GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 1, 2024

Makenzi Peters
Carveth Village of Middleville
690 W Main Street
Middleville, MI 49333

RE: License #: AH080236758
Investigation #: 2024A1028061
Carveth Village of Middleville

Dear Makenzi Peters:

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 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, 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 #:	AH080236758
Investigation #:	2024A1028061
Complaint Receipt Date:	06/12/2024
Investigation Initiation Date:	06/18/2024
Report Due Date:	08/12/2024
Licensee Name:	Carveth Village Assisted Living
Licensee Address:	690 W Main St., Middleville, MI 49333
Licensee Telephone #:	(269) 795-4972
Authorized Representative:	Steve Peters
Administrator/ Licensee Designee:	Makenzi Peters
Name of Facility:	Carveth Village of Middleville
Facility Address:	690 W Main Street, Middleville, MI 49333
Facility Telephone #:	(269) 795-4972
Original Issuance Date:	04/30/1999
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	68
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
The facility did not provide care in accordance with the service resulting in Resident A incurring skin lacerations to bilateral forearms.	Yes
Additional Findings	No

III. METHODOLOGY

06/12/2024	Special Investigation Intake 2024A1028061
06/18/2024	Special Investigation Initiated - Letter
06/18/2024	APS Referral
06/18/2024	Contact - Document Received Facility Administrator/Makenzi Peters sent me the requested documentation for special investigation 2024A1028061 via email.
07/16/2024	Contact - Face to Face Interviewed Facility Administrator Mackenzi Peters at the facility.
07/16/2024	Contact - Face to Face Interviewed Employee A at the facility.
07/16/2024	Contact - Face to Face Interviewed Employee B at the facility.
07/19/2024	Contact – Document Received Received requested current service plan via email from Admin/Makenzi Peters.

ALLEGATION:

The facility did not provide care in accordance with the service resulting in Resident A incurring skin lacerations to bilateral forearms.

INVESTIGATION:

On 6/12/2024, the Bureau received the allegations through the online complaint system.

On 6/18/2024, Adult Protective Services (APS) made referral to Homes for the Aged (HFA) through Centralized Intake.

On 6/18/2024, facility administrator, Makenzi Peters, sent me the requested documentation pertaining to Resident A and this investigation via email.

On 7/16/2024, I interviewed Ms. Peters at the facility who reported Resident A was admitted to the facility on 5/20/2024 and was independent with use of walker and independent with transfers at admission, but it was documented in Resident A's medical record that Resident A had a few falls prior to admission to the facility. Resident A was independent with toileting, bathing, dressing, grooming, and eating and only required assistance with medication management at the time of admission. Resident A makes [their] own decisions but does have an appointed person in place to assist if Resident A becomes unable to make own decisions. Resident A was oriented to person, place, and time at admission as well. However, Resident A began to demonstrate falls shortly after admission. Ms. Peters reported Resident A had five falls after admission and the facility contacted Resident A's physician and authorized representative about the falls. Resident A was placed on routine two-hour safety checks due to demonstrated falls and to ensure safety. Ms. Peters reported Resident A's medication was also evaluated and changed and this may have affected Resident A's mobility as well. Resident A was not consistent with using the call-light even though staff repeatedly encouraged [them] to do so, and staff continued to monitor Resident A to ensure safety.

On 7/16/2024, I interviewed Employee A at the facility who reported Resident A was independent with mobility, transfers, and most care upon admission to the facility. The facility managed medications, laundry, meals, and housekeeping for Resident A. Employee A reported it was discovered after admission that Resident A had a history of falls at home when Resident A's medical record was reviewed. Employee A confirmed Resident A had five falls since admission at the facility and that Resident A's physician and authorized representative were notified of the falls. A medication evaluation was completed by the physician, and it was discovered that medication may have been contributing to the falls as well. Employee A confirmed that Resident A receives two-hour safety checks due to recent falls to ensure safety.

On 7/16/2024, I interviewed Employee B at the facility whose statement was consistent with Ms. Peters statement and Employee A's statement.

On 7/18/2024, I reviewed the requested documentation which revealed the following:

- Resident A was independent with dressing, grooming, bathing, toileting, and eating upon admission on 5/20/2024.
- Resident A was independent with mobility using a walker and transfers.

- On 5/29/2024 at 1:35 am, Resident A used the call light to summon staff because [they] had fallen in front of the bed. Resident A reported [they] did not use the walker and lost [their] balance when attempting to sit on bed. No complaints of pain or injuries were noted. Staff assisted Resident A up from the floor and back to bed. Resident A was provided re-education on using walker during mobility and transfers. Resident A's authorized representative and physician notified of the fall.
- On 5/29/2024 at 2:45 pm, Resident A complained of pain in hip and shoulder and requested Tylenol. Resident A was administered Tylenol and advised to let staff know if pain continued to determine if a physician evaluation needed to be requested.
- On 5/302024 at 11:30pm, staff observed Resident A sitting in rocking chair still in day clothes. Staff inquired why Resident A had not gotten ready for bed and Resident A reported "my legs won't work". Staff assisted Resident A to bed to change into sleep clothes, but Resident A reported [they] could do it [their self]. Staff remained in room but provided stand by assist to help Resident A get ready for bed. Staff encouraged Resident A to use the call light and to call staff for assistance if [they] need to use the bathroom. Resident A verbalized understanding with staff monitoring Resident A closely for the rest of the night. Staff notified management as well.
- On 5/31/2024 at 11:00 am, Resident A was assessed by the nurse due to refusal to get up and due to demonstrated decline and was sent hospital for further evaluation. The physician and authorized representative were notified. Resident A was admitted to the hospital for stay.
- On 6/6/2024, Resident A returned to facility with new physician medication orders.
- 6/7/2024 at 11:00 am, the home health company spoke with facility about Resident A being a candidate for possible hospice referral due to diagnosis of chronic lymphocytic leukemia. Physician did not issue a order yet for hospice but facility staff were educated on Resident A's current baseline upon returning to the facility.
- 6/7/2024 at 2:15 pm, the facility received a phone call from the authorized representative who stated Resident A is not going on hospice at this time and that Resident A would be evaluated by primary physician before determining further action pertaining to hospice.
- On 6/8/2024 at 1:30 am, Resident A pulled call light while in bathroom and was observed leaning heavily to right side and holding onto bar while sitting on toilet. Staff observed dried blood on thigh area and upper forearms and asked what happened. Resident A reported the skin tears happened at the hospital and must have reopened. Staff assisted Resident A with toileting, changing of clothes and back to bed due to Resident A complaints of feeling dizzy. Staff cleaned the skin tears as well and reported Resident A's condition to management with Resident A being sent to hospital. The physician and authorized representative were notified.

- On 6/8/2024 at 5:00 am, Resident A returned to facility from hospital and was unsteady, requiring two-person assist. Staff observed skin tear on upper arms and also observed that Resident A had no urine output.
- On 6/8/2024 at 5:00 pm, staff went to Resident A's room to escort [them] to dining room with Resident A requiring two-person transfer due to weakness and imbalance. Resident A required several reminders for safety as well.
- On 6/8/2024 at 9:00 pm, Resident A required two-person assist with nighttime care and reminders due to demonstrating some confusion. Staff continued to monitor Resident A closely throughout evening and night.
- On 6/9/2024 at 2:15 pm, Resident A was observed requiring two-person assist with transfers. Resident A also demonstrated behaviors of verbal aggression towards staff when doing to the dining room.
- On 6/9/2024 at 3:45 pm, Resident A required one person transfer and assist from staff to toilet.
- 6/9/2024 at 4:45 pm, Resident A required two-person assist to transfer to recliner. Resident A demonstrated agitation with staff continuing to monitor Resident A.
- On 6/9/2024 at 7:45 pm, Resident A demonstrated agitation as staff assisted Resident A to bed. Staff to continue to monitor.
- On 6/10/2024 at 1:15 am, during safety checks staff discovered Resident A sitting on floor next to nightstand. Resident A did not use call-light. Resident A reported [they] rolled out of bed with staff re-educating Resident A to use call light for assistance. Resident A incurred a rug burn on each knee with staff treating. Staff assisted Resident A back to bed. The physician and authorized representative were notified, and no new physician orders were issued.
- On 6/10/2024 at 3:30 am, Resident A was observed by staff trying to get out of bed unassisted. Resident A demonstrated agitation as staff assisted Resident A with urinal. Resident A had an incontinence incident with staff assisting Resident A with clean-up, changing of clothes, and changing of bedding. Resident A reminded to use call light Staff to continue to monitor.
- On 6/10/2024 at 10:15 am, Resident A required two-person assist from staff for transfer and care.
- On 6/11/2024 at 10:00 am, Resident A demonstrated confusion prior to breakfast. After breakfast, Resident A demonstrated less confusion and napped in recliner.
- On 6/11/2024 at 4:00 pm, Resident A refused to eat.
- On 6/11/2024 at 4:30 pm, the facility conferenced with the physician's office to notify of them of Resident A's continued decline and behaviors since returning from hospital and to request additional assistive devices.
- On 6/11/2024 at 1:30pm, the facility conferenced with the authorized representative about Resident A's change of status since returning from the hospital. Resident A had a physician appointment on 6/12/2024 and next steps will be discussed after physician appointment.
- On 6/12/2024 at 3:00 am, Resident A pulled call light due to fall in room. Resident A was found on the floor after attempting to transfer from the bed to go to the bathroom. Resident A reported hitting head and demonstrated skin

tears to the head, elbows, and legs. Resident A reported [they] forgot to use the call light prior to getting up. Staff alerted the physician and the authorized representative. Resident A to see physician later in day for appointment to assess and discuss decline.

- On 6/12/2024 at 8:00 am, Resident A was found on the floor next to bed. Staff assisted Resident A back to wheelchair and no complaints of pain or injuries were noted. Resident A demonstrated confusion and required two-person assist.
- On 6/12/2024 at 11:45 am, the facility received communication from the physician about Resident A's decline, falls, medication evaluation and new orders, demonstrated behaviors, current level of assist, and current level of cognition.
- On 6/12/2024 at 10:30 pm, Resident A was two-person assist with transfers and required total assist with evening care.
- On 6/13/2024 at 2:00 am, Resident A demonstrated difficulty standing or pivoting with staff assistance when toileting.
- On 6/13/2024 at 7:30 am, Resident A refused to get out of recliner and refused breakfast.
- On 6/13/2024 at 2:15 pm, Resident A refused lunch and to toilet and continues to demonstrate some confusion. Staff to continue to monitor.
- On 6/13/2024 at 8:15 pm, it was noted Resident A ate all the dinner meal. Also, Resident A was observed by staff on the toilet and Resident A did not use call light. Staff reminded Resident A to use call light due to current weakness with Resident A scoffing at staff. Staff called for additional assistance to help Resident A complete toileting and to take Resident A to spa room for shower. Resident A required two-person assist with transfers and to get into shower. After shower, Resident A required three staff to assist with dressing and transfer wheelchair. Resident A was assisted back to bed with staff continuing to monitor Resident A closely.
- On 6/14/2024 at 8:15 pm, Resident A ate all of the meal and is still requiring two-person assist with transfers and care.
- On 6/15/2024 at 2:15 am, Resident A pulled call light and was observed sitting edge of bed. Resident A demonstrated agitation and impulsiveness with use of urinal resulting in clothing and bedding becoming saturated. Staff assisted Resident A with using urinal and changing of clothing and bedding.
- On 6/16/2024 at 3:30 pm, Resident A was observed floor at end of bed with wheelchair tipped over on side. No complaints of pain or injury were noted but Resident A was attempting to self-transfer. Resident A re-educated on importance of using call-light and to wait for assistance. Resident A reported [they] were crawling on the floor to find something to hit myself with". The physician and authorized representative were notified. No new orders were provided. Staff to continue to monitor Resident A.
- On 6/17/2024 at 9:15 am, Resident A refused breakfast.
- On 6/17/2024 at 11:30 am, Resident A received home health services. Occupational therapy and speech therapy evaluations were ordered as well.

- On 6/17/2024 at 12:30 pm, the facility communicated with authorized representative about current falls and confusion.
- On 6/17/2024 at 4:15 pm, it was documented in the record that physical therapy left a communication note in which Resident A was observed self-transferring and requiring cuing for safety and to lock walker brakes.
- On 6/17/2024 at 4:30 pm, the facility communicated with physician's office about change of medications.
- On 6/17/2024 at 4:45 pm, the facility communicated with home health services about Resident A's falls, interventions, and request for assistive devices for Resident A.
- On 6/17/2024 at 9:45 pm, Resident A was a two-person assist with transfer due to weakness.
- On 6/18/2024 at 11:00 am, it was noted in the record that Resident A was discovered self-transferring and not using the call-light to request assistance.
- On 6/19/2024, Resident A received speech therapy due to Resident A not eating and to ensure food is not being pocketed in mouth.
- On 6/21/2024, Resident A refused dinner.
- On 6/22/2024, Resident A discovered self-transferring to places staff have not left him prior. Resident A has been reminded multiple times throughout shift to use call light system for assistance with transferring.
- On 6/22/2024 at 9:45 am, Resident A refused morning medication administration, stating the medications make [them] "feel ill".
- On 6/22/2024, Resident A reported horrible headache and was lethargic. Vitals taken and fluids given. Wellness director notified.
- On 6/23/2024, Resident A refused breakfast and lunch.
- On 6/24/2024, Resident A refused breakfast and only ate one bite of sandwich and some chips for dinner.
- On 6/24/2024 at 2:30 pm, Resident A was checked on frequently throughout the day due to constantly transferring self to different sitting areas in room.
- On 6/25/2024, Resident A refused breakfast and only ate bites of lunch.
- On 6/26/2024, Resident A only ate a few bites of breakfast and only took half of the morning medication administration.
- On 6/27/2024 at 12:00 am, Resident A refused dinner but with staff encouragement, Resident A finished a bottle of ensure.
- On 6/27/2024 at 6:45 am, Resident A was lethargic and reported feeling sick. Vital were normal and staff continued to monitor.
- On 6/27/2024, Resident A refused breakfast.
- On 6/27/2024 at 7:15 pm, Resident A refused dinner due to "ruining appetite at lunch". Resident A was observed to have self-transferred to bed. Resident A also refused evening medication administration. Resident A continued to refuse all care and medications throughout evening/night shift.
- On 6/29/2024, Resident A ambulated to bathroom on [their] own and then used to the call light to request staff assistance. Staff assisted Resident A with care.
- On 6/29/2024 at 9:30 am, Resident refused breakfast.

- On 6/30/2024, Resident A ate 5% of dinner. Resident A ambulated to the bathroom and called for staff assistance at 7:30 pm, with staff observing blood in urine. The authorized representative was notified and took Resident A to the hospital for further evaluation.
- On 7/3/2024, Resident A received new orders from hospital stay.
- On 7/5/2024, Resident A ate 100% of dinner and 100% of boost supplement drink.
- On 7/6/2024, Resident A are 100& of breakfast and 85% of lunch but refused dinner.
- On 7/21/2024, Resident A fell during the night shift due to family trying to assist Resident A to transfer. Family member and Resident A provided re-education on transferring. Resident monitored throughout rest of shift for any pain or changes in condition.
- On 7/22/2024, Resident A reported not feeling well again with the authorized representative notified and requesting Resident A be sent to hospital. Resident A sent to hospital for further evaluation.
- Evidence of physical therapy and speech therapy working to Resident A to address weakness, imbalance, falls, and lack of appetite.

On 7/19/2024, I completed a follow-up email with Ms. Peters requesting the most recent service plan and record notes. Ms. Peters replied via email that the service plan had not been updated yet, but facility policy is to complete a revaluation of a resident 90 days from admission date. Ms. Peters wrote she is meeting with Resident A's authorized representative the first week of August to discuss any service plan updates that may be needed.

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:	It was alleged the facility did not provide care in accordance with the service resulting in Resident A incurring skin lacerations to bilateral forearms. Interviews, onsite investigation, and review of documentation reveal the following: • The service plan was dated and signed 5/22/2024 by the wellness director on 5/24/2024 and the facility administrator, Makenzi Peters, on 6/10/2024. The service plan is not signed by Resident A or [their] authorized representative. • Per the service plan dated 5/22/2024, Resident A was independent with dressing, grooming, bathing, toileting, and eating. • Resident A incurred falls on 5/29/2024, 6/10/2024, two falls on 6/12/2024, 6/16/2024 and 7/21/2024. • Resident A began to demonstrate an initial decline in condition 5/30/2024, requiring ongoing increased assist to complete transfers, mobility, and care. While the facility provided increased care and safety checks to Resident A during a demonstrated decline, the service plan notates Resident A as still being independent with dressing, grooming, bathing, toileting, eating, mobility using a walker, and transfers. The service plan does not match the level of care that was provided to Resident A once Resident A demonstrated a decline in condition requiring increased assistance with care and mobility and safety checks. The service plan must match the current level of care the resident is receiving and the service plan must be signed by the resident and [their] authorized representative, if any. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Julie Viviano

7/18/2024

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Julie Viviano Date
Licensing Staff

Approved By:

07/30/2024

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