investigation Initiated - Telephone call with complainant |
| 07/13/2022 | Inspection Completed On-site |
| 07/13/2022 | Contact - Face to Face interviews with Resident A and direct care staff members Ronda Ballman and Holden Miller |
| 07/13/2022 | Contact - Telephone call made to licensee designee Anne Kesler |
| 07/13/2022 | Contact - Document Received - Resident A's resident record |
| 08/23/2022 | Exit Conference with Anne Kesler |

**ALLEGATION:**

**Licensee designee Anne Kesler refused to accept Resident A back at the facility upon discharge from the hospital.**

**INVESTIGATION:**

On July 5, 2022, I received a complaint from a representative from adult protective services that stated on July 2, 2022, Resident A was taken to the hospital via ambulance to be evaluated for a fall. The written complaint stated as of July 5, 2022, 3Resident A was medically cleared for discharge from the hospital but had nowhere to go. The written complaint stated licensee designee Anne Kesler refused to allow Resident A to return to the facility via ambulance. The written complaint stated Ms. Kesler reported that the facility staff members cannot provide the level of care Resident A required.

On July 7, 2022, I spoke to assigned APS investigator Carol Stahl who said Resident A frequently gets out of bed, the chair, the toilet, etc. without waiting for assistance from a staff member and then falls. Ms. Stahl said Resident A has been hospitalized multiple times since being admitted to the facility due to falling. Ms. Stahl stated Resident A was most recently hospitalized from July 2, 2022, to July 5, 2022. Ms. Stahl said Resident A was discharged from the hospital and returned to the facility on July 5, 2022. Ms. Stahl said stated prior to Resident A's discharge from the hospital there were conversations between hospital discharge planners and licensee designee Anne Kesler wherein Ms. Kesler relayed that Resident A could not return to the facility without an order for a hospital bed with rails to address Resident A's falls and medication to address Resident A's anxiety. Ms. Stahl said ultimately Ms. Kesler allowed Resident A to return to the facility on July 5, 2022, with an order for a hospital bed with half rails. Ms. Stahl indicated Resident A was scheduled to be evaluated at the facility on July 7, 2022, by her assigned physician from Visiting Physicians Association (VPA).

On July 13, 2022, I spoke to licensee designee Anne Kesler who said Resident A was admitted on June 13, 2022. Ms. Kesler said upon admission Resident A was restless and experiencing anxiety related to the adjustment of moving into the facility. Ms. Kesler said Resident A was intrusively wandering into other residents' bedrooms, getting up without assistance and falling, yelling, and being physically aggressive with staff members. Ms. Kesler said she contacted Resident A's physician and was told that Resident A needed to be seen to receive a prescription for anti-anxiety medication or any assistive devices. Ms. Kesler said Resident A fell and was hospitalized from June 24, 2022 – June 27, 2022, and July 2, 2022 – July 5, 2022. Ms. Kesler said during that time Resident A was scheduled to be evaluated by a physician from VPA but could not be evaluated because she was in the hospital. Ms. Kesler said after the June 2022 hospitalization she attempted to have Resident A evaluated for hospice services but was told she did not provide enough information. Ms. Kesler said Resident A was hospitalized again on July 2, 2022, for falling and that the hospital discharge planner verbally relayed that Resident A was ready to be released from the hospital the same day without any assistive devices to address the falling and without a prescribed medication to address Resident A's anxiety. Ms. Kesler said she determined that she could not ensure Resident A's safety without a hospital bed with full rails and a prescription for medication to treat her anxiety and since the hospital staff members did not provide those things, she relayed that Resident A could not return to the facility. Ms. Kesler said she met with hospital officials in person on July 2, 2022 and explained Resident A's behaviors and fall history and also that Resident A could not be seen and evaluated by her physician until July 7, 2022. Ms. Kesler said on July 5, 2022, Resident A was released from the hospital and returned to the facility with an order for a hospital bed with half rails. Ms. Kesler said at the time of the interview Resident A was discharged from the hospital to the facility and had been evaluated by her primary care physician who recommended medication to assist Resident A with anxiety and insomnia but Resident A's designated representative refused to allow Resident A to

take the medication. Ms. Kesler stated Resident A's designated representative planned to discharge Resident A from the facility on July 13, 2022.

On July 13, 2022, I completed an unannounced onsite investigation at the facility and observed Resident A sitting in a recliner in the living room. I conversed with Resident A, but she was unwilling or unable to answer questions directly related to the allegation in the complaint.

On July 13, 2022, I interviewed home manager and direct care staff member Ronda Ballman who said Resident A was hospitalized three times in total since being admitted to the facility on June 13, 2022. Ms. Ballman said Resident A fell as many as six times in one day and that she fell regularly. Ms. Ballman said Resident A was hospitalized June 24, 2022 – July 1, 2022, and that Resident A returned to the hospital on July 2, 2022 – July 5, 2022. Ms. Ballman said when Resident A was hospitalized between July 2, 2022 and July 5, 2022, the hospital discharge planner verbally discussed discharging Resident A from the hospital and that she was told to tell them that Resident A could not return to the facility without proper equipment to address the falling. Ms. Ballman said ultimately the hospital released Resident A on July 5, 2022, and a hospital bed with half rails was ordered and delivered to help keep Resident A from falling out of bed.

On July 13, 2022, I spoke to direct care staff member Holden Miller who said Resident A fell out of bed, out of the recliner, and off the toilet several times at the facility which is why she was sent to the hospital via ambulance on three separate occasions since being admitted to the facility in late June 2022. Ms. Miller said Resident A was most recently hospitalized on July 2, 2022, due to falling and that Resident A was released two to three days later with a hospital bed with half rails. Ms. Miller said staff members were directed to refer any hospital telephone calls to Ms. Ballman or Ms. Kesler because Resident A could not return to the facility without a hospital bed to keep her safe.

On July 13, 2022, I received written *Charting Notes* for Resident A from June 16, 2022 – July 13, 2022. I noted that the notes documented that Resident A fell on June 21, 2022, June 22, 2022 (five to six times that day), June 24, 2022, June 23, 2022, and July 2, 2022. I noted that many of the documented falls occurred when Resident A got out of bed without assistance.

On July 13, 2022, I reviewed *After Visit Summaries* for Resident A indicating that she was hospitalized from June 24, 2022 – July 1, 2022 and July 2, 2022 – July 5, 2022. Neither *After Visit Summary* indicated that Resident A was abandoned or could not return to the facility upon discharge from the hospital.

| APPLICABLE RULE | |
|---|---|
| **R 400.14302** | **Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.** |
| | **(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident:**<br>**(b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge. If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply:**<br>**(i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.** |
| **ANALYSIS:** | Based on statements from Ms. Stahl, Ms. Kesler, Ms. Ballman, and Ms. Miller along with my observations at the onsite investigation and written documentation at the facility I determined that Resident A did have multiple falls while at the facility for which she was hospitalized on at least two occasions. I determined that Resident A was formally discharged from the hospital on July 5, 2022, at which time she returned to the facility. Though the hospital discharge planner may have verbally notified Ms. Kesler that Resident A was to be discharged from the hospital sometime before July 5, 2022, the written documentation did not reflect that. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ADDITIONAL FINDING:**

**INVESTIGATION:**

On July 13, 2022, I spoke to licensee designee Anne Kesler and facility direct care staff members Ronda Ballman and Holden Miller and all of them stated that Resident A was admitted to the facility with just a cane and no additional assistive

devices to help her ambulate. Ms. Kesler, Ms. Ballman and Ms. Miller stated because Resident A could not be evaluated by her assigned physician at VPA due to being in the hospital and the fact VPA only came to the facility weekly, and she was falling repeatedly, a facility staff member took a walker from storage and gave it to Resident A to use.

On July 13, 2022, I reviewed Resident A's entire resident record and did not note a written physician's order authorizing the use of a walker for Resident A. I noted that Resident A's written *Health Care Appraisal* dated June 23, 2022, indicated Resident A was fully ambulatory and did not authorize any assistive devices for Resident A.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14306** | **Use of assistive devices.** |
| | **(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization.** |
| **ANALYSIS:** | Based on statements from Ms. Kesler, Ms. Ballman, and Ms. Miller along with my observations at the onsite investigation and written documentation at the facility, I determined that the walker Resident A was using was not authorized in writing by a licensed physician. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

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

Leslie Herrguth 08/23/2022

Leslie Herrguth Date
Licensing Consultant

Approved By:

Dawn Timm 08/24/2022

Dawn N. Timm Date
Area Manager