GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 29, 2021

Jacqueline Wright
10564 N. 16th St.
Plainwell, MI 49080

RE: License #: AS390301018
Investigation #: 2021A1024012
Emma's Kare

Dear Jacqueline Wright:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On 1/28/21, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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 (616) 356-0183.

Sincerely,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems
427 East Alcott
Kalamazoo, MI 49001

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390301018
Investigation #:	2021A1024012
Complaint Receipt Date:	12/09/2020
Investigation Initiation Date:	12/09/2020
Report Due Date:	02/07/2021
Licensee Name:	Jacqueline Wright
Licensee Address:	10564 N. 16th St. Plainwell, MI 49080
Licensee Telephone #:	(269) 685-6567
Administrator:	Jaqueline Wright
Licensee Designee:	N/A
Name of Facility:	Emma's Kare
Facility Address:	3617 N. Westnedge Kalamazoo, MI 49004
Facility Telephone #:	(269) 216-3317
Original Issuance Date:	06/24/2009
License Status:	REGULAR
Effective Date:	11/11/2019
Expiration Date:	11/10/2021
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
There is concern Resident A did not receive quality care while in the home because Resident A was discovered to be dehydrated with bed sores.	No
When Resident A began to refuse to eat and walk, no medical care was obtained.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/09/2020	Special Investigation Intake 2021A1024012
12/09/2020	Special Investigation Initiated – Letter-email correspondence with Adult Protective Services (APS) Specialist Melissa Brown
12/12/2020	Contact - Telephone call made with Relative A1 and Relative A2
12/14/2020	Contact - Document Received-letter from Resident A's primary care physician
12/15/2020	Inspection Completed On-site with licensee Jacqueline Wright
12/15/2020	Contact - Document Received-Resident A's *Assessment for AFC Residents, Bronson Patient Level Documentation*
12/15/2020	Contact - Telephone call received from licensee Jacqueline Wright
01/07/2021	Contact - Document Received-letter from Resident A's primary care physician
01/08/2021	Contact - Document Received-email correspondence with Adult Protective Services (APS) Specialist Melissa Brown
01/27/2021	Exit Conference with licensee Jacqueline Wright
01/27/2021	Corrective Action Plan Requested and Due on 02/12/2021
01/28/2020	Corrective Action Plan Received
1/28/2021	Corrective Action Approved

ALLEGATION:

There is concern Resident A did not receive quality care while in the home because Resident A now was discovered to be dehydrated with bed sores.

INVESTIGATION:

On 12/9/20, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. This complaint alleged there is concern Resident A did not receive quality care while in the home because Resident A was discovered to be dehydrated with bed sores. This complaint further stated Resident A also has kidney issues.

On 12/9/20 and 1/8/21, I conducted an interview with Adult Protective Specialist Melissa Brown regarding this allegation. Ms. Brown stated she is also investigating this allegation and has found substantial evidence to support that Resident A was neglected by licensee Jacqueline Wright while living at Emma's Kare adult foster care facility.

On 12/12/20, I conducted an interview with Relative A1 and Relative A2 who stated they are both the Power of Attorney (POA) for Resident A and they believe Resident A was neglected while living at Emma's Kare. Relative A1 and Relative A2 stated Resident A was in good health and ambulatory when Resident A was admitted to Emma's Kare adult foster care facility in October 2020. Both stated neither was never notified by Ms. Wright that Resident A had declined in his health over the two months he lived at the facility. Relative A1 stated she called Ms. Wright on 12/2/20 to inform Ms. Wright that they wanted to pick up Resident A for a visit at which time Ms. Wright suggested to Relative A1 that Resident A needed a hospital bed. Relative A1 stated she then called Resident A's primary care physician's office and was advised that Resident A needed to be seen by his physician in order for a hospital bed to be prescribed. Relative A1 stated when she picked up Resident A on 12/4/20 for his physician appointment, she was alarmed to see that Resident A could no longer ambulate on his own and was extremely frail and weak. Relative A1 stated Ms. Wright never said anything about Resident A's personal care needs not being fully met or physical health worsening at no time when Relative A1 conversed with Ms. Wright prior to 12/4/20. Relative A2 stated Resident A was eventually sent to the hospital on 12/4/20 and was diagnosed with severe dehydration and malnourishment. Relative A2 stated Resident A also was observed to have a large bed sore as well. Relative A1 and Relative A2 stated Resident A's deteriorated health condition resulted from his personal care needs not being attended to by Ms. Wright.

On 12/15/20, I conducted an onsite investigation at the facility and interviewed licensee Jacqueline Wright. Ms. Wright stated Resident A came to live in her home in October 2020 and was discharged in December 2020. Ms. Wright stated Resident

A was admitted to her facility with the assistance of Relative A1 and Relative A2. Ms. Wright stated during the admission process she was not informed about the challenging behaviors that Resident A has demonstrated in the past involving receiving personal care assistance which subsequently impacted the care he received while living in her facility. Ms. Wright stated she was under the impression that Resident A was higher functioning and needed minimal assistance with his activities of daily living however Ms. Wright gradually began to notice that Resident A required more assistance particularly pertaining to his bathing needs and eating. Ms. Wright stated Resident A became very resistant to receiving any assistance with bathing and would not allow Ms. Wright to assist him with bathing certain areas of his body. Ms. Wright stated Resident A would only allow her to assist with bathing his upper body areas therefore to avoid getting into a power struggle with Resident A, Ms. Wright did not make attempts to clean various areas on his lower body. Ms. Wright stated upon admission, Resident A did not have any issues with eating however over time she noticed she needed to remind Resident A to eat or monitor Resident A closely to ensure he ate 3 regular balanced meals a day since there were many times Resident A chose not eat meals. Ms. Wright stated there were also many incidents Resident A did not want to come out of his bedroom to interact with others in the home therefore she noticed Resident A was not as mobile throughout the home as he was when he was initially placed in her home. Ms. Wright stated she informed Relative A1 and Relative A2 of the challenging behaviors Resident A began to demonstrate. Ms. Wright further stated during the last week of Resident A's stay at the facility Resident A hardly ate at all and did not leave his bed. Ms. Wright stated she assumed Resident A had a cold and did not want to force Resident A to do anything if he did not feel well. Ms. Wright stated she continuously offered fluids, meals and offered to assist with activities of daily living regularly during the entire time Resident A lived at her facility.

On 12/15/20, I reviewed Resident A's *Assessment Plan for AFC Residents* (plan) dated 10/2/20. According to this plan, Resident A needed assistance with toileting, dressing, bathing, hygiene, mobility, and hygiene. According to this plan, Resident A had assistive equipment devices such as a walker or wheelchair and had physical limitations. Resident A did not require assistance with eating and had no history with eating issues.

I also reviewed Resident A's *Bronson Patient Level Documentation* (documentation) dated 12/4/20. According to this documentation, Resident A had medical history that consist of Dementia and COPD and over the last six months has been diagnosed with adult failure to thrive with generalized weakness and inability to ambulate. Other past medical history included Chronic Obstructive Pulmonary disease, Dementia, former heavy tobacco smoker and severe malnutrition. According to this documentation, Resident A was brought to the hospital due to family expressing concerns of his worsening condition. According to the documentation Resident A currently has a pressure ulcer that was not infected and Resident A appeared to be severely dehydrated with acute kidney injury. The documentation stated Resident A will be discharged to a nursing facility and upon discharge Resident A was

diagnosed with Acute Kidney Injury Stage III, Leukocytosis, Lactic Acidosis, Dehydration, Severe malnutrition, Hypernatremia, Hyperchloremia, Generalized weakness, and Thrombocytopenia.

On 1/7/2021, I reviewed a letter dated 1/6/2021 written by Stephen Robinson MD. According to this letter, Resident A was seen in his vehicle at the doctor's office on 12/4/20 due to weakness and an inability to walk. According to the letter, from 11/16/16 to 3/11/19 Resident A continuously had problems with gait weakness and falling. The letter stated on 8/19/20 he was seen by Dr. Seth Egleston and in his report, it was noted that Resident A was not taking his medications, had limited ADL's, gait impairment, and confusion. The letter stated at this exam Resident A was disheveled, smelled of urine, chronically ill, emaciated and protein calorie malnourished but there were no signs of bed sores, bruises or moderate to severe dehydration. These issues were determined prior to Resident A's admission to Emma's Kare AFC.

I also reviewed a letter dated 8/19/20 written by Seth Egleston MD. According to this letter, Resident A was evaluated on 8/19/20 for a medical competency evaluation. This letter stated it is determined that Resident A has a diagnosis of Moderate Dementia, no longer able to care for himself, and medical decisions to perform ADL's therefore he will therefore require a guardian, Power of Attorney and 24-hour care since he is at risk to himself and possible others. The letter stated Resident A will therefore require long term care placement if this is not possible to be provided for in the home.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	Based on my investigation which included interviews with Relative A1, Relative A2, licensee Jacqueline Wright, review of Resident A's *Assessment for AFC Residents* and *Bronson Patient Level Documentation* there is not enough evidence to support the allegation that licensee Jacqueline Wright did not attend to Resident A's protection and safety needs at all times. Ms. Wright reported she offered Resident A food and liquids prior to his physician appointment on 12/04/2020 but Resident A refused on multiple occasions and acted as if he did not feel well. Ms. Wright further stated she offered and assisted Resident A with personal care tasks as much as he allowed without upsetting Resident A. Despite Resident A having these challenging behaviors Ms. Wright stated she offered meals and assistance to Resident A during the entire time Resident A lived at her facility. Ms. Wright stated she informed Resident A's relatives of Resident A's challenging behaviors and believe Resident A's relatives misguided her with inaccurate information on Resident A's health condition and behaviors during admission. According to hospital records, Resident A had a past medical history that included adult failure to thrive, Chronic Obstructive Pulmonary disease, Dementia, former heavy tobacco smoker and Severe malnutrition and on 12/4/20 Resident A was admitted to the hospital and additionally diagnosed with dehydration, kidney injury and having a pressure ulcer. Two letters from Resident A's physician stated Resident A had severe medical issues six months prior to Resident A being admitted to Emma's Kare. Resident A resided in Ms. Wright's home for two months and during this time even when Resident A became resistant to care, Ms. Wright attended to Resident A's personal care needs by offering to assist with activities of daily living, offering fluids, and meals.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

When Resident A began to refuse to eat and walk no medical care was obtained.

INVESTIGATION:

This complaint also alleged when Resident A began to refuse to eat and walk yet no medical care obtained.

On 12/12/20, I conducted an interview with Relative A1 and Relative A2 who stated Ms. Wright never informed them that Resident A's health had deteriorated during the

two months he resided at Emma's Kare which had impacted his activities of daily living. Relative A1 stated she took Resident A to the hospital due to the severity of his condition she observed when she picked him up on from Ms. Wrights care on 12/4/20.

On 12/15/20, I conducted an onsite investigation at the facility and interviewed licensee Jacqueline Wright. Ms. Wright stated Resident A began showing signs of illness during the last week he resided in her care in December 2020. Ms. Wright stated Resident A stopped eating and would only eat jello and chicken broth on some days. Ms. Wright stated Resident A would also not leave his bed which was uncharacteristic of Resident A. Ms. Wright stated she notified Resident A's relatives however did not seek medical care because she assumed Resident A just had a cold. Ms. Wright stated she did not make contact with any health professionals regarding Resident A's health while Resident A resided in her home.

On 12/15/20, I reviewed Resident A's Assessment Plan for AFC Residents (plan) dated 10/2/20. According to this plan, Resident A did not require assistance with eating and had not issues with eating.

APPLICABLE RULE	
R 400.14310	**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:	Based on my investigation which included interviews with Relative A1, Relative A2, licensee Jacqueline Wright, review of Resident A's *Assessment for AFC Residents,* there is evidence to support the allegation that when Resident A began to refuse to eat and walk no medical care was obtained. According to Resident A's *Assessment Plan for AFC Residents,* Resident A had no history of issues with eating. Ms. Wright stated she noticed Resident A showed signs of illness because he would not hardly eat and would not leave his bed which was uncharacteristic of Resident A. Despite observing these adverse changes in Resident A's physical condition, Ms. Wright stated she did not obtain care or call Resident A's physician for guidance.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 12/15/2020, Ms. Wright stated she failed to obtain a health care appraisal for Resident A at admission or within the 2 months that Resident A resided in the home.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	Ms. Wright failed to obtain a health care appraisal for Resident A at admission or within the 2 months that Resident A resided in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 12/15/2020, Ms. Wright stated she failed to record the weight for Resident A at admission or during either of the two months Resident A resided in the home.

INVESTIGATION:

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.

ANALYSIS:	Ms. Wright failed to record the weight for Resident A at admission or during the two months Resident A resided in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Relative A1 and Relative A2 stated Ms. Wright informed them that when Resident A started refusing to eat, she modified his diet to liquids only. Relative A1 and Relative A2 stated Resident A never had a physician's order to have a special diet.

On 12/15/20, Ms. Wright stated when Resident A began to show signs of illness by refusing to eat meals, she modified his diet to liquids only and fed him chicken broth. Ms. Wright stated she did not contact a medical professional nor did she have a physician's order to make this change.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet.
ANALYSIS:	Relative A1 and Relative A2 stated Ms. Wright informed them that when Resident A started refusing to eat, she modified his diet to liquids only. Relative A1 and Relative A2 stated Resident A never had a physician's order to have a special diet. In addition, Ms. Wright stated when Resident A began to show signs of illness by refusing to eat meals, she modified his diet to liquids only and fed him chicken broth. Ms. Wright stated she did not contact a medical professional nor did she have a physician's order to make this change.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 12/15/20, Ms. Wright stated since she did not handle or receive any personal spending funds for Resident A at admission or during Resident A's stay at her facility, she did not complete and maintain in the home any records pertaining to resident funds which included *Resident Funds Part I* and *Resident Funds Part II* forms and a record of his valuables.

APPLICABLE RULE	
R 400.14316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: **(i) Resident funds and valuables record and resident refund agreement**
ANALYSIS:	Ms. Wright stated since she did not handle or receive any funds from Resident A at admission or during Resident A's stay at her facility, she did not complete and maintain in the home any records pertaining to resident funds which included Funds I and II forms and a record of his valuables.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 1/27/21, I conducted an exit conference with licensee Jacqueline Wright. I informed Ms. Wright of my findings and allowed her an opportunity to ask questions and make comments.

On 1/28/21, I received and approved an acceptable correction action plan.

IV. RECOMMENDATION

An acceptable corrective action plan was approved therefore I recommend the current license status remain unchanged.

Ondrea Johnson 1/28/21
Ondrea Johnson Date
Licensing Consultant

Approved By:

Dawn Timm 01/29/2021
_____
Dawn N. Timm Date
Area Manager