GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 23, 2022

Trina Jewett
Culver Meadows Senior Living, Inc.
5840 Culver Rd.
Traverse City, MI 49684

RE: License #: AL280303758
Investigation #: 2022A0870023
Culver Meadows Senior Living

Dear Ms. Jewett:

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 (231) 922-5309.

Sincerely,

Bruce A. Messer, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 342-4939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL280303758
Investigation #:	2022A0870023
Complaint Receipt Date:	03/31/2022
Investigation Initiation Date:	03/31/2022
Report Due Date:	05/30/2022
Licensee Name:	Culver Meadows Senior Living, Inc.
Licensee Address:	1661 N. West Silver Lake Traverse City, MI 49684
Licensee Telephone #:	(231) 943-9430
Administrator:	Trina Jewett
Licensee Designee:	Trina Jewett
Name of Facility:	Culver Meadows Senior Living
Facility Address:	1661 N. West Silver Lake Traverse City, MI 49684
Facility Telephone #:	(231) 943-9430
Original Issuance Date:	01/27/2010
License Status:	REGULAR
Effective Date:	06/30/2020
Expiration Date:	06/29/2022
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A may have been sexually abused by Resident B.	No
Additional Findings	Yes

III. METHODOLOGY

03/31/2022	Special Investigation Intake 2022A0870023
03/31/2022	APS Referral This referral came from the Michigan Department of Health and Human Services, Adult Protective Services.
03/31/2022	Special Investigation Initiated - Telephone Telephone case discussion with Grand Traverse County DHHS Adult Protective Services worker Kieran Goodman.
04/01/2022	Inspection Completed On-site Interview with facility staff and residents.
04/04/2022	Inspection Completed On-site Meeting with Licensee Designee Trina Jewett and obtained resident records and staff work schedules.
04/05/2022	Inspection Completed On-site Interviews conducted with staff members and visiting Nurse Practitioner Rebecca Wiggins.
04/11/2022	Contact - Telephone call made Email with APS worker Goodman.
04/22/2022	Contact - Telephone call made Email with APS worker Goodman.
04/27/2022	Contact - Telephone call made Email with APS worker Goodman.
05/04/2022	Contact - Telephone call received Email from APS worker Goodman.
05/16/2022	Contact - Telephone call received Email from APS worker Goodman.

05/20/2022	Inspection Completed-BCAL Sub. Compliance
05/20/2022	Exit Conference Exit Conference completed with Licensee Designee Trina Jewett.

ALLEGATION: Resident A may have been sexually abused by Resident B.

INVESTIGATION: On March 31, 2022, I spoke with Grand Traverse County Department of Health and Human Services, Adult Protective Services worker Kieran Goodman. Mr. Goodman stated he has been assigned to investigate the above allegation. We discussed coordinating our investigations and communicating with law enforcement. He noted he had faxed the allegations to the Grand Traverse County Sheriff's Office and requested a SANE (Sexual Assault Nurse Examiner) exam be conducted. Mr. Goodman informed me later this same day that Michigan State Police trooper Andrea Tillman has been assigned to investigate this allegation and that Resident A's son will be taking Resident A to Munson Hospital Traverse City later this day for the SANE exam. We coordinated an on-site investigation to be conducted at the Culver Meadows Senior Living AFC home for the following day.

On April 1, 2022, Mr. Goodman and I conducted an on-site special investigation at the Culver Meadows Senior Living AFC home. We met with home manager Jamie Dobrowolski. Ms. Dobrowolski stated that facility staff noticed significant bruising along Resident A's pubic area on March 26, 2022. She suggested that this injury may have happened on March 25th or 26th. Ms. Dobrowolski stated that staff member Michelle Corby mentioned to Nurse Practitioner Rebecca Wiggins "I think (Resident B) did something to her." Ms. Dobrowolski stated that Resident B has a history of making inappropriate sexual comments and behaviors towards facility staff. Ms. Dobrowolski stated that she, along with Ms. Wiggins, interviewed Resident A that day, March 26, 2022, questioning her about her bruising. She stated Resident A told her that she had fallen and pointed to an area in the living room. Ms. Dobrowolski stated Resident A stated, "I fell right down" and did not indicate that she had any pain. She also noted that Resident A, when asked if she was afraid of anyone in the facility, stated she "is not afraid of anyone." Resident A also stated, when asked, that no one has touched her inappropriately.

On April 1, 2022, I observed Resident A in the hallway near her bedroom in the south wing of the facility. Resident A appears to have impaired mental acuity due to dementia. I did not conduct an interview with her due to these circumstances.

On April 1, 2022, I observed Resident B in his bedroom, which is in the North wing of the facility. Resident B was asleep at the time and an interview was not conducted.

On April 1, 2022, I asked Ms. Dobrowolski for copies the *Assessment Plan for AFC Residents (BCAL-3265)* for all the facility's residents. Additionally, I requested staff

work schedules, Resident A's health appraisal and the facility resident register. I informed her that I would pick these items up on the following Monday, April 4, 2022.

On April 4, 2022, I conducted an on-site investigation at the facility. I met with Ms. Dobrowolski and Licensee Designee Trina Jewett. I discussed the allegations and status of the investigation with Ms. Jewett, informing her that Mr. Goodman and I, along with Trooper Tillman would return the following day to conduct further interviews. I was provided with the requested documents from my April 1, 2022, on-site.

On April 4, 2022, I reviewed Resident A's *Assessment Plan for AFC Residents (BCAL-3265)*. This assessment states that Resident A is not alert to surroundings and describes that she is "disoriented to time, place, and situations." It further describes under the heading of exhibits self-injurious behavior "not purposeful, history of falls, poor safety awareness due to severe cognitive impairment."

On April 4, 2022, I reviewed Resident A's *Health Care Appraisal (BCAL-3947).* This appraisal, dated June 23, 2021, notes Resident A has "dementia" that she "is forgetful" and she "uses walker."

On April 4, 2022, I reviewed Resident B's *Assessment Plan for AFC Residents (BCAL-3265)*. This assessment notes under the category "controls sexual behavior" that "yes" he does control his sexual behavior. It further notes that Resident A controls his aggressive behavior and that he has no history of physical aggression.

An interview by this Consultant was not conducted with Resident B due to the ongoing law enforcement investigation.

On April 5, 2022, I conducted an on-site investigation at the facility. I was accompanied by Adult Protective Services worker Kieran Goodman and Michigan State Police Trooper Andrea Tillman. We spoke with Ms. Dobrowolski who clarified for us that staff member Rachel Wilcox noted the bruising on Resident A. Ms. Wilcox then alerted staff member Ashley Kolarik, who then informed Nurse Practitioner Rebecca Wiggins, who was present in the facility at the time. Ms. Wiggins then conducted an exam of Resident A. Ms. Dobrowolski noted that "days later" staff member Michelle Corby made the comment to Ms. Wiggins that she thinks Resident B did something to Resident A.

On April 5, 2022, I conducted an interview with staff member Rachel Wilcox. Ms. Wilcox stated she observed a three-inch streak of dried blood in Resident A's brief when she was changing Resident A "last week." She stated she did not ask Resident A about the blood and noted that Resident A "is not very verbal." Ms. Wilcox stated Resident A's behavior was "normal." She stated she informed Ms. Wiggins about the blood and Ms. Wiggins went to check on Resident A. Ms. Wilcox stated she has observed Resident A wander into other resident bedrooms, but she

has never seen her go into Resident B's room, nor has she observed Resident B go into Resident A's room.

On April 5, 2022, I conducted an interview with staff member Michelle Corby. Ms. Corby stated she was working when Ms. Wilcox found blood in Resident A's brief. She noted she was not in the room, nor did she observe the blood. Ms. Corby stated she was told by another staff, Ashley, that Ms. Wiggins found "extreme trauma" to Resident A and "there was no way it was from a fall." Ms. Corby stated that Resident B is "inappropriate" and has made comments that he wanted to get Resident A and other female residents in his room. Ms. Corby stated she has never observed Resident A in Resident B's room, nor has she observed Resident B go into Resident A's room. She further stated she is unaware of Resident B doing anything physically inappropriate with a resident, "just with the staff." Ms. Corby stated that staff do conduct room checks every 20 minutes throughout the nighttime hours.

On April 5, 2022, I conducted an interview with Nurse Practitioner Rebecca Wiggins. Ms. Wiggins informed me that she conducted an exam of Resident A on March 29, 2022. She stated her exam showed Resident A has a "blunt trauma' to her buttocks, a yeast infection, and scratching of her labia. Ms. Wiggins stated the blood found in her depends, and abrasion to her labia, could have been caused by Resident A scratching herself due to itching caused by the yeast infection. She noted she did not find any tearing of Resident A's labia or rectum. She noted the bruising, caused by an unknown blunt force trauma, appeared to be from a "fall onto something hard." Ms. Wiggins noted that Resident A is not able to give reliable answers to questions asked of her, due to her dementia.

On April 11, April 22, April 27, May 4 and May 16, I communicated with APS worker Kieran Goodman. Mr. Goodman stated he spoke with Trooper Tillman regarding the status of the SANE exam. He stated he was told that the "kit is still pending testing."

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 stated she had fallen in the living room. She denied being in any pain, denied being afraid of anyone in the home and denied that anyone had touched her inappropriately. Facility staff state they have never seen Resident B go into Resident A's room, nor Resident A go into Resident B's room.

	Nurse Practitioner Rebecca Wiggins, who examined Resident A, found blunt trauma which appeared to have been caused by a fall onto something hard, an abrasion to Resident A's labia, which could have been caused by scratching due to a yeast infection. No tearing of the labia or rectum was found. There is no evidence to support the allegation that Resident A may have been sexually abused. Resident A is being treated with dignity and her personal needs, including protection and safety, are being attended to at all times in accordance with the provisions of the act.
CONCLUSION:	VIOLATION NOT ESTABLISHED

Note: This report may be amended if the results of the SANE exam provide information that would change the analysis or conclusion of this investigation.

ADDITIONAL FINDINGS:

During the course of this special investigation, it was noted that the *Assessment Plan for AFC Residents (BCAL-3265)*, for Resident A, had not been completed at the time of her admission into the facility. Documentation provided by the facility note that this assessment was completed on April 4, 2022 and signed by facility manager Jamie Dobrowolski. Ms. Dobrowolski noted that Resident A had been admitted into the facility on June 22, 2021. There was no indication that this assessment had been completed with Resident A or Resident A's designated representative as this form lacked those signatures.

The *Assessment Plan for AFC Residents (BCAL-3265)* for Resident C states it had last been completed on October 8, 2020.

The *Assessment Plan for AFC Residents (BCAL-3265)* for Resident E states it had last been completed on January 31, 2021.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall

	maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	The Licensee failed to complete a written assessment plan, at the time of admission, with Resident A or her designated representative. The Licensee failed to complete a written assessment on an annual basis with Residents C and E.
CONCLUSION:	**VIOLATION ESTABLISHED**

On May 20, 2022, I conducted an exit conference with Licensee Designee Trina Jewett. I explained my findings as noted above. Ms. Jewett stated she understood, and that she would develop and submit a corrective action plan to address the cited finding. She had no further questions pertaining to this special investigation.

IV. RECOMMENDATION

I recommend, contingent upon the submission of an acceptable corrective action plan, the status of the license remain unchanged.

May 23, 2022

Bruce A. Messer Date
Licensing Consultant

Approved By:

May 23, 2022

Jerry Hendrick Date
Area Manager