STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

June 16, 2021

Jennia Woodcock
Community Health Care Management
1805 E Jordan
Mt. Pleasant, MI 48858

RE: License #: AM370085652
Investigation #: 2021A0466027
Country Place III

Dear Ms. Woodcock:

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 (517) 284-9727.

Sincerely,

Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM370085652
Investigation #:	2021A0466027
Complaint Receipt Date:	04/27/2021
Investigation Initiation Date:	04/27/2021
Report Due Date:	06/26/2021
Licensee Name:	Community Health Care Management
Licensee Address:	2033 Westbrook Ionia, MI 48846
Licensee Telephone #:	(989) 855-3784
Administrator:	Jennia Woodcock
Licensee Designee:	Jennia Woodcock
Name of Facility:	Country Place III
Facility Address:	1809 E. Jordan Mount Pleasant, MI 48858
Facility Telephone #:	(989) 773-6320
Original Issuance Date:	05/29/2001
License Status:	REGULAR
Effective Date:	06/08/2020
Expiration Date:	06/07/2022
Capacity:	10
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION:

	Violation Established?
DCW Katelynn Wiggins allowed Resident B, a female resident, to be present while providing personal care to Resident A who is a male resident.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/27/2021	Special Investigation Intake 2021A0466027
04/27/2021	Special Investigation Initiated – Telephone call, Complainant interviewed.
04/27/2021	Contact - Document Received Email from Katie Hohner, recipient right advisor.
04/27/2021	Inspection completed On-site- No on-site investigation was completed due to COVID-19 restrictions.
05/04/2021	Contact - Telephone call made to DCW Lisa Bowers interviewed.
05/04/2021	Contact - Telephone call made to DCW Katlynn Wiggins interviewed.
05/04/2021	Contact - Telephone call made to DCW Kayla Smith, could not leave a voicemail as voicemail was full but I sent a text message for her to call me.
05/04/2021	Contact - Document Received from Katie Hohner, ORR.
05/06/2021	Contact- Document Sent to Jennia Woodcock.
05/07/2021	Contact - Document Received from Jennia Woodcock.
06/15/2021	Contact- Document Sent to Jennia Woodcock.
06/15/2021	Contact - Document Received from Jennia Woodcock.
06/16/2021	Exit Conference with Jennia Woodcock.

ALLEGATION: DCW Katelynn Wiggins allowed Resident B, a female resident, to be present while providing personal care to Resident A who is a male resident.

INVESTIGATION:
On 04/27/2021, Complainant reported direct care worker (DCW) Katelynn Wiggins allowed Resident B, a female resident, to be present while providing personal care to Resident A, a male resident. Complainant reported the personal care included providing perineal care and changing Resident A. Complainant reported the bathroom door which is connected to Resident A's bedroom was also left open while Resident A was provided personal care. Complainant reported that anyone walking by could have seen DCW Wiggins providing personal care to Resident A. Additionally, another DCW, Kayla Smith, who was in training was also present in the bedroom while DCW Wiggins provided personal care to Resident A.

On 04/27/2021, Katie Hohner, recipient right advisor reported DCW Wiggins was training DCW Smith when she allowed Resident B into Resident A's bedroom while providing him personal care which included providing perineal care and changing Resident A's adult incontinence brief and clothing. Ms. Horner reported that DCW Smith started working at the facility on April 9, 2021 and she has not completed Recipient Rights Training. Ms. Horner reported that she was told that Resident B was in Resident A's bedroom while Resident A was being changed. Additionally, Ms. Horner reported DCW Wiggins reported that it takes two people to change Resident A and only one staff is working at night. Ms. Hohner reported Resident A can talk, however he does not have the cognitive ability to answer questions nor can he recall or talk about situations that have occurred.

On 05/04/2021, Ms. Hohner reported that she verified with Resident A's case manager Julie Oliver that there is not a requirement for Resident A to have two staff change him or transfer him.

On 05/04/2021, Ms. Hohner provided a written *Recipient Rights Complaint* authored by Lisa Bowers and dated 04/25/2021. In the "describe what happened" section of the report it stated, "This staff went into house 3 to offer a donut. Both staff Katelynn Wiggins and newer staff were in [Resident A's] bedroom changing him a Resident female was standing there in the room watching then left the room. [sic] I left then I went back to use the restroom and the same female resident was in the males bedroom standing there watching staff change him pericare, dress him. [sic] I immediately notified on call management and text the on-call administrator and assistant administrator."

On 05/04/2021, Ms. Hohner provided a written *Recipient Rights Complaint* authored by Resident A dated 04/25/2021. "Lisa came into this unit 3 offering staff donuts. I was in another resident's room while they were changing him to give them gloves and his new bedding. Lisa was in on it while not on clock. [sic] Shortly after she went to unit two to talk to their staff. I then overheard unit two staff talking to my staff that

Lisa had told unit two staff that I was in the resident's room when I wasn't supposed to be and how she called rights when she is not supposed to talk about one unit to another."

On 05/04/2021, I interviewed DCW Lisa Bowers who reported that on 04/25/2021 although she was working at another licensed facility on the same property, she went into this adult foster care (AFC) facility to see if any of the DCWs on duty wanted a donut. DCW Bowers reported that when she walked into the facility, she observed DCW Wiggins and DCW Smith in Resident A's bedroom with the door open providing Resident A with personal care that included perineal care and changing Resident A's adult incontinence brief and clothing. DCW Bowers also reported that Resident B, who is female, was in Resident A's bedroom who is male while he was provided personal care. DCW Bowers reported that when she entered that facility, she asked Resident B what she was doing, and reported that Resident B left Resident A's bedroom. DCW Bowers reported that after she left the facility, she ended up coming back into the facility a second time because she had to use the restroom. DCW Bowers reported that when she entered the facility the second time, she observed that Resident A's bedroom door was shut but the bathroom door that connects to his bedroom was opened. DCW Bowers reported observing DCW Wiggins and DCW Smith were still providing him personal care which could be seen through the open bathroom door. DCW Bowers reported that when she went into Resident A's bedroom for a second time, Resident B was in the bedroom with DCW Wiggins and DCW Smith as they continued to provide him personal care. DCW Bowers reported that DCW Wiggins was training DCW Smith so she understood why they were both in the room. Additionally, DCW Bowers reported that Resident A can take two people to at time to move him because he does not assist. DCW Bowers believes that DCW Wiggins should have secured Resident A's privacy before providing him with personal care. DCW Bowers believes that both his bathroom and bedroom door should have been shut and that Resident B should not have been in his bedroom. DCW Bowers reported that although Resident A talks, he does not have the cognitive ability to give consent for Resident B to be in his bedroom while he was provided personal care.

On 05/04/2021, I interviewed DCW Wiggins who reported that on 04/25/2021, DCW Bowers came into the facility to offer the DCWs on duty donuts when she and DCW Smith were in Resident A's bedroom. DCW Wiggins reported that Resident A's bedroom door may have been cracked open a little but that it was not wide open and that Resident A's bathroom door was closed. DCW Wiggins reported that DCW Bowers entered Resident A's room thought the bathroom that connects to his bedroom. DCW Wiggins reported that Resident A is in a private room and that he requires a two person assist and that is why DCW Smith was in the room with her. DCW Wiggins reported that Resident B was in the room because she likes to be "helpful" and she is like an "extra pair of hands" so she had brought her some gloves and clean sheets for Resident A's bed. DCW Wiggins reported that Resident B is high functioning and that she is with the DCWs all of the time "helping out." DCW Wiggins reported that Resident A was not naked when Resident B was in the

bedroom and that Resident B left the room on her own without any prompting after she brought the gloves and bedding that was needed.

On 05/06/2021, I interviewed Resident B who reported that she likes to help the DCWs on duty and that she walks around the facility asking the DCWs on duty if they need her to get them anything. Resident B reported that on 04/25/2021, she checked in with DCW Wiggins and DCW Smith to see if they needed anything when they were in Resident A's room. Resident B reported that they asked her to get some bed linens and bed pads. Resident B reported that Resident A's bedroom door was slightly cracked open when she entered the room to see if she could help. Resident B reported that she left the door slightly cracked while she went to get the needed items for the DCW Wiggins and DCW Smith. Resident B reported that she did not see Resident A's private parts. Resident B reported that she likes to keep busy by helping the DCWs. Resident B reported that she likes to do dishes, laundry, and vacuuming.

On 05/07/2021, I reviewed Resident A's written *Assessment Plan for AFC Residents* dated 03/20/2021 which documented that Resident A requires a one-person assist for toileting, bathing, grooming, dressing, personal hygiene, and walking/mobility. Resident A's written *Assessment Plan for AFC Residents* documented that Resident A uses a Hoyer lift, wheelchair, and hospital bed.

On 06/15/2021, I interviewed Resident A's case manager Julie Oliver who reported that Resident A is a one-person assist as reported by the licensee designee Jennia Woodcock. Additionally, case manager Oliver reported that she did not have any additional information about this incident.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**

ANALYSIS:	Complainant, Ms. Hohner, DCW Bowers, DCW Wiggins and Resident B, all reported that Resident B was in Resident A's bedroom while he was being provided personal care. DCW Wiggins reported that Resident B was in Resident A's bedroom because she likes to be "helpful" and she is like an "extra pair of hands" so Resident B had brought DCW Wiggins some gloves and clean sheets for Resident A's bed. Resident B reported in a written *Recipient Rights Complaint* that she was "in another resident's room while they were changing him to give them gloves and his new bedding." A violation has been established as Complainant, Ms. Hohner, DCW Bowers, DCW Wiggins and Resident B, all reported that Resident B was in Resident A's bedroom while he was being provided personal care therefore Resident A was not treated with due recognition of personal dignity, individuality, and the need for privacy.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

On 05/04/2021, DCW Wiggins reported that Resident B likes to be "helpful" and Resident B is like an "extra pair of hands." DCW Wiggins reported that Resident B brings her things when she needs them. DCW Wiggins reported that Resident B is high functioning and that she is with the DCWs all of the time "helping out."

On 05/06/2021, I interviewed Resident B who reported that she likes to help the DCWs on duty and that she walks around the facility asking the DCWs on duty if they need her to get them anything. Resident B reported that on 04/25/2021 she got some bed linens and bed pads for DCW Wiggins and DCW Smith. Resident B reported that she likes to keep busy by helping the DCWs. Resident B reported that she likes to do dishes, laundry, and vacuuming.

On 05/07/2021, I reviewed Resident B's written *Assessment Plan for AFC Residents* dated 09/14/2020 which documented in the "Participates in Household Chores" section of the report "will at times."

APPLICABLE RULE	
R 400.14305	**Resident protection**
	(2) All work that is performed by a resident shall be in accordance with the written assessment plan.

ANALYSIS:	Resident B and DCW Wiggins both reported that Resident B likes to be helpful and bring the DCWs things that they need. Resident B also reported that she likes to help with the dishes, laundry, and vacuuming. Resident B's written assessment plan did not document the work that she does therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 06/16/2021 I conducted an exit conference with Jennia Woodcock who understood the findings of the investigation.

IV. RECOMMENDATION

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

06/16/2021

Julie Elkins Date
Licensing Consultant

Approved By:

06/16/2021

Dawn N. Timm Date
Area Manager