GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 26, 2022

Connie Clauson
Pleasant Homes I L.L.C.
Suite 203
3196 Kraft Ave SE
Grand Rapids, MI 49512

RE: License #: AL390007090
Investigation #: 2022A0462023
Park Place Living Centre #B

Dear Mrs. Clauson:

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 that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Michele Streeter, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-9037

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL390007090
Investigation #:	2022A0462023
Complaint Receipt Date:	03/09/2022
Investigation Initiation Date:	03/09/2022
Report Due Date:	05/08/2022
Licensee Name:	Pleasant Homes I L.L.C.
Licensee Address:	Suite 203 3196 Kraft Ave SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Janet White
Licensee Designee:	Connie Clauson
Name of Facility:	Park Place Living Centre #B
Facility Address:	4218 S Westnedge Kalamazoo, MI 49008
Facility Telephone #:	(269) 388-7303
Original Issuance Date:	01/01/1989
License Status:	REGULAR
Effective Date:	04/20/2021
Expiration Date:	04/19/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Direct care workers did not adequately attend to Resident A's personal care and health care needs.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/09/2022	Special Investigation Intake 2022A0462023 Special Investigation Initiated - Email to Complainant.
03/16/2022	Contact - Telephone interview with Senior Care Partners registered nurse Sonia Hubartt.
03/16/2022	Unannounced investigation onsite. Face-to-face interviews with administrator Janet White, resident care manager Sonya Gibson and DCW Mary Daily. Observation of residents. Contact- Requested and received documentation.
03/18/2022	Contact- Separate telephone interviews with Senior Care Partners clinical registered nurse Darla Henry, nurse practitioner Jamie Shoemaker, and clinical care manager Kristine Waber.
03/22/2022	Contact- Separate telephone interviews with DCWs Brielle Kimbrough, Chaleigh Lewis, Sheena Givhan, Allayiah Bates, and Deja Hayes.
04/15/2022	Contact- Requested documentation.
04/18/2022	Contact- Email exchange with administrator Janet White. Received requested documentation.
04/22/2022	Contact- Left a voicemail for licensee designee Connie Clauson regarding conducting an exit conference.
04/25/2022	Contact- Left second voicemail for licensee designee Connie Clauson regarding conducting an exit conference.

ALLEGATION: Direct care workers did not adequately attend to Resident A's personal care and health care needs.

INVESTIGATION: On 03/09/2022 the Bureau of Community and Health Systems (BCHS) received the above allegation via the BCHS online compliant system. According to the written complaint, Resident A received "wound care" services in the facility by medical staff members from his responsible agency Senior Care Partners (PACE)**.** On 03/07 a clinical nurse with PACE observed Resident A in the facility, sitting in his wheelchair and slumped over. The clinical nurse requested from direct care workers (DCW) "Brio and Lenaya" assistance with transitioning Resident A from his wheelchair into his bed. However, Resident A's bed was not dressed with bedding. The two DCWs stated this was because Resident A preferred to sleep in his chair and not in his bed. According to the written complaint, the clinical nurse explained Resident A was to sleep on his new "pressure reduction low air mattress." Subsequently, Resident A needed to be assisted in and out of bed and then transitioned back and forth between his chair and his bed throughout the day, as he was not to sit for long periods of time.

The written complaint indicated Resident A was observed to be "very unkept." According to the written complaint, Resident A was observed wearing an adult brief that was heavily soiled with stool that was dried on his skin and spread all the way to the edges of his bottom, penis and his catheter. Resident A's brief was changed. However, DCW "Lenaya" stated she did not have anything to clean Resident A with, as PACE had not provided the facility with supplies for Resident A's peri-care and brief changes. The clinical nurse asked the DCWs what they used to clean Resident A when supplies were not available. DCW "Brio" wet a "blue chux pad" and harshly wiped Resident A's bottom.

According to the written complaint Resident A's wound, which was located on his bottom, was heavily contaminated with brown loose stool. The area was bleeding and the wound was observed to be purple and black with extremely raw, jagged tissue. The clinical nurse cleansed Resident A's wound with wound wash, dressed the wound, and covered it with a large "sacral border dressing." The written complaint indicated Resident A's bottom had worsened from "reddened" to a large open unstageable wound. The clinical nurse informed the two DCWs Resident A's wound was to be monitored regularly. According to the written complaint, DCW "Lenaya" gave a lot of "push back" and stated the facility did not provide this "level of care."

I conducted a search of "chux pads" on the internet search engine Google. According to certhealth.com, chux pads are disposable, waterproof and absorbent bed pads for incontinence and are not used as sanitary wipes and/or for peri-care.

On 03/09, via email, I informed Complainant I was assigned to investigate the allegation DCWs did not adequately attend to Resident A's personal care and health

care needs. Complainant reported Resident A had been discharged from the facility and was currently residing in a hospice care facility.

On 03/16 I conducted a telephone interview with PACE clinical nurse Sonia Hubartt, who informed me Resident A passed away peacefully at a hospice care facility. Ms. Hubartt stated she was the clinical nurse who provided care to Resident A at the facility on 03/07 and confirmed the allegations in the written complaint. According to Ms. Hubartt, verbal instructions regarding Resident A's personal care and health care needs were provided to facility staff members by medical staff members from PACE on various occasions. However, while she was at the facility on 03/07, it appeared DCWs were not providing this level of care to Resident A.

On 03/16 I conducted an unannounced investigation at the facility and interviewed administrator Janet White and resident care manager Sonya Gibson. According to Ms. White, Resident A previously resided at a neighboring facility, also owned and operated by the licensee. Ms. White stated Resident A was discharged back to the neighboring facility on 02/19, following his second hospitalization in the month of February. It was established that while at the neighboring facility, Resident A had declined significantly and now required "total care." Ms. White explained Park Place Living Center #B was better equipped to care for residents with a higher level of acuity. Therefore, on 02/24 Resident A was discharged from the neighboring facility and admitted into Park Place Living Centre #B. According to Ms. White, Resident A resided at Park Place Living Centre #B for only 13 days before being discharged to a hospice care facility on 03/09.

Ms. Gibson stated that when Resident A resided at the neighboring facility, he was able to ambulate with a walker on his own. Upon his admission into Park Place Living Centre #B on 02/24, Ms. Gibson stated it was established Resident A could no longer bear weight and required assistance with transferring via the assistance of two-three DCWs and/or the use of a mechanical lift. Ms. Gibson stated Resident A also had a catheter, was incontinent of his bowels, and had a wound on his bottom. Ms. Gibson confirmed Resident A required "total assistance" with his activities of daily living (ALDs). Ms. Gibson stated medical staff members from PACE provided "wound care" to Resident A in the facility several times a week. Ms. Gibson explained that if the bandages on Resident A's wound came off, DCWs were supposed to notify medical staff members at PACE. According to Ms. Gibson, DCWs checked on Resident A and changed his brief every hour, if needed. Ms. Gibson stated Resident A was resistant to sleeping in a bed. Subsequently, per Resident A's wife's request, DCWs allowed Resident A to sleep in his recliner where he felt most comfortable. According to Ms. Gibson, DCWs "repositioned" Resident A several times throughout the day by "shifting him." Ms. Gibson stated the last few days of his residency at the facility, Resident A did sleep in his bed. According to Ms. Gibson, every resident, including Resident A, was offered assistance with a shower or bath twice a week, or more if requested/necessary.

Ms. Gibson stated she did not work at the facility on 03/07. According to both Ms. Gibson and Ms. White, they believed the individual identified as “Brio” in the written complaint was DCW Brielle Kimbrough. Ms. Gibson and Ms. White stated there was no DCW named “Lenaya” employed at the facility. According to Ms. Gibson and Ms. White, on 03/07 Ms. Kimbrough and fellow DCWs Mary Daily and Elaisha Burrell all worked at the facility.

While onsite, I conducted a face-to-face interview with Ms. Daily who confirmed that on 03/07 she worked at the facility from 7:00AM to 2:45PM with Ms. Kimbrough. According to Ms. Daily, she left the facility at 2:45PM to attend a doctor’s appointment, then returned to the facility at 5:15PM and worked until 11:00PM with Ms. Burrell. Ms. Daily’s statements regarding Resident A’s current care needs were consistent with the statements Ms. Gibson provided to me. Ms. Daily stated Resident A’s shower/bath days were scheduled on the facility’s second shift. According to Ms. Daily, she rarely worked the facility’s second shift. Subsequently, in the 13 days Resident A resided at the facility, she never personally provided him with assistance with a shower/bath. Ms. Daily stated she did not recall having any interactions with staff members from PACE on 03/07. According to Ms. Daily, on 03/07, after dinner and before leaving the facility at 11:00PM, she personally emptied Resident A’s catheter bag and changed his brief. Ms. Daily stated Resident A did not have a bowel movement prior to her changing his brief that evening. Ms. Daily did not mention conducting any type of wound care/monitoring for Resident A when she provided care to him on 03/07.

While onsite, I observed nine residents in the facility’s living room area gathering for lunch. All nine residents appeared clean and well-groomed. During my investigation there appeared to be an adequate number of facility staff members present.

On 03/18 I conducted separate telephone interviews with clinical nurse Darla Henry, nurse practitioner Jaimie Shoemaker, and clinical care manager Kristine Waber, who all worked for PACE.

Ms. Henry confirmed that shortly before his admission into the facility Resident A experienced a rapid decline. According to Ms. Henry, she verbally educated DCWs at the facility on how to change Resident A’s bandages on his wound, apply barrier cream, etc. However, it did not appear as though DCWs provided this care to Resident A, as evidenced by his wound getting worse. Ms. Henry stated that one occasion a DCW, whose name she could not recall, told Ms. Henry, “we haven’t seen the wound in a week.” According to Ms. Henry, while providing care to Resident A at the facility she also observed dried feces on his buttocks. Ms. Henry stated that while it had become more difficult to provide Resident A assistance with attending to his personal hygiene since his decline, DCWs “could have done a better job” at keeping him clean. According to Ms. Henry, she spoke with Ms. Gibson regarding concerns Resident A was not receiving adequate care. Ms. Henry stated that following her discussion with Ms. Gibson, the care DCWs provided to Resident A was “much better.” However, shortly after this, Resident A was discharged and

admitted into a local hospice facility where he passed away peacefully with his family by his side.

Ms. Shoemaker also confirmed that before Resident A's passing, he experienced a decline in his health. Ms. Shoemaker stated that while she observed Resident A to be "unkept" on several occasions while at the facility, Resident A's clothes appeared to be clean. According to Ms. Shoemaker, given Resident A's medical and physical condition, it would have been difficult for DCWs to provide Resident A with bathing assistance in a shower and/or bathtub. Subsequently, Resident A would have required bathing assistance via a "bed bath." Ms. Shoemaker stated there were occasions when she also observed Resident A at the facility sitting in a soiled brief. Ms. Shoemaker confirmed Resident A had a catheter. Ms. Shoemaker stated DCWs were required to monitor and clean the catheter, and empty the catheter bag, as needed. However, according to Ms. Shoemaker, it appeared DCWs were not providing Resident A's with consistent "catheter care", as required. Ms. Shoemaker stated that while it was true Resident A was resistant to sleeping in his bed, DCWs were told multiple times to not allow Resident A to sleep in his recliner, per his preference, but to have him sleep on his "low air loss mattress" to assist with healing the wound on his buttock area. However, Resident A appeared to always be in observed sitting in his recliner according to Ms. Shoemaker's observations.

According to Ms. Waber, she provided care to Resident A at the facility on 03/08, the day after Ms. Hubartt expressed her concerns that Resident A's personal care and health care needs were not being met. Ms. Waber stated that during her visit she observed as DCWs correctly used a mechanical lift to transfer Resident A from his recliner and into this bed. According to Ms. Waber, she checked Resident A's wound. While it appeared the wound care DCWs provided to Resident A was "good", as evidenced by the wound being cleaned and bandaged correctly, she confirmed Resident A's wound looked "bad." Ms. Waber stated the DCWs she interacted with on 03/08 were very knowledgeable and she had no concerns regarding the care Resident A was receiving during her visit on 03/08.

On 03/22 I attempted to conduct a telephone interview with Ms. Burrell, who according to Ms. White, Ms. Gibson, and Ms. Daily, worked at the facility on 03/07. However, her cellular voicemail system was not set up. Subsequently, I was unable to leave Ms. Burrell a voicemail. Via email, I requested from Ms. White an alternative telephone number for Ms. Burrell. Ms. White informed me Ms. Burrell had been terminated on 03/21 and she had no other way of contacting her.

I conducted a telephone interview with Ms. Kimbrough who confirmed she worked at the facility on 03/07. According to Ms. Kimbrough, she just started working at the facility on 02/14. However, Ms. Kimbrough stated she was a "seasoned" DCW with several years of caregiving experience. Ms. Kimbrough confirmed Resident A required "total assistance" with ADLs. According to Ms. Kimbrough, Resident A required two-three person transfer assistance and/or assistance with transferring via a mechanical lift. Ms. Kimbrough confirmed Resident A's shower/bath days were

scheduled on the facility's second shift. According to Ms. Kimbrough, she worked on the facility's first shift. Subsequently, in the 13 days Resident A resided at the facility, Ms. Kimbrough stated she never personally provided him with assistance with a shower/bath. Ms. Kimbrough stated she assumed that given Resident A's medical and physical condition, he would have required bathing assistance via a "bed bath." According to Ms. Kimbrough, Resident A appeared clean whenever she provided care to him. According to Ms. Kimbrough, every resident who required assistance with adult brief changes were checked and/or changed at least every two hours. Ms. Kimbrough stated that residents' briefs were always checked and/or changed right before the end of first shift and prior to DCWs reporting to work second shift. According to Ms. Kimbrough, near the end of first shift on 03/07 "nurses" from PACE reported to the facility direct care staff members that personal care needed to be provided to Resident A. Ms. Kimbrough stated Resident A's brief had been checked and/or changed approximately two hours prior to the nurse's arrival at the facility. According to Ms. Kimbrough, a nurse informed her Resident A's brief was soiled with feces. Ms. Kimbrough stated she changed Resident A's brief and confirmed Resident A had a bowel movement. Ms. Kimbrough also confirmed the wound on Resident A's bottom was contaminated with stool and there was also stool on Resident A's catheter. Ms. Kimbrough stated there were no sanitary wipes available in Resident A's bedroom. Subsequently, she wet a blue chux pad and used it to provide peri-care to Resident A. Ms. Kimbrough confirmed the wound on Resident A's bottom was "the worst I had ever seen." Ms. Kimbrough stated she did not know DCWs were responsible for providing any type of "wound care" to Resident A and she had not been previously instructed on how to clean and/or cover Resident A's wound. Ms. Kimbrough stated the nurse cleaned Resident A's wound, applied a bandage and then left wound care supplies in Resident A's bedroom for DCWs. Ms. Kimbrough confirmed Resident A was resistant to sleeping in a bed and preferred to sleep in his recliner. According to Ms. Kimbrough, she was also unaware DCWs were to "reposition" Resident A on an ongoing basis.

I conducted separate telephone interviews with DCWs Chaleigh Lewis, Sheena Givhan, Allayiah Bates, and Deja Hayes, who according to documentation provided to me by Ms. White, were employed as DCWs at the facility.

According to Ms. Lewis, she left for vacation on 03/02 and was off of work for approximately 6 days. Subsequently, she provided care to Resident A at the facility on only two-three occasions. Ms. Lewis confirmed Resident A required "total assistance" with ADLs and required two-three person transfer assistance and/or assistance with transferring via a mechanical lift. According to Ms. Lewis, upon Resident A's admission into the facility on 02/24, via the use of a mechanical lift, she transported Resident A into the shower and provided him with bathing assistance. Ms. Lewis confirmed every resident who required assistance with adult brief changes were checked and/or changed at least every two hours. According to Ms. Lewis, while she changed Resident A's brief a few times, he never had a bowel movement prior to her changing his brief. Ms. Lewis stated she never observed dried feces on Resident A when she changed his brief. Ms. Lewis confirmed Resident A was

resistant to sleeping in a bed and only wanted to be in his recliner. According to Ms. Lewis, Resident A's wife instructed DCWs to permit Resident A to do "whatever he wanted." Therefore, Resident A was allowed to sleep in his recliner. Ms. Lewis stated that upon Resident A's admission into the facility on 02/24, he had a small closed sore on his bottom, and not a wound. Subsequently, medical staff members from PACE did not provide DCWs with instructions for wound care upon his admission. Ms. Lewis stated that on 03/08, upon her return to work following a six day vacation, she learned that the closed sore on Resident A's bottom had progressed to an open wound. According to Ms. Lewis, on 03/08 she approached nurses from PACE who were at the facility providing care to Resident A, as "they really weren't communicating" (regarding instructions for wound care). Ms. Lewis stated a nurse informed her she just changed the bandage on Resident A's wound and left wound care supplies in his bedroom. According to Ms. Lewis, the nurse informed her that should the bandage become soiled or wet, DCWs were to change the bandage and let PACE know. Ms. Lewis stated the nurse also instructed her to "reposition" Resident A every two hour. Ms. Lewis stated this was the first she had heard of Resident A requiring ongoing "repositioning."

Both Ms. Givhan and Ms. Bates stated they rarely worked in the facility. Subsequently, they had never provided care to Resident A.

Ms. Hayes stated her primary role/responsibility at the facility was to administer medications to residents. However, she also "jumped in" to assist with direct resident care when needed. Ms. Hayes stated, "I didn't get the chance to work with him (Resident A) much because he (Resident A) wasn't there long and I only work part-time". Ms. Hays confirmed Resident A required "total assistance" with ADLs. Ms. Hayes stated Resident A's adult brief was checked and/or changed every one-two hours. According to Ms. Hayes, she checked Resident A's brief a few times and on these occasions, he was always dry and clean. According to Ms. Hayes, on one occasion she assisted another DCW by "supporting" Resident A while the other DCW changed his soiled brief. Ms. Hayes stated she stood in front of Resident A. Subsequently, she never observed the wound on his bottom. However, according to Ms. Hayes, another DCW trained her on how to apply barrier cream to Resident A's wound if necessary. Ms. Hayes stated it was her understanding Resident A was "repositioned" every two hours.

During my unannounced investigation at the facility on 03/16, I requested and received from Ms. White a copy of Resident A's written *Health Care Appraisal* (HCA) and *Assessment Plan for AFC Residents*. Ms. White stated that required department forms were not completed and/or updated upon Resident A's transfer from the neighboring facility to Park Place Living Centre #B on 02/24. Subsequently, the documents Ms. White provided to me were from Resident A's residency at the neighboring facility. Ms. White also provided me with a document titled, "*Plan of Care*" for Resident A, which was created by PACE.

The written HCA provided for Resident A was dated 01/17 and did not reflect his current medical information/condition. I established the facility utilized a form titled, "*Resident Evaluation*" (assessment plan) to assess Resident A's personal care, supervision, and protection needs. Upon review, I concluded this form contain all the components identified in the departments' *Assessment Plan for AFC Residents* form. Documentation on Resident A's assessment plan confirmed that on 01/19 an assessment was conducted on Resident A when he resided at the neighboring facility. Documentation on Resident A's assessment plan did not reflect Resident A's current personal care, supervision, and protection needs. For example, it did not indicate Resident A required "total assistance" with ADLs, required two-three person transfer assistance and/or assistance with transferring via a mechanical lift, wound and catheter care instructions, instructions for routine "repositioning", and appropriate methods for providing Resident A assistance with toileting, adult brief changes, bathing (in shower/bath or via bed bath), etc. Documentation on Resident A's "*Plan of Care*", created by PACE, indicated this plan was generated on 09/30/2021 and also did not reflect Resident A's current personal care, health care, supervision, and protection needs.

While onsite, Ms. Gibson provided me with a copy of a facility form titled, "*Resident Care Shift Checklist*" from 02/24 to 03/07. According to Ms. Gibson, every day DCWs were to document on this form any showers/bathing assistance given to residents on each shift. However, Ms. Gibson stated DCWs were not always good at consistently documenting on this form.

Documentation on the facility's "*Resident Care Shift Checklist*" from 02/24 to 03/07 indicated that on 02/26, DCW "EB" (assumed to be former DCW Elaisha Burrell) provided Resident A with shower assistance. On 03/05, DCW "H" also provided Resident A with assistance in the shower.

On 04/15, via email, Ms. White informed me the facility provided sanitary wipes to DCWs to perform peri-care on residents during brief changes, and these supplies were not provided to the facility by PACE. According to Ms. White, Ms. Kimbrough was "fairly new". Subsequently, on 03/07 Ms. Kimbrough was unaware that sanitary supplies were kept locked and available upon request.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	It has been established that although Resident A experienced a significant decline, upon his admission into the facility on 02/24, no written assessment plan was completed with Resident A's designated person and responsible agency PACE to determine his current personal care needs and the kinds of services required to meet those needs. According to PACE medical staff

	members Sonia Hubartt, Darla Henry, and Jaimie Shoemaker, instructions regarding Resident A's personal care needs were "verbally" provided to DCWs on several occasions. Based upon information collected during my investigation, I established Resident A could not bear weight, required two-three DCW assistance with transferring and/or assistance with transferring via the use of a mechanical lift, had a catheter that required care, was incontinent of his bowels, had a sore on his bottom that later progressed to an open wound that required care, was not to sit for long periods of time, was to be routinely "repositioned", was to sleep on his "low air loss mattress", and required "total assistance" with his ADLs, including brief changes and assistance with bathing, possibly via way of a "bed bath". Based upon my investigation, there appeared to be some occasions when some DCWs provided adequate personal care to Resident A. However, according to multiple medical staff members from PACE, there were other occasions when Resident A was observed to be "unkept", always in his recliner, sitting in soiled briefs, and on at least one occasion observed to have dried feces on his skin that spread all the way to the edges of his bottom, penis and his catheter. It has been established that not every DCW was aware of Resident A's personal care needs, as evidenced by both DCW Brielle Kimbrough's and DCW Chaleigh Lewis' admission that they were unaware Resident A was to be routinely "repositioned" and was to sleep on his "low air loss mattress". According to Ms. Lewis, upon Resident A's admission into the facility on 02/24, he had a small closed sore on his bottom. In the short amount of time Resident A resided at the facility, his closed sore progressed to a large open wound that required care. It is possible that because Resident A was not "repositioned" on a consistent basis and was left to sit for long periods of time, this contributed in part to the progression of his sore. During my investigation, I was also provided with inconsistent statements regarding what type bathing assistance was most appropriate for Resident A given his current status (assistance in a shower/bath or a bath via "bed bath"). Subsequently, based upon my investigation, there is enough evidence to substantiate the allegation that DCWs did not consistently attend to Resident A's personal care needs as defined in the act.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15310	**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:	It has been established that instructions regarding the care of Resident A's wound and catheter, and specifically who was to provide this care, was not documented in an assessment plan completed by the licensee, along with Resident A's designated person and responsible agency PACE. According to licensed medical staff members Sonia Hubartt, Darla Henry, and Jaimie Shoemaker, who all worked for PACE, verbal instructions regarding Resident A's wound and catheter care needs were provided to DCWs on several occasions. Based upon my investigation, there appeared to be some occasions when some DCWs provided adequate health care to Resident A. However, according to multiple medical staff members from PACE, there were other occasions when the instructions regarding the care of Resident A's wound and catheter were not being followed. It has been established that not every DCW was aware of Resident A's health care needs, as evidenced by DCW Brielle Kimbrough's acknowledgement that she did not know she was to provide any type of wound care to Resident A until Ms. Hubartt instructed her to do so on 03/07. Ms. Kimbrough also confirmed Ms. Hubartt's statement that on 03/07, both Resident A's wound and catheter were contaminated with stool. According to DCW Chaleigh Lewis, she also did not know she was to provide any wound care to Resident A until she reached out to a PACE nurse at the facility on 03/08 for direction. Subsequently, based upon my investigation, there is enough evidence to substantiate the allegation that DCWs did not consistently attend to Resident A's health care needs per the verbal instruction of medical staff members from his responsible agency.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14314	**Resident hygiene**
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	It has been established Resident A was incontinent and required peri-care assistance during brief changes via the use of facility provided sanitary wipes. It has also been established Resident A had a large open wound on his bottom that appeared to be worsening. On 03/07, Resident A had a bowel movement that spread all the way to the edges of his bottom, penis and his catheter, and his wound was contaminated with stool. DCW Brielle Kimbrough admitted to using a wet bed pad called a "chux pad" to provide Resident A with peri-care on his bottom where his wound was located. Chux pads are not the same as sanitary wipes, are not to be used for this purpose, and do not afford the opportunity for adequate personal hygiene.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: During my face-to face interview with Ms. White on 03/16, Ms. White reported that required department forms were not completed and/or updated upon Resident A's transfer from the neighboring facility to Park Place Living Centre #B on 02/24. Subsequently, the written HCA, assessment plan, and written Resident Care Agreement (RCA) on record for Resident A were from his residency at a neighboring facility.

Documentation on copies of Resident A's written HCA, assessment plan, and written RCA confirmed Ms. White's statements. Subsequently, Resident A's written HCA and assessment plan did not reflect Resident A's current personal care and health care needs, including his use of a mechanical lift as an assistive device.

On 04/15, via email, I requested from Ms. White a copy of Resident A's physician's order for the use of a mechanical lift in the facility. On 04/18 Ms. White emailed me a copy of medical documentation from Resident A's last hospitalization at Borgess Ascension hospital from 02/16 to 02/19, which included a physical therapy (PT) evaluation conducted by physical therapist Alyssa Perry on 02/17. Documentation on the PT evaluation indicated that when assessed for physical therapy while in the hospital, Resident A was able to transfer with the assistance of a mechanical lift called a "sit-to-stand". Upon reviewing all 18 pages of medical documentation, I established the paperwork did not include a physician's order for the use of a mechanical lift in the facility.

According to Special Investigation Report #2020A0578029, dated 05/11/2020, the facility was in violation of AFC administrative licensing rule 400.15301(10) when it was established that a resident's most recent written HCA was not completed on an annual basis, as required. According to the facility's CAP, dated 05/27/2020, Resident Care Managers were assigned to audit residents' records and update them as needed, to ensure compliance. The facility's CAP indicated the former associate administrator would discuss documentation "due dates" with Ms. White during weekly meetings. All residents' written HCAs would be completed at the time of admission and annually.

According to a renewal Licensing Study Report (LSR), date 04/08/2021, on 04/08/2021 the facility was again in violation of AFC administrative licensing rule 400.15301(10) when it was established that out of 13 resident records reviewed, four resident records had outdated written HCAs, indicating they were not completed on an annual basis, as required. According to the facility's CAP, dated 04/22/2021, Ms. White, who had recently began managing the facility, would ensure all written HCAs were completed and kept current. Documentation on the facility's CAP indicated Ms. Gibson would contact the four residents' designated representatives and primary care physicians and request updated written HCAs. Ms. Gibson was provided with a spreadsheet with current dates of written HCAs. Ms. White also maintained a copy of this spreadsheet to ensure ongoing compliance. According to the facility's CAP, copies of residents' admissions paperwork, including written HCAs, would be kept and updated, as applicable, in the business binder and audited quarterly by the facility's office manager. The facility's CAP indicated written HCAs would be completed at the time of residents' admission, annually, and as needed for changes.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.** **(b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.** **(c) The resident appears to be compatible with other residents and members of the household.** **(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care**

	agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following: **(a) An agreement to provide care, supervision, and protection, and to assure transportation services to the resident as indicated in the resident's written assessment plan and health care appraisal.** **(b) A description of services to be provided and the fee for the service.** **(c) A description of additional costs in addition to the basic fee that is charged.** **(d) A description of the transportation services that are provided for the basic fee that is charged and the transportation services that are provided at an extra cost.** **(e) An agreement by the resident or the resident's designated representative or responsible agency to provide necessary intake information to the licensee, including health-related information at the time of admission.** **(f) An agreement by the resident or the resident's designated representative to provide a current health care appraisal as required by subrule (10) of this rule.** **(g) An agreement by the resident to follow the house rules that are provided to him or her.** **(h) An agreement by the licensee to respect and safeguard the resident's rights and to provide a written copy of these rights to the resident.** **(i) An agreement between the licensee and the resident or the resident's designated representative to follow the home's discharge policy and procedures.** **(j) A statement of the home's refund policy. The home's refund policy shall meet the requirements of R 400.15315.** **(k) A description of how a resident's funds and valuables will be handled and how the incidental needs of the resident will be met.** **(l) A statement by the licensee that the home is licensed by the department to provide foster care to adults.** **(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the**

	appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	It has been established that upon Resident A's admission into the facility on 02/24, no written assessment plan or written RCA were completed for Resident A. It has also been established that upon Resident A's admission, the licensee did not collect a written HCA indicating Resident A's most current medical information/condition.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE SIR#2020A578029, DATED 05/11/2020, AND CAP, DATED 05/27/2020. SEE LSR, DATED 04/08/2021, AND CAP, DATED 04/22/2021]**

APPLICABLE RULE	
R 400.15306	**Use of assistive devices.**
	(2) An assistive device shall be specified in a resident's written assessment plan and agreed upon by the resident or the resident's designated representative and the licensee. **(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:	It has been established Resident A's use of a mechanical lift as an assistive device was not specified in an assessment plan and subsequently agreed upon by Resident A and/or his designated representative. It has also been established the facility did not obtain a written physician's order authorizing Resident A's use of a mechanical lift as an assistive device while in the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 04/22 and 04/25 I left a voicemail for licensee designee Connie Clauson regarding an exit conference. On 04/26, via email, I provided Ms. Clauson with a copy of this report.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

04/18/2022

Michele Streeter — Date
Licensing Consultant

Approved By:

04/20/2022

Dawn N. Timm — Date
Area Manager