GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 10, 2021

Chelsea Rink
Mission Point Health Campus of Jackson
703 Robinson Rd.
Jackson, MI 49203-2538

RE: License #: AH380301277
Investigation #: 2022A0784014
Mission Point Health Campus of Jackson

Dear Ms. Rink:

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 (517) 284-9730.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AH380301277 |
| | |
| **Investigation #:** | 2022A0784014 |
| | |
| **Complaint Receipt Date:** | 11/12/2021 |
| | |
| **Investigation Initiation Date:** | 11/12/2021 |
| | |
| **Report Due Date:** | 01/11/2021 |
| | |
| **Licensee Name:** | Mission Point Health Campus of Jackson, LLC |
| | |
| **Licensee Address:** | 30700 Telegraph Road<br>Bingham Farms, MI 48205 |
| | |
| **Licensee Telephone #:** | (502) 213-1710 |
| | |
| **Administrator:** | Juliana Bright |
| | |
| **Authorized Representative:** | Chelsea Rink |
| | |
| **Name of Facility:** | Mission Point Health Campus of Jackson |
| | |
| **Facility Address:** | 703 Robinson Rd.<br>Jackson, MI 49203-2538 |
| | |
| **Facility Telephone #:** | (517) 787-5140 |
| | |
| **Original Issuance Date:** | 10/25/2010 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 10/23/2020 |
| | |
| **Expiration Date:** | 10/22/2021 |
| | |
| **Capacity:** | 40 |
| | |
| **Program Type:** | ALZHEIMERS<br>AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| • Staff subjected Resident A to an unauthorized and unwanted procedure<br>• Staff conducted an unauthorized procedure | Yes |
| Additional Findings | No |

## III. METHODOLOGY

| | |
|---|---|
| 11/12/2021 | Special Investigation Intake<br>2022A0784014 |
| 11/12/2021 | Special Investigation Initiated - Telephone<br>Interview conducted with administrator Juliana Bright by licensing staff Jessica Rogers |
| 11/12/2021 | Contact - Document Received<br>Email received from Jessica Rogers with detailing communication she had with Ms. Bright and director of nursing (DON) Stacey Keast |
| 11/15/2021 | Contact - Telephone call made<br>Interview with Ms. Bright |
| 11/15/2021 | Contact - Document Sent<br>Investigative document request sent by email to Ms. Bright and authorized representative Chelsea Rink |
| 11/16/2021 | Contact - Document Received<br>Investigative documents received by email from Ms. Bright |
| 12/03/2021 | Contact - Face to Face<br>Interviews with Ms. Bright and Ms. Keast |
| 12/03/2021 | Exit Conference<br>Conducted with authorized representative Juliana Bright |

**ALLEGATION:**

- **Staff subjected Resident A to an unauthorized and unwanted procedure**
- **Staff conducted an unauthorized procedure**

**INVESTIGATION:**

On 11/12/21, the department received this online complaint from adult protective services (APS) centralized intake. The information provided indicated the facility self-reported the information, and that APS denied the allegations for investigation.

According to the complaint, on 11/12/21 at approximately 5am, associate Jennia Chroprowicz preformed a straight catheter on Resident A to gather a urine sample. This was an unauthorized invasive procedure out of the scope and practice from her certification and was not ordered by a physician.

Review of the facility licensing file revealed incident reporting from the facility was received timely relating to the allegations. The report read "Resident reported to Clinical AL Director that she was woke up in the middle of the night to be strait cath. The employee performed and unauthorized invasive procedure. The doctor never ordered the invasive procedure. The employee obtained a sample of urine and sent it to the lab. We have reported this to the complaint number intake department 855-444-3911 as abuse to the resident"

On 11/12/21, I received and email from licensing staff Jessica Rogers detailing information she received during a telephone interview with administrator Juliana Bright and director of nursing (DON) Stacey Keast on 11/12/21. The email read, in part, "I confirmed this resident resides in HFA. They stated they are investing this further and self-reported the situation to us by our intake unit. Stacey stated she is trying to obtain a statement from the staff member. Stacey stated the staff member did straight cath the resident and sent her urine to the lab for a suspected UTI. Stacey knows the staff member should not have straight cathed and does not know why she did. Additionally, Stacey stated the resident does have frequent UTIs and she had just tested her urine earlier that day. Stacey stated she is obtaining written statements from the resident's physician to verify that she did not give an order for the straight cath, as well as from obtaining statements from other staff who worked that night and the employee herself. Both are aware there is now an open investigation in which you are assigned."

On 11/15/21, I interviewed administrator Juliana Bright by telephone. Ms. Bright confirmed information provided in Ms. Rogers email. Ms. Bright stated she interviewed Resident A who reported to her another staff member was present during the unauthorized procedure named Charity Olmsted. Ms. Bright stated Ms. Olmsted is a nurse who was working in the attached nursing home at the time. Ms.

Bright stated that Ms. Olmsted reported she only assisted with the procedure upon request from Ms. Chroprowicz. Ms. Bright stated she has received statements from staff involved and from Resident A's physician who confirmed no order was provided for such a procedure. Ms. Bright stated Ms. Chroprowicz apparently decided to pursue the procedure because she was unsuccessful in obtaining a urine sample to have Resident A tested for a UTI. Ms. Bright stated HFA staff should not be performing such procedures regardless of any orders and that staff should not perform any procedures without the proper order from a physician. Ms. Bright stated Resident A was distraught from the experience as she had not wanted it to be done.

On 12/03/21, I interviewed Ms. Bright at the facility. Ms. Keast was present during the interview. Ms. Bright stated that Ms. Chroprowicz and Ms. Olmsted no longer work at the facility. Ms. Bright stated Ms. Chroprowicz was terminated and Ms. Olmsted left for a different position. Ms. Bright stated that as she discussed the circumstances with Ms. Chroprowicz and Ms. Olmsted, prior to their employment ending, their stories regarding the circumstances differed in detail. Most notably, Ms. Bright stated Ms. Chroprowicz denied performing the straight catheter procedure and stated she had requested Ms. Olmsted not just to help, but to perform the procedure. Ms. Bright stated it is possible that Ms. Chroprowicz did perform the procedure, and that either way it should not have been done. Ms. Bright stated Resident A had been tested for a UTI earlier in the day and was negative and that there was no reason to perform a urine test of any kind anyway. Ms. Bright stated Ms. Chroprowicz essentially coerced Resident A into having the straight cathetaor procedure done even thought there was no apparent reason for it to be completed. Ms. Bright stated Ms. Chroprowicz had indicated to her that she pursued the procedure because she was instructed by nurse Diane Colvin during shift change that day that Resident A needed a urinalysis. Ms. Bright stated she interviewed Ms. Colvin who stated she did discuss possibly getting a urinalysis for Resident A but never suggested having the straight catheter procedure completed. Ms. Bright stated that Ms. Colvin only discussed possibly obtaining a urine sample because she was not aware that one had been obtained earlier in the day. Ms. Bright stated Resident A's physician did not discuss obtaining a urinalysis with anyone at the facility and did not receive any message on his answering service regarding a need for such a procedure and stated as much in writing. Ms. Keast agreed with statements provided by Ms. Bright.

I reviewed written statements, provided by Ms. Bright, from Ms. Chroprowicz, Ms. Olmstead and Ms. Colvin and Resident A's primary physician. The statements read consistently with statements provided by Ms. Bright.

| **APPLICABLE RULE** | |
|---|---|
| **MCL 333.20201** | **Policy describing rights and responsibilities of patients or residents** |
| | **(1) A health facility or agency that provides services directly to patients or residents and is licensed under this** |

| | |
|---|---|
| | **article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization, which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.** |
| **For Reference: MCL 333.20201** | |
| | **(e) A patient or resident is entitled to receive adequate and appropriate care, and to receive, from the appropriate individual within the health facility or agency, information about his or her medical condition, proposed course of treatment, and prospects for recovery, in terms that the patient or resident can understand, unless medically contraindicated as documented in the medical record by the attending physician, a physician's assistant with whom the physician has a practice agreement, or an advanced practice registered nurse.** |
| **ANALYSIS:** | The complaint alleged staff conducted a catheter procedure on Resident A which was not ordered or instructed by her physician and which she did not want. The investigation confirmed no order was in place at the time the catheter procedure was conducted. In addition, the investigation revealed the procedure was inappropriately conducted against Resident A's wishes while it was also not necessary based on Resident A's condition at the time. Based on the findings the facility is not in compliance with this rule. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

On 12/3/21, I discussed the findings of the investigation with authorized representative Juliana Bright.

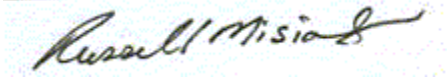
## IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

12/7/21

Aaron Clum — Date
Licensing Staff

Approved By:



12/10/21

Russell B. Misiak — Date
Area Manager