GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 14, 2021

Stephanie Hildebrant
Wood Care X, Inc., d/b/a Caretel Inns of Linden
910 S. Washington Ave.
Royal Oak, MI 48067

RE: License #:	AL250281706
Investigation #:	2021A0872008
	Monet House Inn

Dear Mrs. Hildebrant:

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. 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 (810) 787-7031.

Sincerely,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
4809 Clio Road
Flint, MI 48504
(989) 293-5222

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL250281706
Investigation #:	2021A0872008
Complaint Receipt Date:	11/12/2020
Investigation Initiation Date:	11/12/2020
Report Due Date:	01/11/2021
Licensee Name:	Wood Care X, Inc., d/b/a Caretel Inns of Linden
Licensee Address:	910 S. Washington Ave. Royal Oak, MI 48067
Licensee Telephone #:	(248) 543-7300
Administrator:	Stephanie Hildebrant
Licensee Designee:	Stephanie Hildebrant
Name of Facility:	Monet House Inn
Facility Address:	202 S. Bridge Street Linden, MI 48451
Facility Telephone #:	(810) 735-9400
Original Issuance Date:	06/25/2008
License Status:	REGULAR
Effective Date:	08/08/2019
Expiration Date:	08/07/2021
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 10/27/20, Resident A fell and did not receive external medical attention. On 10/29/20, she was experiencing extreme pain. She was taken to the hospital and diagnosed with several broken ribs and a punctured lung, presumably from her fall on 10/27/20.	Yes
On 10/31/20, Resident A was found on the floor in her room, naked except for a soiled brief. She was on the floor for an unknown period of time.	Yes

III. METHODOLOGY

11/12/2020	Special Investigation Intake 2021A0872008
11/12/2020	APS Referral This complaint was referred by APS but was denied for investigation
11/12/2020	Special Investigation Initiated - Letter I emailed the assisted living director, Michelle Moore, and requested documentation regarding Resident A
11/16/2020	Contact - Document Received Documentation received from Ms. Moore
01/12/2021	Contact - Telephone call made I left a message for Relative A1
01/12/2021	Contact - Telephone call received I interviewed Relative A2
01/12/2021	Contact - Telephone call made I interviewed staff Patty Hensley
01/12/2021	Contact - Telephone call made I interviewed Relative A3
01/12/2021	Contact - Document Received I received documentation and photographs from Relative A2 via email

01/14/2021	Contact - Telephone call made I interviewed staff Trinidy Tomlin
01/14/2021	Contact - Document Received I exchanged emails with Ms. Moore
01/14/2021	Inspection Completed-BCAL Sub. Compliance
01/14/2021	Exit Conference I conducted an exit conference with the licensee designee, Stephanie Hildebrant, via telephone

ALLEGATION:

- **On 10/27/20, Resident A fell and did not receive external medical attention. On 10/29/20, she was experiencing extreme pain. She was taken to the hospital and diagnosed with several broken ribs and a punctured lung, presumably from her fall on 10/27/20.**
- **On 10/31/20, Resident A was found on the floor in her room, naked except for a soiled brief. She was on the floor for an unknown period of time.**

INVESTIGATION: Due to the Coronavirus pandemic, an onsite inspection was not conducted during this investigation. However, on 1/12/21 I conducted an interview via Facetime with staff Patty Hensley.

Resident A was admitted to Monet House Inn Adult Foster Care facility on 7/28/17. She is diagnosed with numerous medical conditions including osteoarthritis, hypotension, hypothyroidism, chronic pain, difficulty of gait and mobility, Parkinson's, and Alzheimer's.

I reviewed several Incident/Accident Reports regarding Resident A falling from her bed or slipping out of her wheelchair. According to the reports, she sustained falls on 9/16/20, 9/27/20, 10/08/20 and 10/17/20. Each time, staff notified Relative A1 and management. Staff assessed Resident A for injuries and completed range of motion assessments. Each time, Resident A was determined to not need further medical attention. The corrective measures taken were staff increased monitoring, reminded Resident A to use her call light for help, ensured that her call light was within reach, and to make sure that her toileting needs were met.

Resident A was put on hospice care on 10/05/20 due to complications from Alzheimer's disease. After her fall on 10/08/20, hospice ordered a floor mat to use next to Resident A's bed.

I reviewed an Incident/Accident Report dated 10/27/20 completed by staff Patty Hensley. According to the report, Ms. Hensley entered Resident A's room and found her

on the floor. Ms. Hensley contacted Resident A's hospice nurse, management, and Relative A1. Resident A's vitals were taken, and staff performed a range of motion assessment, which Resident A was able to complete. Ms. Hensley noted a small skin tear on Resident A's left knee. The corrective measures taken were staff ensured that her bed mat was in place and her bed was lowered to the lowest setting. Resident A did not receive any additional and/or external medical treatment as a result of this fall.

I reviewed an Incident/Accident Report dated 10/29/20 completed by staff Patty Hensley. According to the report, Ms. Hensley noted that Resident A appeared to be in a lot of pain and had bruising on her right hip and abdomen which appeared to be from her fall on 10/27/20. Ms. Hensley contacted hospice and Relative A1. Hospice suggested Resident A be sent to the hospital. Resident A was taken to Ascension Genesys hospital and was diagnosed with multiple rib fractures and pneumothorax. She was released back to the facility.

I reviewed an Incident/Accident Report dated 10/31/20 completed by staff Trinity Tomlin and Nakailya Brown. According to the report, staff again found Resident A on the floor. Staff notified hospice and Resident A's family. Resident A's hospice nurse examined Resident A and since this was her 2nd fall in as many days, she was transferred to Ascension Genesys hospital for treatment. Resident A sustained no hematomas or lacerations from this fall. Staff noted that Resident A's floor pad was in place, her bed was on the lowest setting, and staff were closely monitoring her, but she was unable to use her call light.

I reviewed staff progress notes from 10/26/20 through 10/31/20. According to the note dated 10/28/20 completed by staff Patty Hensley, Resident A complained of pain in her legs from her fall on 10/27/20. Ms. Hensley notified management and Relative A1 who instructed staff to give Resident A Tylenol (which had already been approved by DO Covieo).

According to the note dated 10/29/20 completed by staff Keymoshi Daniels, she attempted to get Resident A up for a shower, but she appeared very tired and "out of it." She also appeared to be in "some pain." Later, Ms. Daniels attempted to give Resident A bed bath and noticed a large bruise on her right back/side torso area. Ms. Daniels put in a request for a doctor visit.

According to the note dated 10/30/20 completed by staff Valerie Dzapo, Resident A returned from the hospital via ambulance. She was transferred to her bed and staff made sure her call light was in reach. Resident A was sleeping but did respond to verbal and tactile stimuli.

According to the note dated 10/31/20 completed by staff Valerie Dzapo, when she arrived at work, Resident A was being transported to the hospital. Ms. Dzapo spoke to staff who told her that earlier, Resident A was found on the floor next to her bed. Staff notified hospice and family who came to the facility and decided that Resident A needed to be sent to the hospital.

I reviewed the discharge paperwork from Ascension Genesys hospital dated 10/30/20. Resident A was admitted on 10/29/20 and diagnosed with multiple rib fractures and pneumothorax. On 10/30/20, she was deemed “stable” by hospital staff. She was given a Lidoderm patch on her right flank for pain and was returned to Monet House Inn AFC under hospice care.

On 1/12/21, I interviewed staff Patty Hensley via FaceTime. Ms. Hensley said that she has worked at Monet House Inn for approximately two years. She said that while Resident A was a resident of Monet House Inn, she cared for her on multiple occasions. Ms. Hensley said that Resident A had dementia and her condition was declining. By the time she was discharged from Monet House Inn on 10/31/20, she was getting to the point where she was very confused. According to Ms. Hensley, prior to Resident A’s discharge, her falls were increasing in frequency. Resident A would try to get up out of bed, her wheelchair, or her recliner and if she did so without asking for assistance from staff, she would often fall. Ms. Hensley said that on a few occasions, she caught Resident A before she fell to the floor and would remind her to ask for assistance before trying to transfer on her own. Ms. Hensley confirmed that on 10/27/20, she found Resident A on the floor. Ms. Hensley stated that she examined Resident A and contacted Relative A1, hospice, and management. Ms. Hensley said that at that time, she did not feel that Resident A needed outside medical care.

On 1/12/21, I interviewed Relative A2 via telephone. Relative A2 said that she has joint Durable Power of Attorney along with Relative A1. According to Relative A2, Resident A suffered from dementia and her condition declined to the point that the family felt hospice services were warranted. In October 2020, Resident A began receiving hospice services and a hospice nurse was going to Monet House Inn twice a week to provide care to Resident A. Relative A2 said that prior to hospice, Resident A’s falls increased in frequency. She said that staff would notify Relative A1 about Resident A’s falls, but due to the Coronavirus pandemic, family was not able to visit Resident A until hospice services were secured.

According to Relative A2, on 10/27/20 Resident A fell. Staff did not contact family until 10/28/20. At that time, family was told that Resident A did not need outside medical attention. On 10/29/20, staff called family and told them that Resident A appeared to be in pain. Family and hospice instructed staff to have Resident A transported to the hospital. Hospital staff discovered that Resident A had several broken ribs and a punctured lung, presumably from her fall on 10/27/20. One of the emergency room doctor’s suggested Resident A have surgery but the hospice nurse recommended non-surgical intervention and agreed to increase hospice services to seven days per week. Relative A2 said that Resident A was discharged from the hospital on 10/30/20 and returned to Monet House Inn. At that time, Resident A’s gerontologist told family that Resident A only had about 7-10 days to live.

On 10/31/20 at approximately 12:00pm, Relative A2 and Relative A3 went to Monet House Inn to visit with Resident A. When they got to the facility, they were intercepted

by staff “Kai” who told them that Resident A had fallen earlier that morning and said that she was still on the floor. Kai said that she was told previously “not to touch” Resident A so she left her on the floor, stating that she did not want to move her for fear of hurting her ribs. Relative A2 said that she and Relative A3 went into Resident A’s room and found her lying on the floor mat next to her bed. Relative A2 said that Resident A was naked except for a urine soaked brief and socks. Resident A was shivering on the floor, her lips were blue, and she appeared to be in pain. She did not have a pillow under her head nor was she covered with a blanket. In addition, her bedroom was “filthy.” Relative A2 said that she took photographs of the condition Resident A was in and said that she would email them to me. Resident A’s hospice nurse came to the facility, took Resident A’s vitals, and sent her to the hospital. Relative A2 said that hospital staff admitted Resident A for a 3-day observation. Relative A2 told me that due to the condition Resident A was found in on 10/31/20 and due to, what family felt was ongoing neglect, Resident A did not return to Monet House Inn once she was discharged from the hospital. Instead, on 11/03/20, Resident A was admitted to a different Adult Foster Care facility and she passed away under hospice care on 12/17/20.

Relative A2 told me that on 10/31/20, she took photographs of the condition Resident A was in when she found her, and she would send them to me.

On 1/12/21, I interviewed Relative A3 via telephone. Relative A3 confirmed that on 10/31/20 at approximately 12:00pm, she and Relative A2 went to Monet House Inn to visit with Resident A. While they were walking down the hallway, a female staff told them that Resident A had fallen again, and they did not know when the fall occurred. The staff said that she was trying to clean Resident A up but there were no other staff available to help her. According to Relative A3, when they got to Resident A’s room, she and Relative A2 found Resident A on the floor. Resident A was laying on the floor, almost completely naked, shivering, incoherent, and in pain. Relative A3 said that Resident A had a nightgown lying nearby and her brief was halfway up her thighs. Relative A3 stated that she got down on the floor and attempted to cuddle Resident A and warm her up, but Resident A kept shivering and was very confused. Relative A3 told me that seeing Resident A on the floor “was the most devastating sight I’ve ever seen.” According to Relative A3, the hospice nurse got to the facility shortly thereafter and had Resident A sent to the hospital.

On 1/12/21, I reviewed photographs sent to me by Relative A2. The photographs showed Resident A laying on the floor, on a mat by her bed. Resident A was naked except for a disposable brief and socks. There were tangled blankets and sheets to the sides of her which appear to have fallen off her bed. She did not have a pillow under her head, and she was not covered with any blankets. She had extensive bruising all along her side, back, and abdominal area.

On 1/14/21, I exchanged emails with the Assisted Living Director, Michelle Moore. Ms. Moore said that on 10/31/20, staff Trinidy Tomlin and Nakayla Brown were working at the time of Resident A’s fall. However, Ms. Brown has since resigned from her position as Direct Care Worker.

On 1/14/21, I called Ms. Brown but I received an automated message stating that her phone is unable to accept calls.

On 1/14/21, I interviewed staff Trinidy Tomlin via telephone. Ms. Tomlin said that she has worked for Caretel Inns Adult Foster Care facilities for approximately one year. She said that she normally works in Homer House Inn or Turner House Inn but due to staffing issues, she has been working in the other Inns as well.

Ms. Tomlin confirmed that on 10/31/21 she worked 1st shift with staff Nakayla Brown. Ms. Tomlin said that she believes Ms. Brown has since quit because she has not seen her in a while. According to Ms. Tomlin, when she came on shift, the outgoing 3rd shift staff told her that due to Resident A's injuries, staff are not supposed to touch her for fear of causing her pain. Ms. Tomlin said that when she first checked on Resident A that morning, she found her in bed with only a hospital gown on which was slipping off and not secure to her body. Resident A did not have a brief on, so her bed was soiled. Ms. Tomlin said that she and Ms. Brown removed the soiled sheet from Resident A's bed, put a pad underneath her, and put a brief on her. Later that morning, when she checked on Resident A, she found her laying on the mat, on the floor next to her bed. Ms. Tomlin said that Resident A was naked except for a brief and she was shivering so Ms. Tomlin covered her up with a blanket. Ms. Tomlin called the on-call phone number and told that individual that Resident A had apparently fallen and was on the floor. The on-call individual told Ms. Tomlin that Resident A's hospice nurse was on her way and would deal with the situation. Ms. Tomlin told me that she thought that due to Resident A's injuries, staff were not supposed to try to move her which is why she and Ms. Brown left her on the mat rather than trying to get her back into bed.

Later that morning, Resident A's relatives arrived at the facility to visit with her. Ms. Tomlin said that by that time, she and Ms. Brown were getting the other residents ready for lunch. Ms. Tomlin said that she told the relatives that Resident A had fallen and was still on the floor because staff did not know how to safely transfer her back to bed without possibly causing further injuries. Ms. Tomlin estimates that Resident A was on the floor for approximately 30-45 minutes before her relatives showed up.

On 1/14/21, I conducted an exit conference with the licensee designee, Stephanie Hildebrant, via telephone. I discussed the results of my investigation and explained which rule violations I am substantiating. Ms. Hildebrant agreed to complete and submit a corrective action plan upon the receipt of my investigation report. She also said that she would be further investigating this situation herself and would be addressing all the concerns.

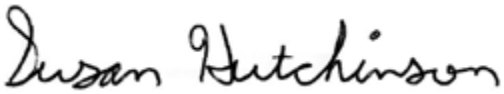
APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	On 10/31/20, staff Trinidy Tomlin and Nakayla Brown found Resident A laying in bed, naked with soiled sheets and an ill-fitting hospital gown. Later, on 10/31/20, staff Trinidy Tomlin found Resident A lying on the floor, on a mat by her bed. She was naked except for a brief and she was shivering. Ms. Tomlin said that she contacted on-call and was told that Resident A's hospice nurse was on the way and would deal with the situation. Ms. Tomlin said that she covered Resident A with a blanket and left her on the floor. On 10/31/20 at approximately 12:00pm, Relative A2 and Relative A3 found Resident A lying on the floor in her room, on a mat by her bed. She was naked except for a brief and socks. She was shivering and in pain and Relative A2 said her lips were turning blue. She did not have a pillow under her head nor a blanket. Ms. Tomlin said that she estimates Resident A was on the floor for approximately 30-45 minutes before her relatives showed up. I conclude that the actions by the facility and staff are a direct violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.

ANALYSIS:	On 10/27/20, Resident A fell. Staff Patty Hensley assessed her for injuries, took her vitals, and performed range of motion tests. Resident A did not receive any external medical attention. On 10/29/20, Resident A appeared to be in extreme pain, so she was taken to Ascension Genesys Hospital at which time she was diagnosed with several rib fractures and a punctured lung. I conclude that Monet House Inn did not seek appropriate medical care for Resident A at the time of her fall on 10/27/20 which is a direct violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

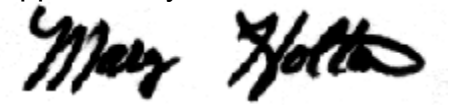
Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.



January 14, 2021

Susan Hutchinson Licensing Consultant	Date

Approved By:



January 14, 2021

Mary E Holton Area Manager	Date