GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 5, 2022

Rebecca Duncan
Curry House II
5858 S. 47 Mile Road
Cadillac, MI 49607

RE: License #: AH830337522
Investigation #: 2022A1028031
Curry House II

Dear Ms. Duncan:

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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
Cell (616) 204-4300

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

I. IDENTIFYING INFORMATION

License #:	AH830337522
Investigation #:	2022A1028031
Complaint Receipt Date:	02/17/2022
Investigation Initiation Date:	02/22/2022
Report Due Date:	04/19/2022
Licensee Name:	CHT Curry House MI Tenant Corp.
Licensee Address:	450 S. Orange Ave Orlando, FL 32801
Licensee Telephone #:	(231) 876-0611
Authorized Representative/Administrator:	Rebecca Duncan
Name of Facility:	Curry House II
Facility Address:	5858 S. 47 Mile Road Cadillac, MI 49607
Facility Telephone #:	(231) 876-0611
Original Issuance Date:	05/01/2013
License **Status:**	REGULAR
Effective Date:	11/01/2021
Expiration Date:	10/31/2022
Capacity:	56
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A is not receiving care in accordance with the service plan.	No
The facility is short staffed and unable to meet the needs of residents.	No
Resident A is not receiving medications in a timely manner.	No

III. METHODOLOGY

02/17/2022	Special Investigation Intake 2022A1028031
02/22/2022	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
02/22/2022	APS Referral APS referral emailed to Centralized Intake
03/10/2022	Inspection Completed On-site Onsite inspection completed
03/10/2022	Contact - Face to Face Interviewed Admin/Rebecca Duncan at the facility.
03/10/2022	Contact - Face to Face Interviewed facility staff/Susan Neil at the facility
03/10/2022	Contact - Face to Face Interviewed care staff/Annette Dagen at the facility
03/10/2022	Contact - Face to Face Interviewed care staff Dawn Wonsey at the facility
03/14/2022	Contact – Telephone call made Interviewed Resident A’s authorized representative by telephone.
04/05/2022	Exit Interview

ALLEGATION:

Resident A is not receiving care in accordance with the service plan.

INVESTIGATION:

On 2/17/2022, the Bureau received the allegations from a complainant through the online complaint system.

On 2/22/2022, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 3/10/2022, I interviewed the facility authorized representative/administrator, Rebecca Duncan, at the facility. Resident A resides in assisted living with facility care and hospice care per the service plan. The authorized representative and a private caregiver also assist Resident A with care as well. Ms. Duncan reported a potential placement into the memory care unit of the facility was offered to Resident A, but ultimately declined by Resident A's authorized representative. Ms. Duncan reported Resident A's service plan was developed with Resident A's authorized representative and that all staff follow it. Ms. Duncan provided me a copy of Resident A's service plan for my review.

On 3/10/2022, I interviewed Employee A at the facility. Employee A reported Resident A receives care from facility staff, hospice, a private caregiver, and the authorized representative. Employee A reported staff follow the service plan.

On 3/10/2022, I interviewed Employee B and Employee C at the facility. Employee B and Employee C's statements are consistent with Ms. Duncan's and Employee A's statements.

On 3/10/2022, I reviewed Resident A's service plan which revealed Resident A requires assistance with all care. Resident A's private caregiver is also included in the service plan. The service plan is dated 3/4/2022.

On 3/14/2022, I interviewed the authorized representative by telephone. The authorized representative reported Resident A currently resides in assisted living and that [they], hospice, facility care staff, and a paid caregiver assist Resident A with care. The authorized representative reported Resident A's service plan was recently updated to reflect care changes as well. The authorized representative confirmed a placement in the memory care unit was offered by the facility, but [they] declined the placement for Resident A. The authorized representative reported while there have been previous concerns with Resident A's care, it was brought to management's attention and the concerns were addressed and resolved.

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.
ANALYSIS:	Resident A receives assist from facility care staff, hospice care staff, a private caregiver, and the authorized representative in accordance with the service plan. While there were previous concerns, the authorized representative reported those concerns were satisfactorily addressed. There is no evidence to support this allegation. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility is short staffed and unable to meet the needs of residents.

INVESTIGATION:

On 3/10/2022, Ms. Duncan reported the facility currently has 20 residents with appropriate staff to resident ratio. Ms. Duncan reported there are four to five care staff, a med tech and a float care staff are assigned to first and second shifts. There are two to three care staff, a med tech and float care staff assigned to third shift. Ms. Duncan reported if there are call-ins, float care staff, agency staff, or management will fill in the shift shortage. Ms. Duncan provided me a copy of the call-light response log and working staff schedule for my review.

On 3/10/2022, Employee A reported the facility is not currently short staffed but have been in the past and call-ins do occur. Employee A reported there are four to five care staff, a med tech and float care staff are assigned to first and second shifts; and there are two care staff, a med tech and float care staff assigned to third shift. Employee admitted when call-ins occur management, agency staff, or facility staff will fill-in so the shift shortage is covered.

On 3/10/2022, Employee B’s statements are consistent with Ms. Duncan’s and Employee A’s statements.

On 3/10/2022, I reviewed the working staff schedule from February 2022 to March 2022 which revealed a few call-ins, but facility staff and/or management covered the shifts to prevent the shortage.

I also reviewed call light response log from February 2022 to March 2022 which revealed appropriate call light response times.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	The facility demonstrates appropriate care staff to resident ratio and is able to meet the needs of residents appropriately. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A is not receiving medications in a timely manner.

INVESTIGATION:

On 3/10/2022, Ms. Duncan reported hospice currently handles Resident A's medications and physician orders and the authorized representative is in good communication with the facility and hospice about Resident A's medication. However, Ms. Duncan reported there have been some issues with certain staff and the authorized representative concerning Resident A's mediation administration by facility care staff. Ms. Duncan reported care staff are in good communication with hospice and Resident A's authorized representative about medications as well to ensure Resident A's medications are correct and administered in a timely manner. Ms. Duncan provided me a copy of Resident A's medication administration record for my review.

On 3/10/2022, Employee A reported to [their] knowledge there have been some issues with medications not being delivered in a timely manner to the facility from hospice and/or the pharmacy, but not with administration. Employee A reported only med technicians administer resident medications. Employee A reported Resident A's authorized representative is in good communication with the facility and hospice concerning Resident A's medications and administration.

On 3/10/2022, Employee C's statements are consistent with Employee A's statements.

On 3/10/2022, I reviewed Resident A's medication administration record. No concerns were noted.

On 3/14/2022, Resident A's authorized representative reported there have been issues with facility care staff not administering medications in a timely manner. The authorized representative reported that as of today, 3/14/22 at 10:03am, Resident A's 9am medications had still not been administered. The authorized representative reported that while there have been issues with late medication administration, [they] feel like it is being addressed. However, the authorized representative reported at times [they] have had to ask staff to administer medications and that staff have given [them] the medications from the medication cart to take back to Resident A's room to administer the medications. The authorized representative also reported Resident A has an order for crushed medications and [they] have crushed the medications and administered the medication(s) so Resident A receives the medications in a timely manner. The authorized representative reported Resident A's private caregiver does not administer any medications, only facility care staff or hospice care staff.

On 3/14/2022, I reviewed Resident A's service plan which revealed Resident A requires assistance with all care due to cognition and decline. Resident A's medication administration is managed by the facility med technician. The service plan reads:

Effective Date: 3/4/2022
Med Mgmt: Administers
Provide: Med Aide
Time(s): AM, PM
Medication management will be monitored by a licensed nurse. The MT will assist the resident to take medications, will order medications from the pharmacy, store medications per pharmacy directions, monitor for side effects, and communicate with the physician or PCP as needed for issues and concerns.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.

ANALYSIS:	Per Resident A's service plan, medication administration is to be completed by facility *'med aide'* only to include the passing and crushing of all medications. However, it was discovered Resident A's authorized representative has administered and crushed Resident A's medications on several occasions to ensure Resident A receives medication in a timely manner. The handling of Resident A's medication administration by anyone other than trained facility staff and/or medical professionals presents a potential risk of harm for Resident A. This is also in violation of Resident A's service plan and the state rule for safe resident medication administration.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an approved corrective action plan, I recommend the status of this license remain the same.

Julie Viviano

3/14/22

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Julie Viviano Date
Licensing Staff

Approved By:

Andrea L. Moore

04/05/2022

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Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section