GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 13, 2022

Joseph Bacall
Michigan House Senior Living
18533 Quarry Road
Riverview, MI 48193

RE: License #: AH820389597
Investigation #: 2022A1027054
Michigan House Senior Living

Dear Mr. Bacall:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed the authorized representative and dated.

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. 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) 241-1970.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820389597
Investigation #:	2022A1027054
Complaint Receipt Date:	05/02/2022
Investigation Initiation Date:	05/05/2022
Report Due Date:	07/01/2022
Licensee Name:	Michigan House Senior Living LLC
Licensee Address:	12525 Hale Street Riverview, MI 48193
Licensee Telephone #:	(248) 538-0585
Administrator:	Gabriela Birkner
Authorized Representative:	Joseph Bacall
Name of Facility:	Michigan House Senior Living
Facility Address:	18533 Quarry Road Riverview, MI 48193
Facility Telephone #:	(734) 283-6000
Original Issuance Date:	10/25/2019
License Status:	REGULAR
Effective Date:	04/25/2021
Expiration Date:	04/24/2022
Capacity:	42
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A lacked care.	No
Additional Findings	Yes

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.

III. METHODOLOGY

05/02/2022	Special Investigation Intake 2022A1027054
05/05/2022	Special Investigation Initiated - On Site
05/05/2022	Contact - Document Received Telephone interview conducted with Resident A's hospice nurse.
05/06/2022	Contact - Document Sent Email sent to administrator Gabriela Birkner requesting additional information
05/11/2022	Contact - Document Received Email received from Ms. Birkner with requested documentation/information
05/13/2022	Inspection Completed-BCAL Sub. Compliance
06/08/2022	Exit Conference Conducted by telephone with authorized representative Joseph Bacall and administrator Gabriela Birkner

ALLEGATION:

Resident A lacked care.

INVESTIGATION:

On 5/2/2022, the department received a complaint forwarded from the attorney general's office which read Resident A admitted to the facility on 11/1/2021 and expired on hospice services on 3/9/2022. The complaint read Resident A lacked care. The compliant read Resident A was not turned every two hours and she developed pressure sores on her sacrum, heels, toes, and left ear. The complaint read Resident A had facial grimacing, arms were flexed, and legs were bent. The complaint read Resident A was not offered fluids. The complaint read Resident A did not have medical supplies specifically sheepskin or cushions for her feet.

On 5/5/2022, I conducted an on-site inspection at the facility. I interviewed Employee #1 who stated Resident A admitted to the memory care unit on hospice services. Employee #1 stated Resident A initially was ambulatory with assistance and had a small pressure sore in which hospice and their staff healed. Employee #1 stated Resident A started to decline in which her appetite decreased resulting in a lack of nutrients. Employee #1 stated Resident A needed assistance to the dining room, however once she declined, staff provided food as well as fluids in her room as well as mouth swabs. Employee #1 stated Resident A eventually was mostly bed bound and developed pressure sores in the last weeks of her life from a lack of nutrients. Employee #1 stated staff turned Resident A every two hours however she was very painful in the last days of her life, so there would be times staff would allow her to rest for longer periods of time if she was comfortable. Employee #1 stated Resident A's hospice nurse provided the wound dressings and educated the staff on care of the wounds which was completed as ordered. Additionally, Employee #1 stated all durable medical equipment was ordered through the hospice agency.

While on-site, I interviewed Employee #2 whose statements were consistent with Employee #1. Employee #2 stated Resident A was deaf but able to communicate most often by using a dry erase board. Employee #2 stated staff provided care according to her service plan and observed other staff providing care accordingly.

While on-site, I interviewed Employee #3 who statements were consistent with Employee #1 and #2. Employee #3 stated Resident A had declined and staff would attempt to get her in a wheelchair, however she would complain of pain so staff would assist her back to bed. Employee #3 stated Resident A was prescribed pain medications to keep her comfortable.

On 5/5/2022, I conducted a telephone interview with Resident A's hospice nurse. The nurse stated Resident A was able to communicate her needs and had a natural disease progression decline. The nurse stated Resident A had a stage II pressure sore upon admission to the facility which healed shortly after admission. The nurse stated in the last few weeks of Resident A's life, her skin began to breakdown causing pressure sores from decreased intake. The nurse stated the first day she discovered Resident A had developed wounds, she utilized the dressing supplies brought for Resident A's roommate until she could deliver more from her agency's stock the next day. The nurse stated she did not have those additional supplies with her and did not provide them until a resident needed them. The nurse stated the

pressure sore on Resident A's buttock area became "unstageable" and she developed other pressures sores on her feet. The nurse stated she would complete Resident A's wound care at her visits unless it was completed by staff in which they completed the wound care as ordered. The nurse stated the facility staff were accustomed to providing wound care with their residents and had done a "fabulous job" healing wounds in coordination with her orders. The nurse stated in Resident A's last days of life she educated staff and family not to force water intake and utilize saturated mouth swabs because dehydration was "normal and good for endorphins and to decrease pain." The nurse stated Resident A's wounds were not able to be healed at the later stages of her disease progression thus medications were utilized for pain, as well as changing positions and elevating areas of her body such as her heels. The nurse stated Resident A's needs were met with the durable medical equipment she ordered, and her agency did not use sheepskin for resident's feet, so it was not ordered.

I reviewed Resident A's initial assessment of care needs dated 10/13/2021 which read consistent with staff and the hospice nurse's interviews. The assessment read Resident A was independent with eating, but "does not eat much."

I reviewed Resident A's service plan which read consistent with staff and the hospice nurse's interviews.

I reviewed Resident A's medication administration records (MAR) for February and March 2022. The MARs read Resident A received Morphine and Tramadol as needed for pain.

I reviewed the hospice physician medication orders which were consistent with Resident A's MARs.

I reviewed Resident A's comprehensive skin assessments conducted from 11/2/2021 through 3/3/2022 which read consistent with staff and the hospice nurse's interviews. Assessment dated 11/12/2021 read Resident A had a healing bed sore. Assessments in February 2022 read Resident A had developed a bed sore.

I reviewed Resident A's hospice chart notes and physician orders dated 10/30/2021 through 3/8/2022. The charts notes read consistent with statements from the hospice nurse. Hospice note dated 11/9/2021 stated "she will drink water. Please push fluids." Hospice note dated 1/11/2022 read "5 lb gain since December." Hospice note dated 2/10/2022 read "2 lb weight loss in the past month." Hospice note dated 3/1/2022 read "Eyes open but not focusing. Not verbally responding and leaning to the right. Did eat lunch 1:1 feed and drank ensure." Hospice note dated 3/3/2022 read "per staff ate a few bits of muffin yesterday and applesauce – sips of water. No oral intake today." Physician order dated 3/4/2022 read "wound care to coccyx, cleanse daily, apply medihoney and cover with foam dressing. Turn on sides q (every) 4 hours. Change dressing daily." Hospice note dated 3/8/2022 read "Wound dressing changed, wound 90% necrotic/black tissue, no drainage. Morphine

given prior. Wound to coccyx. Left hip unstageable, foam dressing applied. Heel boots on bilaterally to unstageable wounds. Left ear black/red, barrier cream applied. Dtr (daughter) instructed on oral care with mouth swabs. Starting to hear faint terminal congestion. Please give hycosimine if gets worse, dtr aware."

I reviewed intake records for November and December 2021, as well as January through March 2022 in which staff documented fluids such as water, apple juice and coffee were offered and provided to Resident A.

I reviewed Resident A's weight which read on 10/30/2021 -118 lbs (pounds), 12/14/2021 - 118.5 lbs, 1/21/2022 – 121.5 lbs, 2/10/2022 – 119.5 lbs, and 2/25/2022 – 116.5 lbs.

I reviewed the medical equipment pickup invoice dated 3/9/2022 which read Resident A had a full electric bed, gel mattress overlay, concave mattress, over bed table, two fall pads, shower chair, 18-inch wheelchair with footplates, gel cushion for the wheelchair, and a pressure pad alarm.

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 admitted to the facility on hospice services. Facility documentation as well as staff and hospice nurse attestations revealed Resident A had declined and her wounds had developed in February 2022. Wound care and equipment were provided as prescribed by the hospice licensed health care professional. Additionally, review of MARs revealed facility staff administered pain medications as prescribed by the hospice licensed health care professional. Intake and weight records revealed Resident A had received fluids throughout her stay at the facility and gained weight in December and January. Thus, there was insufficient evidence to support Resident A lacked care.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of Resident A's MARs revealed the following medication was not initialed as given Aspirin on 2/13/2022, 2/19/2022 and 2/25/2022. Additionally, the MAR read the following medications were not initialed as given on 2/19/2022 and 2/25/2022 HM Stool Softner, Levothyroxine, Metoprolol Succinate, Omeprazole, and Sertraline.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	Facility staff failed to mark any reason for the missed doses and the MARs were left blank, therefore it cannot be confirmed why the medication administration was not completed as scheduled. Thus, the facility did not comply with rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/8/2022, I shared the findings of this report with authorized representative Joseph Bacall and administrator Gabriela Birkner. Mr. Bacall verbalized understanding of the findings.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action, I recommend the status of the license remain unchanged.

Jessica Rogers 5/13/2022

Jessica Rogers Date
Licensing Staff

Approved By:

Andrea L. Moore 06/07/2022

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