GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 15, 2022

Steven Steffey
Eley Acres Holdings LLC
1012 N. Leroy Street
Linden, MI 48430

RE: License #:	AH030379710
Investigation #:	2023A1021003
	Vicinia Gardens of Otsego

Dear Mr. Steffey:

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 authorized representative 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,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH030379710
Investigation #:	2023A1021003
Complaint Receipt Date:	10/11/2022
Investigation Initiation Date:	10/11/2022
Report Due Date:	12/10/2022
Licensee Name:	Eley Acres Holdings LLC
Licensee Address:	1012 N. Leroy Street Linden, MI 48430
Licensee Telephone #:	(810) 577-6928
Administrator:	Kelly Steffey
Authorized Representative:	Steven Steffey
Name of Facility:	Vicinia Gardens of Otsego
Facility Address:	700 Eley Street Otsego, MI 49078
Facility Telephone #:	(269) 350-0718
Original Issuance Date:	09/02/2016
License Status:	REGULAR
Effective Date:	03/02/2022
Expiration Date:	03/01/2023
Capacity:	56
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident B has frequent falls.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/11/2022	Special Investigation Intake 2023A1021003
10/11/2022	Special Investigation Initiated - Telephone interviewed AR by telephone
10/11/2022	APS Referral referral was sent from APS
10/17/2022	Contact - Document Received received chart documents
10/17/2022	Contact - Telephone call made interviewed SP1
10/17/2022	Contact - Telephone call made interviewed SP2
11/15/2022	Exit Conference Exit conference with authorized representative Steven Steffey

ALLEGATION:

Resident B has frequent falls.

INVESTIGATION:

On 10/11/22, the licensing department received a complaint with allegations Resident B has frequent falls at the facility. The complainant alleged that around 9/14/22, Resident B admitted to the facility and has fallen five times. The complainant alleged the facility only contacted Relative B1 after the fall on 9/29/22. The complainant alleged the family requested an X-ray to be completed but the facility only ordered physical therapy. The complainant alleged that on 10/9/22, Resident B was transferred to the hospital with diagnosis of a broken hip and urinary tract infection (UTI).

On 10/11/22, I interviewed facility owner Pamela Reese. Ms. Reese reported Resident B admitted to the memory care unit on 9/14/22. Ms. Reese reported Resident B has history of leg and back pain. Ms. Reese reported Resident B has fallen a few times at the facility and the facility has placed interventions such as increased checks and chair alarm. Ms. Reese reported on 9/29/22, Resident B fell and had no signs or symptoms of pain. Ms. Reese reported a few days after the fall, Resident B complained of pain and physical therapy was ordered. Ms. Reese reported a few days later the facility sent Resident B out for a medical evaluation due to pain. Ms. Reese reported Resident B is still at the hospital.

On 10/17/22, I interviewed staff person 1 (SP1) by telephone. SP1 reported Resident B had an unwitnessed fall on 9/21/22 on her shift. SP1 reported Resident B was unable to state why she fell but that she did fall on her hip. SP1 reported she left a message with Relative A1, and her supervisor was to contact Resident B's physician. SP1 reported she completed an incident report. SP1 reported after the fall, Resident B was complaining of pain and could not walk. SP1 reported there was no visible injuries only pain. SP1 reported a few days after the fall, the facility contacted the family for a prescription for pain medication as Resident B did not have any as needed pain medications. SP1 reported the facility tried to keep Resident B comfortable by re-adjusting her legs and placing her legs on pillows.

On 10/17/22, I interviewed SP2 by telephone. SP2 reported when a resident admits to the facility, they have the option to keep their physician or to switch to the facility physician which is affiliated with Careline group. SP2 reported when Resident B admitted to the facility, the facility did not have a physician on file. SP2 reported when Resident B fell on 9/16/22, the facility did not have a physician to contact. SP2 reported when Resident B fell on 9/21/22, the family was contacted but no physician was contacted. SP2 reported when Resident B fell on 9/29/22, the information was sent to Careline group. SP2 reported she contacted the nurse practitioner with Careline Group, Angela Coplin, to inform her of Resident B's fall and the family requesting X-rays to be done. SP2 reported Resident B had her first visit with Careline group on 10/3/22. SP2 reported Resident B was sent out to the hospital on 10/9/22 and had a partial hip replacement. SP2 reported when Resident B admitted to the facility, the family reported Resident B had chronic pain in her leg and hip.

I reviewed observation notes for Resident B. The notes read,

> *9/16: Resident was sitting in her room watching television upon arrival. Staff assisted her at meal time to join the other residents in the dining area. She consumed about 25% of her meal. Mainly consumed the salad but disregarded the pizza. Staff brought her snacks and soda to her room. Maintenance man found resident on the floor sitting due to her knees buckling when she started to stand up. Staff assisted in taking her vitals and standing her back up. Vitals were normal and no serious injury was committed. Staff made sure to fill out a incident report and it was turned into the clinical coordinator. Resident was medication complaint and nothing else to report at this time*.

9/21: Resident did have a fall today. Her hip is hurting her pretty bad. Her legs are elevated with a pillow under her left hip. Is needing help using restroom.

9/22: Resident had a hard time falling asleep as she stated that her left hip was in a lot of pain and she could hardly stand up or walk to use it. Did brief checks but was dry. Med compliant with no concerns to report at this time.

9/22: med compliant resident was not wanting to use bathroom today leg hurting from fall yesterday.

9/23: 2 person assist since recent fall. Needs prompting using toilet and needs assistance.

9/24: med compliant still having pain left leg.

9/25: Med compliant still not able to bear weight still says she is in a lot of pain very anxious today about wanting to leave not wanting to eat.

9/28: resident was tired and had hip pain.

9/29: when staff checked on her around 2am, she was laying down on the floor she said was attempting to go to bed.

9/29: med compliant resident had a fall after dinner unwitnessed family notified having lots of leg pain.

10/2: she was restless tonight she barely had any sleep tonight, her hip is still bothering her, I gave her Tylenol for the pain.

10/4: (Resident B) had a bad night she continue to slide out of her chair during the night about 4 times, she complained about being in pain.

10/5: called daughter at request of home care to grant permission for (Physical Therapy) that was ordered by NP. Daughter was more concerned about x-rays that she was wanting resident to have. Explained NP care plan to have PT done to help with discomfort in legs, knees, and hips. Also to have decrease falls. Daughter seemed disinterested in this plan but said she will try to call home care back.

10/7: she was in pain complaining about her hip I gave her couple Tylenol.

10/7: med compliant no issues came down to the dining room for breakfast today ate lunch in her room. Complaining about leg pain still.

10/8: med compliant refused dinner says she is in a lot of pain.

10/9: resident had a good night. Pressed pendent when needing to use the restroom. Was complaining of knee and hip pain. Med compliant with no other concerns to report at this time.

10/9: staff reported resident crying due to excruciating pain in leg/hip region. Resident was sent out by ambulance to go to the hospital for a check up. Family member reported to another staff aid in regards to the resident. She informed staff aide that residents hip is broken. Family is waiting to hear back on the report from the physician to see if surgery is needed. They may keep resident overnight. Resident is currently marked out of the facility in the system. Staff filled out an incident report and it's in the clinical coordinators mailbox."

I reviewed incident reports for the falls for Resident B. The report for 9/16/22, revealed Relative A1 was notified but no physician was notified. The narrative read,

"9/16: Maintenance man found resident sitting on the floor and heard noises passing by her room. Assessment was done by staff. Vitals taken and family notified. Will be switching from necklace pendent to wrist pendent."

There was no incident report for the fall on 9/21/22.

The incident report for the fall on 9/29/22 at 2:30am revealed Relative A1 was contacted at 10am and the physician was emailed. The narrative read,

"During resident check we went in her room and she was sleeping on the floor even though we left her in her chair. She said she fell when she was attempting to stand up and go to the bathroom. Vitals normal and range of motion normal. No injuries. Reminded her to us the pendent when she need help. Increase bathroom breaks. Increase resident checks to 1 hour."

The incident report for fall on 9/29 at 5 revealed Relative A1 was notified and no physician was notified. The narrative of the report read,

"Unwitnessed fall. Vitals ROM assisted to chair. Will discuss chair alarm? Discuss PT w/ family and NP to decrease falls."

I reviewed service plan for Resident B. The service plan revealed Resident B was supervision level with transfers, supervision for ambulation, 2hour toileting assistance.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to**

	exercise rights and responsibilities; additional patients' rights; definitions.
	(1) A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization, which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.
For Reference: MCL 333.20201	**(2) (e) A patient or resident is entitled to receive adequate and appropriate care, and to receive from the appropriate individual within the health facility or agency, information about his or her medical condition, proposed course of treatment, and prospects for recovery, in terms that the patient or resident can understand, unless medically contraindicated as documented by the attending physician in the medical record.**
ANALYSIS:	Resident B fell at the facility on 9/16, 9/21, 9/29, and again on 9/29. The facility completed an assessment by conducting neuro checks, vital signs, and range of motion. Interviews with staff members and review of documentation revealed days following the fall, Resident B progressed to requiring 2 person assist transfer and pain. Multiple caregivers observed Resident B's increased need for assistance and yet no medical attention was obtained until Resident B was transferred to the hospital on 10/9. From the time Resident B was witnessed falling, increased weakness, and loss of leg function was 23 days. The facility did not comply with ensuring Resident B was provide adequate and appropriate care.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident

	or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.
ANALYSIS:	Interviews conducted and document review revealed the facility did not appropriately notify the resident's physician following the fall on 9/16, 9/21 and 9/29. The resident's authorized representative was not notified on 9/21.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Interventions on Resident B's incident report were increase checks and the use of possible chair alarm.

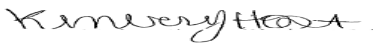
Review of Resident B's chart notes revealed Resident B was a two person assist transfer.

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:	Following Resident B's falls, the facility reported various interventions, but these interventions were not reflected in Resident B's service plan. In addition, Resident B required increased assistance, and this was also not noted in the service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/15/22, I conducted an exit conference with authorized representative Steven Steffey, administrator Kelly Steffey, and new administrator Pam Reese.

IV. RECOMMENDATION

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



10/17/22

Kimberly Horst Date
Licensing Staff

Approved By:

11/15/2022

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