GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 18, 2022

Ferdinand Policarpio
Genesis Senior Place LLC
775 Quill Creek Dr
Troy, MI 48085

RE: License #: AS500401950
Investigation #: 2022A0990004
Genesis Senior Place

Dear Mr. Policarpio:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 (248) 975-5053.

Sincerely,

LaShonda Reed, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(586) 676-2877

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500401950
Investigation #:	2022A0990004
Complaint Receipt Date:	11/12/2021
Investigation Initiation Date:	11/12/2021
Report Due Date:	01/11/2022
Licensee Name:	Genesis Senior Place LLC
Licensee Address:	775 Quill Creek Dr Troy, MI 48085
Licensee Telephone #:	(248) 251-2711
Administrator:	Imelda Soan
Licensee Designee:	Ferdinand Policarpio
Name of Facility:	Genesis Senior Place
Facility Address:	45514 Engel Dr Utica, MI 48317
Facility Telephone #:	(248) 251-2711
Original Issuance Date:	01/22/2020
License Status:	REGULAR
Effective Date:	07/07/2020
Expiration Date:	07/06/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The staff were not trained to have a PEG machine for feeding Resident A and the staff did not know how to use it.	Yes
Resident A had bedsores after 10 days living in the home. Resident A had stage two bed sores that were stage three and four when she was removed from the home.	Yes
The staff refused delivery of Resident A's air mattress.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/12/2021	Special Investigation Intake 2022A0990004
11/12/2021	APS Referral Adult Protective Services (APS) referral not made since the resident is deceased.
11/12/2021	Special Investigation Initiated – Letter I emailed the Licensee Designee (LD) Ferdinand Policarpio. Mr. Policarpio emailed documents requested.
12/01/2021	Inspection Completed On-site I conducted an unannounced onsite special investigation. I interviewed direct care staff Carmen Camitan and Maria Clacio.
12/21/2021	Contact - Document Received I reviewed documents requested at an earlier date.
12/21/2021	Contact - Telephone call made Telephone call made to Evergreen Hospice. I spoke with Gerald Wang-administrator. Mr. Wang was reluctant to provide information regarding the hospice nurse assigned to Resident A.
01/27/2022	Contact - Telephone call made I conducted a phone call to Relative A.

01/27/2022	Contact - Document Received I received and reviewed photos of Resident A received from Relative A.
02/04/2022	Contact - Telephone call made I contacted Evergreen Hospice. I was informed that the hospice nurse that was assigned to Resident A was no longer employed. No contact information was provided.
02/04/2022	Contact – Document Received I conducted an internet search on the use of Javity ®/PEG machine.
02/04/2022	Contact – Document Sent I emailed Mr. Policarpio for further clarification regarding feeding machine use and bedsores. I received a facsimile from Mr. Policarpio with answered questions and a document.
02/08/2022	Contact - Telephone call made I conducted a phone interview with Mr. Policarpio and Imelda Soan, administrator. A partial exit conference conducted pending interview with hospice nurse.
02/09/2022	Contact - Telephone call made I left a detailed voice message with Purita Bernardez, prior Evergreen Hospice nurse a day prior. Ms. Bernardez returned call and a phone interview conducted.
02/11/2022	Contact - Document Received I reviewed Michigan Department of Health and Human Services (MDHHS) epidemic orders.
02/11/2022	Exit conference I conducted an exit conference with Mr. Policarpio and Ms. Soan.

ALLEGATION:

The staff were not trained to have a PEG machine for feeding Resident A and the staff did not know how to use it.

INVESTIGATION:

On 11/12/2021, I received the complaint online. In addition to the above allegation, it was reported that Resident A moved into Genesis Senior Place on 09/30/2021 and was removed from Genesis Senior Place on 10/30/2021 due to lack of proper care.

Resident A passed away at the new home, and the approximate date of death was not reported nor the name of the new home. Resident A moved into Genesis Senior Place receiving hospice service. Resident A was on a feeding tube and the staff did not know how to use the PEG machine/feeding tube. It was reported that after Resident A was removed from Genesis Senior Place the reporting person was told that certain facilities are not permitted to used PEG machines and that Genesis Senior Place did not have authority to use PEG machines. It was also reported that staff were feeding Resident A through the feeding tube while she was lying down which is, not supposed to be done.

On 12/01/2021, I conducted an unannounced onsite special investigation. I interviewed direct care staff Carmen Camitan and Maria Clacio. I observed three residents sitting in the living room area and the residents were not interviewed due to their limited cognitive abilities and memory deficits per, Ms. Clacio. Ms. Clacio and Ms. Camitan said that Resident A was admitted to the home receiving hospice services and needed a feeding tube. Ms. Clacio and Ms. Camitan both said that they had never used a feeding tube prior to Resident A's residency and had to be taught how to use it by the hospice nurse "Heather" from Evergreen Hospice. Ms. Clacio said that "Heather" told her to add 200ml of water to the machine and the amount (which was not recalled) of feeding substance. I observed that there was a language barrier and both staff were difficult to understand.

On 12/21/2021, I reviewed documents requested at an earlier date. I observed that Resident A was admitted to the home on 09/30/2021. I reviewed a discharge summary from The Lodge at Taylor in which, was provided in lieu of the *Health Care Appraisal* requested. The discharge summary was from the prior rehabilitation facility that Resident A resided in from 09/19/2021 until 09/30/2021 before moving into Genesis Senior Place. The discharge summary documented that Resident A is to receive one time per day Jevity® (feeding tube nutrition) 105 via pump per PEG at 65ML/hr. times 18 hours a day to provide 1170ML total volume, 1755 kcals, 75g PRO and 899ML free fluid. Resident A was admitted to The Lodge at Taylor due to COVID-19 positive status, a due to injuries for a fall at an assisted living facility (name not documented) in which, Resident A sustained a non-displaced Cervical (C-8) lateral mass and facet fracture requiring cervical collar while out of bed, she a sustained nasal fracture and is labeled as a total assist for activities of daily living (ADL's). I observed that a *Health Care Appraisal* was not completed for Resident A.

On 01/27/2021, I conducted a phone interview with Relative A. Relative A said that Resident A temporarily resided at The Lodge at Taylor which is a long-term skilled nursing care and a short-term rehabilitation facility. Relative A said that Resident A was there due to being hospitalized for COVID-19 and a fall with injuries and then she was transferred to Genesis Senior Place. Relative A said that Resident A was "kicked out" of The Lodge at Taylor after receiving ten days of care. At that time, Resident A was placed into hospice services and moved into Genesis Senior Place. Relative A was informed by Mr. Policarpio that his staff could use a feeding machine. Relative A said that he was informed by a hospice nurse (name could not be recalled) that Resident A was to receive three bottles of water a day into the feeding tube and from his

understanding, the staff at Genesis Senior Place did not use the feeding machine properly. Relative A observed a staff person (name or specific date not provided) administering Resident A's feeding machine fluids while she was lying down. Relative A said that Resident A risked regurgitation due to being fed lying down and was to be sitting upright when feeding. Relative A observed the staff take the feeding machine away and began feeding Resident A via syringe in her stoma port because they did not know how to work the machine. There were disagreements between the staff and Evergreen Hospice regarding the care Resident A received. Relative A said that Resident A was in distress and had to be sedated while living in the home due to lack of care.

On 02/04/2022, I conducted an internet search on the use of Javity ®/PEG machine. I observed that a person receiving feeding tube nutrition with following instructions: DO NOT lie flat during your feeding and wait for one hour after your feeding before you lie down (lying down can cause you to vomit or cough). Vomiting or coughing up lesser amounts of liquid can be dangerous, causing you to inhale fluid into your lungs.

On 02/08/2022, I received a facsimile from Mr. Policarpio which documented that Resident A's feeding machine was to be used continuous/intermittent. Resident A was being provided Ensure® formula via PEG machine. The nutrition from the PEG machine was to be used for 18 hours per intermittent with water flush of 300 ML very six hours. Resident A was using the feeding machine only from 10/01/2021 through 10/04/2021. The staff were trained to use the feeding machine from the hospice nurse Purita Bernardez. The Ensure® was a verbal order to by the hospice nurse three times per day via bolus feeding. In addition to Ms. Bernardez training, the staff that used the feeding machine, the administrator Imelda Soan who is a nurse, followed-up with training the staff. Mr. Policarpio said that Evergreen Hospice did not bring the formula or Ensure® to the home.

On 02/08/2022, I conducted a phone interview with Mr. Policarpio and Imelda Soan, administrator. Ms. Soan said that Ms. Bernardez trained the staff on how to use the feeding machine. Ms. Soan said that she was familiar with using the feeding machine because she is a nurse. Ms. Soan said that she did all the troubleshooting if the feeding machine was not working and set the machine up each night. The staff only had to turn on the machine by pushing a button. At times, staff added water to the machine which lasted for 18 hours. Ms. Soan said that the feeding machine food was inside of a bag that the staff did not handle. Ms. Soan said that Resident A was always fed while sitting up. There was a note above her bed to remind staff that Resident A should be elevated during feeding. Ms. Soan said that Resident A was not given Ensure® or the feeding machine after 10/04/2021. Ms. Soan could not provide any written documentation as to why the feeding machine and Ensure® ended. Ms. Soan said that all orders were verbal from Ms. Bernardez. Ms. Soan said that Resident A's medications came with her at admission. Ms. Soan said that Ms. Bernardez reviewed the meds and decided that nothing needed to be changed. Ms. Soan said all medication orders were verbal.

On 02/09/2022, I conducted a phone interview with Purita Bernardez, prior Evergreen Hospice Nurse. Ms. Bernardez said that she has been a nurse for 55 years. Ms. Bernardez no longer works for Evergreen Hospice and worked there from June 2021 until early January 2022 and stopped working there for personal reasons. Ms. Bernardez said that she became Resident A's hospice nurse while she was hospitalized at Mt. Clemens General Hospital in early September 2021. Ms. Bernardez met Resident A once with the family at the hospital and thereafter at Genesis Senior Place. Ms. Bernardez did not see Ms. Bernardez while she was at The Lodge at Taylor.

Ms. Bernardez said that she trained the staff at Genesis Senior Place on how to use the feeding machine. Ms. Bernardez said that Ms. Soan was present when she trained the staff, and she is a Registered Nurse. Ms. Bernardez said that an average person could operate the feeding machine if trained properly. Ms. Bernardez observed that the staff were afraid to use the feeding machine and does not think they were using it. Ms. Bernardez said that she visited the home 1-2 times per week and when there, the machine was never being used and turned off. Ms. Bernardez said that Evergreen Hopsice did not prescribe the Ensure® and believes that this was prescribed by Resident A's prior placement before admission to Genesis Senior Place. Ms. Bernardez believes that the staff were giving Resident A Ensure® through syringes into her bolus. Ms. Bernardez did not observe this but did observe a large syringe.

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:	There is no Health Care Appraisal or prescription on file authorizing that Resident A was prescribed a feeding machine or Ensure®. On 12/01/2021 during the onsite investigation, Ms. Clacio and Ms. Camitan both said that they had never used a feeding tube prior to Resident A's residency and had to be taught how to use it by the Evergreen Hospice staff. Relative A has observed the staff take the feeding machine away and begin feeding Resident A via syringe in her port because the staff did not know how to work the feeding machine. According to the hospice nurse Ms. Bernardez, the feeding machine was not used and she believes that Resident A was being fed Ensure® through her feeding tube opening because the staff could not operate the feeding machine. Ms. Bernardez said that the staff were not comfortable using the feeding machine.

	As a result, Resident A was not fed properly via the feeding machine due to the direct care staff limited training and lack of being comfortable. Although, Ms. Soan is a Registered Nurse, she was not always present to operate the feeding machine.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(1) A licensee shall not accept, retain, or care for a resident who requires continuous nursing care. This does not preclude the accommodation of a resident who becomes temporarily ill while in the home, but who does not require continuous nursing care.
ANALYSIS:	On 12/01/2021, Ms. Clacio and Ms. Camitan said that Resident A was admitted to the home receiving hospice services and requiring a feeding machine. Ms. Bernadez confirmed that Resident A became a hospice patient while hospitalized at Mt. Clemens General Hospital early in September 2021. Resident A was admitted to Genesis Senior Place requiring continuous nursing care as evidenced using a feeding machine and receiving hospice services prior to admission to the home on 09/30/2021. Resident A was a patient at the Lodge Taylor Rehabilitation facility prior to admission to Genesis Senior Place from 09/19/2021to 09/30/2021.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

- **Resident A had bedsores after 10 days living in the home. Resident A had stage two bed sores that were stage three and four when she was removed from the home.**
- **The staff refused delivery of Resident A's air mattress.**

INVESTIGATION:

On 11/12/2021, in addition to the above allegations, it was reported that the staff at Genesis Senior Place did not rotate Resident A every two hours and as a result her pressure sores worsened. According to the reporting source, Resident A had bedsores after 10 days of residing at Genesis Senior Place. On 10/23/2021, the reporting source was told by staff that Resident A bed sores were stage II, but he later found out after she moved, that they were stage III. The reporting source reported that Ms. Soan and staff let Resident A "rot." Resident A was moved from the facility on 10/30/2021. It was reported that the hospice company and Genesis Senior Place staff were not doing their job to take care of Resident A. In addition, there were five other residents living in the home, but Resident A was the only resident bedbound and could not walk and the other five residents were okay. The reporting source said that on 10/26/2021 the owner Mr. Policarpio was contacted because Ms. Soan denied an air mattress that was delivered to the home.

On 12/01/2021, I interviewed direct care staff Carmen Camitan and Maria Clacio. Ms. Camitan said that Resident A was bedbound and could not walk. Ms. Clacio said that Resident A arrived at Genesis Senior Place with bedsores on her tailbone and left hip at admission. Resident A bedsores worsened because hospice refused to provide supplies for cleaning the bedsores. Ms. Camitan and Ms. Clacio denied having knowledge about the air mattress being denied as a delivery. Ms. Camitan and Ms. Clacio were told not to allow any visitors into the facility including a wound nurse in October 2021 (actual date could not be recalled) due to a resident having active COVID-19 virus infection in the home. Ms. Camitan and Ms. Clacio said that they were on staff when a wound nurse came from Evergreen Hospice for Resident A but told the nurse, that she could not enter because of COVID-19 positive case.

On 12/21/2021, I observed that Resident A's *Health Care Appraisal* was not completed. I observed that there is no prescription order for a hospital bed or air mattress for Resident A.

On 01/27/2021, I conducted a phone call to Relative A. Relative A said that Resident A was supposed to be turned every two hours. Relative A said that the staff at Genesis Senior Place allowed Resident A to remain in the bed, not turning her every two hours and lying in her own urine. Relative A said that Resident A was always wet during visits. There was a hospice nurse that came to check the wounds, but the bedsores worsened. Relative A noticed the bedsores around October 10-11 of 2021. Relative A said that Evergreen Hopsice is being investigated as well. Relative A said that the hospice nurse kept telling him that the bedsores were stage II or III, but when she moved out of the home Resident A's bedsores were stage IV. When Resident A was discharged the bedsores were black. Resident A was in much pain and had to be placed on Morphine when she moved to her new home at Walnut Creek. Relative A said that Resident A lived 30 days after moving from Genesis Senior Place. Relative A said that the staff at Genesis Senior Place told him that Resident A arrived with bedsores which he disagrees.

Relative A said that he ordered the air mattress for Resident A because he researched on the internet that this would be better for a person with bedsores. Relative A ordered and set-up delivery of the mattress. Relative A said that Genesis Senior Place refused the delivery because they did not have enough staff to help move Resident A and the existing furniture around. Relative A called the owner Mr. Policarpio about this, and he did not know what was going on. The bed was not delivered until days later and Relative A could not recall the specific dates.

On 01/27/2022, I observed six photos of Resident A's bedsores from Relative A via email. The photos showed Resident A's buttocks area with large ulcers with decaying skin tissue.

On 02/08/2022, I received a facsimile from Mr. Policarpio which documents the staff changed Resident A's brief three times per day and as needed. Resident A was repositioned every two hours with a turning wedge and heals elevated. Resident A's wounds were gently cleansed with light soap and water, patted dry and Neosporin® and Calmospetine® ointment on the wounds. Resident A's hospital bed and air mattress was delivered on 09/13/2021 before Resident A arrived at the facility. The alternating bedsore mattress arrived at the home on 10/26/2021.

On 02/08/2022, I conducted a phone interview with Mr. Policarpio and Imelda Soan, administrator. Mr. Policarpio said that Evergreen Hospice was not providing good services to Resident A. Mr. Policarpio recommended that the family find a new hospice service however, the family did not want to change the hospice service. Mr. Policarpio said that Evergreen Hospice did not supply the home with Resident A's wound care ointments or bandages. Resident A's ointments and wound care medications were supposed to be brought to the home by Evergreen Hospice, but they did not provide. Ms. Soan said that the air mattress was not refused at delivery. Ms. Soan said that the delivery company called at night, and they agreed to bring it back during daytime hours. Ms. Soan said that Resident A also had a Hoyer Lift that hospice ordered. Ms. Soan said all orders were verbal and not documented in writing. Ms. Soan said that Resident A was turned every two hours. The family provided the home with the Neosporin® for the wounds. Ms. Bernardez, hospice nurse said that she could not bring supplies because she could not open the supply room at Evergreen Hospice.

On 02/09/2022, I conducted a phone interview with Purita Bernardez, prior Evergreen Hospice Nurse. Ms. Bernardez said that prior to Resident A moving into Genesis Senior Place, she did not observe any bedsores. Ms. Bernardez observed that there was some redness on her bottom prior to admission to the home. Ms. Bernardez said that after the bedsores were discovered by the staff at Genesis Senior Place, Ms. Soan told her that Resident A arrived with bedsores. When Ms. Bernardez initially saw the bedsores at Genesis Senior Place, they were stage I or II in early October 2021. Ms. Bernardez said that the staff began using Neosporin® on the wounds. Ms. Bernardez believes that there was an order from the hospice doctor (Dr. Enicinas) for Neosporin®. Ms. Bernardez showed the staff how to apply the Neosporin® to Resident A's bottom and how to properly clean the wounds. Ms. Bernardez informed the staff to turn

Resident A every two hours. Ms. Bernardez does not believe that the staff were turning Resident A as required, because the staff expressed their reluctance to work with Resident A because she was physically aggressive due to dementia. Ms. Bernardez said that Resident A would become belligerent, hitting, biting, and kicking staff. Ms. Bernardez said that the staff are Philippine as she is, and she would explain care instructions in their dialect. Ms. Bernardez said that Resident A's bedsores were worsening. Ms. Bernardez kept telling staff that Resident A's bottom needed to be dry and changed frequently. Ms. Bernardez said that Resident A's bandages were to be changed once a week or as needed and the staff were responsible for doing this. If the wound bandages needed to be changed while she was present, she would change them.

Ms. Bernardez said that Resident A's supplies for her wound care were supplied by Evergreen Hospice. Ms. Bernardez would call their supply person at Evergreen Hopsice and order what was needed. Ms. Bernardez would pick-up supplies at the office which she had to order from their supply person. One time, the staff at Genesis Senior Place called her for supplies, and she informed the staff person (name could not be recalled) that she could not get supplies because they must be pre-ordered and she does not have access to the supply room. When Ms. Bernardez last saw Resident A at Genesis Senior Place, the bedsores on her bottom were black. The family was present at Genesis Senior Place on her final visit with Resident A. Ms. Bernardez said that at that time, the family decided to move Resident A to a new home because they were not satisfied with the care received.

Ms. Bernardez said that Resident A's hospital bed was delivered to the home before she was admitted to the home in early September 2021. Ms. Bernardez does not remember the details regarding the air mattress order.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: (d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.

ANALYSIS:	On 12/01/2021, direct care staff, Ms. Camitan said that Resident A bedsores worsened because Evergreen Hospice refused to provide supplies for cleaning the bedsores. Ms. Camitan and Ms. Clacio said that Resident A was admitted into the home with bedsores. Per Relative A, Ms. Bernardez, Mr. Policarpio and Ms. Soan Resident A was to be turned every two hours. Ms. Bernardez does not believe that the staff were turning Resident A as required because the staff expressed their reluctance to work with Resident A because she was physically aggressive due to dementia. I observed eight photos of Resident A's buttocks area with large ulcers with decaying skin tissue. Relative A noticed the bedsores around October 10, 2021. Ms. Bernardez was informed of the bedsores in mid-October by Ms. Soan. Prior to this, Ms. Bernardez was not aware that Resident A had bedsores. Resident A wounds worsened per Ms. Bernardez. Based on the investigation, there were limited supplies received for Resident A to treat the bedsores on her buttocks. Ms. Bernardez admitted that there were issues at times receiving supplies from Evergreen Hospice to treat the wounds. It cannot be determined if staff were turning Resident A as needed based on the progression of the bedsores.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization.
ANALYSIS:	Per Ms. Soan, Resident A had a Hoyer Lift which Evergreen Hospice ordered. Ms. Soan said that all orders were verbal and not documented in writing. Ms. Bernardez reviewed Resident A's medical information at admission that the family provided. Ms. Bernardez did not change or add any new medical orders in writing. Ms. Soan said all orders were verbal. According to Ms. Policarpio, Resident A received a hospital bed delivered to the home on 09/13/2021 prior to her moving into the home. According to Ms. Bernardez, hospice nurse, Resident A used a hospital bed and air mattress. Ms. Bernardez believes

	that these items were ordered by the family and not by hospice. Ms. Bernardez said that there is possibility that a physician could have given a verbal order, however, she is unsure. To date, there is no written documentation that was provided regarding the Hoyer Lift, hospital bed or air mattress prescribed for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 12/21/2021, I observed that Resident A's *Health Care Appraisal* was not completed. I requested Resident A's *Health Care Appraisal* on 11/12/2021.

On 02/08/2022, I received a facsimile from Mr. Policarpio for clarification on items within the investigation. Mr. Policarpio documented that Resident A's *Health Care Appraisal* was not completed because the hospice nurse/Evergreen Hospice Purita Bernardez refused to sign it.

On 02/08/2022, I conducted a phone interview with Mr. Policarpio and Imelda Soan, administrator. Mr. Policarpio said that he received the discharge summary from Resident A's prior placement (The Lodge at Taylor) and accepted that in lieu of the *Health Care Appraisal*. Ms. Soan and Mr. Policarpio said that they asked the hospice nurse Purita Bernardez to complete the *Health Care Appraisal* and was told by Ms. Bernardez that she could not complete it, but her office could. Ms. Soan said that Ms. Bernardez said that she would take the *Health Care Appraisal* back to her office to be completed. Mr. Policarpio and Ms. Soan both stated that the *Health Care Appraisal* was never completed. Mr. Policarpio and Ms. Soan admitted to not asking Resident A's family to have the *Health Care Appraisal* completed.

On 02/09/2022, I conducted a phone interview with Purita Bernardez, prior Evergreen Hospice Nurse. Ms. Bernardez said that she does not recall the staff asking her to complete the *Health Care Appraisal*.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(11) A licensee shall contact a resident's physician for instructions as to the care of the resident if the resident requires the care of a physician while living in the home. A licensee shall

	record, in the resident's record, any instructions for the care of the resident.
ANALYSIS:	I requested a *Health Care Appraisal* for Resident A on 11/12/2021. I received a copy of a discharge summary from The Lodge at Taylor rehabilitation facility in lieu of the *Health Care Appraisal*. Resident A resided at Genesis Senior Place for 43 days and a *Health Care Appraisal* was not completed.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 11/12/2021, according to the reporting source, Ms. Soan denied a wound nurse access to the home to care for Resident A. The reporting source said that the wound nurse was not allowed inside of the home due to there being active COVID-19 in the home.

On 12/01/2021, I interviewed direct care staff Carmen Camitan and Maria Clacio. Ms. Camitan and Ms. Clacio said that they were told not to allow any visitors including a wound nurse into the facility in October 2021 (actual date could not be recalled) due to a resident having active COVID-19 virus infection. Ms. Camitan and Ms. Clacio said that they were on staff when a wound nurse came from Evergreen Hospice for Resident A but told the nurse that she could not enter because of a COVID-19 positive case.

On 01/27/2021, I conducted a phone call to Relative A. Relative A said that there were problems entering the home. Relative A said that the hospice service told him that they had ordered a wound specialist to treat Resident A's bedsores, but the staff refused the wound specialist inside of the home due to active COVID-19.

On 02/08/2022 during a phone interview, Ms. Soan said that the wound care nurse was not allowed inside of the home and a note was posted on the door that no visitors were allowed.

On 02/09/2022, I conducted a phone interview with Purita Bernardez, prior Evergreen Hospice Nurse. Ms. Bernardez said that the hospice wound nurse's name was Paula Morano (no contact information known). Ms. Bernardez said that Ms. Morano works as a wound nurse consultant for Evergreen Hospice. Ms. Morano told Ms. Bernardez that the staff would not allow her access to the home because there was active COVID-19 in the home. Ms. Bernardez said that the wound nurse should not have been denied access.

On 02/11/2022, I reviewed the Michigan Department of Health and Human Services (MDHHS) Epidemic Orders (QSO-2039-NH) as follows: Entry of Healthcare Workers and Other Providers of Services *All* healthcare workers must be permitted to come into the facility as long as they are not subject to a *work exclusion* or showing signs or

symptoms of COVID-19. *In addition to health care workers, personnel educating and assisting in resident transitions to the community should be permitted entry consistent with this guidance.* We note that EMS personnel do not need to be screened, so they can attend to an emergency without delay. We remind facilities that all staff, including individuals providing services under arrangement as well as volunteers, should adhere to the core principles of COVID-19 infection prevention and must comply with COVID-19 testing requirements.

On 02/11/2022, I conducted an exit conference as well as emailed technical assistance to Mr. Policarpio and Ms. Soan. They were informed of the violations. I emphasized that the resident's care is an agreement between the licensee and the resident/ designated representative. I discussed that the acceptance of residents requiring continuous nursing care is becoming a trend as I had investigated this allegation in a different facility that the licensee operates that was also substantiated. Mr. Policarpio understands this rule and agrees to admit residents within the scope of adult foster care services. I also discussed that the required paperwork such as, the *Health Care Appraisal,* etc. should be completed with the assistance of the resident/designated representative. Mr. Policarpio agrees to submit a corrective action plan once the report is received.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(1) Care and services that are provided to a resident by the home shall be designed to maintain and improve a resident's physical and intellectual functioning and independence. A licensee shall Ensure® that all interactions with residents promote and encourage cooperation, self-esteem, self direction, independence, and normalization.
ANALYSIS:	Ms. Camitan and Ms. Clacio were on shift when a wound nurse came from Evergreen Hospice for Resident A to treat the bedsores in October 2021, but they told the nurse that she could not enter because there was a COVID-19 positive resident. On 01/27/2022, Relative A confirmed that the wound specialist was not allowed inside of the home to treat Resident A because there was active COVID-19. Ms. Soan admitted that the staff did not allow the wound nurse into the home to care for Resident A due to active COVID-19 in the home. Ms. Bernardez was told by the would nurse consultant Ms. Morano, that the staff denied her access in the home due to COVID-19 in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

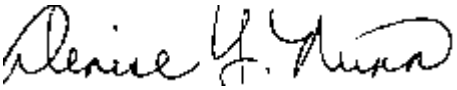
IV. RECOMMENDATION

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

02/18/2022

LaShonda Reed Date
Licensing Consultant

Approved By:



02/18/2022

Denise Y. Nunn Date
Area Manager