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 #: 2022A1028020
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 that 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 #:	2022A1028020
Complaint Receipt Date:	12/16/2021
Investigation Initiation Date:	12/16/2021
Report Due Date:	02/15/2022
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?
Employee A posted a demeaning text about Resident A to the facility group text and to social media.	Yes
Resident B sat in feces for several hours.	Yes
Care staff did not administer medications correctly to residents.	Yes

III. METHODOLOGY

12/16/2021	Special Investigation Intake 2022A1028020
12/16/2021	Special Investigation Initiated - Letter 2022A1028020 - APS referral emailed to Centralized Intake
12/16/2021	APS Referral 2022A1028020 - APS referral emailed to Centralized Intake
12/29/2021	Inspection Completed On-site 2022A1028020
12/29/2021	Contact - Face to Face Interviewed Administrator, Jenny Bishop, at the facility.
12/29/2021	Contact - Face to Face Interviewed Resident C at the facility.
12/29/2021	Contact – Face to Face Interviewed Resident D at the facility.
01/20/2022	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:

Employee A posted a demeaning text about Resident A to the facility group text and to social media.

INVESTIGATION:

On 12/16/2021, the Bureau received the allegations from the online complaint system.

On 12/16/21, 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 the facility has a group text on the facility cellphones that is to be used for facility related information only such picking up shifts, call-ins, or resident care information. Ms. Bishop reported it was brought to her attention in November 2021 that Employee A texted an inappropriate message to the facility group text with Employee B responding to the text message. The message was identified Resident A by first name and was demeaning about Resident A. Ms. Bishop reported she later heard it was posted to Facebook but was unable to find the post on Facebook. Ms. Bishop reported everyone on the facility group text was provided education on resident rights and respect and the use of appropriate social media. Ms. Bishop reported Employee A and Employee B were provided additional training. Ms. Bishop provided me screenshots of the facility group text with the demeaning message. Ms. Bishop was unable to provide me evidence of staff training and Employee A's and Employee B's additional training in relation to this incident. Ms. Bishop reported former care staff coordinator Kathy Busalucchi and former memory care director Emily Vandenbos were also involved with this incident but are no longer employed at the facility.

On 12/29/21, I interviewed Resident C at the facility. Resident C reported care staff are often on their personal phones and have personal conversations during care routines. Resident C stated, "I have to ask them to put their phone down because they don't pay attention when helping me because they are too busy laughing and having personal conversations on their phones right in front of me".

On 12/29/21, I interviewed Resident D at the facility. Resident D's statements are consistent with Resident C's statement about care staff having personal conversations on their phones and being on their phones during care routines.

On 1/20/22, I interviewed the complainant by telephone. The complainant reported this inappropriate text was brought to Kathy Busalucchi's attention and Ms. Bishop's attention and "nothing was really done to correct it. There was no follow-up or training about this incident and how inappropriate it was." The complainant reported Employee A posted the demeaning text to Facebook as well and has a history of

making comments about residents using identifying information on social media. The complainant provided supportive evidence of incident to me.

As of 1/20/22, I have been unsuccessful in making contact with former care staff coordinator Kathy Busalucchi and former memory care director Emily Vandenbos.

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:	An inappropriate and demeaning text about Resident A was sent to the facility group text on 11/14 by Employee A. This incident was brought to management's attention with Ms. Bishop reporting education was provided to all staff on resident rights and respect and the use of appropriate social media. However, there is no evidence that any training or education took place as a corrective action concerning this incident. This incident was very unfortunate and inappropriate. The facility did not provide Resident A protection and did not take appropriate corrective measures to ensure an incident of this nature and/or employee behaviors of this nature does not occur again.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[Reference Special Investigation Report (SIR) # 2022A1028006 dated 11/08/2021, SIR 2021A1026009 dated 02/01/2021, and SIR 2021A1026002 dated 01/04/2021]**

ALLEGATION:

Resident B sat in feces for several hours.

INVESTIGATION:

On 12/29/21, Ms. Bishop reported Resident B is no longer at the facility, but that Resident B required assist with toileting. Ms. Bishop reported Resident B was an

alcoholic and the family was caught giving Resident B homemade marijuana pills. Ms. Bishop reported Resident B was discharged due to smoking Ms. Bishop provided me Resident B's and Resident C's service plan and record notes for my review.

On 12/29/21, I interviewed Resident C at the facility. Resident C reported care staff do not come when the call light pendent is pushed. Resident C states it "may be two hours or more for an aide to come help or they just don't come at all. I need help with showers, and I often do not get it in a timely manner or not at all sometimes." Resident C reported needing assistance with toileting but was left waiting for over an hour several times before care staff arrived to help. Resident C reported the only time staff come to the room is when it is mealtime. Resident C reported [they] do not receive the care they require in a timely manner or at all. Resident C reported concerns to [Ms. Busalucchi] in October and again in November 2021 but reported "little improvement has been made."

On 12/29/21, I interviewed Resident D at the facility. Resident D's statements are consistent with Resident C's statement about resident care provided by care staff.

On 12/30/21, I reviewed Resident B's service plan which revealed Resident B demonstrates daily confusion requiring consistent prompting. Resident B required assist with toileting and is incontinent. Resident B was to be toileted before and after meals and before bed. Resident B was allowed to smoke with staff assist in the designated area.

On 1/20/22, I interviewed the complaint by telephone. The complainant reported Resident B was left to sit in feces by a third shift employee. Resident B was discovered sitting in feces by a family member during a visit on first shift. The complainant reported the third shift staff knew Resident B required assist and left the building and went home instead. The complainant provided me evidence to support this incident.

As of 1/20/22, I have been unsuccessful in making contact with Resident B and [their] authorized representative.

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:	Resident B required assist with toileting and is incontinent. Resident B was left to sit in feces for several hours by care staff. There is significant evidence Resident B's personal needs, protection, and safety were not met and that care staff did not provide Resident B care consistent with the service plan.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[Reference Special Investigation Report (SIR) # 2021A1021017 dated 02/23/2021 and 2021A1010043 dated 08/11/2021]**

ALLEGATION:

Care staff did not administer medications correctly to residents.

INVESTIGATION:

On 12/29/21, Ms. Bishop reported there have been medication errors reported by care staff and found through chart audits as well. Ms. Bishop reported all medication errors were reported to the department and care staff were re-educated and re-trained on medication administration by Ms. Busalucchi. Ms. Bishop provided me copies of the medication error incident reports along with Resident C's medication administration record.

On 12/29/21, Resident C reported [their] bedtime medications are taken every night at 10:30pm and [they] often have to call staff to administer the medications. "I stay up to make sure the aides will bring me my medications on time and so I don't miss medications". Resident C reported care staff have tried to administer the medications more than two hours before the correct time administration and medications have been more than two hours late in administration. Resident C reported some of the medications ran out recently and it was days before they were refilled, despite Resident C informing care staff and Ms. Busaluchhi that the prescriptions needed to be filled. Resident C also reported [they] require assistance with the checking of blood sugar several times a day and care staff does not assist with this as often as required.

On 12/29/21, Resident D's statements are consistent with Resident C's statements. Resident D reported experiencing late medication administration, medications not being refilled in a timely manner, and missed medication administration.

On 12/30/21, I reviewed Resident C's medication administration record along with the medication error incident reports. Resident C's MAR review revealed:

- Resident C requires multiple daily blood sugar checks.

- Resident C refused MiraLAX on 10/8 and the physician was notified. No other refusals of medication noted.
- MAR is incomplete for tracking of fasting blood sugars for October 2021.
- Resident C is to take one tablet of Norvasc 10mg every night at bedtime. The MAR is complete for 11/13, 11/19, 11/20, 11/21, 11/22, 11/23, 11/27, and 11/29.
- Resident C is to take one tablet of Buspirone 15mg four times daily. The MAR is incomplete for the 6am, 11am, and 4pm administration time on 11/12. On 11/18, 11/19, and 11/20, the 11am, 4pm, and 7pm administration time is incomplete. On 12/24, the 6am, 11am, and 4pm administration time is incomplete. On 12/25, the 11am and 4pm administration time is incomplete. On 12/26, the 7pm administration time is incomplete.
- Resident C is to use on Salonpas pain patch daily on the right shoulder. The MAR is incomplete for November 2021.
- Resident C is to take one tablet of Metformin 500mgby mouth daily. The 11/12, 11/17, and 11/24 administration is incomplete.

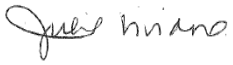
Review of the medication administration error incident reports reveal missed medication for Resident E and Resident F on 12/13. The incident reports noted *"Staff will be re-educated on the medication administration process and possibly disciplined for failure to follow process".*

On 1/20/22, the complainant reported multiple medication errors brought to management's attention over the last several months to include the MAR's not being completed correctly and "some records were backdated". The complainant reported Ms. Busalucchi was aware of the errors and "did not provide any more training to correct the issues."

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:	Review of Resident C's medication administration record along with review of the medication error incident reports revealed significant medication errors among different residents. Care staff are not administering resident medications correctly or in accordance with the service plans.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



1/20/2022

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Julie Viviano Date
Licensing Staff

Approved By:

11/02/2022

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