STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

April 7, 2022

Leah Allen
Oscoda Assisted Living, LLC
219 Church St.
Auburn, MI 48611

RE: License #: AL350390822
Investigation #: 2022A0360019
Oscoda Assisted Living, LLC

Dear Ms. Allen:

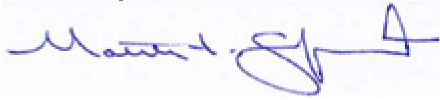
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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 (989) 732-8062.

Sincerely,



Matthew Soderquist, Licensing Consultant
Bureau of Community and Health Systems
Ste 3
931 S Otsego Ave
Gaylord, MI 49735
(989) 370-8320

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL350390822
Investigation #:	2022A0360019
Complaint Receipt Date:	03/09/2022
Investigation Initiation Date:	03/09/2022
Report Due Date:	04/08/2022
Licensee Name:	Oscoda Assisted Living, LLC
Licensee Address:	5113 Cedar Lake Road Oscoda, MI 48750
Licensee Telephone #:	(989) 569-6766
Administrator:	Leah Allen
Licensee Designee:	Leah Allen, Designee
Name of Facility:	Oscoda Assisted Living, LLC
Facility Address:	5113 Cedar Lake Rd. Oscoda, MI 48750
Facility Telephone #:	(989) 450-8323
Original Issuance Date:	08/13/2018
License Status:	REGULAR
Effective Date:	02/13/2021
Expiration Date:	02/12/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A had multiple falls and injuries including burns on her hands and found with broken glass.	Yes

III. METHODOLOGY

03/09/2022	Special Investigation Intake 2022A0360019
03/09/2022	Special Investigation Initiated - Telephone Relative 1-A
03/10/2022	APS Referral online complaint
03/15/2022	Inspection Completed On-site home manager Nicole Chesser, DCS Michelle Norris
04/04/2022	Contact – Telephone Call Made Relative 1-A
04/04/2022	Contact – Telephone Call Made DCS Anne Patterson
04/04/2022	Contact – Telephone Call Made DCS Lindsey Corcoran
04/05/2022	Contact – Telephone Call Received Home manager Nicole Chesser
04/06/2022	Contact - Document Received Home manager Nicole Chesser
04/06/2022	Exit Conference With administrator Leah Allen

ALLEGATION: Resident A had multiple falls and injuries including burns on her hands and found with broken glass.

INVESTIGATION: On 3/9/2022 I was assigned a complaint from the LARA online complaint system.

On 3/9/2022 I contacted Relative 1-A. Relative 1-A stated Resident A was currently admitted to St. Mary's hospital in Saginaw. Resident A had to have hip surgery due to a fall, had to have a feeding tube put in place and had evidence of a brain bleed that they are monitoring which could have resulted from recent falls or falls in the past year. Relative 1-A stated there were numerous incidents at Oscoda Fields where Resident A fell and was hurt over the past couple of months. She stated there was also an incident where Resident A was found with broken glass and was sent to the hospital for evaluation because they thought she may have ingested some of it. She stated Resident A had another fall on 2/24/2022 or 2/25/2022 in which she hurt her hip and arm. Relative 1-A stated they will likely be relocating Resident A to a skilled nursing facility once she is discharged from the hospital.

On 3/15/2022 I conducted an unannounced onsite inspection at the facility. The home manager Nicole Chesser stated they issued Resident A 30-day discharge notice on 2/23/2022 due to incidents on 12/9/2021, 1/25/2022, and 1/28/2022. She stated on 12/9/2021 Resident A was found in another resident's room. The corrective measures taken were to implement 15-minute checks on Resident A and 30-minute room sweeps of the entire facility. On 1/25/2022 Resident A was found with burns and cuts on the tips of her fingers from turning up the supplemental baseboard heat in her bedroom and putting her fingers in the heater slots. The corrective measures taken were to implement 15-minute checks on Resident A.

Ms. Chesser stated that on 1/28/2022 Resident A was found in another room with broken glass from a vase and cuts on her legs. Ms. Chesser stated Resident A was sent to the hospital for the broken glass incident and had to have a scope done to make sure she did not ingest any glass. She stated Resident A returned to the facility the next day. The corrective measures put in place included transporting to hospital and 30-minute checks of Resident A when she returned to the facility.

Ms. Chesser then provided me with incident reports from 2/9/2022 and 2/25/2022. The incident report dated 2/9/2022 documented that Resident A was found with a small cut on her face and a black eye and bruising on her arm. A head-to-toe assessment was done, and no other marks or injuries were noted. The incident report from 2/25/2022 documented that Resident A was using her walker and fell backwards onto the floor and that her walker scraped her elbow. The area on her arm that was scraped started to swell. They checked her vitals which were good, but she was sent to the hospital due to swelling on her arm. Ms. Chesser then provided me with skin assessments that were completed on 1/19/2022 which documented 2 little cuts that were bleeding on her face. On 1/20/2022 a skin assessment documented sores on both of Resident A's knees and top of her feet. On 1/25/2022 a skin assessment documented the burns and cuts on Resident A's fingers. On 2/12/2022 a quarter sized lump on her head and scratches on her shoulder, right arm, and a mark on her hand were noted. On 2/14/2022 a skin assessment documented two bruises the size of golf balls on the backside of Resident A's upper thighs. On 2/24/2022 a bruise, abrasion, and bump on Resident A's right arm was noted.

Ms. Chesser also provided a copy of Resident A's written assessment plan dated 11/22/2021, resident care agreement dated 11/23/2021 and an augmented standard assessment dated 12/21/2021. Resident A's written assessment plan noted that she was to receive one-person assistance when walking. Regarding special equipment it documented that she uses a walker if needed. Resident A's augmented standard assessment dated 12/21/2021 documented that Resident A needs extensive ambulation assistance, has an unsteady gait, uses a wheelchair and is to be using her wheelchair at all times. It also documented that Resident A is diagnosed with dementia and has a history of falls. It was also documented that she wanders the building all day and night and has a history of elopement.
While at the facility on 3/15/2022 I interviewed direct care staff Michelle Norris. Ms. Norris stated on 1/25/2022 she went into Resident A's room and noticed that she had turned on her wall mounted electric baseboard heater all the way to high. Resident A had blisters on her fingers and some had burst. She had blood on her hands. She stated she cleaned Resident A's hands and applied some burn cream and bandages. She stated they were supposed to be doing 15-minute bed checks, but they were not being done. She stated she observed Resident A with a bruised eye on 2/10/20222 from an unknown origin. She stated on 2/25/2022 she came into work after midnight and found Resident A had just fallen in the living room. She stated she thinks Resident A may have hit one of the pillars when she fell. She stated she noticed Resident A's elbow was starting to swell and she called the home manager Nichole Chesser. Ms. Chesser reported to the facility at 6:20 a.m. and an ambulance was called for Resident A. Ms. Norris stated she didn't see any head trauma but heard after the fact that Resident A may have had a brain bleed and a rib fracture in addition to an elbow fracture. Ms. Norris provide me a photo of Resident A's elbow which showed significant swelling above the elbow and a 2–3-inch abrasion.

On 4/4/2022 I contacted Relative 1-A. Relative 1-A stated Resident A was discharged from St. Mary's hospital in Saginaw on Saturday. She stated she was admitted to a skilled nursing facility in Rose City. She stated Resident A just started talking again. She stated during the stay at the hospital Resident A had a feeding tube and hip surgery and they monitored her for a brain bleed. She stated the hospital could not determine if the brain bleed was from previous falls or more recent falls, but it appeared to be under control.

On 4/4/2022 I contacted direct care staff Anne Patterson. Ms. Patterson stated after the 12/9/2021 incident Resident A was placed on 15-minute checks. She stated the 15-minute checks never stopped after they started. She stated Resident A needed constant supervision. She stated they did start documenting the 15-minute checks on a sheet.

On 4/4/2022 I contacted direct care staff Lindsey Corcoran. Ms. Corcoran stated Resident A was placed on 15-minute checks and they were documented. She stated she was busy and could not talk any further.

On 4/5/2022 I contacted the home manager Nicole Chesser. Ms. Chesser stated after the 12/9/2021 incident the corrective measures put in place were to have staff do 15-minute checks of Resident A. She stated at the time she did not have staff start documenting the 15-minute checks until after the 1/25/2022 incident when Resident A was found with burns and cuts on her fingers. She stated she then implemented a check sheet that staff would document that they completed the 15-minute checks on Resident A to verify her safety. She stated that despite the 15-minute checks Resident A's injuries kept happening, so she wanted the staff to document that they were completing the checks. She stated she would provide a copy of the check sheet.

On 4/6/2022 I received a copy of a 15-minute check sheet for Resident A from Ms. Chesser. The check sheet documented check marks and/or initials that 15-minute checks were being completed for Resident A starting January 27th through February 23rd. The entire day of February 24th was blocked out with a brown marker. Resident A was transported to the hospital on February 25th and did not return to the facility.

On 4/6/2022 I contacted the administrator, Leah Allen. Ms. Allen stated that when they typically put a resident on 15-minute checks it is not documented. She stated after the 12/9/2021 incident Resident A was put on 15-minute checks as they were working with the family and physician to reduce Resident A's wandering, falls and injuries. She stated Resident A spent a lot of time in the living room of the facility so for a lot of the day she was in constant supervision of the staff. She stated after the 1/25/2022 incident she noticed a lot of Resident A's injuries were happening during 2nd shift and she was concerned that they may not being doing as good of a job with their 15-minute checks and requested that they start documenting using the check sheet.

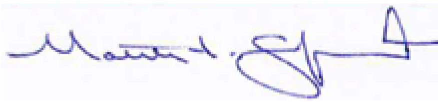
APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Resident A had numerous falls, injuries marks and bruises starting in December 2021. After a 12/9/2021 incident in which Resident A was found in another resident's room she was placed on 15-minute checks. Despite this corrective action, Resident A suffered burns on the tips of her fingers on 1/23/2022. Corrective measures were again put in place to include the documentation of the 15-minute checks of Resident A. Despite this, Resident A was discovered in another room with cuts to her leg and broken glass on 1/25/2022. On 2/9/2022

	Resident A was discovered with an unexplained cut and bruising on her eye. On 2/25/2022 Resident A fell around midnight and hurt her arm. An ambulance was called after 6 a.m. and Resident A was hospitalized at St. Mary's Hospital in Saginaw, had to have a feeding tube put in place and had hip surgery. Resident A has now been discharged and admitted to a skilled nursing facility. There is a preponderance of evidence that Resident A's personal needs, including protection and safety, were not attended to at all times.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 04/06/2022 I conducted an exit conference with the administrator Leah Allen. Ms. Allen stated she would submit a corrective action plan for approval.

IV. RECOMMENDATION

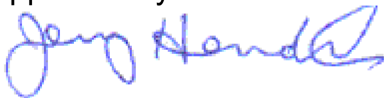
Upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.



04/06/2022

Matthew Soderquist — Date
Licensing Consultant

Approved By:



04/07/2022

Jerry Hendrick — Date
Area Manager