GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 12, 2025

David Benjamin
A&D Charitable Foundation Inc
3150 Enterprise Dr
Saginaw, MI 48603

RE: License #: AH730401359
Investigation #: 2025A1019042
Community Village

Dear Licensee:

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 authorized representative and a date.

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,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH730401359
Investigation #:	2025A1019042
Complaint Receipt Date:	03/25/2025
Investigation Initiation Date:	03/25/2025
Report Due Date:	05/24/2025
Licensee Name:	A&D Charitable Foundation Inc
Licensee Address:	3150 Enterprise Dr Saginaw, MI 48603
Administrator:	Shannon Robinson
Authorized Representative:	David Benjamin
Name of Facility:	Community Village
Facility Address:	3200 Hospital Rd Saginaw, MI 48603
Facility Telephone #:	(989) 792-5442
Original Issuance Date:	03/18/2020
License Status:	REGULAR
Effective Date:	09/18/2024
Expiration Date:	07/31/2025
Capacity:	90
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Improper treatment of Resident A.	Yes
Resident A did not receive pain medication.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/25/2025	Special Investigation Intake 2025A1019042
03/25/2025	Special Investigation Initiated - Letter Contacted complainant to obtain additional information.
03/26/2025	APS Referral
03/27/2025	Inspection Completed On-site
03/28/2025	Contact - Telephone call received Telephone interview completed with administrator Shannon Robinson.
03/28/2025	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: Improper treatment of Resident A.

INVESTIGATION:

On 3/25/25 the department received a complaint alleging concerns over staff treatment of Resident A on the evening of 3/18/25. The complaint read:

> *Patient was found hanging off the bed, patient needed assistance but was unable to call for help due to his call button not working so he called 911 for assistance, when my partner and I arrived, the patient stated he was in severe pain, and wanted pain medications and assistance from the facility staff but none of the staff were nearby to help. Upon our arrival staff was sitting in the common room on their cellphones. My partner and I assisted the patient back into bed, and a staff member came into the room and began berating and yelling at the patient*

saying that he is always doing this. The patient has chronic medical conditions which makes him have decreased mobility. The staff member began yelling at myself when I told her there was no reason to be yelling at the patient, when I told her that the patient was unable to reach any staff member, she stated that the call buttons do not work, and they don't work in multiple of the wings of the facility which they are aware of but do nothing to fix, and then the staff member stated that the patient has a cellphone he could have called the facility. I told the staff member that they never answer their phones, and the patient stated his phone was a 911 only phone which does not allow for any calls besides for 911. Staff then continued to berate the patient and yell at myself. When leaving the facility, as the patient did not want to be transported to the hospital, I advised the staff that he was in pain and requested some of his already prescribed and on scene medications for pain, and the staff member stated that they were not going to give any to him even if he hasn't already gotten his prescribed scheduled dose.

During follow up correspondence with the complainant, she confirmed the allegations and reported having directly witnessed the events, as did her partner. The complainant was unable to provide any staff names. The complainant reported that EMS dispatch attempted to contact facility staff prior to EMS' arrival but reported that no one answered the facility phone.

During follow up correspondence, Witness 1 was interviewed. Witness 1 reported the following:

On 3/18/2025 at 20:54, my partner and I were dispatched to Community Village of Saginaw to [Room A] for patient [Resident A].

Upon our arrival at the facility the patient was found in a position where his top half was on the bed with his legs on the floor struggling to keep himself on the bed. Patient reported he was unable to get ahold of staff due to his medical alert necklace not functioning properly. Shortly after my partner began assessing the patient, facility staff came into the room and became verbally aggressive with the patient demanding to know why he called for an ambulance when the nurse was just in the room. When the patient tried to explain he attempted to use his medical alert necklace, the staff member stated she knew the necklaces were not functional in multiple units and rooms and he should've just called the facility.

My partner and I asked the staff member to please remain calm and let the patient explain without being interrupted, the staff member became verbally aggressive with us as well stating "He is a frequent flying with a paper trail to prove it". Patient reported he attempted to call the facility but his phone is a 911 only phone. The staff member was asked if there was a plan to fix the necklaces to which she responded no. The patient reported he was in pain due to a recent fall and a history of Multiple Sclerosis but staff had not been giving him his

prescription medication. We asked staff if they would be willing to provide the patient his medication to which they responded "He's fine".

On 3/27/25, I conducted an onsite inspection. The administrator Shannon Robinson and authorized representative David Benjamin were not present. While onsite, I interviewed Employee 1. Employee 1 denied knowledge of the incident on 3/18/25 but reported that he is very familiar with Resident A and the level of care he requires. Employee 1 reported that Resident A is wheelchair bound and requires assistance with transferring, toileting and bathing. Employee 1 reported that Resident A is cognitively alert and oriented and does know how to properly use his call pendant but reported that there have been issues with the call pendant system and called the system "*unreliable at best*". Employee 1 reported that care staff on the floor carry cell phones on their person that the pendant alerts go to. Employee 1 reported that he also had a phone but admitted that he wasn't logged into it. Employee 1 reported that Employee 2 oversees the call pendant system and can better speak to it.

While onsite, I interviewed Employee 2. Employee 2 reported that there have been issues with the call pendant system for "*at least two weeks and I think they are looking to change out the whole system*". When asked to clarify the issues, Employee 2 reported "*There are phantom calls that drop off before staff can clear them*." and that residents are reporting that they have pushed their pendant but there is no record of the calls. Employee 2 confirmed that care and medication passing staff keep phones on their person where the call pendant alerts go to and does not believe there are issues with the phone devices. Employee 2 reported that he recently tested the entire system and believes that currently it is working fine. I requested that Employee 2 provide call pendant response data for Resident A for the previous month. I observed Employee 2 run the report which did not reveal that Resident A pushed his pendant at all during the timeframe reviewed. Employees 1 and 2 reported that this seemed unlikely given the level of care Resident A requires.

While onsite, I was taken to Resident A's room by Employee 1 and had Employee 1 leave the room before I interviewed the resident. Prior to interviewing the resident, I had him push his call pendant and began timing how long it took staff to respond. During his interview, Resident A confirmed that on 3/18/25, he was falling out of bed and used his call pendant for staff assistance. Resident A reported that when staff did not respond timely, he called 911 Resident A reported that facility staff yelled at him and EMS staff when they came in to assist him. Resident A stated that facility staff never assisted him back into bed and were very rude and disrespectful to him and EMS, calling it a "*tongue lashing*". Resident A could not provide the names of the staff who were present during the incident.

After interviewing Resident A for over 20 minutes without a staff response to the call pendant alert, I went to look for staff. I located a staff member at a nearby medication cart (med cart #1) and observed her to be talking on her cell phone via air pods. I then proceeded to locate Employee 2 to inquire if the pendant alert went through to the designated staff phones. Employee 2 went over to med cart #1 and

the staff at the cart told him that her pendant phone was dead. Employee 2 went to a second staff person and observed that the alert went through on her phone, but she responded that she was "*busy*" and that's why she hasn't tended to Resident A.

On 3/28/25, I conducted a phone interview with the administrator. The administrator reported that she is aware that the call pendant system has been "*spotty*" recently and that staff have been instructed to conduct increased rounding on the residents. The administrator reported that there is a call in to the company that provides the pendant system and that they are working to resolve the issue. Regarding the incident on 3/18/25, the administrator reported that she would provide an incident report and obtain staff statements.

On 3/28/25, the administrator submitted an incident report that read:

> *EMS arrived stating resident called them telling them he was about to fall off of the bed and could not get ahold of staff. When entering residents room half of his body was still on the bed and he stated it felt like he was slipping. Staff and EMS boosted resident up so he was fully on the bed. Resident never made contact with actual floor. Resident states he is okay. No bumps, bruises, skin tears, etc. Resident also state he never hit his head. EMS staff just assisted with boosting resident up into bed.*

On 3/31/25, the administrator submitted statements from three staff members working at the time of the incident on 3/18/25. The statements were inconsistent with that from the complainant and Witness 1 (all three staff denied receiving the pendant alert and two staff denied that there was a missed call from EMS on the facility landline phone). The staff statements also contradicted information provided in the incident report. When questioned about the discrepancies, the administrator replied:

> *My care staff are not certified aides nor licensed nurses. They are not dumb just not exposed to some things or trained in other areas. I see you are a long term care surveyor. I came from that world and have been here just over 8 months. So different than what I am used to. I do have good staff. They adjust to change well, eager to learn and have absorbed a lot. I understand that HFA facilities don't have the same expectations as SNFs but I believe we are capable of exceeding those expectations. I know my great staff did not impress you at all when you were here. Those ones get weeded out.*

In additional follow up correspondence with the administrator, she reported that the call pendant company reported that the system is working fine and the issues that the facility is experiencing are "*user errors*".

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(2) (e) A patient or resident is entitled to receive adequate and appropriate care, and to receive, from the appropriate individual within the health facility or agency, information about his or her medical condition, proposed course of treatment, and prospects for recovery, in terms that the patient or resident can understand, unless medically contraindicated as documented in the medical record by the attending physician, a physician's assistant with whom the physician has a practice agreement, or an advanced practice registered nurse.
ANALYSIS:	Two credible and unbiased witnesses directly observed facility staff yell at Resident A and not provide him the care he was requesting. Interviews with Resident A also confirm the allegations.
CONCLUSION:	**VIOLATION ESTABLISHED**

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.**
For Reference 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:	The facility lacked an organized program of protection to ensure prompt attention to residents when their pendant is activated. Attestations from staff reveal a faulty and unreliable call pendant system. While onsite, I directly observed staff not responding to Resident A's call pendant, staff talking on their cell phone while Resident A was waiting for assistance and observed a dead cell phone device that staff are to rely on to inform them when a call pendant goes off.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A did not receive pain medication.

INVESTIGATION:

The complaint alleged that on 3/18/25, Resident A reported to be in severe pain, but staff were not responding to his calls for help. The complainant reported that she personally informed facility staff that Resident A was in pain and requested he receive medication, to which staff replied that they were not going to give him any.

Witness 1 reported that he also informed facility staff that Resident A was in pain, but they were unwilling to provide him with medication.

Resident A recalled the events on 3/18/25 and reported that he asked for pain medication, but that staff did not give it to him.

While onsite, I requested a copy of Resident A's medication administration records (MAR). I observed that Resident A had a prescription for tramadol (instructed to take 1 tablet by mouth daily every 12 hours for low back pain) and a prescription for ibuprofen (instructed to take 1 tablet by mouth every 6 hours as needed for pain). On the date in question, I observed that staff documented they administered Tramadol to Resident A at 7:47pm.

In the statements submitted by the administrator, staff denied that Resident A was in pain and that is why they didn't give him any additional medication. In follow up correspondence with the administrator, she reported:

> *He did not report pain when the tramadol was given nor when the RCT followed up when the EMS drivers left. The RCT manager and the supervisors report that it is practice to wait an hour. If he didn't report pain until the EMS personnel came he would not have received anything. When they left he reported again that he had no pain.*

Resident A's MAR did not list any instruction that his pain medications need to be administered at least an hour apart and based on the time that Witness 1 attested they arrived at the facility, more than an hour had passed since Resident A received his tramadol.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.
ANALYSIS:	Resident A is prescribed tramadol on a scheduled basis for back pain and ibuprofen on an "as needed" basis for pain. Facility staff attest that the resident denied being in pain and the MAR indicates that no pain medication was given following EMS' visit, however the two credible and unbiased witnesses along with Resident A all attest that pain medication was requested and refused by staff. Per the administrator, staff are to wait an hour in between administering his pain medications, however this instruction was not listed on the MAR.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

While onsite, Resident A's service plan was reviewed. Under the ambulation section, the service plan dated 6/26/24 reads "*Walks independently with a walker*." Employee 1 reported that Resident A has not ambulated with a walker since he moved into the facility and has always used a wheelchair for mobility.

APPLICABLE RULE	
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.

ANALYSIS:	Resident A's service plan was not updated to reflect his current mobility and ambulation status.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon completion of an acceptable corrective action plan, I recommend no changes to the status of the license at this time.

04/02/2025

_____

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

05/12/2025

_____

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