GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 18, 2023

Connie Clauson
Bishop Hills L.L.C.
3196 Kraft Ave SE
Grand Rapids, MI 49512

RE: License #: AH410236738
Investigation #: 2023A1021091
Bishop Hills Elder Care

Dear Mrs. Clauson:

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

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 #:	AH410236738
Investigation #:	2023A1021091
Complaint Receipt Date:	09/28/2023
Investigation Initiation Date:	09/28/2023
Report Due Date:	11/28/2023
Licensee Name:	Bishop Hills L.L.C.
Licensee Address:	4951 11 Mile Rd. NE Rockford, MI 49341
Licensee Telephone #:	(616) 719-5100
Administrator:	Debra Smith
Authorized Representative:	Connie Clauson
Name of Facility:	Bishop Hills Elder Care
Facility Address:	4951 11 Mile Road, NE Rockford, MI 49341
Facility Telephone #:	(616) 866-8227
Original Issuance Date:	02/29/1996
License Status:	REGULAR
Effective Date:	11/06/2022
Expiration Date:	11/05/2023
Capacity:	47
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A provided care inconsistent with service plan.	Yes
Additional Findings	Yes

III. METHODOLOGY

09/28/2023	Special Investigation Intake 2023A1021091
09/28/2023	Special Investigation Initiated - Telephone left message with complainant
09/29/2023	Contact - Telephone call made interviewed administrator
09/29/2023	Contact - Document Received received Resident A's documents
09/29/2023	Contact-telephone call made Interviewed Staff Person 1
10/03/2023	Contact-Telephone call made Interviewed SP2
10/18/2023	Exit Conference

ALLEGATION:

Resident A provided inadequate care.

INVESTIGATION:

On 09/28/2023, the licensing department received a complaint with allegations Resident A was transferred to the emergency department due to a fall at the facility. The complainant alleged at the hospital, Resident A was found to have dried feces in her Depend and that Resident A had to be shaved to remove the dried feces.

On 09/29/2023, I interviewed administrator Debra Smith by telephone. Ms. Smith reported that on 09/21/2023, Resident A was found on her bedroom floor with a laceration to her arm. Ms. Smith reported due to the laceration, Resident A was sent to the emergency room. Ms. Smith reported it was reported to the facility that Resident A’s Depend was full of dried feces. Ms. Smith reported Resident A is very

combative with care staff and is not receptive to receiving care. Ms. Smith reported Resident A has kicked, punched, and yelled at care staff when they attempt to provide care. Ms. Smith reported Resident A is incontinent and does wear a Depend. Ms. Smith reported when Resident A is incontinent, care staff will try to clean Resident A to their best ability. Ms. Smith reported that it is expected for care staff to check on Resident A every two-three hour. Ms. Smith reported Resident A is now signed onto Hospice services and the company has prescribed Ativan gel to assist with Resident A's behaviors.

On 09/29/2023, I interviewed staff person 1 (SP1) by telephone. SP1 reported Resident A is very combative and is resistant to receiving care. SP1 reported Resident A will be incontinent in her bedroom, on the floor, and in the bathroom. SP1 reported care staff will clean Resident A the best that Resident A allows them to do so. SP1 reported they check on Resident A approximately three times during the shift. SP1 reported she worked on 09/21/2023 but was not assigned to Resident A's hallway.

On 10/03/2023, I interviewed SP2 by telephone. SP2 reported she worked on 09/21 and provided care to Resident A. SP2 reported she went to check on Resident A in her room and observed Resident A to be on the floor with a laceration to her arm. SP2 reported she called for additional staff assistance and Resident A was transferred to the emergency room. SP2 reported she had checked on Resident A every hour and had observed Resident A to be asleep in her bed. SP2 reported during her shift Resident A was not incontinent and did not require any assistance with the bathroom. SP2 reported Resident A can be combative with staff and it can be difficult to provide bathroom assistance to Resident A.

Resident A's observation notes read,

> *"09/06: Med passer went in residents room to give resident her morning medication. Staff tried sitting up resident and resident began to scream and yell and started hitting staff. Three other staff members went down at different times to get resident to at least get up into the bathroom to get changed. Resident still was yelling and hitting and refusing to get out of bed.*
> *08/21: 4:30 am resident checked on and was observed with BM in bed. Res asleep and did not ring to tell staff she needed to be changed. She also was upset she had to get up and wanted to stay laying in it. We were able to get her up and into clean brief and changed her bed. She wouldn't let us change her shirt though that had what looked like dried chocolate down the front of it.*
> *08/19: Res was very resistant to any cares today. Yelling and screaming to leave her alone. The second aid was finally able to get her toileted and dressed around noon."*

Resident A's service plan read,

"Altered sleep cycle. Can become combative when woken up to change brief and assist to bathroom. Ensure sleep area is quiet and at preferred temperature. Provide routine bedtime activities such as snack, quiet music. Likes TV to fall asleep. Complete hourly checks. Requires reminders to bathroom or protective garment usage. Remind discreetly and privately."

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 conducted and review of documentation revealed Resident A wears Depends, is incontinent and often has accidents in her room, and can be combative with care staff when care is offered. Review of Resident A's service plan revealed lack of detail as to the level of care Resident A required and staff responsibility to provide said care. For an example, there was no mention of Resident A's level of incontinence, combative behaviors, use of PRN Ativan, and methods to manage behaviors.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 10/03/2023, I interviewed the complainant by telephone. The complainant alleged Resident A has had multiple falls in the past month. The complainant alleged the facility has encouraged Resident A to utilize her call light which is difficult for Resident A to do as Resident A has advanced dementia. The complainant alleged the facility has not placed appropriate interventions to decrease Resident A falls.

SP2 reported Resident A has had frequent falls. SP2 reported Resident A has a door alarm on her door to alert caregivers when Resident A is leaving her room. SP2 reported there are no mechanisms in place to alert caregivers when and if Resident A has fallen in her room.

Review of Resident A's observation notes revealed Resident A had the following falls:

08/15: unwitnessed fall in room
08/27: fall in room while caregivers present

09/02: Fall in bathroom
09/03: Unwitnessed fall in room
09/08: Unwitnessed fall in room
09/18: fall in dining room
09/20: fall in dining room
09/21: unwitnessed fall in room
09/21: unwitnessed fall on patio

Review of incident reports for each fall included:

09/02: Resident got up on her while in the bathroom. Staff recorded she sat down and in the process sitting on the toilet and sliding down to the fall. Incident was witnessed by several staff. She was assessed with no s/s of injury noted. She was assisted up by staff. Family and physician notified.
09/03: Asked her to ring for help if she feels unsteady. Resident observed on her floor in the middle of her floor. She was unable to report what happened. Staff assessed her and assisted her up. No s/s of injury noted. Resident remains with ambulation as in she can transfer self and will forget to ask for assistance with help.
09/07: Resident observed on the floor in the middle of her room. No S/S of injury noted. Resident is able to get up on her own and does forgot to ask for assistance. Will continue to monitor.
09/18: Resident was witnessed getting up and falling backwards. She was assisted with needs. No injury noted. She was assisted back to her w/c and offered a drink. Staff was close by but unable to get to her fast enough to prevent her from falling.
09/20: Make sure wheelchair brakes are locked. Resident has been active in getting up on her. She lost her balance and fell out of her wheelchair. Resident was in the dining room with several people around. Unable to get to her in time to prevent her falling.
09/21: Resident has had several falls in the past few days. She has been monitored with staff close by during some of these falls. Resident will be assessed for hospice on Monday 9/25/23.
09/21: Needs to use call light for assistance. Resident was transferred to the emergency department for evaluation and treatment as needed. She received sutures to her upper right arm and needs to be seen to remove sutures in 10 days. Labs were completed and she returned to Bishop Hills. Provider in to see resident on 9/21/23. Resident due to sign up for hospice on 09/25/23. Continue to monitor for infection."

Resident A's observation notes read,

"08/17: door alarm not on at first room check, alarm set. No c/o from fall on 08/15.
08/30: Ativan order was changed from once daily as needed to once scheduled at 4 pm and once daily as needed.

08/19: Res was very resistant to any cares today. Yelling and screaming to leave her alone. The second aid was finally able to get her toiled and dressed around noon.
08/25: Resident at dinner was very mad and was yelling at resident next to her. When staff stepped in to try to settle her down she was yelling at staff and calling them names. She was taken to her room and Ativan was given at 5:34. Resident went to bed approx. at 7 pm and was sleeping when attempt was made to give her hs meds. Resident was still sleeping. Meds no passed.
08/27: Resident was very aggressive and angry this morning. Staff tried siting resident up to take medication resident hit staff. Resident yelling at staff to leave her alone that she didn't want to get up. Staff stated resident needed to take her blood pressure medication and get changed and that she could lay back down resident very angry continuing to yell. Resident also flung water on floor, herself, and staff member trying to help. Staff unable to give resident medication. Was able to get resident up into the bathroom.
09/06: Med passer went in residents room to give resident her morning medication. Staff tried sitting up resident and resident began to scream and yell and started hitting staff. Three other staff members went down at different times to get resident to at least get up into the bathroom to get changed. Resident still was yelling and hitting and refusing to get out of bed.
09/08: very anxious today.

Resident A's service plan read,

"Resident has had more than 1 fall in the last 3 months."

APPLICABLE RULE	
R 325.1921	**Admission and retention of residents.**
	(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.**
	(p) "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:	Interviews conducted and review of documentation revealed Resident A was a fall risk as demonstrated by having multiple falls, trying to get up unassisted, and demonstrating anxious behaviors. Resident A had nine falls within a 30- day period. The facility did not appropriately update service plan nor implement appropriate corrective methods to prevent future falls from occurring for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Kimberly Horst 10/09/2023

Kimberly Horst Date
Licensing Staff

Approved By:

Andrea L. Moore 10/17/2023

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