GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 1, 2022

Dawn Foulke
Clinton Creek, Inc.
4438 Ramsgate Lane
Bloomfield Hills, MI 48302

RE: License #: AH500387884
Investigation #: 2022A1019034
Clinton Creek Assisted Living & Memory Care

Dear Ms. Foulke:

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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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.

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,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500387884
Investigation #:	2022A1019034
Complaint Receipt Date:	03/01/2022
Investigation Initiation Date:	03/02/2022
Report Due Date:	04/30/2022
Licensee Name:	Clinton Creek, Inc.
Licensee Address:	4438 Ramsgate Lane Bloomfield Hills, MI 48302
Licensee Telephone #:	(248) 701-5043
Administrator:	Karrie Dove-Drendall
Authorized Representative:	Dawn Foulke
Name of Facility:	Clinton Creek Assisted Living & Memory Care
Facility Address:	40500 Garfield Road Clinton Township, MI 48038
Facility Telephone #:	(586) 354-2700
Original Issuance Date:	07/18/2019
License Status:	REGULAR
Effective Date:	01/18/2022
Expiration Date:	01/17/2023
Capacity:	62
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Inadequate care of residents leading to death.	No
Clean bedding is not available.	No
The facility does not have adequate incontinence supplies available.	No
Residents' food is served on dirty dishes.	No
Additional Findings	Yes

III. METHODOLOGY

03/01/2022	Special Investigation Intake 2022A1019034
03/02/2022	Special Investigation Initiated - Telephone Called complainant to conduct interview. Left voicemail requesting return phone call.
03/15/2022	Contact - Telephone call made Second call placed to complainant, left voicemail requesting return phone call.
03/16/2022	Inspection Completed On-site
03/16/2022	Inspection Completed BCAL Sub. Compliance
04/01/2022	Exit Conference

The complainant identified some concerns that were not related to licensing rules and statutes for a home for the aged. Therefore, only specific items pertaining to homes for the aged provisions of care were considered for investigation. The following items were those that could be considered under the scope of licensing.

ALLEGATION:

Inadequate care of residents leading to death.

INVESTIGATION:

On 3/1/22, a complaint was submitted that read “Residents are dying because of the care”. The complaint did not name any residents who have passed aware due to care related concerns and did not provide a timeframe in which the deaths allegedly occurred. The complainant was contacted by telephone, however those calls were not returned. As a result, I was unable to obtain any additional information regarding the allegations.

On 3/16/22, I conducted an onsite inspection. I interviewed administrator Karrie Dove-Drendall at the facility. Ms. Dove-Drendall stated that five residents (Residents A, B, C, D and E) have passed away in the last 90 days. Ms. Dove-Drendall stated that Residents A and B were receiving hospice services and those were expected deaths. Ms. Dove-Drendall stated that Resident C was in poor health and a history of heart issues (pacemaker) and stroke. Ms. Dove- Drendall stated that on 2/26/22, Resident C was discovered on the floor during staff rounds on third shift. Ms. Dove-Drendall stated she was taken to the hospital where she was put on hospice but never returned to the facility. Ms. Dove-Drendall stated that Resident C passed away on 3/8/22. Ms. Dove-Drendall provided an incident report outlining the event. The incident report read “We were doing our 1:00 clock [sic] rounds that’s when we saw her sleeping. We woke her up and got her off the floor. Vitals was [sic] taken and it was fine. She had [a] large knot on the left side of her head. EMS was called and she was taken to the hospital.” Ms. Dove-Drendall stated that Resident D passed away at the hospital on 12/28/21 after she fell at the facility on 12/21/21. Ms. Dove-Drendall stated that Resident D was independent with mobility and care related tasks but had a history of brain bleeds. Ms. Dove-Drendall provided an incident report outlining the event. The incident report read “RA was doing rounds and found resident laying in the middle of the floor in her bathroom on her stomach/side of her face, gushing blood. Trash can was laying on the side of her and her walker was also next to her. Big puddle of blood.” Ms. Dove-Drendall stated Resident E’s death was unexpected and stated that he died at the facility on 2/24/22. Ms. Dove-Drendall provided a progress note outlining the event that read “At 7:59 RA altered Med Tech that resident was face down on the floor and not moving. Med Tech alerted Nurse in the break room on [the] way to residents room. Upon entry resident was cold to touch and blue with no pulse. 911 was notified along with family.”

Ms. Dove-Drendall stated that she was later informed by Resident E’s sister in law “That he had less than six months to live” but reported that she was only told this information after he passed away.

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	**(2) (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:	Over the timeframe reviewed, five residents had passed away. Given the information provided, I am unable to link the deaths to poor care at the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility does not have adequate incontinence supplies available.

INVESTIGATION:

The complaint read “They only have small briefs, and most residents aren’t small.” Ms. Dove-Drendall stated that the facility reorders incontinence supplies every two weeks and has multiple storage areas where the supplies are kept. Ms. Dove-

Drendall stated that residents who receive hospice services are supposed to get their supplies through hospice directly but stated that some staff use the house supply for everyone which is making them go through inventory faster. Ms. Dove-Drendall stated that in each supply closet there is a list of residents who are to receive the supplies but believes that staff are not always checking the list before using the supplies. While onsite, I toured the facility with Ms. Dove-Drendall where I observed supplies in several areas of the facility and noted that there were briefs of all sizes.

APPLICABLE RULE	
R 325.1933	**Personal care of residents.**
	(1) A home shall provide a resident with necessary assistance with personal care such as, but not limited to, care of the skin, mouth and teeth, hands and feet, and the shampooing and grooming of the hair as specified in the resident's service plan.
ANALYSIS:	Visual observation of several storage closets throughout the facility reveal ample supply of incontinence products in an array of sizes.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Clean bedding is not available.

INVESTIGATION:

The complaint read “they don’t have no clean linen to put on the bed”; no additional information was provided. Ms. Dove-Drendall stated that laundry is completed daily, and that residents bedding is changed twice weekly (and more often if needed). Ms. Dove-Drendall took me to two separate storage areas where overflow linens are held. I observed an adequate supply of extra bedding, sheets, mattress covers and also observed multiple loads of laundry being completed.

APPLICABLE RULE	
R 325.1935	**Bedding, linens, and clothing.**
	(2) The home shall assure the availability of clean linens, towels, and washcloths. The supply shall be sufficient to

	meet the needs of the residents in the home. Individually designated space for individual towels and washcloths shall be provided.
ANALYSIS:	The facility had two storage areas full of clean linens for residents and demonstrated consistent laundry procedures.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents' food is served on dirty dishes.

INVESTIGATION:

The complaint read "The dishes are dirty and they aren't clean they make them feed residents on dirty dishes." Ms. Dove-Drendall took to me to the commercial kitchen where I observed lunch being prepared and served. I observed several stacks of plates and bowls that were being used during lunch service, all were clean, and none were visibly dirty. Ms. Dove-Drendall then took me to the dining room where several residents were eating lunch. Ms. Dove-Drendall stated that drinkware is kept in the cupboards in the dining room. I proceeded to inspect the various mugs and cups and did not observe any that were dirty. Ms. Dove-Drendall along with Employee A explained that the facility uses a three compartment sink in combination with a high temperature dish machine to clean the dishes. Ms. Dove-Drendall and Employee A stated that all dishes are first sanitized through the three compartment sink process and then are put through the dish machine.

APPLICABLE RULE	
R 325.1976	**Kitchen and dietary.**
	(6) Food and drink used in the home shall be clean and wholesome and shall be manufactured, handled, stored, prepared, transported, and served so as to be safe for human consumption.
ANALYSIS:	The facility demonstrated adequate dish sanitizing protocol and I did not observe any dirty dishes being used to serve food.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

As noted above under the first allegation, Residents C and D had falls with injury and subsequent hospitalization. On 2/26/22, Resident C was observed on the ground with a large knot on her head. On 12/21/21, Resident D was observed on her bathroom floor in a pool of blood. Both residents passed away at the hospital following their falls and never returned to the facility. The facility did not submit incident reports to licensing staff on either injury/hospitalization. When questioned about the lack of reporting, Ms. Dove-Drendall acknowledged that both events should have been reported and that she “dropped the ball”.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.
For Reference R 325.1901	**Definitions.**
	(17) "Reportable incident/accident" means an intentional or unintentional event in which a resident suffers harm or is at risk of more than minimal harm, such as, but not limited to, abuse, neglect, exploitation, or unnatural death.
ANALYSIS:	Residents C and D were hospitalized after falling and sustaining injury at the facility. Facility staff failed to notify the department of either incident.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 4/1/22, I shared the findings of this report with authorized representative Dawn Foulke.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no changes to the status of the license at this time.

03/18/2022

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Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

04/01/2022

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