GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

Eric Simcox
Kingsley Senior Living
44100 Connection Way
Canton, MI 48188

April 25, 2024

RE: License #: AH820402301
Investigation #: 2024A1011008
Kingsley Senior Living

Dear Mr. Simcox:

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 licensee's 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 submit your corrective action plan to usual assigned HFA licensing staff Brender Howard.

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 (877) 458-2757.

Sincerely,

Andrea Krausmann, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street - P.O. Box 30664
Lansing, MI 48909
(586) 256-1632

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820402301
Investigation #:	2024A1011008
Complaint Receipt Date:	02/12/2024
Investigation Initiation Date:	02/13/2024
Report Due Date:	04/13/2024
Licensee Name:	Antioch Connection Canton MI, LLC
Licensee Address:	799 Windmiller Drive Pickerington, OH 43147
Licensee Telephone #:	(614) 861-8128
Administrator:	Eric Simcox
Authorized Representative:	Josie Gentry
Name of Facility:	Kingsley Senior Living
Facility Address:	44100 Connection Way Canton, MI 48188
Facility Telephone #:	(734) 405-7500
Original Issuance Date:	08/10/2022
License Status:	REGULAR
Effective Date:	02/10/2023
Expiration Date:	02/09/2024
Capacity:	92
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Insufficient staff on duty to respond to call lights and provide for resident care needs.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/12/2024	Special Investigation Intake 2024A1011008
02/13/2024	Special Investigation Initiated - Telephone Called complainant and left voice mail requesting call-back.
02/13/2024	Contact - Telephone call received Interviewed complainant.
02/13/2024	APS Referral Forwarded allegations to adult protective services (APS) via referral form attached to email.
02/23/2024	Inspection Completed On-site Interviews conducted, observations made, and records reviewed.
02/26/2024	Contact - Document Received Letter from Compliant Coordinator, Adult Services APS Oakman Adult Services District informing me that my referral will not be investigated. It does not meet requirements for APS investigation.
04/25/2024	Exit Conference – SIR #2024A1011008 sent to authorized representative Eric Simcox via email.

ALLEGATION:

Insufficient staff on duty to respond to call lights and provide for resident care needs.

INVESTIGATION:

On 02/12/2024 I received the allegations from the department's intake unit. On 02/13/2024, I interviewed the complainant by telephone and forwarded the allegations to adult protective services.

The complainant explained staff are not responding to resident call alert devices in a timely manner and they are not taking care of residents' daily living needs. The complainant said Resident A recently had a stroke and due to partial paralysis, she is unable to fully care for herself. Resident A relies on staff to assist her with dressing, toileting, and such. The complainant said Resident A called the complainant at 10:15 am the morning of 02/10/2024, saying she had spilled food on her clothes, she felt "gross", and no staff was coming to her room. The complainant called Resident A back at noon and Resident A still had problems getting staff to respond and assist. The complainant then drove to the facility and at approximately 3:30 pm on 02/10/2024, the complainant observed Resident A sitting on the couch with her room to be "a mess". The complainant said both breakfast and lunch trays were still in the room. The complainant said the straw in Resident A's beverage did not have the paper cover removed and consequently, Resident A could not drink the beverage. Also, the bowl of soup had a cover that Resident A could not open independently. The complainant reported having pushed Resident A's call alert button at 3:34 pm and staff did not come to the room until 4 pm. The complainant said Staff person #1 said the call light system had been turned off. The complainant said other residents have been making the same complaints of staff not responding timely to the call alert buttons and not providing the care they need.

On 02/23/2024, in the absence of administrator Josie Gentry, I met with Business Office Manager Kiera Coakley and Regional Operations Manager Sara Reynolds at the facility. Upon request, Ms. Coakley provided printed copies of various dates of the facility's call light response times. In this sample of three days, elapsed time responses to the rooms ranged from 00:00 [zero minutes and zero seconds] to the highest of 2:42:47 [2 hours: 42 minutes: 47 seconds]. The following are documented call lights with elapsed response times greater than 20 minutes. The call lights revealed the following extended leave response times:

Date	Time Hour:Minute:Seconds	Room #	To Room Elapsed Time Hour:Minute:Seconds
02/03/2024	12:03:26 AM	229	59:45
02/03/2024	5:48:46 AM	225	39:26
02/03/2024	6:57:13 AM	110	2:06:38
02/03/2024	8:12:59 AM	225	1:33:53
02/03/2024	8:21:06 AM	115	1:17:41
02/03/2024	9:00:48 AM	229	48:07
02/03/2024	9:49:25 AM	246	1:33:54
02/03/2024	10:16:29 AM	225	1:10:06
02/03/2024	11:06:15 AM	215	19:43
02/03/2024	11:27:35 AM	101	1:03:29
02/03/2024	1:24:11 PM	101	20:14
02/03/2024	2:26:51 PM	233	20:41
02/03/2024	5:08:25 PM	101	28:24

02/03/2024	5:52:01 PM	233	35:54
02/03/2024	6:01:55 PM	229	27:20
02/03/2024	6:31:46 PM	213	41:20
02/03/2024	7:39:26 PM	229	27:29
02/03/2024	8:13:18 PM	215	1:12:19
02/03/2024	9:32:07 PM	213	39:24
02/03/2024	9:50:07 PM	215	22:07
02/03/2024	11:37:55 PM	229	26:36

02/09/2024	3:02:00 AM	215	3:14:05
02/09/2024	4:52:47 AM	225	1:23:55
02/09/2024	5:33:03 AM	229	27:47
02/09/2024	6:22:27 AM	213	1:41:49
02/09/2024	6:55:03 AM	225	58:54
02/09/2024	7:00:30 AM	110	46:40
02/09/2024	7:49:48 AM	246	1:21:28
02/09/2024	8:41:35 AM	115	29:40
02/09/2024	9:24:04 AM	115	22:08
02/09/2024	10:17:51 AM	229	25:06
02/09/2024	12:11:38 PM	229	24:42
02/09/2024	1:18:54 PM	215	38:58
02/09/2024	1:46:15 PM	233	21:49
02/09/2024	3:16:54 PM	225	1:02:43
02/09/2024	3:56:54 PM	115	21:30
02/09/2024	4:31:48 PM	233	1:55:43
02/09/2024	4:34:29 PM	215	1:53:03
02/09/2024	5:52:52 PM	213	34:40
02/09/2024	5:56:49 PM	225	30:42
02/09/2024	6:51:59 PM	115	2:12:33
02/09/2024	7:05:18 PM	121	1:59:14
02/09/2024	7:30:05 PM	110	1:34:26
02/09/2024	7:32:27 PM	215	1:32:05
02/09/2024	7:53:28 PM	229	1:11:04
02/09/2024	8:30:55 PM	213	33:36
02/09/2024	9:06:23 PM	213	1:03:08
02/09/2024	9:15:00 PM	229	56:49
02/09/2024	9:17:28 PM	215	52:44

02/11/2024	3:37:29 AM	239	1:28:24
02/11/2024	7:34:20 AM	229	1:04:07
02/11/2024	7:54:30AM	243	30:17
02/11/2024	8:47:44 AM	246	1:35:43
02/11/2024	8:49:35 AM	225	38:09
02/11/2024	11:21:24 AM	229	1:00:59
02/11/2024	12:46:43 PM	229	2:42:47

02/11/2024	12:53:13 PM	215	48:37
02/11/2024	1:10:43 PM	213	27:05
02/11/2024	2:01:40 PM	215	43:24
02/11/2024	2:35:15 PM	213	58:31
02/11/2024	3:33:20 PM	225	30:08
02/11/2024	4:14:40 PM	101	38:30
02/11/2024	4:25:29 PM	110	27:23
02/11/2024	7:54:38 PM	215	1:08:04
02/11/2024	8:23:58 PM	229	54:37
02/11/2024	9:24:09 PM	213	22:17

On 02/23/2024, I interviewed five residents [Residents A, B, C, D, E] separately at the facility. Call light response time documentation above revealed all five individuals were living in rooms that had extended call alert response times by staff of 20 minutes or more. The five residents verbally confirmed that response times have taken 20 minutes or more. The five residents also had various complaints of the staff being in a hurry. Residents A and D had complaints of inappropriate staff treatment but none of them reported being afraid to report their concerns to administrative staff.

In my interview, Resident A affirmed the allegations made by the complainant. Resident A also said that staff are especially slow in the morning when she needs assistance to go to the toilet, and added, “They don’t understand that uncomfortable feeling”. Resident A also explained how staff do not provide the care she requires such as removing the lid of a soup bowl or the paper off the straw. Resident A explained that since her stroke, she has a hard time verbalizing what she is wants to say and that it takes a little time to get the words out. Resident A said, “They are in so much of a hurry that they do not have patience to wait form me to get out the information”. Resident A also said that a particular staff “threw clothes at me and said ‘Get dressed!’. I can’t. I need help. . . She was very mean to me”. Resident A said she reported that particular staff twice and that the staff person “made the kindest excuse”. Resident A affirmed that that things have improved but said of the particular staff person, “She treats me fake better”.

I reviewed Resident B’s service plan at the facility. The service plan revealed Resident B requires two-person assist with a sliding board for transfers, has balance problems when standing, requires a bedside commode and bed pan for toileting with hands on assist from staff, and set up for meals with a bedside table.

In my interview, Resident B said “There’s not enough help. Service is so delayed. Today, in my wheelchair, I need a Hoyer [lift] to get in bed. I waited an hour. They come in, clear the thing [call alert button] but do not do the thing that I need. They say they’ll come back but they don’t. Sometimes I put my hand over it and say you’re not clearing it until I get what I need.” Resident B explained that staff said the administrator directed the staff to respond to the call alert buttons by going into the

resident's room and clearing the alert. Then staff are to tell the resident that they'll come back to them after they finish whatever they're doing. Resident B said that the staff don't come back for a while. Resident B also explained that the Hoyer lift requires two staff to operate it. However, on occasion, one staff member tried lifting Resident B with the Hoyer alone. Resident B said, "She almost dumped me out of the Hoyer. It's supposed to be two people." Resident B also described an incident receiving care from two staff. While the two staff were on each side of the bed leaning over Resident B, Resident B said, the two staff were "fighting" with one another. Resident B had to tell the staff to take their argument outside the resident's room and not while providing care to Resident B. Resident B said the issue is that the facility has had more resident admissions but no increase in staffing.

Resident C's service plan includes the need of a Hoyer lift for all transfers, and "extensive" assistance with bathing, dressing, escorts and hygiene.

In my interview, Resident C said at times there is only one staff member to care for all the residents on the floor, and "many of them [residents] are in bad shape. Some people can't move and need help. They need people to pour coffee for them. . . In the beginning, I was raising hell. There's a break through in my brief and it goes on the pad and sometimes I wait for ½ hour. When they had sick people, I heard them [residents] yelling and everything. Normally, it takes them ½ hour [to respond]". It is noted that in the above sample of call alert response times, Resident C's room has multiple occasions of more than an hour of response time.

Resident D's service plan includes the need of a Hoyer lift for all transfers, "total" assistance with toileting, bathing, and dressing.

In my interview, Resident D said staff response times can be 1 ½ to 2 hours wait. Resident D said, "Now [administrator] Josie [Gentry] has them [staff] run in to shut off call [alert] buttons and to tell you why they can't care for you and run out of the room. It's an hour or more before they come back". Resident D explained staff shutting off the call alert buttons is to make the response times look good, but it does not reveal the true response time for care. Resident D explained that staff routinely say, "Could you wait 15 minutes while I do this other resident then I'll be back to you". Resident D said they do not return for a very long time. Resident D said one night there were no staff responding to the call alert system and Resident D was calling out "Help! Help!". Resident D said the staff "got pissed off" for calling for help.

Resident D said, "There is quite a turnover in caretakers and some [staff] were abusive". Resident D said of current staff being "heavy handed and threatening". Resident D said staff can be "rough" during brief changes and staff put their elbow in Resident D's back, where back surgery had occurred. Resident D said staff will grab and pinch and say, "She's not in pain". Resident D recalled a scheduled conference meeting with administrator Josie Gentry, and just before the meeting the staff came into Resident D's room and reportedly said, "Remember, you've been changed 14 times a day!". Resident D said the facility's head nurse told Resident D, "We don't

want the drama here. You're to report to me every day". Resident D said, "I'm looked at as a problem to them. They perceive me as a gossip and a busy body. They have said, 'You're nosey and you should take care of yourself'." Resident D explained having discussions about friends in the facility that were ill or hospitalized, and staff told Resident D, "You're under HIPPA. You can't talk about friends."

Resident E's service plan includes the need for a Hoyer lift, one person physical assistance in a wheelchair, fall risk due to poor self-awareness and vision impairment, "dependent" for bathing and oral care, "totally dependent" for dressing, and one person assist on and off the toilet.

In my interview, Resident E said of staff response times to the call alert button, "They come sometimes. Other times they make the excuse that they are understaffed. I've waited an hour and a half before. It happens quite often."

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:	Recorded call alert response times indicate residents are routinely waiting in excess of 20 minutes, and often more than an hour, to receive needed personal care from staff consistent with their service plans. Interviews with residents confirmed the documented response times are accurate. Consequently, the documentation and resident statements indicate that the home does not have adequate and sufficient staff on duty at all times to provide for resident needs consistent with resident service plans.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

In my interview, Resident D said her pain medication and Resident F's diabetes medication are not being administered as ordered. Resident D said Hydroco/Apap is prescribed to be administered at specific times four times a day. Resident D said when staff are an hour late with the pain medication, not only does it increase her pain it results in her blood pressure rising significantly, and she already takes medication for high blood pressure.

Review of Resident D's medication administration record (MAR) revealed a physician's order for Hydroco/Apap Take one tablet four times daily scheduled at 8:00, 12:00, 16:00 and 20:00. Staff entries into the MAR from 2/16 to 2/23/24 revealed staff are frequently administering the medication Hydroco/Apap in excess of an hour late. Of the thirty doses administered during this time frame, twelve doses were administered more than an hour later that the scheduled times. Four doses were between an hour and an hour and 18 minutes late, two doses were an hour and 20 minutes late; one was an hour and a half late; three doses were more than two hours late; and two doses were more than two and a half hours late.

The MAR system automatically documented these twelve doses as "LATE". Contrary to this, staff then entered responses such as "n/a"; "within time", "gave on time late check off because tech doing resident care"; "resident care"; "on time"; "late check off" and "within time". In addition to these twelve doses being administered more than an hour late, another three doses were administered 50 minutes or more after the scheduled time.

I was unable to interview Resident F because he was sleeping. However, review of Resident F's MAR revealed two medications.

The first is a scheduled Humalog 3 units daily with meals. Hold for blood glucose less than 100 *Call MD if less than 70 or greater than 400. Inject 15 minutes prior to meals. Scheduled daily at 8:00, 12:00, 16:00.

The second is a sliding scale Humalog inject three times daily with meals. Dosage was in accordance with blood glucose levels as follows:
201-250 = 1U
251-300 = 2U
301-350 = 3U
351-400 = 4 U
HBG less than 100 *Call MD if less than 70 or greater than 400.
Inject 15 minutes prior to meals. Scheduled daily at 8:00, 12:00, 16:00.

Staff entries into Resident F's MAR from 2/16 to 2/23/24 revealed only one staff entry to record both the scheduled and the sliding scale doses at a time. This would typically result in a minimum of 3 units plus however many sliding scale units were needed. However, staff documentation was inconsistent whether they were included the scheduled 3-unit dose along with the sliding scale dose. Documentation indicates errors in administration. The first four columns are documentation from the MAR. The EXPECTED DOSE column is deduced from the physician orders and the blood glucose reading that was recorded.

Date time dose scheduled	Time staff documented administration	Blood Glucose Reading	Quantity administered	Notes		EXPECTED DOSE

2/16/24 8:00 am	11:01 am			OUT OF FACILITY		
2/16/24 12:00 am	2:20 pm			Oof [out of facility] at the time came back after 2pm		
2/16/24 4:00 pm	4:44 pm	204	1.0			3 + 1 = 4
2/17/24 8:00 am	9:31 am	147				3
2/17/24 12:00 pm	12:38 pm	147				3
2/17/24 4:00 pm	4:39 pm	270	5.0			3 + 2 = 5
2/18/24 8:00 am	10:23 am	137				3
2/18/24 12:00 pm	1:31 pm	237				3 + 1 = 4
2/18/24 4:00 pm	4:48 pm	167	3.0			3
2/19/24 8:00 am	9:18 am	125				3
2/19/24 12:00 pm	12:00 pm			given		3 + ? No BG
2/19/24 4:00 pm	4:32 pm	139	3.0			3
2/20/24 8:00 am	7:26 am	110				3
2/20/24 12:00 pm	12:42 pm	134				3
2/20/24 4:00 pm	5:16 pm	133	0.0	LATE:		3
2/21/24 8:00 am	9:31 am	148				3
2/21/24 12:00 pm	12:35 pm	208	1.0			3 + 1 = 4
2/21/24 4:00 pm	4:31 pm	221	1.0			3 + 1 = 4
2/22/24 8:00 am	8:30 am	180				3
2/22/24 12:00 pm	1:28 pm	142				3

2/22/24 4:00 pm	4:46 pm	120	0.0			3
2/23/24 8:00 am	9:45 am	218	1.0	LATE: n/a		3 + 1 = 4
2/23/24 12:00 pm	1:15 pm	282	2.0	LATE: resident care		3 + 2 = 5

Of the above MAR documentation only three doses are recorded as having been administered in accordance with the expected dose on 2/17, 2/18 and 2/19/24 at 4 pm doses, although these were recorded a half hour or longer past the expected times. All other entries omit the 3 unit scheduled dose as having been administered. Also, several entries are recorded as having been administered more than an hour past the scheduled times. See: 2/16 at 8:00 am; 2/18 at 12:00; 2/19 at 8:00; 2/20 at 4:00; 2/21 at 8:00; 2/22 at 12:00; 2/23 at 8:00 and 2/23/24 at 12:00 doses. In addition, there was no blood glucose reading and no number of units recorded as having been administered on 2/19/24 at 12:00.

APPLICABLE RULE	
R 325.1932	**Resident's medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.
ANALYSIS:	Documentation on the Medication Administration Records for Resident D and Resident F reveal medications are not given pursuant to orders. Documentation indicates incorrect doses, late administration, and, at times, medications are not recorded as having been administered at all.
CONCLUSION:	**VIOLATION ESTABLISHED**

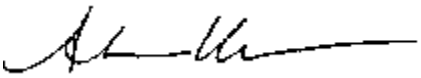
INVESTIGATION:

Resident F is prescribed scheduled and sliding scale doses of Humalog daily 15 minutes before meals at daily at 8:00, 12:00, 16:00. On Resident F's MAR, the 2/16/24 at the 8:00 am dose staff recorded "Out of Facility" at 11:01 am. It is unknown why the staff waited for three hours before attempting to administer the 8:00 am dose. Also, on Resident F's MAR, the 2/16/24 12:00 pm dose staff wrote, "OUT OF FACILITY" and "oof at the time – came back after 2pm". There was no documentation to indicate Resident F was provided the appropriate information, medication and instructions during the time he was out of the facility.

APPLICABLE RULE	
R325.1932	**Resident's medications**
	(4) If a resident requires prescription or over-the-counter medication or medications while out of the home, the medication or medications are not identified as self-administered, staff responsible for the medication management shall ensure that the resident, or the staff person that assumes responsibility for the resident, has all appropriate information, medication and instructions.
ANALYSIS:	Resident F's MAR on 2/16/2024 at 8:00 and 12:00 doses provided no evidence to confirm Resident F was provided the appropriate information, medication, and instructions during the time he was out of the facility. Staff only recorded that he was out of the facility. It is unknown whether he received his medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.



3/14/2024

Andrea Krausmann Date
Licensing Staff

Approved By:

04/23/2024

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