GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 20, 2022

Richard Ebeling
Dayspring Assisted Living Residence
572 Lake Forest Lane
Muskegon, MI 49441-4714

RE: License #: AH610236774
Investigation #: 2023A1021020
Dayspring Assisted Living Residence

Dear Mr. Ebeling:

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 #:	AH610236774
Investigation #:	2023A1021020
Licensee Complaint Date:	12/08/2022
Investigation Initiation Date:	12/09/2022
Report Due Date:	02/07/2023
Licensee Name:	Dayspring Inc.
Address:	572 Lake Forest Lane Muskegon, MI 49441
Licensee Telephone #:	(231) 780-2229
Administrator:	
Authorized Representative:	Richard Ebeling
Name of Facility:	Dayspring Assisted Living Residence
Facility Address:	572 Lake Forest Lane Muskegon, MI 49441-4714
Facility Telephone #:	(231) 780-2229
Original Issuance Date:	11/01/2000
License Status:	REGULAR
Effective Date:	07/06/2022
Expiration Date:	07/05/2023
Capacity:	72
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Staff failed to respond and treat distress of Resident A	Yes
Additional Findings	No

III. METHODOLOGY

12/08/2022	Special Investigation Intake 2023A1021020
12/09/2022	Special Investigation Initiated - On Site
12/09/2022	Contact- Interviewed SP1
12/09/2022	Contact- Interviewed SP2
12/13/2022	Contact- Interviewed SP3
12/14/2022	Contact- Interviewed administrator
12/20/2022	Exit Conference Exit Conference

The complainant identified some concerns that were not related to home for the aged licensing rules and statutes. Therefore, only specific items pertaining to homes for the aged provisions of care were considered for investigation. The following items were those that could be considered under the scope of licensing.

ALLEGATION:

Staff failed to respond and treat distress of Resident A

INVESTIGATION:

On 12/08/22, the licensing unit received an anonymous complaint with no resident name but did provide the following allegations and information. The complainant alleged Resident A has fallen due to lack of supervision at the facility. The complainant alleged Relative A1 came to the facility and observed Resident A had a

soiled Depend, feces on the doorknob, a bruise on her forehead, and was very weak. The complainant alleged Relative A2 came to the facility and tried to take Resident A for a walk, but she could barely walk. The complainant alleged family took Resident A to the hospital where they discovered that she has three broken ribs.

Due to the anonymous nature of the complaint, I was unable to obtain any additional information.

On 12/9/22, I conducted an onsite inspection. I interviewed director of operations Nathaniel Ebeling at the facility. Given the information provided, Mr. Ebeling felt confident that the complaint was referring to Resident A. Mr. Ebeling reported Resident A tested positive for Covid-19 on 11/28/22 and in the evening fell in her room. Mr. Ebeling reported after the fall Resident A reported of left shoulder and left hip pain. Mr. Ebeling reported after this fall, a mobile x-ray was completed, and no fractures were found. Mr. Ebeling reported on 12/3/22, Resident A had another fall in her room. Mr. Ebeling reported after the fall, Resident A's range of motion was within normal limits. Mr. Ebeling reported the physician was contacted and advised staff to contact him again if any injuries were found. Mr. Ebeling reported on 12/6/22, an order was obtained for a mobile x-ray. Mr. Ebeling reported on 12/6/22, relatives of Resident A came to the facility, refused the x-ray, and transported Resident A to the hospital. Mr. Ebeling reported the family provided notice of discharge and Resident A will not be returning to the facility. Mr. Ebeling reported when a resident is positive for Covid-19, they are quarantined to their room. Mr. Ebeling reported Resident A was active within the community and would often wander throughout the facility. Mr. Ebeling reported prior to these falls, Resident A was not a frequent faller. Mr. Ebeling reported Resident A had increased diarrhea and incontinence due to the Covid-19 medication. Mr. Ebeling reported Resident A had increased weakness due to the Covid-19 diagnosis.

I was unable to interview Resident A due to Resident A no longer being a resident at the facility.

On 12/9/22, I interviewed staff person 1 (SP1). SP1 reported she was working the day Resident A had her second fall. SP1 reported with staff assistance Resident A was able to get off the floor. SP1 reported Resident A's range of motion was fine and her vitals were within normal limits. SP1 reported at the time of the fall, Resident A did not complain of pain.

On 12/9/22, I interviewed SP2 reported she provided care to Resident A following the falls. SP2 reported Resident A complained of hip pain especially when ambulating. SP2 reported medication technicians administered pain medications with little to no relief of pain. SP2 reported the facility nurse and administrator were out of the facility and therefore the concerns of Resident A's pain could not be addressed. SP2 reported this was a change for Resident A.

On 12/13/22, I interviewed SP3. SP3 reported she provided care to Resident A following the second fall. SP3 reported she went into Resident A's room and observed Resident A to have a soiled Depend and soiled sheets. SP3 reported due to the Covid-19 medication Resident A had diarrhea and had increased weakness. SP3 reported she changed Resident A's sheets and Depend. SP3 reported following the second fall Resident A complained of pain. SP3 reported Resident A was limping when she ambulated which was a change for Resident A. SP3 reported prn Tylenol was administered for pain, but the medication was not effective. SP3 reported she confirmed with the facility staff resource and was advised to administer the two tablets of Tylenol for pain.

On 12/14/22, I interviewed the administrator Shelly Simmons by telephone. Ms. Simmons reported Resident A tested positive for Covid-19 on 11/27 and was placed in quarantine in her room. Ms. Simmons reported Resident A fell at the facility on 11/28/22. Ms. Simmons reported following this fall, a mobile x-ray was completed with no injuries found. Ms. Simmons reported Resident A had another fall at the facility on 12/3/22. Ms. Simmons reported she was not the on-call manager during the second fall and was not made aware of the fall until she returned to work on 12/5/22. Ms. Simmons reported on the morning of 12/5/22, she went to Resident A's room and assisted her to the bathroom, walked her to the dining room, and helped her play, Bingo. Ms. Simmons reported Resident A did not complain of pain and she did not see any signs of distress. Ms. Simmons reported she then received a text message from Resident A's family inquiring about the fall, pain level, feces on the floor, and request for an x-ray. Ms. Simmons reported she did not observe any feces on the floor in Resident A's room nor the carpet stained. Ms. Simmons reported due to the Covid-19 medication, Resident A had increased incontinence. Ms. Simmons reported she then found the incident report in the facility nurse mailbox with information on the fall. Ms. Simmons reported the incident report revealed Resident A had a fall, there was no observed injuries, the physician was notified and told the facility to keep his office updated if there were any changes. Ms. Simmons reported the care staff did not document the fall in Resident A's observation notes. Ms. Simmons reported she then had care staff document the fall in the notes. Ms. Simmons reported she reached out to the physician office for a mobile x-ray order and received the order late in the day on 12/5/22. Ms. Simmons reported the mobile x-ray was scheduled for 12/6/22. Ms. Simmons reported on 12/6/22, Resident A's family came to the facility, refused the mobile x-ray, and transported Resident A to the emergency room. Ms. Simmons reported Resident A's family provided notice of discharge and Resident A will not return to the facility. Ms. Simmons reported if a resident has a change in status, care staff are to contact on the on-call manager for direction. Ms. Simmons reported if a resident is having pain, the care staff are to contact the physician for direction.

I reviewed facility progress notes for Resident A. The progress notes read,

> *"11/28: RLC assessed resident in her room as she was witnessed on the floor in her bedroom/bathroom. She is c/o of left shoulder pain. Shoulder & deltoid area*

are tender to the touch. ROM (range of motion) is affected. She can not lift her arm w/o pain. She is able to raise her right arm. No bruising noted. She can squeeze RLC's fingers with bilateral hands. RCP will administer PRN Tylenol and ice. Page placed to Dr. Klein. 2 view shoulder x-ray ordered. Also discussed anti-viral treatment option as resident is Covid positive. Call placed to Medical DPOA. Message left to Call RLC.
11/28: Received return call from (DPOA). Reviewed fall & the option to treat Covid w/ anti-viral paxlovid. Daughter would like to treat if treatment criteria is met. Call placed to pharmacy to review. GFR 77 on 7.27.22 which meets criteria & no drug interactions. From to be faxed to facility for completion. Page placed to Dr. Klein to request the script to pharmacy.
11/28: RLP reported that resident is C/O of L hip pain and is pain when ambulating. Call placed to on-call provider. Order placed.
11/28: call placed to (DPOA). Detailed message left to inform her antiviral Paxlovid has been ordered.
11/29: went into residents room to give her 6pm meds and to toilet resident. Resident was crying a lot telling RLP that she was in so much pain and hurt everywhere. First shift gave resident PRN Tylenol 500mg x2 every 4 hours and applied ice to side. I continued this throughout 2nd shift. Resident received PRN 500mg x2 with 6pm meds, resident was asleep at 9pm so RLP did not wake her but PRN can be given again if she wakes up with pain. RLP informed nurse of residents status and she had RLP call Dr. Office. RLP talked to PA about residents pain. She did not recommend resident receive a stronger medication for pain. She asked if the family could provide a topical gel for pain and recommended a bedside commode. She also recommended X-rays be re-taken on resident. Residents Paxlovid 300/100mg tablets arrived and RLP gave PM dose. 10:25pm Resident was out bed gave PRN dose for pain.
11/30: Xray results returned normal. Dr. Klein informed. Call placed to (DPOA) to inform as well on 11.29.
11/30/22: RLP requested Admin to check residents left leg, states resident c/o pain when standing or walking. Admin examined legs, front and back. No concerns. Resident able to stand without c/o if pain.
12/5: Resident off covid quarantine. Precautions clear as of 12/04/22. Resident stable, C/O L-hip/leg pain but able to ambulate.
12/5: Late entry on 12/3 at 6:15pm. Found resident on floor between bed and window. Unable to report what happened. At end of shift BP 128/71, P 64, R 17, O2 94.
12/6: At 745A received order for L hip, shoulder and pelvic XR. Scheduled with Mobile X @ 7:50A for today 12.06.22
12/6: @ approx. 10:30A two granddaughters present in resident's room requesting mobile XR for hip/pelvic and shoulder ordered by Dr. Klein. Family stated to administrator they would taking her to ED. Administrator went to room to assess. (Relative A1) asking questions about XR, time of orders, hx of most recent fall. As admin started to attempt to provide information, granddaughters extremely upset and got very rude to administrator, cursing and telling

administrator to get the "f" out of the room. Administrator continued to apologize and left the room.
12/6: Administrator and director of operations called (Relative A1) to check on Residents status. Per (Relative A1) Resident has three fractured ribs, L side # 3,5,7. Resident is staying over night in hospice then provider recommending rehab after hospital stay. Questions answered for family as well as questions 12/04 when (Relative A1) came to visit resident. (DPOA) to communicate with family about calling facility questions or concerns. Staff informed about HIPPA and appropriate communication with POA or granddaughter."

I reviewed Resident A's medication administration record (MAR) for Resident A. The MAR revealed Resident A was prescribed Tylenol Acetaminophen 500mg with instruction to administer 1-2 tablets by mouth every 4 hours as needed. Resident A was administered this medication on 11/7, 11/28, three times on 11/29, 11/30, twice on 12/1, once on 12/2, 12/3, twice on 12/4, and on 12/5. The notes revealed this pain medication was administered due to pain and five times this medication did not help.

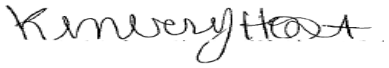
I reviewed Resident A's service plan. The service plan read,
"Independent with walker."

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.**
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 fell at the facility on 12/3/22. The facility completed an assessment by conducting vital signs, range of motion, and

	inquiring about pain. Interviews with staff members and review of documentation revealed Resident A was able to move all extremities and denied pain. The days following the fall, Resident A progressed to reporting pain when ambulating and requiring PRN pain medication. Multiple caregivers observed Resident A's increased pain levels and yet no additional interventions or medical attention was arranged for Resident A until 12/05/22. The facility did not comply with ensuring Resident A was provide adequate and appropriate care.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



12/14/22

Kimberly Horst Date
Licensing Staff

Approved By:

12/19/2022

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