GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 25, 2024

Robert Kornfeld
The Orchards at Canterbury Village
5601 Hatchery Road
Waterford, MI 48329

RE: License #: AH630380234
Investigation #: 2025A0784008
The Orchards at Canterbury Village

Dear Robert Kornfeld:

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

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630380234
Investigation #:	2025A0784008
Complaint Receipt Date:	10/29/2024
Investigation Initiation Date:	10/29/2024
Report Due Date:	12/28/2024
Licensee Name:	Canterbury Village MI Opco LLC
Licensee Address:	362 E Kennedy Blvd Lakewood, MI 08701
Licensee Telephone #:	Unknown
Administrator:	Jennifer Rosado
Authorized Representative:	Robert Kornfeld
Name of Facility:	The Orchards at Canterbury Village
Facility Address:	5601 Hatchery Road Waterford, MI 48329
Facility Telephone #:	(248) 674-9292
Original Issuance Date:	01/05/2018
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	32
Program Type:	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Inadequate supervision plan for Resident A	Yes
Additional Findings	No

III. METHODOLOGY

10/29/2024	Special Investigation Intake 2025A0784008
10/29/2024	Special Investigation Initiated - Telephone Interview with complainant
10/31/2024	Inspection Completed On-site
10/31/2024	Exit Conference Conducted with administrator Jennifer Rosado at the facility

ALLEGATION:

Inadequate supervision plan for Resident A

INVESTIGATION:

On 10/29/2024, the department received this complaint.

According to the complaint, a resident fell sometime in the summer of 2024 and died shortly after.

On 10/29/2024, I interviewed complainant by telephone. Complainant stated that sometime in the summer of 2024, a resident fell, hit her head. Complainant stated they did not witness this fall but heard about it from others. Complainant stated this resident a known fall risk with poor safety awareness. Complainant stated Resident A was known to have a history of falling due to attempting to walk or transfer on her own. Complainant stated the resident did not have a proper plan in place for her supervision. Complainant stated that after the fall, the resident was sent to the hospital and did not return as she passed away shortly after. Complainant stated they could not recall the residents name but, that the facility would be aware of who this resident is.

On 10/31/2024, I interviewed administrator Jennifer Rosado at the facility. Administrator stated that based on the information provided, she believed Resident

A is the person being referred to in the complaint as the last incident with Resident A fit the circumstances noted. Administrator stated Resident A transferred to the facility from the attached nursing home and lived at the facility for a short period of time. Upon searching Resident A's record on file, Administrator confirmed Resident A was transferred to the facility on 6/24/2024. Administrator stated Resident A was placed on hospice services when she transferred to the facility. Administrator stated Resident A was a person who was a high fall risk and had poor safety awareness. Administrator stated Resident A could not walk or transfer safely on her own. Administrator stated Resident A did have a few falls in the nursing home prior to transferring to the facility. Administrator stated Resident A had a tendency to attempt to transfer and walk on her own as she did not understand her inability to do so safely. Administrator stated that on 6/29/2024, it was reported that Resident A was discovered on her floor around approximately 11:30 pm on the floor next to her bed with one shoe on, her feet under her wheelchair, and a bump on the back of her head. Administrator stated Resident A was sent out to the hospital. Administrator stated Resident A did not return to the facility as she had passed away. Administrator stated employee 1, responsible for Resident A's direct care that evening, reported having last checked on Resident A shortly after 10pm. Administrator stated employee 1 reported that she and employee 2 assisted Resident A with getting her dressed for bed, medication administration and getting into bed. Administrator stated employee 1 reported having checked on Resident A twice between assisting her to bed and discovering her on the floor in her room. Administrator stated employees 1 and 2 both provided written statements attesting to events of 6/29/2024.

I reviewed written statements from employees 1 and 2, provided by administrator, which read consistently with statements provided by administrator.

I reviewed a facility *Incident Report*, pertaining to the incident on 6/29/2024 with Resident A, provided by Administrator. Under a section titled *Description of Incident/Accident*, the report read, in part, "at 11:36pm on Saturday 29th of June, resident was found by caregiver in her room on the floor next to her bed. Writer observed resident with one shoe on foot and legs under wheelchair. Resident was unresponsive with foam coming from mouth. Resident sustained a bump on the back of her head".

I reviewed Resident A's service plan, provided by Administrator. Under a section titled Mental Status and Behaviors, the plan included several pre-set descriptions with check boxes. The description next to the box checked in this section for Resident A read "Heavy impairment in all areas thus requiring constant orientation; prone to wandering, unable to remember personal information; confused as to time and place".

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
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.
For Reference: R 325.1901	**Definitions.**
	(t) "Service plan" means a written statement prepared by the home in cooperation with a resident, the resident's authorized representative, or the agency responsible for a resident's placement, if any, that identifies the specific care and maintenance, services, and resident activities appropriate for the individual resident's physical, social, and behavioral needs and well-being, and the methods of providing the care and services while taking into account the preferences and competency of the resident.

ANALYSIS:	The complaint alleged Resident A was a person who was a known fall risk with poor safety awareness without a proper plan in place for her supervision, and that she subsequently fell on 6/29/2024 leading to injury. When interviewed, administrator confirmed Resident A was a known fall risk person with poor safety awareness who fell on 6/29/2024. Administrator also indicated Resident A had falls in the nursing home prior to transferring to the facility. Review of incident reporting and staff statements confirmed Resident A's fall and subsequent head injury. While staff statements indicated employee 1 checked on Resident A frequently prior to her fall, review of the service plan revealed the plan was noticeably absent of any information pertaining to the frequency or duration of safety checks necessary for Resident A's supervision. While the plan does indicate Resident A is a person with "Heavy impairment in all areas requiring constant orientation", no specific information is provided in the plan indicating the extent to which Resident A is a fall risk or had poor safety awareness. Additionally, administrator noted that Resident A was place on hospice care on 6/24/2024, upon her transfer to the facility, however the plan did not include any mention of hospice involvement. Based on the findings, the allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

Aaron L Clum 11/25/2024

Aaron Clum Date
Licensing Staff

Approved By:

Andrea L Moore 11/27/2024

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