GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 13, 2022

John Drews
Country Living Of Hillsdale LLC
101 Village Green Blvd.
Hillsdale, MI 49242

RE: License #: AL300296087
Investigation #: 2022A1032013
Country Living of Hillsdale, LLC

Dear Mr. Drews:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Dwight Forde, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W. Unit 13, 7th Floor
Grand Rapids, MI 49503
(616)-240-3850

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL300296087
Investigation #:	2022A1032013
Complaint Receipt Date:	07/18/2022
Investigation Initiation Date:	07/19/2022
Report Due Date:	08/17/2022
Licensee Name:	Country Living Of Hillsdale LLC
Licensee Address:	101 Village Green Blvd. Hillsdale, MI 49242
Licensee Telephone #:	(517) 398-5333
Licensee Designee/Administrator	John Drews
Name of Facility:	Country Living of Hillsdale, LLC
Facility Address:	1133 N. Lake Pleasant Rd. Hillsdale, MI 49242
Facility Telephone #:	(517) 437-4611
Original Issuance Date:	10/03/2008
License Status:	REGULAR
Effective Date:	04/03/2021
Expiration Date:	04/02/2023
Capacity:	20
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Staff did not treat Resident A with basic dignity and respect upon her return to the home.	No
Staff did not take appropriate action to address Resident A's medical decline.	No
Additional Findings	No

III. METHODOLOGY

07/18/2022	Special Investigation Intake 2022A1032013
07/19/2022	Special Investigation Initiated - Face to Face
07/19/2022	Inspection Completed On-site
07/29/2022	Contact - Document Received
08/05/2022	Contact - Telephone call made Telephone call with John Drews, Licensee Designee
08/09/2022	Contact - Telephone call made Left VM for complainant
08/09/2022	Contact - Telephone call received Contact made with Relative A
09/08/2022	Contact - Telephone call received Contact made with Nurse Practitioner Penny Wallman
09/13/2022	Exit Conference

ALLEGATION:

Staff did not treat Resident A with basic dignity and respect upon her return to the home.

INVESTIGATION:

On 7/19/22, I interviewed Resident Care Manager Jessica Gordon at the home. Ms. Gordon stated that she had participated in Resident A's admission interview and denied that staff ignored Resident A when she first came, or that Resident A was ignored when she returned from being away hospitalized or upon her return for respite.

I inspected the home, and the rooms were well maintained. There were other visitors present and the residents were having lunch. Some employees did approach me to see if I needed anything. I observed lunch being served and the employees were cordial with the residents.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	There was insufficient evidence to suggest that Resident A was not treated with dignity and respect. Resident A was no longer at the home, but based on the interactions with the employees and the residents during meal time, there is an indication that the residents are going treated with dignity and respect.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff did not take appropriate action to address Resident A's medical decline.

INVESTIGATION:

Ms. Gordon stated that the home transmitted an incident report from 6/22/22 detailing steps the home took to address Resident A's medical issues. She stated

that the home had provided water to Resident A and had monitored her blood pressure. Ms. Gordon stated that Resident A would often remove the chair alarms. Ms. Gordon stated that the licensee, Jon Drews, is a registered nurse and is often on site. She mentioned that a visiting nurse also comes to the home. Ms. Gordon denied that the home pressured Resident A's family into obtaining hospice care.

On 7/29/22, I reviewed Resident A's assessment plan, care agreement and Health Care Appraisal forms. The documents were in compliance.

On 8/5/22 I interviewed Licensee John Drews via telephone. Mr. Drews stated that he would have had no way of knowing that Resident A was in decline but stated that the home took steps to have Resident A cared for in a medical facility. He stated that residents are encouraged to drink liquids throughout the day and acknowledged that residents with Alzheimer's disease or dementia receive extra prompts. He stated that the home does not forcefully encourage families to seek hospice care services. He mentioned that Resident A had a visiting nurse practitioner Penny Wallman from Dr. Karim's office.

On 8/9/22, I interviewed Relative A. Relative A stated that Resident A was moved from a home called Village Green, to Country Living II in February 2022. Relative A stated that this was due to the need for more supervision and personal care due to Resident A's decline in health. Relative A stated that Resident A was hospitalized after being seen for a doctor's visit because she was dehydrated, and that a nurse had recommended that the home increase her water intake. Relative A reported that care was problematic in that the family was not properly notified of the need for a change in homes, and that there was not an adequate level of nurses at the home. Relative A stated that the family was pressured into obtaining hospice care, as opposed to the home having adequate nursing staff to address Resident A's medical needs. Relative A expressed that the home did not properly address Resident A's falls and would not set the chair alarms.

On 9/8/22, I interviewed Bronson Healthcare Nurse Practitioner Penny Wallman via telephone. Ms. Wallman stated that Resident A was originally living at Village Green, a more independent setting. Resident A then experienced a decline in health and was moved to Country Living, per Ms. Wallman. Ms. Wallman stated that during Resident A's stay at Country Living, she was not neglected and was provided with water. Ms. Wallman reported that Resident A would typically participate in the home's programming, rather than remain in her room, and was quite sociable. Ms. Wallman stated that while hospice care was recommended, the family was not pressured into doing so. She stated that Resident A would remove the chair alarms, and that this behavior is quite common with people who suffer from dementia.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Based on the Incident Report, as well as interviews conducted with the nurse practitioner who visited the facility, it does not appear that the home did not adequately address Resident A's rapid decline. The home appears to have made attempts to follow recommendations such as providing Resident A with water and setting Resident A's chair alarms.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 9/13/22, I conducted an exit conference with licensee designee John Drews. He agreed with the finding of the investigation.

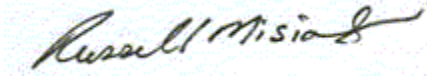
IV. RECOMMENDATION

I recommend no change to the status of this license.

9/13/22

Dwight Forde Date
Licensing Consultant

Approved By:



9/20/22

Russell B. Misiak Date
Area Manager