GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 24, 2021

Ryan Goleski
The Haworth Center
30301 W. 13 Mile Road
Farmington Hills, MI 48334

RE: License #: AH630236793
Investigation #: 2021A1027045
The Haworth Center

Dear Mr. Goleski:

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) 284-9727.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
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 #:	AH630236793
Investigation #:	2021A1027045
Complaint Receipt Date:	07/30/2021
Investigation Initiation Date:	07/30/2021
Report Due Date:	09/29/2021
Licensee Name:	Detroit Baptist Manor
Licensee Address:	30301 W 13 Mile Rd. Farmington Hills, MI 48334
Licensee Telephone #:	(810) 626-6100
Administrator/Authorized Representative:	Ryan Goleski
Name of Facility:	The Haworth Center
Facility Address:	30225 13 Mile Road Farmington Hills, MI 48334
Facility Telephone #:	(248) 539-3131
Original Issuance Date:	05/09/1999
License Status:	REGULAR
Effective Date:	11/18/2020
Expiration Date:	11/17/2021
Capacity:	59
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A lacked care prior to hospitalization.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/30/2021	Special Investigation Intake 2021A1027045
07/30/2021	Special Investigation Initiated - Letter Email sent to AR/Admin R. Goleski requesting information/documentation pertaining to investigation
08/03/2021	Contact - Document Received Received requested documentation from AR/Administrator R. Goleski
08/24/2021	Contact - Telephone call made Telephone interview conducted with care manager Latosha Moore
08/24/2021	Contact - Telephone call made Voicemail left with director of nursing Kathie Ogden
08/24/2021	Contact - Telephone call received Telephone interview conducted with director of nursing Kathie Ogden
08/24/2021	Inspection Completed-BCAL Sub. Compliance
08/24/2021	Contact – Document Received Home care documentation received from K. Ogden
08/25/2021	Contact - Document Received Received requested documentation from AR/Administrator R. Goleski
08/27/2021	Exit Conference Conducted with authorized representative R. Goleski

ALLEGATION:

Resident A lacked care prior to hospitalization.

INVESTIGATION:

On 7/30/21, the department received a complaint which alleged Resident A had to be rushed to the hospital due to her worsening medical condition. The complainant alleged Resident A died because of her medical condition.

On 8/10/21, I conducted a telephone interview with the complainant. The complainant stated Resident A's daughters visited with Resident A at the facility on 7/22 and observed swelling in her left foot, left arm and abdomen and lips. The complainant stated Resident has had history chronic heart failure for a long time and had a wound on her left leg for approximately three years. The complainant stated Resident A had a nurse from a home care agency who would come to the facility and apply unna boots to Resident A's bilateral lower legs. The complainant stated Resident A was transferred to the hospital to on 7/25 per family request. The complainant stated Resident A was admitted to the hospital and once the Unna boots were removed by hospital staff, she observed new wounds both her right and left legs as well as buttock area. The complainant stated Resident A was placed on hospice services while at the hospital and died.

On 8/24/21, I conducted a telephone interview with care manager Latosha Moore. Ms. Moore stated on the day Resident A transferred to the hospital, Resident A's daughter had called the facility to notify them of her visit planned with Resident A. Ms. Moore stated after her family called, her and facility staff assisted Resident A with grooming and helped her prepare for her daughter's visit. Ms. Moore stated approximately 30 to 40 minutes later Resident A's daughter arrived and informed her that Resident A's oxygen was off. Ms. Moore stated she checked her oxygen saturation which was approximately 60%, so she reapplied her oxygen and re-checked her saturation after placing her oxygen back on, which was approximately 95%. Ms. Moore stated Resident A's daughter called her sister, who then arrived at the facility and requested Resident A be sent to the hospital. Ms. Moore stated Resident A had been physically declining since her admission to the facility. Ms. Moore stated Resident A declined to sleep in her bed or elevate her legs, as well as wear her oxygen at times.

On 8/24/21, I conducted at telephone interview with director of nursing Kathie Ogden. Ms. Ogden statements were consistent with Ms. Moore. Ms. Ogden stated sometimes facility staff would need to call Resident A's daughter to speak with Resident A for her to comply with her care. Ms. Ogden stated Resident A was "stable with her heart and kidneys" conditions prior to the hospitalization and had physicians visit her at the facility. Ms. Ogden stated Ms. Moore was on the

medication Lasix for her swelling but they could not give her a higher dose due to her kidney function.

I reviewed Resident A's move in record which was consistent with statements from statements from the complainant.

I reviewed Resident A' service plan. The plan read consistent with statements from Ms. Moore and Ms. Ogden. The plan read "[Resident A] has a behavior problem, resists care, has episodes for demanding to go to the hospital, attention seeking behaviors, calls family members with unsubstantiated complaints. Very needy and demanding." The plan indicates that Resident A's authorized representative was aware of the behaviors and read "[Resident A's Authorized representative] will assist with behaviors. Additionally, the plan read specific interventions for facility staff to implement for Resident A's behaviors such as assessing and anticipating needs such as food, thirst, toilet needs, body positioning, pain, self-expression, security and affection as well as other interventions. The plan read "[Resident A] has oxygen therapy related to COPD (Chronic Obstructive Pulmonary Disease) and anxiety." The plan read specific interventions for facility staff to ensure Resident A will not have sign/symptoms of respiratory distress such as assisting with positioning to help breathe easier by elevating the head of the bed if tolerated as well other interventions. The plan read [Resident A] has memory loss/dementia related to dementia diagnosis and provided many interventions for staff. The plan read [Resident A] has chronic pain related arthritis, chronic physical disability PVD (Peripheral Vascular Disease) with fluctuating edema of LE (lower extremities)." The plan read specific interventions for facility staff to implement for Resident's A pain such as administer medications per physician orders, offer and give half hour before treatments or care that can be uncomfortable, then to monitor and observe for its effectiveness and notify physician if not effective as well as other interventions. The plan read "[Resident A] has potential and actual impairment to skin integrity of the lower extremities related to PVD and non-compliance with the plan of care. Does not elevate legs as needed and does not call for assistance when needed. Followed by HCS (home care staff) and wound physician." The plan read specific interventions for facility staff to implement for Resident A's wounds such to educate and encourage good nutrition and hydration to promote skin integrity as well as other interventions.

I reviewed Resident A's medication administration records (MAR) which read consistent with her service plan and Ms. Moore's statements. Additionally, the MAR was initialed by the caregivers three times daily for "O2 (oxygen) 2-4 Liters via NC (nasal cannula) for SpO2 less than 90% on room air. Document SpO2 every shift and prn (as needed) every shift for SOB (shortness of breath) or difficulty breathing related to chronic obstructive pulmonary disease." Resident A's MAR read "take and record blood pressure and pulse daily one time a day to monitor blood pressure" which caregivers initialed daily. Resident A's MAR also read and was initialed daily by caregivers to provide Resident A "health shake 120 ml one time a day to promote wound health with lunch."

I reviewed the facility's task records for Resident A. The task records read caregivers were to complete tasks and observations such as bathing/showering, bed mobility, bladder documentation, bowel documentation, assistance with dressing, assistance with eating, locomotion on the unit, monitor skin, monitor pain, monitor behaviors, requires assistance with oral care, requires assistance with personal hygiene, provide snacks, and requires assistance with transfers to toilet on every shift. The task record read staff initials and a time when the task was completed. The task record was left blank for the following dates 7/8/21, 7/9, 7/10, 7/15, 7/17, 7/20, 7/21 and 7/23. The task record read staff initialed tasks as completed on 7/26, 7/27, 7/29, 7/30 and 7/31 in which facility documentation read the resident had transferred to the hospital on 7/25 and did not return to the facility.

I reviewed the facility's Health Status Note for 7/25/21 for Resident A which read "resident refused to keep oxygen on, and legs elevated which caused her a low O2 (oxygen) and legs to become swollen. She refused to sleep in her bed."

I reviewed the facility's progress note for Resident A which read "resident daughter came in and request for her to be sent to hospital for fluid retention and shortness of breath she was sent to henry ford bloomfield hospital all parties were notified." Additionally, a handwritten note on the progress note read "sent to HFWB (Henry Ford West Bloomfield) Hospital 7/25/21."

I reviewed the facility's medical professional notes for Resident A. A note from 7/20/21 written by nurse practitioner Lisa Dugas read "Reason for visit: Evaluation of three or more chronic conditions to prevent decline and reduce hospitalizations." The note read "Elderly female with chronic lymphedema, recurrent vascular wounds, PVD, HTN (hypertension), Vitamin D deficiency." The note read "Disabled 88 year old female. Up in recliner, napping. Resident awakened very confused and agitated." The note read "BLE (bilateral lower extremities) wrapped in ACE bandages. Open wounds on left second toe and right 2nd, 3rd, 4th toes. Right wrist deformed." A note from 6/15 written by nurse practitioner Lisa Dugas read consistent with the note from 7/20.

I reviewed a wound physician notes from 7/6/21, 5/21 and 4/28 for Resident A. The physician note from 5/21 read "Patient refers that the Unna boot was bothering her and she removed it. She was instructed that she should not do this and she should notify us or the nurse if any situations arise. Compliance with elevation of the legs with the heels above hip levels has been questionable." The physician notes from 7/6 read a description of three wounds, two on the left leg and one on the right leg. The physician note read "Assessment: Prognosis Guarded." The physician note read "In comparison to the previous visit, the left posterior leg is new and all other wounds show deterioration." The physician note read "Patient is taking her medication as prescribed by her primary care physician and her dietary intake is adequate. Patient was found without any compression Unna boot dressings. Caregivers refer that they

were removed a couple of hours ago so that the patient could have her bath but evidentially they were not applied properly before because there was edema which has not been resolved with the compression therapy. They were instructed that the Unna boot dressings need to be applied in a tight fashion in order to eliminate the control and swelling of the legs. The nurse in charge of this case will be notified for clarification of this issue. Compliance with elevation of the legs with the heels above the hip levels has been questionable." The physician note read "dressings are to be done in a similar fashion as described today on a twice a week basis."

I reviewed the home care skilled nurses' notes for Resident A from 7/8/21, 7/12, 7/16, 7/19, and 7/23. The skilled nurse notes from 7/8 read Resident A had a wound located on her right lower leg calf area and another on left lower leg, requiring Unna boot dressing changes twice weekly. The note also read Resident A removed the Unna boot dressing because it was too tight. The note read Resident A had +2 non-pitting edema on her bilateral lower extremities, as well as feet and toes. The skilled nurse notes from 7/12 read consistent with notes from 7/8. Additionally, the 7/12 note read Resident A developed blisters on her toes bilaterally and the skilled nurse notified the wound physician. The skilled nurse notes from 7/16 read consistent with notes from 7/8 and 7/12. Additionally, the note read Resident A was non-compliant with elevating her legs and the physician was aware. The skilled nurse notes from 7/19 read consistent with previous notes reviewed. The 7/19 note read Resident A's blisters on her toes were weeping and the nurse sent pictures to the physician. The skilled nurse notes from 7/23 read consistent with previous notes.

I observed pictures provided by the complainant of Resident A's wounds. The pictures were consistent with the wound assessment from the wound physician and skilled nurses' notes.

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.
For Reference: R325.1901	**(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:	Interviews with the complainant and facility staff, along with review of documentation revealed Resident A had many complex medical conditions along with non-healing wounds. Resident A received care twice weekly from a licensed health care professional in the preceding month prior to hospitalization, however Resident A did not always comply with orders from her licensed health care professional. Pictures of Resident A's wounds seemed to be consistent assessments completed by her health care professionals in July. However, review of the documentation establishing Resident A's care revealed many dates on the task records were left blank. Given the training provided and the availability of the sheets to complete the task, it minimally reflects the possibility of care not provided.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 7/30/21, the department received a complaint which alleged Resident A had to be rushed to the hospital due to her worsening medical condition.

On 8/10/21, I conducted a telephone interview with the complainant who stated Resident A was hospitalized on 7/25/21 then died while receiving hospice services.

On 8/24/21, I conducted at telephone interview with director of nursing Kathie Ogden. Ms. Ogden stated facility staff did not report Resident A's hospitalization to the department.

I reviewed the facility's progress note for Resident A which read "sent to HFWB (Henry Ford West Bloomfield) Hospital 7/25/21."

I reviewed the facility file which revealed the facility did not provide the department an incident report for Resident A's hospitalization.

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:

	(a) The name of the person or persons involved in the incident/accident. **(b) The date, hour, location, and a narrative description of the facts about the incident/accident which indicates its cause, if known.** **(c) The effect of the incident/accident on the person who was involved, the extent of the injuries, if known, and if medical treatment was sought from a qualified health care professional.** **(d) Written documentation of the individuals notified of the incident/accident, along with the time and date.** **(e) The corrective measures taken to prevent future incidents/accidents from occurring.**
ANALYSIS:	Interviews with facility staff, as well as review of facility documentation revealed Resident A transferred to the hospital on 7/25/21. The department was not notified of Resident A's hospitalization. Resident A's unplanned hospitalization placed her at risk for more than minimal harm which required the department to be notified.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 8/27/2021, I shared the findings of this report with Ryan Goleski. Mr. Goleski verbalized understanding of the findings.

IV. RECOMMENDATION

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

8/25/21

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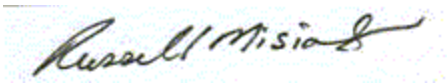
Jessica Rogers Date
Licensing Staff

Approved By:



8/26/21

Russell B. Misiak Date
Area Manager