GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 27, 2023

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

RE: License #: AH380299010
Investigation #: 2023A0585026
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 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 #:	AH380299010
Investigation #:	2023A0585026
Complaint Receipt Date:	01/26/2023
Investigation Initiation Date:	01/26/2023
Report Due Date:	03/25/2023
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:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A had a fall and lacked protection or safety.	Yes
Resident A is not getting her medication or her treatments.	No
Additional Findings	No

The complainant identified some concerns that were not related to licensing rules and statues for Home for the Aged. Therefore, only those rules that applies to Home for the Aged was investigated.

III. METHODOLOGY

01/26/2023	Special Investigation Intake 2023A0585026
01/26/2023	Special Investigation Initiated - Letter Email referral to Adult Protective Service (APS).
01/26/2023	Contact - Telephone call made. Contacted the complainant by telephone to discuss allegations.
02/01/2023	Inspection Completed On-site Completed with observation, interview, and record review.
03/30/2023	Contact – Document Sent Emailed administrator to request additional documents.
04/06/2023	Contact – Document Received Requested document received.

ALLEGATION:

Resident A had a fall and lacked protection or safety.

INVESTIGATION:

On 1/26/2023, the department received the complaint in an email from a complainant.

On 1/26/2023, a referral was made to Adult Protective Services (APS).

On 1/26/2023, I interviewed the complainant by telephone. The complainant stated that Resident A fell at the facility. She stated that she asked the facility for an incident report because she wanted to know what happened. She stated the facility had a riser on Resident A's toilet that was unsafe. She said that Resident A is a two person assist now. She stated that Resident A told her that she was assisted in the bathroom, but an emergency came up and the staff told Resident A not to move that she would be back. The complainant stated that Resident A tried to get off the toilet by herself and due to the toilet being so high, she jumped down and her knees came out and she fell hitting the corner of the table. The complainant stated that Resident A was sent to the hospital the next day. The complainant shared pictures of Resident A.

On 2/1/2023, an onsite was completed at the facility. I interviewed nurse Marianne Clay at the facility. She stated that the census was 18 and there were four care staff to care for the needs of the residents. Ms. Clay stated that Resident A was a one person assist at the time but now she is a two person assist. She stated that they didn't know that she was a fall risk. Ms. Clay stated that the high rise is now off the toilet. She stated that when Resident A came to the facility, she was independent but after she fell, they moved her to memory care. She stated that Resident A can use the call light. She stated that staff assisted Resident A to the bathroom and left her. She stated that when Resident A was finished in the bathroom, she did not call for assistance to get up from the bathroom the day of the incident. Ms. Clay shared copies of Resident A's service plan. She stated that information regarding Resident A is shared with her authorized representative. She stated that Resident 'A did not go the hospital as result of the fall, but she went because of her not feeling well the next day.

On 4/19/2023, I interviewed hospice nurse Katie French by telephone. Ms. French stated that Resident A was admitted to hospice care on 1/15 and discharged on 2/13 due to family refusing additional care. She stated the Resident came to hospice after her fall.

Resident A's service plan dated 12/22/2022 read, "admitted to the facility on 12/22/2022 as a level 4. Independent with toileting and transferring. Hospice service because of significant change on 1/15/2023."

Resident A's service plan dated 1/18/2023 read, "level 1, hospice service, daily PRN, history of fails, dependent, 1:1 assist with gait belt for wheelchair transport. ADL's toileting 1:1 assist, stands up at the bar and pivots to turns.

Incident report for Resident A read, "On 1/12/2023 at 11:00 a.m., Resident A was observed on floor in bathroom laying on right side, head laying under sink with legs stretched out toward toilet. 1 ½ inch bump to right temple with bruising and bruise to right eye lid. Unknown cause." The plan also read, vital taken, ROM initiated, neuro

checks, ice applied to temple as needed. The plan read, authorized representative and doctor was called at 11:15 a.m.

Incident report for Resident A read, “On 1/14/2023 at 5:30 a.m., Resident A had confusion, sob, and weakness, verbalizing she was not feeling well. EMS was called and Resident A was sent to the hospital.”

During the onsite, I observed Resident A. Resident A had bruises on her face, bruising around her eyes, and nose. When asking Resident A what happened, she only said she fell.

A review of pictures of Resident A, shows extensive injuries around the eyes and bruises on the arms.

I call Resident A’s authorized representative. A message was left to return this call. As of the date of this report, no return call was received.

APPLICABLE RULE	
R 325.1931	**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.**
R 325.1901	**Definitions.**
	“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 resident’s service plan states that the resident needs continuous supervision.
ANALYSIS:	Although Resident A was independent, she was left on the toilet by staff and did not come back to assist her. Resident A fell and sustained injuries. Therefore, this claim was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A is not getting her medication or treatment.

INVESTIGATION:

The complainant alleged that she wanted Resident A to have a face mask instead of her nose canula because the nurses have found her several times with the nose canula out of her nose and with a blood oxygen level hovering around 70%. The complainant said that she was informed by the hospice nurse that because she is on only three liters of oxygen that using a mask may make her carbon dioxide levels high. She said the hospice doctor suggested that since she was on hospice that they would not encourage her to put it back on nor would the staff put it back on. She said that Resident A is still eating and drinking which requires her insulin. She said that Resident A still needs her blood pressure medication as well as her blood thinners.

Ms. Clay stated that all medications are given as prescribed. She stated that there are no issues with medication.

Ms. French stated that all medication are prescribed by hospice. She stated that they provide all of Resident A's medication, but the facility staff administer the medication.

A review of Resident A medication administration record (MAR) shows that medication was given as prescribed.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication should be given, taken, or applied pursuant to labeling instructions or signed orders by the prescribing licensed health care professional.
ANALYSIS:	According to the MAR, medication was given as prescribed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

04/26/2023

Brender Howard — Date
Licensing Staff

Approved By:

04/26/2023

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