GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 31, 2024

Heather Watt
Westgate Living Center
1500 N Lowell St.
Ironwood, MI 49938

RE: License #: AH270236923
Investigation #: 2024A0585058
Westgate Living Center

Dear Ms. Watt:

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 that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Brender L. Howard

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street, P.O. Box 30664
Lansing, MI 48909
(313) 268-1788
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH270236923
Investigation #:	2024A0585058
Complaint Receipt Date:	06/17/2024
Investigation Initiation Date:	06/18/2024
Report Due Date:	08/17/2024
Licensee Name:	Atrium Ironwood LLC
Licensee Address:	Suite 200 2550 Corporate Exchange Columbus, OH 43231
Licensee Telephone #:	(614) 416-0600
Authorized Representative/Administrator:	Heather Watt
Name of Facility:	Westgate Living Center
Facility Address:	1500 N Lowell St. Ironwood, MI 49938
Facility Telephone #:	(906) 932-3867
Original Issuance Date:	05/01/1999
License Status:	REGULAR
Effective Date:	09/12/2023
Expiration Date:	09/11/2024
Capacity:	34
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A had a fall, fracturing her right elbow and right hip.	Yes
Additional Findings	No

III. METHODOLOGY

06/17/2024	Special Investigation Intake 2024A0585058
06/18/2024	Special Investigation Initiated - Letter Emailed administrator Heather Watt to request documents.
06/27/2024	Contact - Telephone call made. Called administrator Heather Watt to request documents. A message was left to return call.
06/27/2024	Contact - Document Sent Follow up email was sent to request documents.
06/27/2024	Contact - Telephone call made. Attempted to contact complainant. There was no answer, and a message could not be left due to the mailbox being full.
07/10/2024	Contact - Telephone call received. Administrator called for clarification of documents requested.
07/15/2024	Contact - Document Received Requested documents received.
07/18/2024	Contact – Telephone received. Complainant returned call to discuss incident.
07/31/2024	Exit Conference Conducted via email to authorized representative Heather Watt.

ALLEGATION:

Resident A had a fall, fracturing her right elbow and right hip.

INVESTIGATION:

On 6/17/2024, the department received a complaint through the BCAL online complaint system. The complaint alleged that Resident A was walking alone without gait belt or with assistance and she was attempting to catch up with the person who was leading her to get her hair cut and she fell. The complaint alleged that Resident A fell and fractured her right elbow and her right hip.

On 6/18/2024, a referral was made to Adult Protective Services (APS).

On 7/9/2024, I contacted administrator Heather Watt who stated that Resident A was assisted by aide, and she had a walker. She stated that Employee #1 was walking Resident A to the beauty salon to get her hair done. She stated that after she spoke with the aide [Employee #1] who was with Resident A, she told her that she did not use a gait belt.

On 7/18/2024, I interviewed Employee #1 by telephone. Employee #1 stated that she was assisting Resident A to get beauty shop. She said that Resident A walked own. She said that as Resident A walked, she walked beside her talking. She said when they got to the nurse's station, I left her there talking to other residents while she went to see if a chair was available at the beauty shop. Employee #1 said that she had Resident A to stand against the wall with her walker until she returns. She said that as she was turning the corner coming back, she can hear Resident A hollering for help because she was falling. She said that Resident A does not require a gait belt, but she walks independently with the help of a walker. Employee #1 said that because of the distant to the beauty shop, they are supposed to walk with Resident A. She said that she put Resident A where she thought would be safe. Employee #1 said that she immediately went to Resident A to assist her when she fell.

Service plan for Resident A read, ambulation and transferring requires some assistance to be provided by the staff. Resident uses a walker.

Hospital discharge dated 10/25/2023, revealed, "Resident A was admitted to the hospital on 10/9/2023 after a ground level fall. The patient was walking in a hall, lost her balance and fell on right side. There was no head injury and no loss of consciousness. She complained of right arm pain and a right hip pain. Her vitals were stable X-Ray reveal right olecranon (elbow) and right intertrochanteric (thigh bone) fractures. The discharge notice list Resident A's diagnosis which includes diagnostic heart failure, pulmonary embolism, osteoarthritis, left temple lesion and lower back pain.

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.
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:	Resident A was walking with the assistance of a staff. Staff left Resident A standing alone as she went to see if a chair was available in the beauty shop, during this time, Resident A had a fall sustaining injuries to her right elbow and right hip. The service plan indicates that Resident A walks with assistant from staff and a walker. The facility did not ensure the safety of Resident A by leaving her, even if it was for a short moment. Therefore, this claim was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

07/30/2024

_____

Brender Howard Date
Licensing Staff

Approved By:

07/30/2024

_____

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