GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 16, 2022

Paul Buchholz
Legacy Assisted Living
5025 Ann Arbor Rd.
Jackson, MI 49201

RE: License #:	AH380299010
Investigation #:	2023A1021008
	Legacy Assisted Living

Dear Mr. Buchholz:

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 #:	AH380299010
Investigation #:	2023A1021008
Complaint Receipt Date:	10/27/2022
Investigation Initiation Date:	11/01/2022
Report Due Date:	12/26/2022
Licensee Name:	Ganton Retirement Centers, Inc.
Licensee Address:	7925 Spring Arbor Rd. Spring Arbor, MI 49283
Licensee Telephone #:	(517) 750-0500
Administrator/ Authorized Representative:	Paul Buchholz
Name of Facility:	Legacy Assisted Living
Facility Address:	5025 Ann Arbor Rd. Jackson, MI 49201
Facility Telephone #:	(517) 764-2000
Original Issuance Date:	05/12/2009
License Status:	REGULAR
Effective Date:	08/20/2022
Expiration Date:	08/19/2023
Capacity:	113
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A discharged from the facility.	No
Facility failed to protect Resident A.	No
Additional Findings	Yes

III. METHODOLOGY

10/27/2022	Special Investigation Intake 2023A1021008
11/01/2022	Special Investigation Initiated - On Site
11/02/2022	Contact-Telephone call made Interviewed director of nursing
11/16/2022	Exit Conference Exit conference with authorized representative Paul Buchholz

ALLEGATION:

Resident A discharged from the facility.

INVESTIGATION:

On 10/27/22, the licensing department received a complaint from Adult Protective Services (APS) with allegations Resident A was issued a discharge from the facility. The complainant alleged Resident A hit and kicked the care staff and now staff are telling Resident A and her family they are going to kick Resident A to the street.

On 11/1/22, I interviewed facility manager Kimberly Loomis at the facility. Ms. Loomis reported Resident A was admitted to the facility on 9/27/22. Ms. Loomis reported Resident A will not allow care staff to provide care and becomes aggressive with care staff. Ms. Loomis reported the facility attempted medications, referral to hospice care, and referral to geropsychiatry. Ms. Loomis reported Resident A still had aggressive behaviors and a discharge notice was issued. Ms. Loomis reported the facility provided a 30-day notice. Ms. Loomis reported the facility did not kick out Resident A.

On 11/1/22, I interviewed staff person 1 (SP1) at the facility. SP1 reported Resident A admitted to the facility on 9/27/22 and was very pleasant but then Resident A started to have behaviors with care staff. SP1 reported Resident A would become very combative with staff when staff attempted to provide care to Resident A. SP1 reported staff would be kicked and punched by Resident A. SP1 reported the facility attempted medication adjustments, hospice referral, and geropsychiatry to manage the behaviors of Resident A. SP1 reported Resident A caused harm to staff and a discharge notice for Resident A was issued.

On 11/1/22, I interviewed SP2 at the facility. SP2 reported Resident A was very aggressive with staff. SP2 reported Resident A kicked and punched her. SP2 reported Resident A was a threat to care staff.

On 11/1/22, I interviewed director of nursing Marianne Clay by telephone. Ms. Clay reported Resident A exhibited behaviors whenever care staff attempted to provide care to Resident A. Ms. Clay reported Resident A harmed care staff and a 30 day discharge notice was issued.

I reviewed facility nurses notes for Resident A. There were notes from 10/1-10/31 that revealed multiple behaviors of Resident A aggression with care staff. A sample of the notes that demonstrated behaviors and the need for discharge read,

"10/1/22: Resident has (increased) agitation and (increased) anxiety. Resident refused care stating "don't take my life away." When was asked to come out to the common area Resident refused stating "no way. It looks like a sin."
10/1/22: Resident was combative during pm care. Resident was spitting at (resident associates). Resident attempted to bite, kick, and punch RA's. RA's were able to get resident in her nightgown and into bed.
10/3/22: Resident lowered herself to the floor. Resident slid out of the recliner in the commons area. Resident was trying to get out of the recliner and walk on her own. Resident got upset with staff when they tried to take her back to her apartment to call her daughter. Resident was yelling at staff while they were trying to help other residents go to the dining room for dinner. Resident tried to punch one RA. Staff were trying to keep resident safe. Resident kicked, hit, and pulled hair of the staff trying to help her.
10/4/22: Resident up and down yelling at staff. Resident trying to kick and hit RA and CA pinching trying to bite at 0005. Resident received Ativan mg for increased agitation.
10/4/22: Resident agitated screaming and smacking staff across face when staff attempted to assist Resident out of recliner due to fall risk. Resident refusing medication and spitting at staff in the face. Screaming at staff with all assistance. Resident hitting staff w/ open hand due to behaviors. Resident was petitioned to the emergency room.
10/05/22: Resident (increased) agitation all shift. Hitting & kicking staff. CA admin PRN Ativan 0.5mg PO for (increased) agitation @ 0800. It was (not) effective. Resident still hitting & kicking staff during transfers & toileting.

10/05/22: Resident was combative all shift but while CA and RA were transferring her to go to bed she was hitting, kicking, and scratching. Refused her 2000 PRN Ativan.
10/7/22: Resident in apartment continuously trying to get up. Resident is on a alarm. RA went in multiple times asking where she needed to go if she needed anything. Resident screaming and hitting.
10/15/22: Resident refused all 2000 meds x3 attempts. Resident spit and slapped CA. CA applied PRN ABH cream top on R wrist for (increased) agitation. PRN was effective.
10/20/22: Resident received ABH cream @0515. Resident increased agitation and combative @0615 med effective.
10/26/22: Resident was assessed by gero psych NP as a new patient for combative behaviors. Resident alert and readily answering questions. NP discussed a medication and resident agreed to take. New orders are as follows: start Depakote Sprinkles 125mg po BID.
10/30/22: CA applied PRN ABH cream Top to L wrist @1700 for (increased) agitation. PRN was not effective. CA then admin. PRN Ativan 0.5mg PO @1900. Resident was smacking and kicking staff."

I reviewed the discharge letter for Resident A. The letter was dated 10/5/22 and read,

"It has been a pleasure being able to serve you and your mom, (Resident A) here at Legacy Assisted Living Center.

This letter is to inform you that Legacy Assisted Living can no longer meet (Resident A) individual needs. Because she has harmed others, we are submitting a notice to vacate, immediately, according to our Residential Lease Agreement, page 7, number 1.

Please advise us as soon as you find a place that can safely care for her. We can assist you, if needed.

The resident or authorized representative has the right to file a complaint if there is a disagreement regarding the discharge to:
Office of Children and Adult Licensing, complaint intake Unit 7109 W. Saginaw St 2nd floor PO Box 65, Lansing, MI 489009-8150, Telephone number (866) 856-0126."

I reviewed the facility Discharge/Transfer Policy. The policy read,

"1. The Assisted Living Center shall not retrain a resident if he/she has harmed himself/herself or others or has demonstrated behaviors that pose a risk of serious harm to himself/herself or others unless the Legacy Assisted Living/Alzheimer's center has the capacity to manage the Resident's Behavior."

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(8) A home shall not retain a resident if the resident has harmed himself or herself or others, or has demonstrated behaviors that pose a risk of serious harm to himself or herself or others, unless the home has the capacity to manage the resident's behavior.
ANALYSIS:	Interviews with staff members and review of documentation revealed Resident A harmed staff members. In addition, Resident A demonstrated behaviors that posed harm to herself. The facility made numerous attempts to manage the behaviors of Resident A but were unsuccessful in doing so and a discharge notice was issued.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Facility to protect Resident A.

INVESTIGATION:

The complainant alleged Resident A has hit and kicked the care staff. The complainant alleged staff tried to convince Resident A's family that she was deathly ill and needed to enroll in hospice. The complainant alleged the staff are trying to kill Resident A.

SP1 reported Resident A admitted to the facility on 9/27/22. SP1 reported upon admission Resident A was pleasant but that changed. SP1 reported when care staff attempted to provide care to Resident A, she would become agitated and combative. SP1 reported at nighttime Resident A would attempt to get out of bed and when care staff would go in to assist, Resident A would kick and punch at care staff. SP1 reported the facility would bring Resident A to the common area for increased supervision and safety. SP1 reported Resident A would scream and yell at care staff which would disrupt the residents. SP1 reported it was difficult to re-direct Resident A. SP1 reported Resident A was a two person assist due to her behaviors. SP1 reported the facility attempted to start Melatonin at nighttime to assist with sleeping but Resident A knew she was only on one medication so she would spit out the medication. SP1 reported Resident A was evaluated by geropsychiatry physician for medication review. SP1 reported the facility attempted to start an anxiety medication as needed but Resident A would also spit this out. SP1 reported an ABH cream was started as needed and this would work sometimes. SP1 reported the facility also

started Depakote sprinkles for behaviors. SP1 reported the facility placed an evaluation for hospice services for additional services such as pastoral care, nursing care, and social work. SP1 reported Resident A did not meet criteria for hospice care. SP1 reported the facility never told the family Resident A was dying. SP1 reported families will hear the word hospice and believe the resident is dying. SP1 reported the facility treated Resident A appropriately and provided Resident A with respect even when they would get kicked, hit, and punched.

SP2 reported Resident A was very aggressive with staff. SP2 reported Resident A took a liking to her and would sometimes allow her to provide care to her. SP2 reported Resident A enjoyed singing and fixing her hair. SP2 reported she would try to sit with Resident A to calm her down. SP2 reported the facility treated Resident A with respect and dignity.

At the facility I observed staff members treating residents with dignity and respect as observed by assisting with transfers, providing activities, and offering food and drinks. Resident A was no longer at the facility and therefore I was unable to observe staff interactions with Resident A.

Ms. Clay reported at time of admission Resident A's family did not disclose Resident A's behaviors. Ms. Clay reported Resident A would hit, kick, and punch at staff members. Ms. Clay reported her eyeglasses were broken because of Resident A. Ms. Clay reported the facility attempted to get hospice care involved to have additional services such as pastoral care, nursing care, and social work. Ms. Clay reported she explained this to the family and never said Resident A was dying. Ms. Clay reported Resident A did not meet criteria for hospice care. Ms. Clay reported the staff treated Resident A with dignity and respect even when Resident A was aggressive with staff.

I reviewed Resident A's medication administration record (MAR) for Resident A. The MAR revealed Resident A was administered her medications.

I reviewed Encore Geriatrics progress notes for Resident A. The note was dated 10/06/22 and read,

> *"Patient was seen today at the request of nursing secondary to increased agitation and anxiety. Her dementia is progressing. She is on Ativan every 8 hours as needed. She is also on Clonazepam 1mg TID. She has been refusing. She has been yelling and screaming at staff. She has been hitting at the staff. I do feel at this time she is hospice appropriate. I am going to order a hospice consult if ok with DPOA."*

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:	Interviews with staff members and review of documentation revealed lack of evidence to support the allegation that the facility is trying to kill Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

SP1 and SP2 reported Resident A was a two person assist due to behaviors. SP1 and SP2 reported Resident A exhibited behaviors that were harmful to staff. SP1 and SP2 reported Resident A liked to sing and have her hair combed.

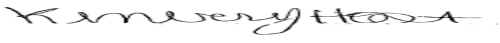
Review of Resident A's service plan revealed this information was not included within the service plan.

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:	Interviews with staff members and review of documentation revealed Resident A's service plan was not reflective of her current care needs.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/16/22, I conducted an exit conference with authorized representative with Paul Buchholz.

IV. RECOMMENDATION

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



11/3/22

Kimberly Horst — Date
Licensing Staff

Approved By:

11/15/2022

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