GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 9, 2022

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

RE: License #: AH410391902
Investigation #: 2022A1028017
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 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 #:	AH410391902
Investigation #:	2022A1028017
Complaint Receipt Date:	12/06/2021
Investigation Initiation Date:	12/07/2021
Report Due Date:	02/05/2022
Licensee Name:	Pathway Operations Kentwood, LLC
Licensee Address:	4352 Breton Road SE, Kentwood, MI 49512
Licensee Telephone #:	(312) 837-0704
Administrator:	Selma Alesevic
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:	11/11/2020
Expiration Date:	11/10/2021
Capacity:	103
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The admission TB test was administered wrong resulting in Resident incurring a lesion.	Yes
Resident A did not receive showers in accordance with the service plan.	Yes
Resident A's bedding is not clean.	Yes
Resident A was served cold hot dogs on several occasions.	No
Additional Findings	Yes

III. METHODOLOGY

12/06/2021	Special Investigation Intake 2022A1028017
12/07/2021	Special Investigation Initiated - Letter 2022A1028017
12/07/2021	APS Referral APS referral emailed to Centralized Intake
12/29/2021	Inspection Completed On-site 2022A1028017
12/29/2021	Contact - Face to Face Interviewed Administrator, Jenny Bishop, at the facility.
12/30/2021	Contact - Document Received Received Resident A's service plan and record from Admin/Jenny Bishop.
01/19/2021	Contact – Telephone call made Interviewed the complainant by telephone
11/9/2022	Exit – Report emailed to AR/Jeffrey Floyd and Admin/Selma Alesevic. Voicemail also left for Ms. Alesevic requesting return phone call if needed. No phone number available for Mr. Floyd.

ALLEGATION:

The admission skin TB test was administered wrong resulting in Resident incurring a lesion.

INVESTIGATION:

On 12/7/2021, the Bureau received the allegations from the online complaint system.

On 12/7/21, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 12/29/21, I interviewed administrator, Jenny Bishop, at the facility. Ms. Bishop reported Resident A was no longer at the facility but was given a tuberculosis test (TB) upon admission at the facility. Resident A had an adverse reaction to the test and was subsequently sent to the physician for treatment due to the reaction. Ms. Bishop reported staff followed the physician orders for treatment. Ms. Bishop also reported the care staff coordinator, Kathy Busalacchi, who assisted Resident A with the initial TB test and subsequent treatment is no longer employed at the facility. Ms. Bishop provided me Resident A's medication administration record with available notes for my review.

On 12/30/21, I reviewed Resident A's record with notes which revealed Resident A admission date was 9/8 and Resident A was administered a TB skin test on 9/9. Resident A was later assessed and treated with a topical ointment and Tylenol on 9/21 for a developing lesion from a possible adverse reaction to the TB skin test that occurred on 9/9. Resident A was reassessed and treated again on 9/28 and 10/7 at follow-up visits with Careline physicians due to Resident A's continued skin irritation. It was also documented that Resident A has a separate occurrence of skin cancer requiring treatment as well.

Review of Resident A's medication administration record revealed the facility provided Resident A treatment and care consistent with physician orders.

On 1/19/22, I interviewed the complainant by telephone. The complainant reported Resident A was administered the TB skin test on 9/9, the day after Resident A moved into the facility. Resident A did not have a chest x-ray or evidence of a TB skin test prior to admission to the facility. The complainant reported Resident A later developed a lesion on the right forearm near or at the TB skin test site resulting in further treatment from a dermatology specialist. The complainant reported "I feel the staff did not address the lesion effectively and did not follow the doctor orders with the ointment due to it worsening over time".

As of 1/20/22, I have been unsuccessful in making contact to interview former care staff coordinator Kathy Busalacchi.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(7) An individual admitted to residence in the home shall have evidence of tuberculosis screening on record in the home which consists of an intradermal skin test, chest x-ray, or other methods recommended by the local health authority performed within 12 months before admission.
ANALYSIS:	Resident A received a TB skin test resulting in an adverse reaction. A lesion with irritation later formed near the TB skin test site. However, Resident A has a separate documented history of skin cancer, and it cannot be determined if the lesion formed as a result of an adverse reaction from the TB skin test or if it is a result of skin cancer. While it is very unfortunate Resident developed a lesion requiring further treatment, the facility ensured Resident A was assessed, monitored, and treated on 9/21, 928, and 10/7 by the facility physicians. The facility also demonstrated care and medication administration consistent with the physician orders. However, Resident A's admission date is 9/8 and the TB test was administered by the facility staff on 9/9, after Resident A's admittance to the facility. A resident admitted to the facility must have evidence of negative TB test within 12 months prior to admission. Resident A was admitted to the facility without evidence of a prior TB test.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[Reference Special Investigation Report (SIR) # 2021A1021017 dated 02/23/2021]**

ALLEGATION:

Resident A did not receive showers in accordance with the service plan.

INVESTIGATION:

On 12/29/21, Ms. Bishop reported Resident A was to receive showers at least two times weekly but could request extra as desired. Ms. Bishop reported Resident was very resistant to care and staff assist and would often refuse showers. Ms. Bishop provided me Resident A's service plan and record notes for my review.

On 12/30/21, I reviewed Resident A's service plan which revealed the following:

- Resident A had severe hearing loss and refused to wear hearing aids.
- Resident A demonstrated cognitive decline, requiring prompting as needed.
- Resident A required oxygen and would refuse to use it in the dining room.
- Resident A required one to two person assist with all care, transfers, and ambulated using a walker.
- Resident A is resistant to care planned within the service plan.

Review of the record notes revealed no evidence of refusal of showers by Resident A.

On 1/19/22, the complainant reported Resident A was resistant to care at first, as "[Resident A] was very set in [their] ways". The complainant reported with encouragement from family, Resident A became agreeable to assist from care staff with showers. The complainant reported Resident A had a total of four showers from 9/8 to 11/16. The complainant reported speaking with resident care coordinator about being consistent with days and times for Resident 's showers, stating "We agreed to Mondays and Thursdays or Tuesdays and Fridays at 10:30am. I didn't really care what days [Resident A] got them, as long as [Resident A] knew when to expect them and was provided the showers set forth in the care plan". The complainant confirmed Resident A did refuse showers "to my knowledge, possibly three times total in the first two weeks of stay, but the aides just stop coming altogether and no longer asked [Resident A] to shower". The complainant reported family would assist when they could with grooming and showers, felt "the aides left it up to the family and just stop providing showers".

APPLICABLE RULE	
R 325.1933	**Personal care of residents.**
	(2) A home shall afford a resident the opportunity and instructions when necessary for daily bathing, oral and personal hygiene, daily shaving, and hand washing before meals. A home shall ensure that a resident bathes at least weekly and more often if necessary.

ANALYSIS:	Resident A requires one person assist with showers. It was reported Resident A was resistant to assistance with showers and often refused showers. However, there is no evidence in Resident A's record of refusal of showers. There is evidence Resident A did not receive showers in a timely manner and/or did not receive showers in accordance with the service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A's bedding is not clean.

INVESTIGATION:

On 12/29/21, Ms. Bishop reported bedding is changed one to two times per week by housekeeping staff or as needed if a resident has an accident or illness. Ms. Bishop reported since housekeeping is short staffed, care staff are also assisting with the changing of bedding.

On 12/29/21, I completed an onsite inspection of the facility which revealed eight resident rooms with dirty or soiled bedding. I was unable to inspect Resident A's room due to Resident A no longer residing at the facility.

On 12/30/21, I reviewed Resident A's service plan which revealed the changing of bedding would occur one time per week.

I reviewed the record notes which revealed on 9/22 Resident A refused to let care staff change the bedding.

On 1/19/22, the complainant reported Resident A's bedding was not changed in timely manner and "family would change the sheets so [Resident A] would have clean sheets." The complainant reported care staff did not assist Resident A with the changing of sheets unless asked and "even then it still didn't happen as routinely as it should have".

APPLICABLE RULE	
R 325.1935	**Bedding, linens, and clothing.**
	(1) Bedding shall be washable, in good condition, and clean, and shall be changed at least weekly or more often as required.
ANALYSIS:	Review of Resident A's service plan reveal Resident A's bedding was to be changed one time per week, but there is evidence this did not occur in accordance with the service plan. Onsite inspection revealed eight resident rooms with dirty, stained, or soiled bedding on the bed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A's laundry is not laundered within a timely manner.

INVESTIGATION:

On 12/29/21, Ms. Bishop reported the housekeeping department has been short staffed due to Covid-19. Care staff are currently assisting with the laundry**,** "primarily third shift staff, but all are required to assist as needed". Ms. Bishop reported it is taking longer to complete laundry due to the department being short staffed, but no longer than 24 hours later.

On 12/29/21, I completed an onsite inspection of the facility which revealed an overabundance of dirty laundry and linen piles in resident rooms and in the west hallway laundry room. Five residents were also observed wearing dirty and/or stained clothing.

On 12/30/21, I reviewed Resident A's service plan which revealed laundry would be completed by the facility once a week.

On 1/19/22, the complainant reported Resident A's laundry was not laundered in a timely manner and several items disappeared as well. The complainant reported "laundry would sit for well over a week unless family did it". The complainant reported "family ended up doing the laundry to be sure [Resident A] had clean clothes".

APPLICABLE RULE	
R 325.1935	**Bedding, linens, and clothing.**
	(3) The home shall make adequate provision for the laundering of a resident's personal laundry.
ANALYSIS:	Review of Resident A's service plan, along with on-site inspection reveal that while laundry services are provided by the facility, the services are not being completed in a timely manner to ensure residents have clean clothing and linens.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A was served cold hot dogs on several occasions.

INVESTIGATION:

On 12/29/21, Ms. Bishop reported hot dogs and hamburgers were served to residents as a meal "maybe during the summer but not recently". Ms. Bishop reported alternative meals are always offered as well if a resident does not like the main entrée. Ms. Bishop reported no knowledge of food being served cold or of complaints about the menu.

On 12/29/21, I completed an onsite inspection of the kitchen which revealed chicken and rice and/or turkey sandwiches with two choices of a side, dessert and a beverage were being served for lunch that day.

On 1/19/22, the complainant reported Resident A received cold hot dogs with no side dishes, no alternative meals offered, and no condiments for the hot dogs. The complainant reported this occurred on several occasions but did not have the specific dates, just that Resident A complained about it several times.

APPLICABLE RULE	
R 325.1952	**Meals and special diets.**
	(5) A home shall prepare and serve meals in an appetizing manner.

ANALYSIS:	During the onsite inspection, the facility kitchen staff prepared and served meals in an appetizing manner. An alternative meal was also offered for residents who did not like the entrée or who had a special diet.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

Additional Findings

On 12/29/21, The menus posted in the kitchen were from April 2021 and May 2021 and were not updated. When questioned about the menu dates, Ms. Bishop reported the menus are on a rotating six-week schedule. Ms. Bishop reported “Corporate develops the menus, and the PDF is locked so we cannot change the date or month on the menu”. The meal being served today, 12/29, did not match the menus posted in the kitchen.

APPLICABLE RULE	
R 325.1953	**Menus**
	(1) A home shall prepare and post the menu for regular and therapeutic or special diets for the current week. Changes shall be written on the planned menu to show the menu actually served.
ANALYSIS:	Onsite inspection along with review of posted menus revealed the meal being served for lunch on 12/29 did not match the posted menu. Also, the posted menus were more than six months outdated.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[Reference Special Investigation Report (SIR) # 2021A1010042 dated 8/17/21]**

IV. RECOMMENDATION

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

Julie Viviano

1/20/2022

Julie Viviano Date
Licensing Staff

Approved By:

Andrea L. Moore

11/02/2022

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