GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 14, 2022

MCAP Grand Rapids Opco, LLC
P.O. Box 2604
Charlottesville, VA 22902

| | |
|---|---|
| RE: License #: | AL410404572 |
| Investigation #: | 2022A0356031 |
| | Commonwealth at Grand Rapids Peace Harbor |

Dear Ms. Byrne:

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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI  49503
(616) 901-0585

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AL410404572 |
| | |
| **Investigation #:** | 2022A0356031 |
| | |
| **Complaint Receipt Date:** | 07/20/2022 |
| | |
| **Investigation Initiation Date:** | 07/21/2022 |
| | |
| **Report Due Date:** | 09/18/2022 |
| | |
| **Licensee Name:** | MCAP Grand Rapids Opco, LLC |
| | |
| **Licensee Address:** | P.O. Box 2604<br>Charlottesville, VA 22902 |
| | |
| **Licensee Telephone #:** | (248) 773-4600 |
| | |
| **Administrator:** | Ellen Byrne |
| | |
| **Licensee Designee:** | Ellen Byrne |
| | |
| **Name of Facility:** | Commonwealth at Grand Rapids Peace Harbor |
| | |
| **Facility Address:** | 1171 68th Street S.E.<br>Grand Rapids, MI 49508 |
| | |
| **Facility Telephone #:** | (616) 281-8054 |
| | |
| **Original Issuance Date:** | 11/02/2020 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 05/02/2021 |
| | |
| **Expiration Date:** | 05/01/2023 |
| | |
| **Capacity:** | 20 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>ALZHEIMERS, AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Medical care was not sought immediately when Resident A began to have severe diarrhea at the facility. | Yes |
| Additional Findings | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 07/20/2022 | Special Investigation Intake<br>2022A0356031 |
| 07/21/2022 | Special Investigation Initiated - Telephone<br>Relative #1, requested urgent care documents. |
| 07/21/2022 | Contact - Telephone call received<br>licensing consultant, Rebecca Piccard. |
| 07/21/2022 | APS Referral |
| 07/25/2022 | Contact - Telephone call made<br>Marcia Curtiss, Licensee Designee. |
| 07/26/2022 | Contact - Telephone call made<br>Ericka Zoerhof, facility nurse and Chelsea Slawson, administrator. |
| 07/26/2022 | Contact - Document Received<br>Resident documents. |
| 08/24/2022 | Inspection Completed On-site |
| 08/24/2022 | Contact - Face to Face<br>Jeannine Hayes, regional nurse and Chelsea Slawson, administrator. |
| 08/24/2022 | Contact - Document Received<br>Reviewed facility documents. |
| 08/30/2022 | Contact - Document Sent<br>text sent to Relative #1 requesting Urgent Care paperwork. |
| 09/01/2022 | Contact - Telephone call made<br>Called Relative #1 and asked her to send Urgent Care documents to me, as of 09/13/2022 I have not received the documents. |

| | |
|---|---|
| 09/14/2022 | Exit Conference-Ellen Byrne, Licensee Designee. |

**ALLEGATION: Medical care was not sought immediately when Resident A began to have severe diarrhea at the facility.**

**INVESTIGATION:** On 07/20/2022, I received a complaint through the Attorney General Hotline dated 07/07/2022. The complainant reported that Resident A contracted Clostridium difficile (C-Diff) at the facility and had diarrhea for the first two weeks at the facility and the facility was not equipped to diagnose, train or recognize the symptoms of the disease. The complainant reported C-diff was diagnosed when Resident A went to the hospital after Resident A was dehydrated for two weeks in the facility.

On 07/21/2022, I interviewed Relative #1 via telephone. Relative #1 stated Resident A was admitted to the facility on 05/27/2022 and left on 06/27/2022 when staff at the facility called EMS (emergency medical services) and they transported Resident A to St. Mary's hospital, where he was admitted and did not return to the facility. Relative #1 stated Resident A was diagnosed at the hospital on 06/27/2022 with C-diff, he remained in the hospital until 07/14/2022 when he was transferred to a hospice home. Relative #1 stated Resident A was fine the first two weeks he was in the facility, then approximately the week of 06/13/2022, Resident A began to have "terrible", progressively worsening diarrhea. Relative #1 stated a male direct care worker at the facility (name unknown) called her and asked if Resident A "pooped a lot" and if that was common for him to go so much, that is how bad the diarrhea became according to Relative #1. Relative #1 stated she took Resident A to Urgent Care on 06/22/2022 because of severe diarrhea, they checked his vitals and gave Relative #1 a stool sample kit for staff at the facility to take a sample from Resident A. Relative #1 stated staff at the facility completed the stool sample kit and she returned the kit to Urgent Care. Relative #1 stated Urgent Care did not diagnose Resident A with C-diff from the sample kit yet he was still experiencing severe diarrhea. Relative #1 stated Resident A should have seen the facility doctor and asked Kevin Hagler, (staff) at the facility why they did not have Resident A see the facility doctor when he began having issues with diarrhea. Relative #1 stated Mr. Hagler told her he would have needed consent. Relative #1 stated no one called her or Relative #2 or asked Resident A about seeing the facility doctor. Relative #1 stated they would have consented to have Resident A see the facility doctor if they had been asked.

On 07/25/2022, I interviewed Marcia Curtiss, Licensee Designee via telephone. Ms. Curtiss stated no one knows where Resident A contracted C-diff. Other residents at the facility did not exhibit signs or symptoms of the disease but Resident A went to urgent care when he began to have diarrhea and they did not diagnose C-diff and Resident A returned to the facility.

On 07/26/2022, I interviewed Ericka Zoerhof, facility nurse via telephone. Ms. Zoerhof stated Relative #1 did not want to use the facility Nurse Practitioner, Elizabeth Taylor but rather, they wanted to go through the VA (Veteran's Administration). Ms. Zoerhof stated Chelsea Slawson, administrator, attempted four times to reach the VA and left four voicemail messages to set-up medical services for Resident A with no return contact from the VA. Ms. Zoerhof stated Relative #1 took Resident A to urgent care on 06/22/2022 to address Resident's diarrhea, gave staff the kit to complete a stool sample, which was completed and Relative #1 reported everything came back "clear" and negative. Ms. Zoerhof stated Relative #1 did not provide any paperwork from urgent care. Relative #1 took Resident A to Prime Care urgent care and the diagnosis came from information provided by Relative #1, not from documents received from Prime Care. Ms. Zoerhof stated they completed the stool kit as requested by Relative #1 and believed the information given to them from Relative #1 to be true and accurate. Ms. Zoerhof stated staff at the facility are aware of C-diff and no other residents or staff were experiencing diarrhea during the time Resident A was at the facility.

On 07/26/2022, I received and reviewed the IR (Incident Report) dated 06/28/2022, written by Chelsea Slawson that documented, *'(Resident A) was observed very weak and severe confusion due to severe diarrhea. No action indicated, other-called AMR to transport to St. Mary's.'*

07/26/2022, I received and reviewed Resident A's assessment plan for AFC residents dated 05/28/2022. The assessment plan documents that Resident A is capable of toileting with no staff assistance. The assessment plan does not indicate that Resident A needed assistance with toileting due to diarrhea upon admission to the facility.

On 07/26/2022, I received and reviewed Resident A's health care appraisal (HCA) dated 05/26/2022 and signed by Donald McMillan, DO. The information attached to the HCA documents Resident A's evaluation at Holland Hospital on 05/21/2022, signed by Margaret Young, NP and Ryan Langley, DO and documents Resident A was seen for, *'Cellulitis of the left arm and possible tear of the scapholunate ligament.'* The report documents, *'patient denies abdominal pain, nausea, vomiting, diarrhea. Blood cultures were drawn, and (Resident A) received a gram of IV Rocephin.'* The report assessment/plan documents Resident A also received an *'initial empiric IV vancomycin.' Both Rocephin and Vancomycin are antibiotics. *Note: According to https://www.cdc.gov/cdiff/index.html 'most cases of* C. diff *infection occur while you're taking antibiotics or not long after you've finished taking antibiotics.'*

On 07/26/2022, I received and reviewed the facility progress notes dated 06/13/2022-06/27/2022. The progress notes are as follows:

- 06/13/2022, 1:17p.m., documented by Chelsea Slawson, 'Called VA for order for Imodium and a stool sample, (Resident A) has uncontrollable diarrhea.'

- 06/14/2022, 1:19p.m., documented by Chelsea Slawson, ‘no call back from VA, left another message.’
- 06/15/2022, 1:19p.m., documented by Chelsea Slawson, ‘no call back from VA, called again and left another message.’
- 06/22/2022, 1:22p.m., documented by Chelsea Slawson, ‘(Relative #1) took (Resident A) to urgent care, collected stool sample. (Relative #1) notified that all tests came back negative, attempted to call VA again, left another message.’
- 06/27/2022, 12:47p.m., documented by DCW (direct care worker) Arlene Kemp, ‘(Resident A) was observed very weak and severe confusion due to severe diarrhea.’

On 08/24/2022, I interviewed Chelsea Slawson, administrator at the facility. Jeannine Hayes, regional nurse was present during this interview. Ms. Slawson stated when Resident A was admitted to the facility on 05/27/2022, no issues with diarrhea were noted. Ms. Slawson stated after the first two weeks, Resident A began to have loose stools throughout the day and on 06/22/2022 Relative #1 took Resident A to urgent care when the diarrhea worsened. Resident A provided staff with a stool kit from urgent care, staff completed the kit with Resident A and Relative #1 took the sample back to urgent care. Ms. Slawson stated Relative #1 reported to Ms. Slawson that “everything came back negative.” Ms. Slawson stated she does not know what kinds of tests they ran from the stool sample, Relative #1 did not provide them with any documentation from urgent care, and they had no reason to question the information Relative #1 relayed to them regarding Resident A’s urgent care visit. Ms. Slawson stated Resident A became weaker and was lethargic on 06/27/2022, staff called 9-1-1 and sent him to the hospital immediately.

Ms. Slawson and Ms. Hayes stated Resident A came to this facility on 05/27/2022 from the hospital and stated that possibly Resident A got C-diff while in the hospital before being placed in this facility, however, Resident A’s diarrhea did not begin until a couple of weeks after admission. Ms. Slawson described Resident A as having loose stools throughout the day once the diarrhea started two weeks after admission and while Resident A was physically able to toilet himself, staff assisted him each time to make sure he was properly cleaned. Ms. Slawson stated no one on his wing at this facility contracted C-diff. Resident A used a communal bathroom often in the facility and no one else had any signs or symptoms of C-diff. Ms. Slawson stated staff at the facility are aware of the signs and symptoms of C-diff.

Ms. Slawson stated Relative #1 chose not to sign-on with the facility doctor as they wanted to stick with the VA for Resident A’s medical care. Ms. Slawson stated they did not have the facility doctor see Resident A for the continued diarrhea because Relative #1 wanted Resident A to be seen by the VA. Ms. Slawson stated Mr. Hager provided Ms. Slawson with the paperwork at admission to sign-up for the facility doctor and Relative #1 did not sign the paperwork. Ms. Slawson stated she tried several times to reach VA during the four weeks Resident A was at this facility to set up medical visits for Resident A through the VA. Ms. Slawson stated the VA did not

respond and then Resident A was sent out to the hospital on 06/27/2022 and did not return to the facility from the hospital so she was never able to set up the VA for Resident A's medical services. Ms. Slawson stated during the week of June 13, 2022, she and Ms. Zoerhof had an informal meeting with Relative #1 at the facility and discussed getting Resident A services through the VA. They discussed Ms. Slawson's frustration with getting in contact with anyone at the VA and during that same meeting discussed Relative #1's frustration also regarding getting services set-up through the VA. Ms. Slawson stated at that time, Relative #1 never mentioned that she would like Resident A to see the facility doctor.

On 07/21/2022, 08/30/2022 and 09/01/2022, I requested that Relative #1 provide documentation from urgent care for review. On 07/21/2022, I requested the medical report while interviewing Relative #1 via telephone. She stated she would email them to me. On 08/30/2022, I texted Relative #1 and requested the documents and on 09/01/2022, I called and spoke to Relative #1. Relative #1 stated she would email the information to me and as of 09/13/2022, I have not received the urgent care documentation.

On 09/14/2022, I conducted an exit conference with (new) Licensee Designee, Ellen Byrne via telephone. Ms. Byrne stated she understood the information, analysis, and conclusion of this applicable rule and will submit an acceptable corrective action plan.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.15310** | **Resident health care.** |
| | (4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately. |
| **ANALYSIS:** | Based on investigative findings, Resident A did not have signs or symptoms of diarrhea or C-diff initially when admitted to this facility. On or about 06/13/2022, Resident A began to experience diarrhea that was explained as "severe", yet Resident A was not seen by a medical professional until 06/22/2022 when Relative #1 took him to the urgent care. There were approximately nine days that Resident A was experiencing a sudden adverse change in physical condition and medical care was not sought immediately. Therefore, a violation of this applicable rule is established. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ADDITIONAL FINDING**

**INVESTIGATION:** On 07/26/2022, I received and reviewed Resident A's assessment plan for AFC residents dated 05/28/2022. The assessment plan was completed by Ms. Slawson on 05/28/2022 but there are no signatures on the document by the Licensee Designee, no signature by Relative #1 or any responsible agency (if applicable) on the assessment plan per the applicable rule.

On 09/13/2022, I interviewed Ms. Slawson and she acknowledged that she does not have a signed assessment plan for Resident A.

On 09/14/2022, I conducted an exit conference with (new) Licensee Designee, Ellen Byrne via telephone. Ms. Byrne stated she understood the information, analysis, and conclusion of this applicable rule and will submit an acceptable corrective action plan. Ms. Byrne stated she is reviewing all required licensing paperwork for the facility and will make sure all necessary documents are signed by the appropriate people.

| **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 licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home. |
| **ANALYSIS:** | Resident A's assessment plan dated 05/28/2022, is not signed by the licensee or Relative #1. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

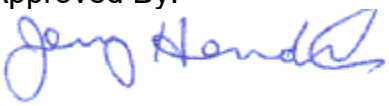
## IV. RECOMMENDATION

| |
|---|
| Upon receipt of an acceptable corrective action plan, I recommend the current status of the license remain unchanged. |

09/14/2022

Elizabeth Elliott Date
Licensing Consultant

Approved By:



09/14/2022

_____

Jerry Hendrick Date
Area Manager