GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 26, 2023

Wendy Haynes-Ennis
Trilogy Health Care of Clinton, LLC
303 N. Hurstbourne Pkwy #2
Louisville, KY 40222-5185

RE: License #: AH330336309
Investigation #: 2023A1010071
The Willows at East Lansing

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.

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) 241-1970.

Sincerely,
Lauren Wohlfert

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa NW Unit 13 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH330336309
Investigation #:	2023A1010071
Complaint Receipt Date:	06/30/2023
Investigation Initiation Date:	07/05/2023
Report Due Date:	08/30/2023
Licensee Name:	Trilogy Health Care of Clinton, LLC
Licensee Address:	#2 303 N. Hurstbourne Pkwy Louisville, KY 40222-5185
Licensee Telephone #:	(517) 203-4042
Authorized Representative/ Administrator:	Wendy Haynes-Ennis
Name of Facility:	The Willows at East Lansing
Facility Address:	3500 Coolidge Road East Lansing, MI 48823
Facility Telephone #:	(517) 203-4042
Original Issuance Date:	02/13/2014
License Status:	REGULAR
Effective Date:	09/23/2022
Expiration Date:	09/22/2023
Capacity:	36
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Staff left Resident A on the floor overnight on 06/27/2023 "because he looked comfortable." Resident A was later sent to the ER and diagnosed with a fractured nose.	No
Additional Findings	Yes

III. METHODOLOGY

06/30/2023	Special Investigation Intake 2023A1010071
07/05/2023	Special Investigation Initiated - Letter Emailed assigned Ingham Co. APS worker Robert Lindley
07/10/2023	Inspection Completed On-site
07/10/2023	Contact - Document Received Received resident service plan, and staff statements
10/26/2023	Exit Conference

ALLEGATION:

Staff left Resident A on the floor overnight on 06/27/2023 "because he looked comfortable." Resident A was later sent to the ER and diagnosed with a fractured nose.

INVESTIGATION:

On 6/30/23, The Bureau received the allegations from Adult Protective Services (APS). The complaint read, "[Resident A] has dementia. [Resident A] was found by a worker at 06/27/23 at 5:30 a.m. 'asleep' on the floor. The worker reportedly thought that he looked comfortable, so they left him there, checked on him at 8:30 a.m. and he was still asleep. It was not until they checked on him sometime prior to 11:30 a.m. that he was 'confused, restless and agitated more than normal.' EMS was called to transport [Resident A] to the hospital emergency room. [Resident A] was examined in the emergency room and diagnosed with a broken nose, indicating that he may have fallen out of bed and onto the floor. [Resident A] was left on the floor for several hours by the Willows staff. Further they had him transported to the ER for confusion and agitation and never mentioned that he had a facial injury with a broken nose."

On 7/5/23, I emailed assigned Ingham County APS worker Robert Lindley. Mr. Lindley reported he spoke with Resident A and Relative A1, however he has not been in contact with staff at the facility.

On 7/10/23, Mr. Lindley and I interviewed administrator in training Jess Pathfinder at the facility. Ms. Pathfinder reported Resident A prefers to sleep on the floor and does so often. Ms. Pathfinder stated as a result, staff will often leave Resident A on the floor if they observe him sleeping there during the night. Ms. Pathfinder said staff are aware of Resident A's preference as it is outlined in the facility's electronic medication administration record (eMAR) software where staff can access this information.

Ms. Pathfinder denied knowledge regarding Resident A's fractured nose or the incident on 6/27/23. Ms. Pathfinder reported Resident A exhibited increased agitation the morning of 6/27/23, therefore EMS staff were contacted, and Resident A was transported to the hospital. Ms. Pathfinder Resident A returned to the facility and is in the secured memory care unit.

Ms. Pathfinder provided me with a copy of Resident A's service plan for my review. The *Mobility Risk Interventions* section of the plan read, "Frequently used items within reach. Call light within reach. Clear pathway to bathroom and room exit door." The *Mobility Performance* section of the plan read, "Requires supervision or escort – Needs someone to escort due to way finding, or for safety or fall risk." The *Transfer Service Plan* section read, "Provide supervision for transfers to/from bed or chair. Provide assistance for transfer (describe) – 1 person. Provide assistive device (describe) – wheel chair."

Ms. Pathfinder provided me with a screenshot of Resident A's preference to sleep on the floor that is outlined in his eMAR. The *Approach* section in Resident A's eMAR read, "Wants to sleep on the floor: resident preference. Start Date 06/23/2023."

Ms. Pathfinder provided me with a copy of Staff Person 1's (SP1) *Statement of Witness Form* that was dated 6/27/23 for my review. The *Statement if given for the following incident* section of the document read, "Resident was attempting to self-transfer. CRCA reported to me that they observed him on the floor when they were checking on him. Upon entering the room he was observed on the floor on his left side. Upon assessment blood to be noted in his mouth due to biting his tongue. 2 abrasions were noted to the anterior forehead. All other ROM, neuro, and skin assessments within normal limits. Provider and wife were notified."

Ms. Pathfinder provided me with a copy of SP2's *Statement of Witness Form* that was dated 6/27/23 for my review. The *Statement if given for the following incident* section of the document read, "I walked into the resident's room during my normal rounding. He was not calling out. I saw him on the floor laying on his left side. I

notified the nurse and assisted as she assessed, and we got the resident up off the floor."

On 7/10/23, Mr. Lindley and I interviewed SP3 at the facility. SP3 reported she was the registered nurse (RN) on first shift on 6/27/23. SP3 stated she was notified by one of the medication technicians (med techs) that Resident A had fallen earlier that morning. SP3 explained staff were completing neurological checks on Resident A frequently as a result. SP3 said during Resident A's neurological checks, staff observed Resident A was no longer at his baseline, so she was contacted to assess him.

SP3 reported she observed Resident A did have a mark near one of his eyes, however she did not observe any injuries near his nose. SP3 stated it did not appear that Resident A injured his nose. SP3 said Resident A was non-compliant during her assessment and she could not understand him when he spoke. SP3 reported she notified Resident A's physician and EMS was contacted due to the change in Resident A's baseline. SP3 said Resident A was admitted to the hospital but has returned to the facility.

On 7/10/23, Mr. Lindley and I attempted to interview Resident A at the facility. We were unable to engage Resident A in meaningful conversation. I did not observe any injuries on Resident A.

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.**
ANALYSIS:	The interviews with SP3, along with my review of SP1 and SP2's statements regarding the incident on 6/27/23, revealed Resident A was observed on the floor. SP3 reported staff completed neurological checks on Resident A after he was observed on the floor and notified her when he was no longer at his baseline. Staff contacted EMS and Resident A was transported and admitted to the hospital.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 7/10/23, Ms. Pathfinder reported Resident A prefers to sleep on the floor in his room. Ms. Pathfinder stated this information is outlined in Resident A's eMAR, not in his service plan. I reviewed Resident A's service plan, his preference to sleep on the floor in his room was not outlined.

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:	Review of Resident A's service plan revealed his preference to sleep on the floor in his room was not outlined.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Wendy Haynes-Ennis on 10/26/23.

IV. RECOMMENDATION

07/31/2023

Lauren Wohlfert Date
Licensing Staff

Approved By:

10/25/2023

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