GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 12, 2022

Kent VanderLoon
McBride Quality Care Services, Inc.
P.O. Box 387
Mt. Pleasant, MI 48804-0387

RE: License #: AS590012177
Investigation #: 2022A0783033
McBride Corlisa Jade Home

Dear Mr. VanderLoon:

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,

Leslie Herrguth, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 256-2181

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS590012177
Investigation #:	2022A0783033
Complaint Receipt Date:	03/15/2022
Investigation Initiation Date:	03/15/2022
Report Due Date:	05/14/2022
Licensee Name:	McBride Quality Care Services, Inc.
Licensee Address:	3070 Jen's Way Mt. Pleasant, MI 48858
Licensee Telephone #:	(989) 772-1261
Administrator:	Cathie Griffis
Licensee Designee:	Kent VanderLoon
Name of Facility:	McBride Corlisa Jade Home
Facility Address:	610 S Fifth Street Edmore, MI 48829
Facility Telephone #:	(989) 427-3244
Original Issuance Date:	09/27/1991
License Status:	REGULAR
Effective Date:	04/08/2022
Expiration Date:	04/07/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was left on a urine – soaked mattress for prolonged periods of time which resulted in skin breakdown on his arm.	Yes
Resident A did not receive assistance with a shower daily which is contrary to his written Person Centered Plan (PCP).	Yes

III. METHODOLOGY

03/15/2022	Special Investigation Intake – 2022A0783033
03/15/2022	Special Investigation Initiated – Telephone call with Complainant
03/18/2022	Contact - Face to Face (Zoom) interviews with direct care staff members Ann Foster, Richard Allen, Mike Mocma, and Judy McDonald
04/12/2022	Inspection Completed On-site
04/12/2022	Contact - Face to Face interview with direct care staff member and facility home manager Cassandra Peterson
04/12/2022	Contact - Document Received – Resident A's resident record
04/12/2022	Contact - Document Received – Employee schedule for March 2022
04/12/2022	Contact - Document Received – *Coach and Counsel* forms for direct care staff members
05/09/2022	Contact - Telephone call made to direct care staff members Jodi Grassel and Bridget Miller
05/10/2022	Contact - Telephone call made to Relative A1
05/11/2022	Exit Conference with Cathie Griffis
05/12/2022	APS Referral

ALLEGATION:

Resident A was left on a urine – soaked mattress for prolonged periods of time which resulted in skin breakdown on his arm.

INVESTIGATION:

On March 15, 2022, I received a complaint via centralized intake that stated Relative A1 contacted the office of recipient rights (ORR) to report skin breakdown on Resident A's arm. The complaint stated Relative A1 said the skin on Resident A's arm was peeling off and red on March 13, 2022. The written complaint stated Complainant made an unannounced visit to Resident A at the facility on March 14, 2022, and noted skin breakdown on Resident A's arm and that his mattress was soaked in urine. The written complaint stated there was a second urine-soaked mattress in the garage. The complaint stated the ORR representative instructed staff members at the facility to remove all urine-soaked items and obtain new ones.

On March 15, 2022, I spoke to Complainant who said she made an unannounced visit to Resident A at the facility on March 14, 2022, and when she walked into Resident A's bedroom the smell of urine was so strong even through a surgical mask that her eyes were watering. Complainant said she asked the staff member working at the facility if Resident A's mattress was wet and the staff member touched Resident A's mattress and it was "soaked." Complainant said she instructed the facility staff members to remove the mattress from Resident A's bedroom and they did. Complainant said she examined the mattress and observed that "it was saturated in urine; three to four inches thick." Complainant said she observed that Resident A had significant skin breakdown on his arm between his wrist and elbow likely caused by being left on a urine – soaked mattress for prolonged periods of time.

On May 10, 2022, I spoke to Relative A1 who said on March 13, 2022, she noted that the skin was "melted off" Resident A's arm between his wrist and his elbow. Relative A1 described the mark as "disturbing," and said it was approximately eight inches in length and "several layers of skin were missing." Relative A1 stated she had taken Resident A away from the facility for a visit when she noticed the skin breakdown so she called the facility and spoke to two different staff members who could not provide an explanation for the skin breakdown. Relative A1 said she has not been allowed to enter the facility since March 2020 due to COVID – 19 protocols. Relative A1 stated the last time she was in the facility more than two years ago she noted that Resident A's mattress was "soaked in urine." Relative A1 said there was no waterproof cover on the mattress and Resident A is a "heavy wetter." Relative A1 stated she immediately purchased a new mattress and waterproof mattress cover and had it delivered to the home for Resident A.

On March 18, 2022, I spoke to direct care staff member Ann Foster who said Resident A was described by a nurse as “a soaker,” and stated Resident A wears three adult incontinence briefs at one time due to his heavy wetting. Ms. Foster said every staff member is responsible for cleaning Resident A’s bed and mattress after he gets up for the day. Ms. Foster acknowledged that Resident A’s mattress was “soaked in urine” when she observed it on Friday March 11, 2022, and that the mattress was switched and thrown out. Ms. Foster said staff members regularly cleaned and sanitized the mattress protector but never unzipped it to inspect the mattress. Ms. Foster stated the mattress protector must not have been “waterproof,” because Resident A’s mattress was saturated in urine. Ms. Foster said that was not the first time she observed Resident A’s mattress “soaked” with urine and that the mattress had been “switched out” several times due to being saturated with urine. Ms. Foster said Resident A had skin breakdown on his arm between his wrist and elbow, but she was not certain what caused the skin breakdown. Ms. Foster said during her shift Resident A is “washed up,” and his adult incontinence briefs are changed at least every two hours.

On March 18, 2022, I spoke to direct care staff member Richard Allen who said Resident A spends a significant amount of time in his bed and stated Resident A wears multiple adult incontinence briefs to manage his urine output. Mr. Allen said he does not change Resident A’s brief as changing briefs is not in his job description. Mr. Allen said while working if he noted that Resident A was wet from urine, he would inform another staff member immediately who would change Resident A promptly. Mr. Allen denied that he ever saw Resident A’s mattress soaked with urine. Mr. Allen stated he noted skin breakdown on Resident A’s arm between his wrist and elbow and surmised that the skin breakdown was due to “being in the same position too long.” Mr. Allen said when staff members changed Resident A’s brief, they did not rotate him or change his position.

On March 18, 2022, I spoke to direct care staff member Mike Mocma who said Resident A spends most of his time in his bed and if he is not in bed he is in his wheelchair. Mr. Mocma said Resident A wears adult incontinence briefs which staff members are required to check and change at least every two hours. Mr. Mocma said when he worked Resident A’s brief was changed every two hours and that Resident A was “washed with soap and water” at each brief change. Mr. Mocma said Resident A’s skin is “generally red” from lying in bed most of the time but that it looked “irritated” on his arm where he lays on the arm on or about March 13, 2022. Mr. Mocma said when he observed the skin irritation he applied “lotion,” which he did not document. Mr. Mocma said he observed Resident A’s mattress was soaked with urine and staff members were simply “wiping down” the mattress protector and urine seeped through the mattress protector onto the mattress.

On March 18, 2022, I spoke to direct care staff member Judy McDonald who said all staff members except for Richard Allen are responsible for changing Resident A’s adult brief at least every two hours which has been consistently done. Ms. McDonald said she has seen Resident A’s mattress soaked in urine before and that the

mattress is typically replaced when the urine smell “gets bad,” but the mattress had a plastic mattress protector on it, so she did not observe that it was soaked in urine in March 2022. Ms. McDonald said she did observe skin breakdown on Resident A’s arm between his wrist and elbow, but she did not know what caused the injury and she did not report the injury to anyone nor document the injury because she believed another staff member already reported it.

On May 9, 2022, I spoke to direct care staff member Bridget Miller who stated all staff members change Resident A’s brief and wash him with soap and water at least every two hours. Ms. Miller stated she never observed Resident A’s mattress soaked in urine and never noted that the mattress smelled like urine. Ms. Miller said Resident A’s mattress had a plastic protective cover to prevent it from getting wet. Ms. Miller said she assisted Resident A with a shower on March 13, 2022, and noticed a “rash” near Resident A’s elbow and also on his “side.” Ms. Miller said she applied “lotion” to the side of Resident A’s torso and on his elbow. Ms. Miller said it was “frequent” for Resident A to get a “rash” on his elbow area “because of the way [Resident A] positions himself.”

On May 9, 2022, I spoke to direct care staff member and facility assistant manager Jodi Grassel who stated every staff member is responsible for changing Resident A’s adult incontinence brief every two hours which has been done based on her observations. Ms. Grassell said she was aware that Resident A’s mattress was “wet” on March 14, 2022, but that Resident A was not in the bed while it was wet. Ms. Grassel denied that she ever previously saw Resident A’s mattress soaked in urine. Ms. Grassel said she never saw any skin breakdown on Resident A’s arm until a representative from ORR pointed it out to her on March 14, 2022. Ms. Grassel said she did not know how the injury occurred and she asked other staff members and “nobody was sure” how the injury was sustained.

On April 12, 2022, I interviewed direct care staff member and facility manager Casandra Peterson who said she did not work from March 3 – March 8, 2022. Ms. Peterson said after she returned to work a representative from ORR showed her a photograph of the skin tear on Resident A’s arm between his wrist and elbow. Ms. Peterson said “the skin was peeling off [Resident A’s] arm” according to what she saw in the photograph. Ms. Peterson said Resident A never had a “skin break” like that in the past even though he does spend a lot of time in bed on his stomach propped up on his elbows. Ms. Peterson said if Resident A’s forearm area gets red in color staff members are to apply “barrier cream” to prevent skin breakdown. Ms. Peterson said after talking with staff members who did not know where the cream was located, it was obvious that staff members had not been applying the cream to Resident A’s arm. Ms. Peterson said no staff member could provide an explanation for Resident A’s arm injury. Ms. Peterson said Resident A is a “heavy wetter,” and wears three briefs at once according to his written PCP and Resident A’s urine still soaks through and gets on the mattress. Ms. Peterson remarked that Resident A's brief is to be changed by a staff member every two hours and it was her “assumption” that staff members were not changing Resident A’s brief every two

hours since his mattress was “soaked.” Ms. Peterson said she and the other staff members did not realize that the mattress protector on Resident A’s mattress was not waterproof and that urine was getting onto the mattress.

APPLICABLE RULE	
R 400.14305	**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:	Based on statements from Complainant, Relative A1, Ms. Foster, Mr. Allen, Mr. Mocma, Ms. McDonald, Ms. Miller, and Ms. Grassel, I determined that Resident A had significant skin breakdown on his arm between his wrist and elbow and no staff member could provide an explanation for the condition of Resident A’s arm on March 14, 2022. Statements from nearly everyone interviewed during the investigation revealed that Resident A prefers to spend most of his time in bed where the mattress was saturated in urine. One can determine that lying on a wet mattress likely caused the skin breakdown on Resident A’s arm which was not addressed at all by most staff members.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A did not receive assistance with a shower daily which is contrary to his written Person Centered Plan (PCP).

INVESTIGATION:

On March 15, 2022, I received a complaint via centralized intake that stated according to the daily care log at the facility, Resident A went six days without a shower which is in violation of his plan of service. The written complaint stated Relative A1 reported that Resident A smelled of strong urine when she visited him at the facility on multiple occasions in March 2022, which is not normal for Resident A.

On March 15, 2022, I spoke to Complainant who said she completed an unannounced investigation at the facility because Relative A1 reported that Resident A smelled strongly of urine on multiple occasions. Complainant said she looked at Resident A’s “shower chart,” and noted that there was no shower documented for

Resident A from March 3, 2022 – March 8, 2022, which is contrary to his plan of service which states Resident A is to receive assistance with a shower daily.

On April 12, 2022, I reviewed Resident A's written *Assessment Plan for AFC Residents* dated November 30, 2021, which stated Resident A requires assistance with bathing. The written assessment plan stated, "Staff will help 100% on personal care using shower chair."

On April 12, 2022, I reviewed Resident A's written *Person Centered Plan* (PCP) dated October 18, 2021. The written PCP stated, "[Resident A] will receive physical assistance in the shower daily."

On April 12, 2022, I reviewed a written chart in Resident A's resident record entitled *Daily Care* for the month of March 2022. According to the written chart Resident A was not offered a shower on March 1, 2022, March 3, 2022, March 5, 2022, March 7, 2022, March 8, 2022, and March 10, 2022.

On April 12, 2022, I received a copy of the written employee schedule and noted that direct care staff members Ann Foster, Richard Allen, Mike Mocma, Bridget Miller, Jodi Grassel, and Judy McDonald worked during the day when Resident A was scheduled to receive assistance with a shower from March 1, 2022 – March 10, 2022.

On April 12, 2022, I received written documentation entitled *Coach and Counsel* for direct care staff members Bridget Miller, Judy McDonald, Michael Mocma, and Jodi Grassel. According to facility manager Cassandra Peterson staff member Richard Allen's employment was terminated. The *Coach and Counsel* forms documented that Resident A was not offered a shower for six days.

On May 10, 2022, I spoke to Relative A1 who said she picks up A from the facility and takes him on outings every Sunday. Relative A1 said on Sunday March 6, 2022, Resident A "smelled like old urine," and appeared as if he had not had a shower in several days. Relative A1 said on Sunday March 13, 2022, Resident A smelled strongly of "old urine" again and she noted that his hair was not brushed and he had not been shaved. Relative A1 said according to Resident A's written PCP he is to get a shower daily and Resident A loves taking showers.

On March 18, 2022, I spoke to direct care staff member Ann Foster who said she worked several days from 7: 00 am – 3:00 pm from March 3, 2022 – March 8, 2022, when Resident A was not offered a daily shower. Ms. Foster said she is familiar with Resident A's written assessment plan and PCP and that she was under the impression Resident A was to be offered a shower every other day. Ms. Foster said Resident A was typically offered a shower during the afternoon shift, so she was not typically responsible for assisting Resident A with a shower. Ms. Foster said she did not assist Resident A with a daily shower from March 3, 2022 – March 8, 2022, because she believed Resident A was to be offered a shower every other day and

because Resident A's shower was not typically done during her shift. Ms. Foster denied that Resident A ever appeared dirty nor that he smelled of urine.

On May 9, 2022, I spoke to direct care staff member and assistant home manager Jodi Grassel who said she normally works the day shift from 7:00 am to 3:00 pm and that Resident A was offered a shower during the afternoon shift from March 3 – March 8, 2022. Ms. Grassel said she looked at the written documentation concerning Resident A's showers and noted that "no shower was documented" from March 3 – March 8, 2022. Ms. Grassel said other residents at the facility had documented behaviors which prevented staff members from offering a shower to Resident A. Ms. Grassel said she did not notice that Resident A went six days without being offered a shower until it was pointed out by a representative from the office of recipient rights (ORR). Ms. Grassel said Resident A had a least one shower in that time frame that was not documented. Ms. Grassel denied that she ever saw Resident A appear dirty or odiferous.

On March 18, 2022, I spoke to direct care staff member Richard Allen who said he normally works the afternoon shift starting at 3:00 pm which is when Resident A was typically offered a shower. Mr. Allen said Resident A's PCP indicated Resident A was to be assisted with a shower daily. Mr. Allen stated between March 3, 2022, and March 8, 2022, he worked several shifts and that he assisted Resident A with a shower on at least one occasion that was not documented. Mr. Allen denied that Resident A was not offered a shower for six consecutive days but acknowledged that Resident A was not offered a shower daily due to the behaviors of other residents admitted to the facility. Mr. Allen stated on the days Resident A was not offered a shower he was "washed up in bed." Mr. Allen stated he did not assist Resident A with a shower very often, and that it was not part of his job description to assist residents with showers. Mr. Allen stated his job description entailed cooking, cleaning, and managing resident behaviors. Mr. Allen said he would only assist Resident A with a shower if another staff member asked him to. Mr. Allen denied that he ever observed that Resident A was dirty or smelled of urine.

On March 18, 2022, I spoke to direct care staff member Mike Mocma who stated he normally works the afternoon shift from 3:00 pm to 11:00 pm with another staff member which is the time of day Resident A is typically offered a shower. Mr. Mocma said according to Resident A's written PCP he is to be offered a shower daily which did not occur from March 3, 2022 – March 8, 2022, due to there not being any hot water at the facility because other residents bathe multiple times daily. Mr. Mocma said when he works, he is typically the person who assists Resident A with a shower and the facility manager advised that Mr. Mocma should not be the only person offering to assist Resident A with a shower. Me. Mocma said he "tries" to offer Resident A a shower "when [he] can," but stated other staff members need to assist Resident A as well. Mr. Mocma said if there was no hot water and Resident A could not shower, he was given a "bed bath." Mr. Mocma denied that Resident A ever appeared dirty or smelled of urine.

On March 18, 2022, I spoke to direct care staff member Judy McDonald who said she normally works the afternoon shift from 3:00 pm to 11:00 pm which is when Resident A was typically offered a shower. Ms. McDonald said according to Resident A's PCP he was to be offered a shower daily which was not done between March 3, 2022, and March 8, 2022. Ms. McDonald said she did not offer Resident A a shower during her shift on those days because she does not feel she should be the only staff member to assist Resident A with a shower and other staff members need to assist him as well. Ms. McDonald stated she did not assist Resident A with a shower "because [she] was trying to get someone else [another staff member] to step up and do it." Ms. McDonald said she was aware that no other staff member assisted Resident A with a shower from March 3, 2022, through March 8, 2022, and that she did not report this to anyone. Ms. McDonald said she "washed up" Resident A in his bed on the days he was not offered a shower.

On May 9, 2022, I spoke to direct care staff member Bridget Miller who said she normally works the afternoon shift from 3:00 pm until 11:00 pm which was usually the time during which Resident A was offered assistance with a shower. Ms. Miller stated she thought Resident A was to get two showers weekly and was not familiar that his written PCP stated he should be assisted with a shower daily. Ms. Miller said Resident A was not offered a shower daily for several days in March 2022 which she did not report or act upon in any way because she did not know Resident A was supposed to be offered assistance with a shower daily.

On April 12, 2022, I interviewed direct care staff member and facility manager Cassandra Peterson who stated she was on vacation from March 3 – March 21, 2022, and that she did not work those days. Ms. Peterson said staff were notified in a staff meeting approximately six months ago that Resident A is to be offered a shower daily according to his written PCP. Ms. Peterson said Resident A was to be offered a shower during the afternoon shift and she spoke to all the staff members responsible for assisting Resident A in the shower that week and that all the staff members received a formal written disciplinary action in their employee files. Ms. Peterson said Ms. McDonald and Mr. Mocma essentially told her that they did not assist Resident A with a shower because "nobody else did" and the two were "trying to prove a point." Ms. Peterson said Mr. Allen told her that assisting Resident A with a shower was not his responsibility, and Ms. Miller and Ms. Grassel could not or did not offer her an explanation for why they did not assist Resident A with his shower from March 3 – March 8, 2022.

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:	Based on the written documentation at the facility and an interview with Relative A1, Resident A prefers to receive assistance with a shower daily which was written in Resident A's PCP on October 18, 2021. Statements from Complainant, Relative A1, Ms. McDonald, Ms. Miller, Ms. Grassel, and Mr. Allen along with written documentation at the facility indicated that Resident A was not helped with a daily shower for various reasons including, to prove a point because only a few staff members assisted Resident A, staff members were not aware that Resident A was to be assisted with a shower daily, and/or it was "someone else's responsibility." The investigation concluded that Resident A was not offered the opportunity for daily bathing.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Leslie Herrguth 5/11/2022

Leslie Herrguth Date
Licensing Consultant

Approved By:

Dawn Timm 05/12/2022

Dawn N. Timm Date
Area Manager