GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 5, 2023

Lori McLaughlin
North Woods Village At Kalamazoo
6203 Stadium Dr
Kalamazoo, MI 49009

RE: License #: AH390394454
Investigation #: 2023A1028044
North Woods Village At Kalamazoo

Dear Ms. McLaughlin:

Attached is the Special Investigation Report for the above referenced facility. 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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AH390394454
Investigation #:	2023A1028044
Complaint Receipt Date:	04/01/2023
Investigation Initiation Date:	04/05/2023
Report Due Date:	06/01/2023
Licensee Name:	MITN, LLC
Licensee Address:	6203 Stadium Dr Kalamazoo, MI 49009
Licensee Telephone #:	(574) 247-1866
Administrator:	Amanda Buhl
Authorized Representative:	Lori McLaughlin
Name of Facility:	North Woods Village At Kalamazoo
Facility Address:	6203 Stadium Dr Kalamazoo, MI 49009
Facility Telephone #:	(269) 397-2200
Original Issuance Date:	03/11/2019
License Status:	REGULAR
Effective Date:	09/11/2022
Expiration Date:	09/10/2023
Capacity:	61
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Staff did not follow Resident A's service plan resulting in multiple falls with injury.	Yes
The facility is short staffed.	No
Medications were found in Resident A's room.	Yes
Additional Findings	No

III. METHODOLOGY

04/01/2023	Special Investigation Intake 2023A1028044
04/05/2023	Special Investigation Initiated - Letter 2023A1028044
04/05/2023	APS Referral No APS referral made due to resident being deceased.
04/05/2023	Contact – Telephone Call Made Interviewed complainant by telephone.
04/05/2023	Contact – Documents Received Received information and pictures from the complainant.
04/11/2023	Inspection Completed On-site Inspection completed on-site due to special investigation.
04/11/2023	Contact - Face to Face Interviewed Admin/Amanda Buhl at the facility.
04/11/2023	Contact - Face to Face Interviewed Employee A at the facility.
04/11/2023	Contact - Face to Face Interviewed Employee B at the facility.
04/11/2023	Contact - Document Received Received Resident A's record for review from Admin/Amanda Buhl.

ALLEGATION:

Resident A was neglected by staff resulting in multiple falls with injury.

INVESTIGATION:

On 4/1/2023, the Bureau received the allegations from the online complaint system.

On 4/5/2023, I interviewed the complainant by telephone who reported Resident A was ignored and neglected resulting in multiple falls with injury at the facility and later death. The complainant reported Resident A had resided in the memory care unit of the facility since November 2021 and began to demonstrate a decline in 2022. An increase in care services was requested due to the decline. Resident A was receiving hospice services and Visiting Angels services as well. The complainant reported due to facility staff not monitoring Resident A consistently with services in the service plan, Resident A incurred multiple falls with injury. The complainant reported the falls were brought to the facility administrator's attention and staff multiple times, but it was not addressed. The complainant reported Resident A passed away at the facility on 3/22/2023 upon returning from a recent hospitalization. The complainant reported they believe the falls with injury and "lack of concern about [Resident A] contributed to [Resident A's] death".

On 4/11/2023, I interviewed the facility administrator, Amanda Buhl, at the facility who reported Resident A resided in memory care unit of the facility since November 2021. Resident A began to demonstrate a decline in spring 2022 with hospice services signing on to monitor and treat Resident A in April 2022. Resident A would refuse care and meals intermittently and demonstrated depression, anxiety, and behaviors intermittently, as well.

Ms. Buhl reported Resident A was closely monitored by hospice staff and facility staff due to increased behaviors and fall risk. Ms. Buhl reported she conferenced with Resident A's authorized representative several times about Resident A's behaviors, decline, and to address the increase in falls. Ms. Buhl reported "it took awhile to get [the authorized representative on board with hospice recommendations and fall prevention methods for [Resident A]". Medication reviews were also completed for Resident A and the facility was in good communication with the physician concerning Resident A's demonstrated behaviors and reactions to medications. Ms. Buhl reported the facility increased care checks for Resident A to 30 minutes to 1 hour for safety and per the authorized representative's request. Ms. Buhl reported the facility updated and followed the service plan in place with all physician and hospice orders for Resident A as well. Hospice also communicated with the authorized representative about preparation for the end-of-life stage

concerning Resident A. Visiting Angels also provided extra supervision for Resident A at the end-of-life stage. Ms. Buhl reported staff did not neglect Resident A, as it would not be tolerated at the facility. Ms. Buhl reported Resident A's demonstrated and documented decline contributed to an increase in falls at the end of life stage and subsequent death.

On 4/11/2023, I interviewed Employee A at the facility who reported Resident A began to demonstrate a decline in overall function in April 2022, with hospice services being recommended to monitor and treat Resident A. Employee A reported knowledge of Resident A's falls and that care levels were increased in the service plan. Employee A reported hospice requested a fall mat and hospital bed for Resident A to help with fall prevention in "March or April [2023]". Resident A would demonstrate depression, anxiety, and/or behaviors with refusals of meals and care intermittently. Employee A reported Resident A's authorized representative was communicated with often along with hospice and the physician. Employee A reported the facility increased Resident A's levels of care along with care checks every 30 minutes to an hour. Employee A reported Resident A's decline contributed to an increase in falls and the facility worked closely with hospice to address the falls and decline. Employee A reported facility staff followed the service plan and physician and hospice orders and recommendations.

On 4/11/2023, I interviewed Employee B at the facility whose statements are consistent with Ms. Buhl's statements and Employee A's statements.

On 4/11/2023, I reviewed Resident A's record which revealed the following:

- Resident A had heart disease, generalized weakness, chronic systolic heart failure, hypothyroidism, dementia, depression, constipation, hypertension, and atrial fibrillation.
- Resident A required assist with all activities of daily living (ADLs) and redirection approaches from staff during refusals and demonstrated behaviors.
- Evidence of Resident A's decline since November 2021.
- Evidence of communication between the facility, the authorized representative, hospice, and the physician.
- Evidence of history of constipation and urinary tract infection with provided treatment.
- Evidence of ongoing confusion, restlessness, paranoia, depression, anxiety, and behaviors with refusals of meals, liquids, and care.
- Evidence of defibrillator monitoring and care.
- Documented falls: possible unwitnessed fall on 1/30/2023 but unable to confirm with resident due to demonstrated confusion, 2/26/2023, 3/15/2023, and unwitnessed fall on 3/4/2023.
- Unwitnessed fall on 3/19/2023. [Resident A] *observed on the floor in bathroom; resident did not have any clothes on and had a bowel movement on the ground; resident has open abrasion on left elbow, bandage was applied; resident was cleaned up by [staff]; resident positioned in bed;*

resident may benefit from an alarm; will continue to monitor for safety and behaviors.

- Documented care checks on Resident A from 30 minutes to 1 hour for Resident A.

On 4/11/2023, I reviewed the information and pictures provided by the complainant which revealed:

- Picture of fall on 2/26/23 with facility staff assisting.
- Pictures of bruising to Resident A's head, upper extremities, and hands from March 2023.
- Evidence a call pendant was requested, but Resident A may not be of good cognition to use it consistently.

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, on-site inspection, and review of documentation reveal Resident A began to demonstrate a decline in March of 2022, with hospice services onboarding in April 2022 to treat and monitor Resident A until end of life stage. Resident A began to demonstrate an increase in falls in January 2023, with five falls documented between January 2023 and March 2023. The last fall occurred on 3/19/2023 with documented injury to Resident A's person. During this fall Resident A was found by facility staff with no clothes on in [their] bathroom and having a bowel movement on the floor. It is documented in Resident A's record that Resident A was to receive care checks every 30 minutes to an hour from facility staff due to being an increased fall risk. There is no documented evidence in the record of a care check performed by facility staff prior to this fall. The last care check was documented on 3/18/2023 at 3:16pm. Resident A's fall was documented occurring on 3/19/2023 at 10:16pm. It cannot be determined if staff checked on Resident A in accordance with the service plan and it cannot be determined if staff provided Resident A care checks prior to the fall on 3/19/2023, as there is no documentation in the record to support this. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility is short staffed.

INVESTIGATION:

On 4/5/2023, the complainant reported there were never any staff around when [they] visited Resident A and this contributed to the increase of Resident A's falls and decline. The complainant also reported Employee C told [them] that "a bunch of staff called in St. Patrick's weekend to go out drinking which is when [Resident A] had the last fall".

On 4/11/2023, Ms. Buhl reported only three employees total across all shifts called in St. Patrick's Day weekend. Ms. Buhl reported the facility is currently overstaffed and even with the call-ins during St. Patrick's Day weekend, all shifts were full and staffed appropriately. There are currently 57 residents in the facility. First and second shifts have five to six care staff and two supervisors staffed. Third shift has three care staff with two supervisors staffed. Ms. Buhl reported the facility is not

short staffed and if call-ins occur, there is enough on-call staff, float staff, and management to cover a vacant shift.

On 4/11/2023, I interviewed Employee A and Employee B at the facility who both reported no knowledge of the facility being short-staffed St. Patrick's Day weekend. Employee A and Employee B reported the facility is not short staffed and their statements were consistent with Ms. Buhl's statements.

On 4/10/2023, I reviewed staffing schedules and also observed on-site an appropriate staff to resident ratio.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	It was alleged the facility is short staff. Interviews, on-site inspection, and review of documentation reveal the facility is appropriately staffed to meet the needs of residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

Additional Findings:

INVESTIGATION:

On 4/5/2023, when interviewed, the complainant reported a Hospice End of Life Care Pack issued to another resident and containing medication was left in Resident A's room by staff in November 2022. The complainant provided pictures of the Hospice End of Life Care Pack to me for my review. Pictures of a loose pill found in Resident A's in October 2022 was also provided to me by the complainant for my review. The complainant reported bringing this issue to the facility's attention but "it was not taken care of and shouldn't have happened as many times as it did". The complainant also provided photographic evidence of medications located on Resident A's end table and bed in Resident A's room.

On 4/5/2023, Ms. Buhl reported the authorized representative reported to staff in October 2022 that a loose pill was found in Resident A's room. Ms. Buhl reported the pill was later identified as Tylenol and all staff to include visiting staff members were educated on medication safety and handling. Ms. Buhl confirmed a hospice staff member completed a check on Resident A and then accidently left a Hospice End of

Life Care Pack in Resident A's room. Due to this error, Ms. Buhl reported a policy was put into place that no Hospice End of Life Care Packs are to be carried on their person and/or taken to any resident room unless they are going to be administered then by hospice. Resident rooms are not to have any medications in them, and all medications must be appropriately secured, handled, and stored by hospice and/or facility staff.

APPLICABLE RULE	
R 325.1932	**Resident Medications**
	(5) A home shall take reasonable precautions to ensure or assure that prescription medication is not used by a person other than the resident for whom the medication is prescribed.
ANALYSIS:	Unsecured medication was found in Resident A's room in October 2022 and again in November 2022. It cannot be determined how the medication became unsecured in Resident A's room on either occasion. Also, in November 2022, a hospice staff member accidently left a Hospice End of Life Care Pack containing medication for another resident in Resident A's room. It is the facility's responsibility and duty to secure all medications and to take reasonable precautions to ensure prescription medication is used correctly by the person it is prescribed for.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, I recommend the status of this license remain unchanged.

Julie Viviano

4/12/2023

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Julie Viviano Date
Licensing Staff

Approved By:

06/05/2023

_____

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