GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 19, 2022

Kelly Cornford
Union Court Assisted Living
302 Fulton St.
St. Charles, MI 48655

RE: License #: AH730301115
Investigation #: 2023A1019004
Union Court Assisted Living

Dear Ms. Cornford:

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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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 (248) 975-5053.

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 #:	AH730301115
Investigation #:	2023A1019004
Complaint Receipt Date:	12/05/2022
Investigation Initiation Date:	12/05/2022
Report Due Date:	02/04/2023
Licensee Name:	Union Court Assisted Living
Licensee Address:	302 Fulton St. St. Charles, MI 48655
Licensee Telephone #:	(989) 865-8100
Administrator and Authorized Representative:	Kelly Cornford
Name of Facility:	Union Court Assisted Living
Facility Address:	302 Fulton St. St. Charles, MI 48655
Facility Telephone #:	(989) 865-8100
Original Issuance Date:	11/19/2009
License Status:	REGULAR
Effective Date:	11/27/2022
Expiration Date:	11/26/2023
Capacity:	86
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Timely medical attention wasn't sought for Resident A.	Yes
Additional Finding	Yes

III. METHODOLOGY

12/05/2022	Special Investigation Intake 2023A1019004
12/05/2022	Special Investigation Initiated - Telephone Called complainant to conduct interview, additional information obtained. Complainant did not provide name or address and wishes to remain anonymous.
12/07/2022	APS Referral Notified APS of the allegations via email referral template.
12/07/2022	Comment Area manager Andrea Moore granted approval to conduct this investigation remotely.
12/07/2022	Contact - Document Sent Emailed admin and AR requesting documentation.
12/16/2022	Contact - Document Sent Email reminder sent to admin for outstanding information requested.
12/16/2022	Inspection Completed BCAL Sub. Compliance

ALLEGATION:

Timely medical attention wasn't sought for Resident A.

INVESTIGATION:

On 12/5/22, the department received a complaint alleging that a resident didn't receive proper medical care after having a stroke. The complaint did not provide a name of the resident or identify when the alleged incident occurred. On 12/5/22, I

conducted a telephone interview with the complainant who stated that Resident A is the resident in question and that the allegation occurred sometime on the night of 10/9/22 or early morning of 10/10/22 during the midnight shift. The complainant stated that facility staff delayed obtaining proper medical care to the resident until hours later.

In follow up correspondence with administrator/authorized representative Kelly Cornford and Employee A, documentation pertaining to the incident was requested. Incident reports were obtained and reviewed. An incident report dated 10/10/22 at 4:36am authored by Employee B read:

> *Resident felt unsteady on legs she had taken some steps thought we would get our balance. When going to reach for wheelchair resident lost balance and fell towards roommates bed with my guidance not to hit head landed on butt. SS notified. Skin tear to left hand.*

The corrective measures listed for the incident read “Take resident to bathroom in wheelchair”. In a different handwriting directly beneath, “Resident was sent to the hospital for further evaluation” was written in. The incident report to did not list what time the resident was taken to the hospital. A second incident report dated 10/10/22 at 6:40am authored by Employee C read “Staff went to do a vital recheck, and noticed that her face was still drooping on left side, speech is a little slurred, staff put residents dentures in to see if that would help at all, and residents teeth kept sliding down.” The corrective measures listed for this incident read “Resident was sent to the hospital for further evaluation and was admitted will follow all discharge instructions and update plan of care as needed.” Staff documented that Resident A went to the hospital at 7:40am. Employee A confirmed that Resident A was not sent to the hospital following the first incident as stated on the report and was sent at roughly 7:40am on 10/10/22 following the second incident.

Resident A’s chart notes were reviewed. On 10/10/22, Employee C authored two notes that read “Resident was sent to the hospital this morning due to facial dropping, slurred speech and pain in left leg” and “Resident has been admitted to the hospital due to having a stroke”.

Staff statements were obtained pertaining to the incidents. Employee B worked on third shift and wrote that she observed Resident A to have slurred speech and facial drooping. Employee B’s statement read that she felt the resident had a stroke and notified her shift supervisor of this. Employee D worked third shift and wrote in depth that she observed stroke like symptoms in Resident A and notified her shift supervisor of her concerns. Employee D documented that her supervisor replied that the resident was fine and that “she didn’t have time to deal with the paperwork” associated with sending her to the hospital. Employee E worked on third shift and also wrote that facial drooping and slurred speech was observed after Resident A’s fall. Employee E wrote that on call management was notified and staff were instructed to “keep an eye on her”.

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: **(c) Assure the availability of emergency medical care required by a resident.**
ANALYSIS:	Multiple staff attested to observing stroke like symptoms in Resident A, however medical attention was not sought until hours later.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

Prior to the request made during this investigative process, LARA had not received the two incident reports on Resident A from 10/10/22. Additionally, neither incident provide a date or time that the resident's physician was notified, and the first incident report does not list a time that the resident's authorized representative was notified.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(1) The home shall complete a report of all reportable incidents, accidents, and elopements. The incident/accident report shall contain all of the following information: **(a) The name of the person or persons involved in the incident/accident.** **(b) The date, hour, location, and a narrative description of the facts about the incident/accident which indicates its cause, if known.** **(c) The effect of the incident/accident on the person who was involved, the extent of the injuries, if known, and if medical treatment was sought from a qualified health care professional.** **(d) Written documentation of the individuals notified of the incident/accident, along with the time and date.**

	(e) The corrective measures taken to prevent future incidents/accidents from occurring. **(2) The original incident/accident report shall be maintained in the home for not less than 2 years.** **(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.**
ANALYSIS:	The facility failed to submit incident reports to the department involving injury and hospitalization with Resident A. Incident reports that were completed lacked pertinent information as required by this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remains unchanged.

12/16/22

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Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

12/19/2022

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