GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

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

April 25, 2024

RE: License #: AH820402301
Investigation #: 2024A1011009
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 #:	2024A1011009
Complaint Receipt Date:	02/16/2024
Investigation Initiation Date:	02/20/2024
Report Due Date:	04/17/2024
Licensee Name:	Antioch Connection Canton MI, LLC
Licensee Address:	799 Windmiller Drive Pickerington, OH 43147
Licensee Telephone #:	(614) 861-8128
Administrator:	Josie Gentry
Authorized Representative:	Eric Simcox
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:	07/31/2024
Capacity:	92
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident I has fallen in his apartment and it has taken 20-25 minutes for someone to answer his call light. He is afraid to report it.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/16/2024	Special Investigation Intake 2024A1011009
02/20/2024	Special Investigation Initiated - Telephone Allegations received today, upon return to office. Left voice mail for complainant requesting call-back.
02/22/2024	Contact - Telephone call made Left second voice mail message for complainant, attempting to interview to obtain more information.
02/23/2024	Contact - Telephone call received Complainant returned my call. Interview conducted.
02/23/2024	Inspection Completed On-site Interviews conducted, observations made, and records reviewed.
03/21/2024	Contact - Telephone call made Interviewed and requested additional information from administrator Josie Gentry.
03/21/2024	Contact – Document Sent Email to administrator Josie Gentry clarifying documentation that I requested.
03/22/2024	Contact – Document Received Administrator Josie Gentry emailed she will submit documentation by the end of the day.
03/22/2024	Contact – Document Received Administrator Josie Gentry emailed she's having trouble attaining call light response information from her computer. She has someone coming out on Monday 3/25/24.

	I replied that business office manager Kiera Coakley had no issues will pulling the call light response sheets. I asked is Kiera no longer working at Kingsley. Please submit them today.
03/26/2024	Contact – Document Sent Email sent to authorized representative Eric Simcox and administrator Josie Gentry requesting the call light response time sheets that I have been requesting since 3/21/2024.
03/26/2024	Contact – Document Received Authorized representative Eric Simcox provided printout of call light response times via email.
04/25/2024	Exit Conference – SIR #2024A1011009 sent to authorized representative Eric Simcox via email.

ALLEGATION:

Resident I has fallen in his apartment and it has taken 20-25 minutes for someone to answer his call light. He is afraid to report it.

INVESTIGATION:

On 2/20/2024, I received the allegations. I interviewed the complainant by telephone on 2/22/2024. The complainant said Resident I was admitted into the hospital due to a fall on 2/4/2024. He was then discharged on 2/20/2024. The complainant said Resident I told the complainant that while he was residing at Kingsley Senior Living, when he pushed the call alert button for staff assistance, it took the staff 25 to 30 minutes to respond. Recently, when he fell at Kingsley, it took so long for staff to respond that he fell asleep on the floor waiting for them. Resident I reportedly told the complainant that he is concerned if residents tell administrative staff, that the staff will retaliate and not take residents to their rooms after meals.

The complainant also said Resident I had a stroke in 2023, and he would vacillate in his statements whether certain allegations actually occurred. Reportedly, Resident I said staff may have kicked him from behind but then reported maybe he fell on his own and the staff were just behind him. Resident I also reportedly told the complainant that things were getting better at Kingsley.

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. I was told that Resident I had not yet returned from his hospitalization. He was sent to a rehabilitation center, and it was unknown when he would be returning. During my time at the facility, I observed staff escorting residents to and

from meals. Staff were engaged and interactive. No residents appeared to be left in the dining room after meal.

Upon request, Ms. Coakley provided copies of Resident I's service plan, his information sheet, an incident report dated 2/1/2024 documenting a fall, some staff care notes and copies of various dates of the facility's call light response times, including 02/02/2024.

I reviewed Resident I's service plan, which was dated 5/16/2023. The service plan indicated Resident I required two-person physical assist with ambulation and transfers along with using a wheelchair. The plan indicates he was a fall risk with an unsteady gait, balance problems when standing and required total assistance. It specifically reads, "Resident is a fall risk r/t left sided weakness. He is a 2 person assist. Provide reminders for resident to use call pendant when needing assistance."

According to the incident report dated 2/1/2024 at 2:30 pm Resident I had a fall on his bathroom floor. Staff called 911 but Resident I refused. Staff care notes also documented this event.

Additional staff notes documented 2/2/2024 indicate at "12:00 am Resident was seen about staff reports (sic) Resident is c/o his Lt knee hurting. Resident is seen lying in bed alert. States pain is 2 [on a scale of] 1-10 and continues down anterior leg with palpation. Resident tells me 'I cannot bear weight. I could yesterday' [name] NP called Telecall with resident. Verbal orders received to send resident to the hospital for futer (sic) imaging. Brother [name] notified."

Contrary to the midnight reference of 12:00 am in the above staff notes, review of the facility's call light response times for 2/02/2024 reveals Resident I's call light was initiated at 10:58:18 am. Staff response time was 42 minutes and 57 seconds or at 11:41:15, close to midday not midnight.

In addition to being sent to the hospital on 2/2/24, staff care notes reveal Resident I had falls on and was sent to the hospital on 12/13, 12/16, and 1/29/24 due to injuries related to the falls.

On 3/21/2024, I called administrator Josie Gentry. Ms. Gentry said Resident I has not returned to the facility and he has submitted a 30-day discharge notice to take effect 3/28/2024. I requested Ms. Gentry submit a few more dates of the facility's call light response times.

On 3/26/2024, I received via email from the licensee's authorized representative Eric Simcox, a copy of the facility's call light response times for dates 12/12, 12/13, 12/16/2023, 01/28, and 02/01/2024.

Review of the call alert response time documents, checking only for Resident I's room, revealed the following elapsed time responses:

Date	Time Hour:Minute:Seconds	Room #	To Room Elapsed Time Hour:Minute:Seconds
12/12/2023	7:28:32 AM	Resident I's room	06:04
12/12/2023	9:42:50 AM	Resident I's room	08:24
12/12/2023	11:07:22 PM	Resident I's room	08:27
*12/13/2023	1:41:00 AM	Resident I's room	33:44
12/13/2023	4:45:07 AM	Resident I's room	03:15
*12/13/2023	5:09:38 AM	Resident I's room	09:45
*12/13/2023	6:36:16 AM	Resident I's room	15:24
*12/13/2023	8:18:55 AM	Resident I's room	50:47
**12/13/2023	10:16:24 AM	Resident I's room	24:30:23
*12/16/2023	12:08:30 AM	Resident I's room	41:59
*12/16/2023	2:41:21 AM	Resident I's room	07:37
*12/16/2023	3:29:38 AM	Resident I's room	27:56
**12/16/2023	6:55:12 PM	Resident I's room	3:38:13
*01/28/2024	3:03:33 AM	Resident I's room	40:55
01/28/2024	9:49:20 AM	Resident I's room	22:17
01/28/2024	11:51:04 AM	Resident I's room	18:47
02/01/2024	1:35:13 PM	Resident I's room	02:46
02/01/2024	3:38:34 PM	Resident I's room	00:57
02/02/2024	10:58:18 AM	Resident I's room	42:57

Nine of the 19 call light response times recorded above included notes. The specific dates and times of the notes are identified by asterisks above with the note that was recorded provided below:

* - "Care Provided before Clearing"
** - "System Trouble"

On 02/23/2024, with Resident I not in the home, I interviewed five residents [Residents A, B, C, D, E] separately at the facility. Call light response time documentation reviewed at the facility 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 the five reported being afraid to report their concerns to administrative staff.

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.

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.

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:	Staff documentation recorded Resident I's multiple falls, some resulting in injuries and requiring to Resident I to be sent to the hospital. Resident I's 5/16/2023 service plan revealed he was at risk of falls and required two-person assist for ambulation and transfers, along with using a wheelchair. Staff were to provide reminders for Resident I to use call pendant when needing assistance. However, recorded call alert response times to Resident I's room ranged from 57 seconds to more than 24 hours. Although nine of the 19 response times recorded the a note of Care Provided Before Clearing or System Trouble, four other call light response times, on three different dates, ranged between 18 minutes 47 seconds and 42 minutes 57 seconds. Therefore, the home was not treating Resident I protection and safety consistent with his service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

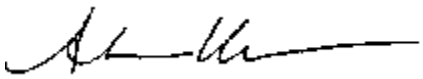
INVESTIGATION:

Resident I's service plan was dated 5/16/2023, more than a year old. There was no annual review of the plan notated and no updates to address his multiple falls.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	Resident I's service plan was dated more than a year ago, 5/16/2023. There was no evidence of the service plan having been updated at least annually nor after having sustained multiple falls, some requiring hospitalization.
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.



04/01/2024

Andrea Krausmann Date
Licensing Staff

Approved By:

04/23/2024

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