GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 18, 2022

Sara Dickendesher
Springvale Assisted Living
4276 Kroger Street
Swartz Creek, MI 48473

RE: License #:	AH250382043
Investigation #:	2022A1021067
	Springvale Assisted Living

Dear Ms. Dickendesher:

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

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

I. IDENTIFYING INFORMATION

License #:	AH250382043
Investigation #:	2022A1021067
Complaint Receipt Date:	09/23/2022
Investigation Initiation Date:	09/26/2022
Report Due Date:	11/23/2022
Licensee Name:	Springvale Assisted Living, LLC
Licensee Address:	3196 Kraft Se, Suite 200 Grand Rapids, MI 49512
Licensee Telephone #:	(616) 464-1564
Administrator:	Stephanie Surinck
Authorized Representative:	Sara Dickendesher
Name of Facility:	Springvale Assisted Living
Facility Address:	4276 Kroger Street Swartz Creek, MI 48473
Facility Telephone #:	(810) 230-6644
Original Issuance Date:	08/15/2017
License Status:	REGULAR
Effective Date:	02/15/2022
Expiration Date:	02/14/2023
Capacity:	73
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A treated disrespectfully.	Yes
Additional Findings	Yes

III. METHODOLOGY

09/23/2022	Special Investigation Intake 2022A1021067
09/26/2022	Special Investigation Initiated – Letter Referral sent to APS
09/27/2022	Inspection Completed On-site
09/28/2022	Contact-Telephone call made Interviewed hospice care nurse Toni Graham
09/30/2022	Contact-Telephone call made Interviewed SP4
11/18/2022	Exit Conference

ALLEGATION:

Resident A treated disrespectfully.

INVESTIGATION:

On 9/23/22, the licensing department received a complaint with allegations Resident A tried to elope from the facility and caregivers grabbed Resident A and dragged him on the ground back to the facility. The complainant alleged Resident A's family was not contacted regarding the elopement. The complainant alleged following this incident, Resident A was found in his room with a soiled brief, no sheets on his bed, and scrapes on his feet. The complainant alleged the facility is punishing Resident A for attempting to leave the facility. In addition, on 9/28, the licensing department received another anonymous complaint with the same allegations.

Both complaints were anonymous and therefore I was unable to gather additional information.

On 9/26/22, the allegations in this report were sent to centralized intake at Adult Protective Services (APS).

On 9/27/22, I interviewed facility administrator Stephanie Surinck at the facility. Ms. Surinck reported Resident A transitioned to memory care on 9/16. Ms. Surinck reported on 9/17 in the evening she received a telephone call from caregivers reporting Resident A was in the enclosed courtyard and was refusing to come back in. Ms. Surinck reported Resident A was aggressive with caregivers by punching, pulling hair, and throwing rocks. Ms. Surinck reported Resident A did not have his walker and caregivers were nervous he would fall. Ms. Surinck reported caregivers were able to lower Resident A to the ground and then transfer him into the wheelchair. Ms. Surinck reported caregivers called Resident A's family with no response. Ms. Surinck reported caregivers called Resident A's hospice company and PRN medications were administered. Ms. Surinck reported caregivers were able to get Resident A back into the building and put Resident A into bed. Ms. Surinck reported during this encounter, Resident A did sustain a small skin tear on his feet because he did not have socks or shoes on while outside. Ms. Surinck reported Resident A did not elope as he never left the enclosed courtyard. Ms. Surinck reported Relative A1 was contacted with no response. Ms. Surinck reported caregivers contacted Relative A2 and Relative A2 reported Relative A1 needed to be notified. Ms. Surinck reported on 9/21, Resident A's family came to visit and reported to care staff they wanted to shower Resident A. Ms. Surinck reported family took sheets from Resident A's room and provided them to the care staff to launder them. Ms. Surinck reported no bowel was found on the sheets. Ms. Surinck reported it is common for Resident A to undress himself and take his sheets off his bed. Ms. Surinck reported Resident A is a very busy resident and is constantly packing and unpacking items in his room. Ms. Surinck reported Resident A is on 30-minute checks. Ms. Surinck reported Resident A has not had any more episodes of aggression or trying to leave the facility. Ms. Surinck reported Resident A's hospice company has adjusted medications and Resident A is adjusting well to the move to memory care. Ms. Surinck reported care staff are not punishing Resident A and Resident A is treated with respect.

On 9/27/22, I interviewed staff person 1(SP1) at the facility. SP1 reported she worked the night Resident A was aggressive with staff. SP1 reported Resident A was agitated the entire shift but was not aggressive. SP1 reported Resident A was checked on every 30 minutes. SP1 reported she observed Resident A go outside to the courtyard and SP2 followed Resident A outside. SP1 reported after five minutes she went to assist SP2. SP1 reported Resident A was vocalizing that he was going to leave. SP1 reported he picked up small rocks and tried to throw them at the caregivers. SP1 reported they lowered Resident A to the ground to keep him safe. SP1 reported she called Relative A1 and Relative A1 did not answer the phone call. SP1 reported she called Relative A2 and Relative A2 reported Relative A1 needed to be notified. SP1 reported she called Ms. Surinck to inform her of what was going on and then called Resident A's hospice company. SP1 reported the hospice company advised PRN medications were to be administered. SP1 reported

caregivers were able to get Resident A back into the facility and he was able to calm down. SP1 reported Resident A was not dragged into the facility. SP1 reported Resident A has not been aggressive or try to leave since this incident. SP1 reported it is common to find Resident A undressed in his room. SP1 reported Resident A recently started to sleep in his bed and will take off his sheets. SP1 reported she has found bowel in his bed. SP1 reported caregivers check on Resident A every 30 minutes to ensure his safety. SP1 reported Resident A is treated with respect.

On 9/27/22, I interviewed SP2 at the facility. SP2 reported she was working the evening Resident A was aggressive with staff. SP2 reported residents were getting ready for bed and she observed Resident A leave the unit and go to the outside courtyard. SP2 reported she followed him outside and Resident A vocalized he was trying to leave. SP2 reported Resident A had rocks in his hand and threw them at caregivers. SP2 reported Resident A was dragging his feet on the ground and did not have shoes or socks on. SP2 reported caregivers were able to get him inside and Resident A calmed down. SP2 reported Resident A has not been aggressive since this incident. SP2 reported it is common for Resident A to undress himself and sit on his unmade bed. SP2 reported Resident A is treated respectfully at the facility.

On 9/27/22, I interviewed SP3 at the facility. SP3 reported she was providing care to Resident A when a family member came to visit him. SP3 reported the family member approached her and requested to shower Resident A. SP3 reported she told the family member hospice had showered Resident A but that they could shower him as well. SP3 reported she went into Resident A's room and found his bed unmade and the family member reported they would make the bed. SP3 reported she had just been in Resident A's room 10 minutes prior to the family member visiting. SP3 reported she did not observe any bowel on the sheets. SP3 reported it is common for Resident A to unmake his bed and to undress himself. SP3 reported Resident A is checked on every 30 minutes. SP3 reported Resident A is treated respectfully.

On 09/28/2022, I interviewed hospice care nurse Toni Graham by telephone. Ms. Graham reported her company, CorsoCare Hospice, has been involved in Resident A's care for a while. Ms. Graham reported they are working to get Resident A's behaviors under control. Ms. Graham reported Resident A was moved to the secure memory care unit on Friday 9/16. Ms. Graham reported Resident A exhibited behaviors the following day, which was a Saturday, and the facility had limited support due to it being the weekend. Ms. Graham reported her company was contacted by the facility with reports Resident A had eloped from the facility and the caregivers were having a difficult time getting him back inside. Ms. Graham reported caregivers reported Resident A did not receive the correct anti-psychotic medications. Ms. Graham reported hospice advised the caregiver to administer a prn medication. Ms. Graham reported following this incident, Resident A has a significant bruise on his lower back and his feet have scrapes on them. Ms. Graham reported the bruises and scrapes appeared after Resident A eloped from the facility.

Ms. Graham reported the injuries are consistent with some sort of a struggle or altercation.

On 9/30/22, I interviewed SP4 by telephone. SP4 reported she was contacted by SP1 and SP2 to assist with getting Resident A back into the building. SP4 reported when she arrived in the memory care unit, she observed Resident A outside but still on the premises of the facility. SP4 reported Resident A was on the ground with no shoes on. SP4 reported caregivers reported Resident A put himself on the ground. SP4 reported SP1 was contacting Resident A's family for them to come to the facility to assist with Resident A. SP4 reported caregivers were able to get Resident A off the ground and at that point Resident A punched SP2 in the chest. SP4 reported resident A also grabbed her hair. SP4 reported Resident A did fall on the ground. SP4 reported caregivers were then able to somehow get Resident A in his wheelchair and transfer him inside. SP4 reported it was a very chaotic scene. SP4 reported when Resident A is agitated, the only resource they have is to contact family.

I reviewed Resident A's service plan. The service plan read,

> *"Exhibits mood variation requiring intervention occasionally but less than daily. Offer reassurance and validation. Engage in activity. Provide distraction."*

I reviewed chart notes for Resident A. The notes read,

> *"9/14: Resident is being rude towards staff. He is insisting on packing his belongings. Wanting staff to help him pack his belongings. When asked where he was moving to resident stated "why do I need to tell you." I tried redirecting him to watch college football on tv which did not work. I tried letting him know it was late at night, and he is still insisting on packing his things."*
> *9/17: Resident tried leaving mc area. We guided him to the ground safely. He grabbed two rocks and tried hitting the employees with them. He punched (SP1) and pulled (SP4) hair. We eventually put him in a wheelchair and back inside the building to his room. Hospice was contacted and she requested that I give him .25mg Seroquel ad 0.5 lorazepam."*

I reviewed hospice documentation. The notes read,

> *9/17: patient had left building and was attempting to elope. Patient became combative with staff. Reviewed medications. Patient had not received bedtime medications at that time. Caregiver also stated she believed patient was to receive Seroquel 50mg, orders were for 75mg at that time and 25mg PRN was available. Also orders for Ativan 0.5mg instructed to give. Called caller back and spoke to patient's wife and daughter. Patient had calmed was in bed sleeping no further needs at this time.*
> *9/18: while at facility seeing another patient stopped and checked on patient as I had received a call last night. Caregiver stated are continuing to give patient*

scheduled and prn Seroquel and Ativan PRN. His agitation and anxiety have decreased per caregivers today. They will call to report any changes or concerns. Patient is alert to self with confusion expresses "unhappiness with facility and being locked in here and wants to go home." He refuses assessment of skin or vitals. He has no s/s of pain or distress at this time. He is not combative or agitated at this time no further needs. Previous order of Ativan 0.5mg every 4 hours PRN rewritten for facility as current in our system. Facility computer showed medication as discontinued. Compared MARs and medication reconciliation. Re wrote order clarification so caregivers could administer Ativan as needed. Patient sitting on his bed fully dressed upon arrival and exit.
9/18: patient had gotten out of door. When they attempted to redirect patient, patient began to throw rocks at them. Patient had been lowered to the ground to prevent injury to himself and caregivers. Caregivers deny any injuries to patient. Reviewed medications discovered patient did not received full PM dose of Seroquel, he had received 50mg of Seroquel. New orders were for 75mg bedtime. Instructed to give the additional 25mg, plus the 25mg PRN if not effective within 20 minutes give 0.5mg of PRN Ativan. Call or state that she needed to get off the phone to attempt to administer medication and to call her back. Did call patients wife back and spoke to her. She stated facility had called her requesting to sit with patient which he has done quite a few times in the past. Wife states if patient is trying to elope or having behaviors when they come to sit with him it escalates as he comes upset when he realizes his family is going home and he cannot return with them. Wife requests PRN and scheduled medications to be given 1st before family coming to sit with him as they do not believe this will be beneficial to the patient. Did call back caregiver and medications were effective patient was resting in bed comfortably no further needs at this time caregiver declines need for visit. Instructed I would be out to facility following day to check on him. Wife called back and updated on findings. Wife declines any further needs. Thanks this caller for the update. Caregiver instructed if any further behaviors or changes in condition to call back on call nurse. Upon arrival to facility today patient sitting on bed fully dressed in room. Patient has alert with confusion patient verbalizes that he does not want to remain in facility wants to go home and is unhappy being locked in this place. Patient is agitated when attempting to assess. Patient declined skin assessment and vitals however as in no signs or symptoms of pain or distress when left alone. Did confirm with caregivers that patient has continued to receive Seroquel or Ativan for agitation and anxiety."

I reviewed Resident A's medication administrator record (MAR). The MAR read,

"Lorazepam Tab 0.5mg with instruction to give 1 tablet by mouth every 4 hours as needed for anxiety. The medication was discontinued on 9/14.
Quetiapine Tab 25mg with instruction to administer 1 tablet by mouth at bedtime along with 50mg tablet for agitation/confusion. The medication order was written on 9/13 and was to be given at 8:00pm."

APPLICABLE RULE	
R 325.1921	**Employees; general provisions.**
	(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**
For Reference: R 325.1901	**Definitions.**
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	Resident A had been known to have behaviors towards staff members. On 9/17, Resident A exited the facility into the courtyard and the caregivers had a difficult time returning him to the facility. Review of Resident A's MAR revealed Resident A did not receive correct medications. In addition, Resident A's service plan was not specific to adequately address the behaviors of Resident A. The facility did not ensure Resident A was protected while under supervision at the facility and therefore the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

Review of Resident A's MAR revealed Resident A was prescribed Lorazepam Tab 0.5mg with instruction to give 1 tablet by mouth every 4 hours as needed for anxiety.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(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 A's service plan lacked detailed information on how the resident demonstrates anxiety and what behaviors require the administration of the medication or if staff can use nonpharmaceutical interventions.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Kimberly Horst 10/3/22

Kimberly Horst Date
Licensing Staff

Approved By:

Andrea L. Moore 11/15/2022

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