GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 2, 2022

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

RE: License #: AH730301115
Investigation #: 2023A1021014
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. 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) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH730301115
Investigation #:	2023A1021014
Complaint Receipt Date:	11/09/2022
Investigation Initiation Date:	11/10/2022
Report Due Date:	1/09/2022
Licensee Name:	Union Court Assisted Living
Licensee Address:	302 Fulton St. St. Charles, MI 48655
Licensee Telephone #:	(989) 865-8100
Administrator/ 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:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A had unwitnessed fall.	Yes
Additional Findings	No

III. METHODOLOGY

11/09/2022	Special Investigation Intake 2023A1021014
11/10/2022	Special Investigation Initiated - Letter referral sent to APS
11/14/2022	Contact - Telephone call made interviewed administrator
11/14/2022	Contact - Document Received received Resident A's documents
11/21/2022	Contact - Telephone call made interviewed SP1
11/21/2022	Contact - Telephone call made interviewed SP2
12/2/2022	Exit Conference Exit Conference

ALLEGATION:

Resident A had unwitnessed fall.

INVESTIGATION:

On 11/9/22, the licensing department received a complaint with allegations Resident A had a fall at the facility. The complainant alleged Resident A had a fall, but the facility staff did not know when the fall occurred. The complainant alleged staff members observed Resident A to have cuts on her forehead and Resident A’s family was contacted. The complainant alleged staff did not call an ambulance and waited to seek medical attention for Resident A.

On 11/10/22, the allegations in this report were sent to centralized intake at Adult Protective Services (APS). APS did not open the investigation.

On 11/14/22, I interviewed administrator Kris Fiting by telephone. Ms. Fiting reported on 11/8/22, first shift staff members observed Resident A to have scrapes on her forehead. Ms. Fiting reported there was no reports of falls on the previous shift. Ms. Fiting reported the caregivers called the DPOA and family wanted to discuss it among themselves before Resident A was transferred to the hospital. Ms. Fiting reported after a few hours the family decided to send Resident A to the hospital and an ambulance was called. Ms. Fiting reported Resident A has significant memory loss and was unable to report what happened. Ms. Fiting reported Resident A ambulates with a walker and is unsteady. Ms. Fiting reported Resident A has bed alarms placed and is on every frequent checks. Ms. Fiting reported the facility acted appropriately with Resident A.

On 11/21/22, I interviewed staff person 1 (SP1) by telephone. SP1 reported she provided care to Resident A the night before Resident A was transferred to the hospital. SP1 reported she checked on Resident A appropriately and did not observe Resident A to have any falls. SP1 reported Resident A slept the entire night in her bed. SP1 reported she did not hear any bed alarms go off. SP1 reported she did not observe any injuries on Resident A.

On 11/21/22, I interviewed SP2 by telephone. SP2 reported on first shift caregivers got Resident A up around 8:00am and Resident A was observed to have scratches on her forehead. SP2 reported Resident A had no other injuries. SP2 reported the facility called Resident A's DPOA between 8:00-9:00am. SP2 reported photographs were sent to the family. SP2 reported the family wanted to discuss it before sending Resident A to the hospital. SP2 reported the family decided to send Resident A to the hospital and she was transferred around 12:00.

I reviewed the incident report submitted to the department. Resident A's DPOA was contacted at 10:00am and the physician was contacted at 1:00pm. The narrative read,

> *"when staff was getting resident up this morning they noticed she has 2 scrapes and a lump on her forehead. Resident was unable to recall what happened."*

I reviewed Resident A's service plan. The service plan read,

> *"Resident is incontinent and needs assistance with peri care 2x daily. She wears Depends that family provides. She is on a 2-hour toileting schedule. Resident goes to bed around 9pm and sleeps till 7am and wakes a few times during the night to toilet. Fall risk; often tries to get up without staff assistance."*

I reviewed Resident A's ADL Log. The log read,

"check alarms every 2 hours to make sure it is on and working."

This was not charted that it was done on 11/7/22 at 10:00pm.

The log read,

"assist to bathroom every 2 hours and PRN while awake."

This was not done at 11:00pm on 11/7/22.

I reviewed facility *Hospital Transfer Policy*. The policy read,

"when a resident is ill or in need of transfer the following procedure is to be followed:

1. *Physician is to be called with the following information*
    a. *Diagnosis*
    b. *Condition changes in detail*
    c. *Full vital signs*
2. *When physician orders transfer, the following must be done:*
    a. *Dial 911*
    b. *Fill out transfer sheet fully, giving as much information as possible.*
    c. *Notify family or designated representative*
    d. *Complete incident report*
    e. *Make an entry in resident assistant notes"*

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.**
	(16) "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:	Resident A was to be checked on every two hours to check alarms and toileting. Review of documentation revealed this was not done appropriately on 11/7/22. In addition, the facility found unexplained injuries in the morning on 11/8/22. Resident A's family was contacted but the physician and a transfer to the hospital was not sought until many hours later. The facility lacked an organized program to ensure the protection of Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/2/22, I conducted an exit conference with authorized representative Kelly Cornford by telephone.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

Kimberly Horst 11/23/22

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Kimberly Horst Date
Licensing Staff

Approved By:

Andrea Moore 11/30/2022

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