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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 #: 2022A1028022
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 #:	2022A1028022
Complaint Receipt Date:	12/27/2021
Investigation Initiation Date:	12/29/2021
Report Due Date:	02/27/2022
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?
Dirty colostomy bags were found in Resident A's kitchenette cupboards and hanging in the closet.	Yes
The facility is short staffed to meet the needs of residents.	Yes
Industrial cleaners are kept in Resident B's room.	Yes

III. METHODOLOGY

12/27/2021	Special Investigation Intake 2022A1028022
12/29/2021	Special Investigation Initiated - Letter 2022A1028022 - APS referral emailed to Centralized Intake
12/29/2021	APS Referral 2022A1028022 - APS referral emailed to Centralized Intake
12/29/2021	Inspection Completed On-site 2022A1028022 - Onsite inspection completed
12/29/2021	Contact - Face to Face Interviewed Admin/Jenny Bishop at the facility
12/29/2021	Contact - Face to Face Interviewed Resident A at the facility
12/29/2021	Contact - Face to Face Interviewed Resident B at the facility.
12/29/2021	Contact - Telephone call made Interviewed Resident C at the facility
01/21/2022	Contact - Telephone call made Interviewed the complainant by telephone
01/24/2022	Contact - Telephone call made Interviewed Resident A's authorized representative 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:

Dirty colostomy bags were found in Resident A's kitchenette cupboards and hanging in the closet.

INVESTIGATION:

On 12/26/21, the Bureau received the allegations from the online complaint system.

On 12/26/21, 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 has Parkinson's with increasing confusion. Ms. Bishop confirmed Resident A was found with dirty colostomy bags hanging in the closet, in the kitchenette area, and in the cabinets next to food. Ms. Bishop reported Resident A often refuses to allow staff to assist with toileting and will not allow staff to clean the room. Ms. Bishop reported Resident A received home health services for the care of the colostomy bags but is unsure if Resident A is still receiving home health services. Ms. Bishop reported she reached out to Resident A's authorized representative several times for assistance with cleaning the room and for care of the colostomy bags, but the authorized representative "has not been cooperative with collaborating care for [Resident A]".

On 12/29/21, I interviewed Resident A at the facility. Resident A reported "I know my room needs to be cleaned. I cleaned it some yesterday". When questioned about home health services assisting Resident A with the colostomy bags, Resident A replied, "they were nice girls but don't come to help anymore".

I inspected Resident A's room during the interview and found the following:

- Resident A's room was very dirty.
- Carpet and bedding were soiled with dirt and what appears to be feces.
- The kitchenette was dirty with food left opened on the counter, dirty utensils and plates in the sink, and the counters were dirty.
- The bathroom was dirty and had feces on the floor.
- There was a used colostomy bag in the bathroom sink.
- There was a used colostomy bag on the living room floor beside Resident A's recliner.

On 12/30/22, I reviewed Resident A's service plan. The review revealed the following:

- The service plan is dated 4/23/21.
- Resident A requires assistance with all care due to Parkinson's diagnosis and bipolar disorder.
- Resident A has history of falls and requires assistance with showering.
- Resident is incontinent and "*has a colostomy and is independent in its management".*
- Resident A requires reminders to use walker.

On 1/21/22, I interviewed the complainant by telephone. The complainant reported dirty colostomy bags were found hanging in Resident A's closet, in the kitchenette area of Resident A's room, and in the bathroom. The complainant reported Resident A's authorized representative was aware that Resident A refused to initially allow care staff to clean the room. The complainant reported Resident A eventually allowed care staff to clean due to the multiple dirty colostomy bags that were found. The complainant reported Resident A was receiving home health services at one time to address the colostomy bags but is unsure if Resident A is still receiving those services.

On 1/24/22, I interviewed Resident A's authorized representative by telephone who reported Resident A has refused assistance with the colostomy bag previously but has been encouraged to allow staff to assist. Resident A was also encouraged to allow staff to assist with the cleaning of the room. The authorized representative reported [they] signed a new service plan for a higher-level care in December 2021 with Ms. Busalucchi in which facility care staff would assist and monitor Resident A's colostomy bag due to home health services are no longer assisting Resident A. The authorized representative reported they initiated a new level of care for Resident A because there was no communication from the facility until [they] reached out to the facility after speaking with Resident A by telephone.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.

ANALYSIS:	Onsite inspection revealed Resident A's carpet, bathroom, and room were soiled. Dirty colostomy bags were found in the bathroom and next to Resident A's recliner in the living room. Per the authorized representative, a new service plan was signed in December 2021 to include staff assistance with colostomy care for Resident A. However, the service plan is last dated 4/23/21. There is no evidence the service plan was updated to reflect this change or that Resident A's needs are being appropriately met in accordance with the service plan.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[Reference Special Investigation Report (SIR) # 2021A1021017 dated 02/23/2021]**

ALLEGATION:

The facility is short staffed to meet the needs of residents.

INVESTIGATION:

On 12/29/21, Ms. Bishop reported the facility has been short staffed in the past, but the facility currently has a 1:8 staff to resident ratio. Ms. Bishop reported there are three to four care staff plus a supervisor for the 7am to 7pm shift and 7pm to 7am shift. Ms. Bishop reported due to the low resident census, the facility has more than enough employees and are not currently short staffed. Ms. Bishop provided me a copy of the working staff schedule from September 2021 to December 2021 for my review. I requested copies of the call light log from September 2021 to December 2021, but Ms, Bishop was unable to provide those. Ms. Bishop reported it was brought to her attention that care staff were sleeping in the model rooms and leaving the building during the night shift. Ms. Bishop reported Ms. Busalucchi completed "pop-ins on the night shift but did not report that anything was ever found".

On 12/29/21, Resident A reported staff will assist with care, but "don't always come when the cord is pulled, and the supervisor is never here. She left. Staff leaves the building at night too."

On 12/29/21, I interviewed Resident B at the facility. Resident B reported care staff "do not always come in a timely manner when the call light is pulled and sometimes do not come at all no matter how many times, I push the pendant". Resident B reported waiting more than three hours for a care staff to arrive to assist with a shower on different occasions. Resident B also reported third shift does not have a supervisor and care staff do not answer the call light pendants because they leave

the building for hours at time. Resident B reported informing former resident care coordinator, Ms. Busalucchi of the issues with care staff and “it was swept under the rug. Staff are not trained, they leave the building all hours of the night without telling anyone, and they are short staffed”. Resident C also reported care staff have been caught sleeping in the model rooms during their shifts.

On 12/29/21, I interviewed Resident C. Resident C reported seeing care staff only at mealtimes and medication administration time. Resident C reported, “I don’t know why I even push the pendant, they don’t come and if they do, it’s hours later”. Resident C reported waiting more than four hours for a shower after the pushing the pendant. Resident C reported there is no supervisor on third shift and care staff leave the building for hours at time during the night. Resident C reported [they] brought their concerns to Ms. Bishop and Ms. Busalucchi, but “I don’t think any of it has improved.”

On 12/30/21, I reviewed the working staff schedule for September 2021 to December 2021. This review revealed two to three full aides and a care staff lead scheduled for each shift. There were multiple call-ins between September 2021 to December 2021 for both shifts but care staff filled in the shift shortages.

On 1/21/22, I interviewed the complainant by telephone. The complainant reported the facility is not short staffed only due to the low census of residents. However, care staff have been caught sleeping in the model rooms during second and third shift. Personal items belonging to a care staff member were also found in bedding of the model room. The complainant reported hearing third shift staff were leaving the building during their shift and returning hours later. The complainant reported Ms. Busalucchi would arrive to the facility early in the morning, but not in the middle of the night shift and unsure if it was due to reports of staff leaving on the night shift or staff sleeping in the model rooms.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.

ANALYSIS:	Due to the current census of residents, the facility is adequately staffed for the day and night shift. However, there is evidence night shift staff have left the building during their shift and that staff are not fully awake during the night shift to provide consistent care or to answer call lights in a timely manner for the residents in accordance with the service plans.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[Reference Special Investigation Report (SIR) # 2021A1021017 dated 02/23/2021 and 2021A1010043 dated 08/11/2021]**

ALLEGATION:

Industrial cleaners are kept in Resident B's room.

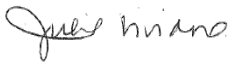
INVESTIGATION:

On 12/29/21, I completed an inspection of Resident B's room. There was an opened bottle of bleach on the floor of the room. When questioned, Resident B reported it is for laundry and to clean the room with.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(3) Hazardous and toxic materials shall be stored in a safe manner.
ANALYSIS:	The bleach bottle found in Resident B's room was easily accessible and presents a potential risk of ingestion and harm to Resident B and other residents in the home with impaired cognition and function.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



1/22/2022

Julie Viviano Date
Licensing Staff

Approved By:

11/02/2022

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