RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

March 12, 2018

Robert Russell Jr.
Superior Woods Healthcare Center
8380 Geddes Rd.
Ypsilanti, MI 48198

RE: License #: AH810287412
Investigation #: **2018A0585006**
Superior Woods Healthcare Center

Dear Mr. Russell Jr.:

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 responsible party 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.

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,

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(313) 268-1788

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH810287412
Investigation #:	2018A0585006
Complaint Receipt Date:	02/22/2018
Investigation Initiation Date:	02/23/2018
Report Due Date:	04/24/2018
Licensee Name:	SSC Superior Township Operating Company, LLC
Licensee Address:	Suite 1400 One Ravinia Dr. Atlanta, GA 30346
Licensee Telephone #:	(770) 829-5100
Administrator:	Catherine Jackson
Authorized Representative/	Robert Russell Jr.
Name of Facility:	Superior Woods Healthcare Center
Facility Address:	8380 Geddes Rd. Ypsilanti, MI 48198
Facility Telephone #:	(734) 547-7644
Original Issuance Date:	01/19/2007
License Status:	REGULAR
Effective Date:	08/16/2017
Expiration Date:	08/15/2018
Capacity:	26
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Residents are falling, and staff are not checking vitals for residents that fall.	No
The nurse is administering medications of one resident to another, medication is not labeled properly, and staff is not keeping correct records.	No
Staff take naps during their shift.	No
Resident are not getting showers	No
Residents do not like the food and are not offered enough beverages to drink.	No
There is mold inside the kitchen and it is unsanitary to serve food.	No
The facility is not documenting and keeping records of falls.	Yes
The facility failed to update service plans.	Yes

III. METHODOLOGY

02/22/2018	Special Investigation Intake 2018A0585006
02/23/2018	APS Referral
02/23/2018	Special Investigation Initiated - Telephone Provided initial allegations to Adult Protective Services (APS)
02/27/2018	Inspection Completed On-site Interviews completed, observations made, and records reviewed.
02/28/2018	Exit Conference

ALLEGATION:

Residents are falling, and staff are not checking vitals for residents that fall.

INVESTIGATION:

On 2/22/18, the department received the allegations from an anonymous complainant via the BCAL Online Complainant website. Therefore, I was unable to gather further information regarding their concerns. In addition, Home for the aged licensing rules do not require medical services such as "vital" taking of residents.

On 2/27/18, I interviewed the administrator Catherine Jackson at the facility. Ms. Jackson stated that there has been only one fall with injuries at the facility within the last month. She stated that one of the residents fell and sustained an injury to her hip and thigh. She stated that it was reported to licensing. Ms. Jackson stated that when a resident suffers a fall, staff assess the resident's wellbeing including review of the resident's vital signs. She confirmed the physician is notified. Ms. Jackson stated that all falls are reported by staff to her.

On 2/27/18, I interviewed direct care worker Decilla Johnson at the facility. Ms. Johnson stated that when a resident suffers a fall staff check to see if they are okay, take vitals, and if there is an injury staff send them out for treatment. Ms. Johnson stated that there have been residents falling, but there were no injuries. She stated that the residents are usually attempting to get out of their chair because they feel they can walk on their own. Ms. Johnson stated staff usually catch them (the residents) before they get all the way up.

On 2/27/18, I reviewed Resident A, B, C, and D's fall reports provided to licensing.

On 2/27/18, I reviewed the fall report for Resident A which notes that she had a fall and sustained an injury to her hip and thigh.

On 2/27/18, I interviewed Resident A at the facility. Resident A stated that she fell in her room. She stated she was putting her socks on, which was typical for her to do and lost her balance. She stated that she "crushed her hip." She stated she had to get stitches and claimed the injury was getting better. Resident A stated that the staff are wonderful, and they came immediately to assist her. Resident A also stated that she had showered independently but since the fall she needs assistance from the staff.

A review of Resident A's service plan confirmed her statements that she was, prior to the fall, independent with ambulation and activities of daily living.

Resident D's report read that he had a fall in his room on 2/7/18 at 1:40 a.m. The report notes that the resident was attempting to get tissue when he fell, causing a laceration. The report did not state where the laceration was.

On 2/27/18, I interviewed Resident D at the facility. Resident D stated that he did not use the call light. He stated that he was in his bed when he attempted to reach his tissue that was on his counter.

I reviewed Resident D's service plan dated 1/23/18. The plan read that he transfers with supervision and uses a wheelchair for mobility.

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 that she was independent in ADL's and mobility prior to her fall 2/19. Interview with Resident A revealed she was not ambulating but rather dressing herself when she became unbalanced and fell. Review of Resident D's plan revealed he did require staff assistance with transfers and mobility. However, Interview with Resident D revealed he wasn't ambulating but rather was in bed reaching for a tissue. He acknowledged he did not summon staff for assistance. Given the circumstances of both Resident A and D's fall and staffs responsibility as identified on the resident's plan, it is unreasonable to believe staff could have anticipated and prevented their falls.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The nurse is administering medications of one resident to another, medication is not labeled properly, and staff is not keeping correct records.

INVESTIGATION:

The complainant did not provide any names of residents they were concerned about.

Ms. Jackson stated the facility contracts with a pharmacy to provide all the medications to the residents of the facility. In addition, Ms. Jackson stated that all medication administration staff must be trained and pass a test with a passing score of 80% or better to ensure they competent in the duty. Ms. Jackson stated that if a resident runs out of medication, the staff will call the pharmacy for replenishment. She also stated that an emergency supply is kept at the facility. Ms. Jackson stated that medication is only given to the resident that it is prescribed for. She stated that the facility does not borrow medication from another resident.

On 2/27/18, I observed medication technician Michelle Jordan administering medications to residents. I observed the medication cart and inspected labeling and expiration dates of the medications. I verified the documentation accuracy of narcotic medications compared to those on hand. There were no expired medications and medication was properly labeled and accounted for. Ms. Jordan stated that they only give medicine to the resident who it is prescribed to.

Relative D1 stated that Resident D gets his medication timely as prescribed.

Resident A stated that although she is independent, staff administer her medication. She stated that she did not have any issues with her medication.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) If a home or the home's administrator or direct care staff member supervises the taking of medication by a resident, then the home shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.** **(5) A home shall take reasonable precautions to ensure or assure that prescription medication is not used by a person other than the resident for whom the medication is prescribed.**
ANALYSIS:	The facility has established a medication training program designed to meet the needs of the employees and residents. Staff that administer medications are provided with the required training and must demonstrate competency no the material covered. Inspection of MAR's, medication cart, and documentation revealed medication was properly labeled and accounted for.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff take naps during their shift.

INVESTIGATION:

The complainant did not provide any names of staff that were alleged to have been sleeping during their shift.

Ms. Jackson stated she has never had anyone notify her of a problem. She stated it was against policy for staff to sleep during their shift.

On 3/8/18, I interviewed direct care worker Julie Trinidad by telephone. Ms. Trinidad stated she has never experienced or seen any staff sleep during their shift. She stated that staff are too busy.

On 3/8/18, I interviewed direct care worker Shanisha Black by telephone. Her statements coincided with Ms. Trinidad's.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	Interviews with staff reveal no basis to this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident are not getting showers

INVESTIGATION:

Ms. Johnson stated that facility have a schedule for showers. She states that residents have the opportunity to take showers 2-3 times a week, and more if they request it. Ms. Johnson stated that she did not know anything about staff sleeping at night and have never received any complaints from residents regarding staff sleeping at night.

On 2/27/18, I interviewed direct care worker Kenja Ewing at the facility. She stated that showers are given 2-3 times a week. Ms. Ewing stated showers are documented

and staff sign the work sheets. She states that if a resident refuses a shower staff will, if the resident is able, have them sign the sheet showing that they refused. Ms. Ewing stated that she has never heard of anyone sleeping at night while on shift.

On 2/27/18 I interviewed Relative D1 and Relative D2 at the facility. Both relatives stated that the staff are taking good care of Resident D. They both stated that Resident D is provided showers and they have no concerns with care he receives from staff.

On 2/27/18, I reviewed staff work sheets for Resident B, C and D. The sheets are used for staff to document when a resident had showered, linen was pulled, washed and new linen was applied. There were no indications that resident was not getting showers.

On 2/27/18, I interviewed Resident B in his room. Resident B stated that his showers are given to him whenever he wants one.

APPLICABLE RULE	
R 325.1933	**Personal care of residents.**
	(2) A home shall afford a resident the opportunity and instructions when necessary for daily bathing, oral and personal hygiene, daily shaving, and hand washing before meals. A home shall ensure that a resident bathe at least weekly and more often if necessary.
ANALYSIS:	Interviews with staff and Resident B combined with review of staff work sheets reveal no basis to this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents do not like the food and are not offered enough beverages to drink.

INVESTIGATION:

Ms. Johnson stated that water is given to residents every shift. She stated that residents' water cups are labeled with the date and time given. Ms. Johnson stated that some of the residents have refrigerators containing beverages in their room and can easily get beverages whenever they want. Ms. Johnson stated that if a resident asks for water between shifts staff will get it for them.

Ms. Ewing stated procedure is that when a resident doesn't like the food they are presented an alternative meal is provided. She stated this is dependent on the resident informing staff of desire for an alternative.

Resident B stated that the food at the facility is generally good. He stated that on the occasion they serve something he doesn't like, they will bring him something else. The resident had a fresh cup of water on his bedside table. The water cup had the date and time on the label.

I observed Resident D in his room visiting with Relative D1, Relative D2, and Relative D3. Resident D stated the food is okay and the staff give him water when he needs it. I observed a full cup of water on his bedside table. Relative D2 stated that the water was fresh because the staff had just brought it in. Relative D1 introduced herself as Resident D's authorized representative and stated that the resident did not have any problems with the food. The visitors said that they are there all the time and have not had any issues with the food or the resident being provided water.

Resident A stated that the food is good, and she has had no problems. She stated that she is capable of getting her own water, but most of the time, the staff ~~get~~ provide her water and anything else she needs.

On 2/27/18, I observed a few residents in the dining room finishing their breakfast. It appeared they had received the meal items listed on the menu. Observation of the breakfast meal revealed all residents receiving plates full of food that was listed on the menu. Food was observed in the home for the aged (HFA) prep kitchen and in the attached nursing home main kitchen that supplies the HFA facility. It was prepared and handled in an appetizing manner.

Ms. Johnson stated the HFA has a prep kitchen for refrigeration of drinks and warming of food. Ms. Johnson confirmed the meals provided are as identified on the menus and that there is enough food for all the residents. She stated if additional food is needed, staff can obtain it from the attached nursing home kitchen.

APPLICABLE RULE	
R 325.1952	**Meals and special diets.**
	(1) A home shall offer 3 meals daily to be served to a resident at regular meal times. A home shall make snacks and beverages available to residents. **(2) A home shall work with residents when feasible to accommodate individual preferences.**

ANALYSIS:	Observation and interviews revealed no evidence to indicate there is insufficient food, unappetizing food, or no alternative food options for residents. Water is given each shift to resident. The water cups are labeled with date and time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

There is mold inside the kitchen and it is unsanitary to serve food.

INVESTIGATION:

On 2/27/18, I observed the HFA and the nursing home kitchen food prep and staging, sink, storage, and cooler areas. I observed the dishwasher, looked in freezers, and ice machine for signs of mold. I looked at the counter tops and floors for signs of rodents and water spots. The kitchen was clean, free from mold.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	Observation of the HFA and nursing home kitchens revealed no evidence of mold in either kitchen.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility is not documenting and keeping records of falls.

INVESTIGATION:

Resident A's fall report read that she was sent to the hospital. The incident report included the type of injury and the date and time the authorized representative and physician were notified. The report did not include the date of fall or the time it occurred.

Resident D's report did not indicate whether his authorized representative or physician was notified of his 2/7 fall. A 2/19 report did not indicate any details about

the circumstances of the fall he suffered on that day; just that resident fell, and hospice was contacted.

Relative D1 stated that Resident D has not fallen at the facility.

Ms. Ewing stated that all falls are documented, resident vitals are taken, and incident reports are completed.

Ms. Johnson's statements coincided with those of Ms. Ewing. In addition, she stated that falls are documented on an incident report that includes date, time and how it happened.

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: **(b) The date, hour, location, and a narrative description of the facts about the incident/accident which indicates its cause, if known.** **(d) Written documentation of the individuals notified of the incident/accidents, along with the time and date.**
ANALYSIS:	Although falls are documented on an incident/accident forms, the forms were incomplete for Resident A and D. Relative D1, as authorized representative, was not notified of Resident D's fall.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility failed to update service plans

INVESTIGATION:

I reviewed Resident A's service plan dated 6/14/17. The plan notes that Resident A is independent with activities of daily living. She transfers independently and uses a walker for mobility but has depended on staff more since her fall. Resident A's plan was not updated with new methods for staff to implement due to her increase needs.

The report for Resident C revealed that she had two falls on 2/19/18, one at 12:30 a.m. with no apparent injury and another one at 10:00 p.m. The resident was noted as having pain and disorientation.

On 2/27/18, I observed Resident C in her room. Resident C was oriented of people and to her surroundings; however, she was not easily understood, therefore an interview could not be obtained. She did not exhibit any signs of distress.

I reviewed Resident C's service plan dated 1/31/18. The plan read that she was bed bound as of 2/12/18 receiving hospice services. In addition, it read that she utilized a four-wheel walker for mobility.

I reviewed Resident D's service plan dated 1/23/18. The plan notes that Resident D is dependent upon the staff for transfers and mobility. Resident D's plan was not updated with new methods for staff to implement regarding his increased needs.

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:	Service plans of Resident A, C and D were not updated after experiencing a significant change in needs.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 3/5/18, I shared the findings of this report with the licensee authorized representative Robert Russell Jr. by telephone.

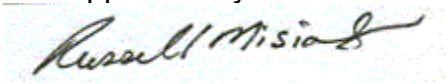
IV. RECOMMENDATION

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

3/9/18

Brender Howard — Date
Licensing Staff

Approved By:



3/9/18

Russell B. Misiak — Date
Area Manager