GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 17, 2023

Steven Steffey
Vicinia Gardens Transition
4045 Vicinia Way
Fenton, MI 48430

RE: License #: AH250382445
Investigation #: 2023A0585003
Vicinia Gardens Transition

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 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 (517) 284-9730.

Sincerely,

Brender L. Howard

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664, Lansing, MI 48909
(313) 268-1788
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH250382445
Investigation #:	2023A0585003
Complaint Receipt Date:	10/11/2022
Investigation Initiation Date:	10/12/2022
Report Due Date:	12/10/2022
Licensee Name:	Vicinia Gardens Transition, LLC
Licensee Address:	1012 N LeRoy Fenton, MI 48430
Licensee Telephone #:	(810) 629-9368
Administrator:	Kelly Steffey
Authorized Representative:	Steven Steffey
Name of Facility:	Vicinia Gardens Transition
Facility Address:	4045 Vicinia Way Fenton, MI 48430
Facility Telephone #:	(810) 629-9368
Original Issuance Date:	09/12/2017
License Status:	REGULAR
Effective Date:	03/12/2022
Expiration Date:	03/11/2023
Capacity:	28
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Residents are being pulled out of bed and made to get out of bed to participate in activities.	No
Residents tested positive for COVID 19. Call button pulled off resident and thrown in the bathroom for using it too much.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/11/2022	Special Investigation Intake 2023A0585003
10/12/2022	Special Investigation Initiated - Letter Emailed received from Adult Protective Services (APS) regarding allegations. Responded back to APS worker Kelly Clark-Huey.
11/10/2022	Inspection Completed On-site Completed with observation, interview and record review.
02/17/2023	Exit Conference Conducted with administrator Kelly Steffey.

ALLEGATION:

Residents are being pulled out of bed and made to get out of bed to participate in activities.

INVESTIGATION:

On 10/11/2022, the department received the allegations via the BCHS Online Complaint website. These allegations were submitted as anonymous; therefore, no additional information could be obtained.

On 10/12/2022, I received an email from Adult Protective Services (APS) worker Kelly Clark-Huey. She reported that she will be the assigned worker.

On 11/10/2022, an onsite was completed at the facility. I interviewed administrator Kelly Steffey at the facility. Ms. Steffey stated that residents are not forced out of bed. She stated they care for the needs of the residents.

On 11/10/2022, I interviewed Employee A by telephone. Employee A stated, Resident [A] had several falls and her chair alarm was missing and was found on the floor. She stated that residents are not forced out of the bed, but they encourage them to get out.

On 11/10/2022, I interviewed Employee B at the facility. Employee B stated that residents can get up when they want to, and they don't make them do anything. Employee B stated that she has not heard or saw anyone pulled residents out of the bed.

On 11/10/2022, I interviewed Employee C at the facility. Employee C stated that she does not know of any incidents where residents were forced out of bed. She stated that residents get up when they are ready to get up.

I interviewed Resident A at the facility. Resident A stated that she was not forced to do activities or anything else she didn't want to do. She stated that staff don't make her do anything.

During the onsite, I observed residents at the facility. The residents were well groomed and was free of any issues.

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.**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(l) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the**

	action to the attending physician or physician's assistant. In case of a chemical restraint, a physician shall be consulted within 24 hours after the commencement of the chemical restraint.
ANALYSIS:	Based on observation, interview and record review, this claim could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents tested positive for COVID 19. Call button pulled off resident and thrown in the bathroom for using too much.

INVESTIGATION:

The complaint alleges that a resident was pulled out of bed and had her call button taken off her and thrown in the bathroom for using it too much. The complaint alleges that resident fell out of bed and broke her hip due to her not having her alarm.

Ms. Steffey stated that Resident A has a bed alarm and has a sensor. She explained that another resident came in Resident A's room and bothered Resident A's alarm and that's when she fell. She stated the call light was found on the counter and no one reported it. She stated the census is 27. Ms. Steffey stated that staff failed to put the alarm on her, and they did an in-service with staff. Ms. Steffey stated that the facility follows the recommendation of Michigan Department of Human Services (MDHS). She stated that there are currently no COVID positive residents or staff. She stated that staff are not forced to work if they have positive, but they go into quarantine. She stated that staff wore 95 masks. She stated quarantine is five days until there are no more symptoms or fever.

Employee B stated Resident A had a fall and went to the hospital. She stated that Resident A has an alarm, and it did not go off. Employee B stated they had some residents with cold like symptoms and they were put on 5 days quarantine. She stated the staff get tested and if they are positive, they are put on 5 days quarantine. She stated that currently, there are not positive cases in the facility.

Employee C stated that there are no active positive COVID cases. She stated that it was very difficult to get memory care to wear mask. She stated they were in quarantine. She stated that quarantine lasted five days until they were symptoms/fever free.

A review of an in-house document dated 10/27/2022 read, “Resident A was found without her pendant on. The root cause/reason was that noted, after third shift did her brief change and changed her short at 6:30 a.m. on 10/26/2022, they did not put her pendant back on her.” The document read, “Addressed with all staff regarding keeping the pendant on and not removing it. Assured that they are waterproof and that at walk through staff needs to be checking to see that they have their pendant on as well.” The document also read that a verbal warning was given to staff member who did not put the pendant back on her.

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.**
ANALYSIS:	The facility was free from COVID and COVID policy appears to be followed as recommended by from MDHS. Resident A’s alarm was left off during a change and she fell resulting in injury. Therefore, this claim was substantiated based on the injury caused as a result of the missing pendant.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION

During the onsite, I requested an incident report regarding the fall incident where Resident A fell out of the bed and broke her hip. As of the date of this report, an incident was not received with all the pertinent information.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(1) The home shall complete a report of all reportable incidents, accidents, and elopements. The incident/accident report shall contain all of the following information:

	(a)The name of the person or persons involved in the incident/accident. **(b)The date, hour, location, and a narrative description of the facts about the incident/accident which indicates its cause, if known.** **(c)The effect of the incident/accident on the person who was involved, the extent of the injuries, if known, and if medical treatment was sought from a qualified health care professional.** **(d)Written documentation of the individuals notified of the incident/accident, along with the time and date.** **(e)The corrective measures taken to prevent future incidents/accidents from occurring.**
ANALYSIS:	An incident report was not available for review.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION

An incident report was not sent to the State for review.

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:	An incident report was not sent to the State. Therefore, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 2/17/2023, I conducted an exit conference with administrator Kelly Steffey by telephone.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remains unchanged.

02/17/2023

Brender Howard — Date
Licensing Staff

Approved By:

01/25/2023

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