GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 23, 2024

Megan Burch
AH Kentwood Subtenant LLC
Ste 1600
1 Towne Sq
Southfield, MI 48076

RE: License #: AL410397696
Investigation #: 2024A0467058
AHSL Kentwood Fieldstone

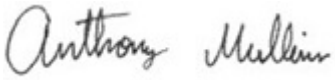
Dear Mrs. Burch:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 (616) 356-0183.

Sincerely,



Anthony Mullins, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410397696
Investigation #:	2024A0467058
Complaint Receipt Date:	08/29/2024
Investigation Initiation Date:	08/29/2024
Report Due Date:	10/28/2024
Licensee Name:	AH Kentwood Subtenant LLC
Licensee Address:	Ste 1600 1 Towne Sq Southfield, MI 48076
Licensee #:	(248) 203-1800
Administrator:	Megan Burch
Licensee Designee:	Megan Burch
Name of Facility:	AHSL Kentwood Fieldstone
Facility Address:	5980 Eastern Ave SE. Kentwood, MI 49508
Facility Telephone #:	(616) 455-1357
Original Issuance Date:	01/22/2019
License Status:	REGULAR
Effective Date:	07/22/2023
Expiration Date:	07/21/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
On 9/3/23, staff did not provide care to Resident A per her assessment plan, resulting in Resident A sustaining injuries to her head and face.	No
Resident A's assessment plan was not signed by her Designated Power of Attorney or the licensee designee.	Yes
Staff did not provide Resident A's Designated Power of Attorney with requested documentation.	Yes

III. METHODOLOGY

08/29/2024	Special Investigation Intake 2024A0467058
08/29/2024	Special Investigation Initiated - Telephone
09/02/2024	Inspection completed – Onsite (unable to complete due to building being a total loss from a recent fire.
09/05/2024	Contact – telephone call made to Nora Lapowski – Hospice Nurse
09/16/2024	Contact – telephone call made to licensee designee, Megan Burch
09/16/2024	Contact – documents received via email from licensee designee, Megan Burch
10/23/2024	APS Referral
10/23/2024	Exit conference with licensee designee, Megan Burch

ALLEGATION: On 9/3/23, staff did not provide care to Resident A per her assessment plan, resulting in Resident A sustaining injuries to her head and face.

INVESTIGATION: On 8/29/24, I received a complaint from the Attorney General's Office indicating that Resident A sustained an injury to her head and face due to a fall and Resident A's Durable Power of Attorney (DPOA) was reportedly never contacted. The complaint alleged that due to the injury Resident A sustained, she is unable to communicate verbally and lost her long-term memory. The complaint stated that Resident A's short-term memory was already gone due to being diagnosed with dementia.

On 8/29/24, I spoke to the complainant via phone and she confirmed the allegations. The complainant stated that she was initially told by staff that they didn't know what happened to Resident A. The following week, staff reportedly told the complainant a story that didn't make sense to her, which was that Resident A fell while a worker was transferring her from her wheelchair to a recliner chair. As a result of the fall, Resident A reportedly hit her head/face on the arm rest. The complainant stated that the arm rest is made of cloth, so the explanation given to her did not make sense or explain the injury to Resident A's face. The complainant stated that since this incident, Resident A is no longer able to speak although she could previously say her name and communicate some things. The complainant stated that Resident A is supposed to be in her wheelchair and not a recliner chair because she is unable to sit up on her own, which is reportedly reflected in her assessment plan.

The complainant sent me a picture of the bruises/wounds to Resident A's face, which were located just above her right eyebrow/forehead and under her right eye. The complainant also shared that Nora Lapowski with The Care Team Hospice was involved and expressed concern about the facility staffs' lack of care to Resident A's facial wounds. The complainant provided me with contact information for Nora Lapowski from hospice.

On 9/5/24, I spoke to Nora Lapowski, nurse with The Care Team Hospice. Ms. Lapowski recalled working with Resident A nearly a year ago. Ms. Lapowski was unable to recall exactly how the injury occurred to Resident A, but she believed that facility staff put Resident A in her recliner chair and the abrasions/wounds to her face were from Resident A sliding down the chair and hitting her face on the arm rest. Ms. Lapowski stated that the facility staff "can only do so much" regarding the abrasions/wounds, which is why they notified the hospice team and they treated the wounds. Ms. Lapowski was unable to recall exactly how much time had passed prior to the hospice agency being notified of the abrasions/wounds. Ms. Lapowski denied having any concerns regarding the care that Resident A received from the AFC staff during her time caring for her.

On 9/16/24, I spoke to licensee designee, Megan Burch via phone regarding the allegations. It should be noted that Ms. Burch was not the licensee of the facility at the time of this incident and the former designee is no longer employed by American House. Ms. Burch confirmed that 9/3/23 was the day that Resident A sustained an injury to her face. When asked how this occurred, Ms. Burch shared that the incident is "convoluted." Ms. Burch read some information from some progress notes on the day in question that indicated that Resident A, "slide off recliner while transferring. Skin tear on forehead from chair." Ms. Burch also emailed all notes related to this injury. I reviewed the notes provided to me, which confirmed Ms. Burch's statement as to how the injury occurred.

Other notes documented on 9/3/23 by regional wellness director, Katrina Aleck indicated that, "the care team (hospice) called this nurse and stated resident has a new skin condition located to facial area. Per Norma (nurse), resident sustained 2-3

skin impairments during a brief change on 1st shift 9/3/23." The note also indicated that Resident A's daughter was informed of the skin condition by the hospice nurse, and the hospice nurse assessed her skin and stated, "resident has soft/frail skin. Will continue to monitor and determine root cause of skin impairment to facial area."

On 9/5/24, Mrs. Aleck documented a progress note that stated that she spoke to the hospice nurse regarding updates on the root cause of Resident A's injury. Ms. Aleck's note stated that per Resident A's daughter, "recliner chair to remain in place and place signage that chair is for visitors only." The note also stated that Resident A moves around a lot and could possibly "shimmy" out of her chair if left unattended. "Signage posted on chair and staff educated to call family members with any new changes in skin ASAP." Despite Resident A's daughter making this statement on 9/5/23, Mrs. Burch stated that this was not documented in Resident A's assessment plan prior to the injury. On 9/5/23, Ms. Aleck assessed the skin tears to Resident A's "upper forehead region and cheekbone region (right side). Skin is free from drainage, resident denies pain at this time. Will continue to monitor. Updated hospice nurse and daughter." On 9/6/23, Ms. Aleck documented a progress note that stated, "called and left a message with daughter, POA at approximately 3:15pm to give status update on resident." The note indicated that Resident A was doing well and listening to music without any increased redness/irritation noted to her skin on the right side of her face.

Regarding the specifics of the injury, it was noted that upon rounds, Resident A positioned herself to the right side (on an angled position), causing the right side of her face to rub on the armrest of the reclining chair. The note indicated that the armrest on the chair did not have a cushion. Resident A was assisted/boosted back up in upright sitting position. However, she sustained two small "friction skin tears" to the upper forehead region and cheek bone region. This note was approved by Ms. Aleck.

Mrs. Burch confirmed that Resident A is no longer a resident as she discharged from the facility on 12/30/23. Ms. Burch confirmed that per the documentation, Resident A's daughter was informed on the day of the incident, and not a week later despite allegations stating otherwise.

I reviewed Resident A's assessment plan that was completed on 7/23/23 (42 days prior to the injury) and there was no documentation to confirm that Resident A was not able to sit in a recliner chair. I also did not observe any documentation to suggest that Resident A was unable to be left unattended for any period of time.

On 10/23/24, I conducted an exit conference with licensee designee, Megan Burch. She was informed of the investigative findings and denied having any questions.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**

	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Mrs. Burch denied that there was anything documented in Resident A's assessment plan indicating that she was not to be transferred to her recliner chair. I reviewed the assessment plan and confirmed this. The Care Team hospice nurse, Ms. Lapowski was interviewed and denied any concern regarding the care that Resident A received at the facility from staff. Therefore, there is not a preponderance of evidence to support this applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A's assessment plan was not signed by her Designated Power of Attorney or the licensee designee.

INVESTIGATION: On 8/29/24, I spoke to the complainant via phone, and she stated that Resident A's 2023 assessment plan was not signed by Resident A's DPOA and the licensee designee of the facility. The complainant also stated that Resident A's assessment plan indicated that Resident A had a wound on her body. However, she was never notified of the wound.

On 9/16/24, I spoke to licensee designee, Megan Burch via phone regarding the allegations. Ms. Burch sent me a copy of Resident A's assessment plans via email. Ms. Burch confirmed that the PDF versions of Resident A's 2023 and 2022 assessment plans are not signed. Ms. Burch was unable to produce a signed copy of Resident A's current assessment plan due to a recent facility fire that destroyed her physical file. Ms. Burch stated that Resident A's signed assessment plans were not saved to their electronic file. It should be noted that I reviewed the assessment plans (both completed prior to Resident A's injury on 9/3/23), and both documents indicated "no" when asked about any active wounds.

On 10/23/24, I conducted an exit conference with licensee designee, Megan Burch. She was informed of the investigative findings and agreed to complete a CAP within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or

	the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Resident A's assessment plans completed in 2022 and 2023 were not signed by the licensee designee or her DPOA, both of which were completed prior to Ms. Burch starting her role as the licensee designee. Therefore, a preponderance of evidence does exist to support this applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff did not provide Resident A's daughter/DPOA with requested documentation.

INVESTIGATION: On 8/29/24, I spoke to the complainant via phone and she stated that Resident A was injured on 9/3/23 from a reported fall. The complainant stated that Resident A's DPOA requested incident reports/notes regarding the fall since September 2023 but has yet to receive them. The complainant stated that the medical records that Resident A's DPOA did receive took nearly a year to obtain from American House.

On 9/16/24, I spoke to licensee designee, Megan Burch via phone regarding the allegation. Ms. Burch confirmed that Resident A's daughter/DPOA did in fact request incident reports regarding Resident A's fall since 2023. However, the incident reports were never sent to Resident A's daughter/DPOA due to American House attorney/legal team stating that incident reports are protected under "QAPA" which she stated was quality assurance, despite Resident A's daughter being her DPOA.

Ms. Burch stated that per the company's attorney/legal team, incident reports are protected unless it is brought to court and the daughter/DPOA has a subpoena for it as incident reports do not fall under normal medical records request. Ms. Burch confirmed that it took nearly a year for American House to provide Resident A's daughter/DPOA with any physical medical records. Ms. Burch stated that this was due to missing forms on file to confirm that Resident A's daughter is in fact the DPOA and that Resident A has been deemed incapable of making decisions for herself. After Resident A's daughter submitted required documentation, American House provided her with some medical records. However, these records did not include the incident reports/progress notes regarding the injury on 9/3/23.

On 10/23/24, I conducted an exit conference with licensee designee, Megan Burch. She was informed of the investigative findings and informed that despite being advised by her attorney to not release the incident reports, AFC licensing rules allow

for the DPOA to receive any records at her request. Ms. Burch agreed to complete a CAP within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.15302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(8) At the time of discharge, a licensee shall provide copies of resident records to the resident and his or her designated representative when requested, and as determined appropriate, by the resident or his or her designated representative. A fee that is charged for copies of resident records shall not be more than the cost of the licensee of making the copies available.
ANALYSIS:	Resident A discharged from the facility on 12/30/23. Resident A's daughter/DPOA has requested incident reports/progress notes regarding an injury that occurred on 9/3/23. Licensee designee, Ms. Burch confirmed that the incident reports have not been released to Resident A's daughter/DPOA due to being protected under "QAPA" per the company's attorney. Despite this, licensing rules clearly indicate that Resident A's designated representative is entitled to resident records when requested that is determined appropriate by the DPOA. Therefore, there is a preponderance of evidence to support this applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

The licensee has requested the license for this facility be closed as a result of a recent fire, which led to the immediate relocation of all facility residents. Upon receipt of an acceptable corrective action plan, I recommend the voluntarily closure of the license.

Anthony Mullins

10/23/2024

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Anthony Mullins Date
Licensing Consultant

Approved By:

10/23/2024

Jerry Hendrick Date
Area Manager