GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 9, 2022

Kimberly Gee
Wood Care X, Inc., d/b/a Caretel Inns of Linden
910 S. Washington Ave.
Royal Oak, MI 48067

RE: License #:	AL250331306
Investigation #:	2022A0872058
	Degas House Inn

Dear Mrs. Gee:

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 and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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) 643-7960.

Sincerely,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL250331306
Investigation #:	2022A0872058
Complaint Receipt Date:	09/22/2022
Investigation Initiation Date:	09/22/2022
Report Due Date:	11/21/2022
Licensee Name:	Wood Care X, Inc., d/b/a Caretel Inns of Linden
Licensee Address:	910 S. Washington Ave. Royal Oak, MI 48067
Licensee Telephone #:	(810) 735-9400
Administrator:	Kimberly Gee
Licensee Designee:	Kimberly Gee
Name of Facility:	Degas House Inn
Facility Address:	202 S Bridge Street Linden, MI 48451
Facility Telephone #:	(810) 735-9400
Original Issuance Date:	05/01/2014
License Status:	REGULAR
Effective Date:	11/03/2020
Expiration Date:	11/02/2022
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Staff failed to provide proper care to Resident A and Resident B.	Yes
Staff made several medication errors with Resident A and Resident B.	Yes

III. METHODOLOGY

09/22/2022	Special Investigation Intake 2022A0872058
09/22/2022	Special Investigation Initiated - On Site
09/23/2022	Contact - Telephone call received I interviewed Relative A1
09/26/2022	APS Referral I made an APS complaint via email
09/26/2022	Contact - Document Sent I sent an email to the licensee designee requesting information about this complaint
09/28/2022	Contact - Document Received I received AFC documentation related to this complaint
10/07/2022	Contact - Telephone call made I interviewed staff Melissa White
10/11/2022	Contact – Telephone call made I interviewed staff Trinidy Tomlin
11/03/2022	Exit Conference I conducted an exit conference with the licensee designee, Kimberly Gee
11/03/2022	Inspection Completed-BCAL Sub. Compliance
11/04/2022	Exit Conference I conducted another exit conference with the licensee designee, Kimberly Gee

ALLEGATION: Staff failed to provide proper care to Resident A and Resident B. Staff made several medication errors with Resident A and Resident B.

INVESTIGATION: On 09/22/22, I conducted an onsite inspection of Degas House Inn and interviewed Resident A. Resident A said that she and Resident B moved into Degas House Inn on 06/17/22. Resident B passed away on 08/26/22. Resident A said that she is concerned about the lack of care that she and Resident B experienced while residents of this facility. Resident A told me that on several occasions, Resident B sat in a wet brief for hours at a time. She said that there were several occasions that she contacted staff for assistance, but staff was too busy to help her and would not assist her for hours. According to Resident A, on one occasion it took over five hours for staff to respond to her call light and during that time, Resident B was sitting in a wet brief. Resident A also told me that staff made several medication errors with her medications and with Resident B's medications.

Resident A provided me with some written concerns made by her family members. I reviewed the documents she provided and noted the following concerns:

- When Residents A and B moved into this facility, family was told that staff would check on them every two hours. Family spent 8-12 hours a day caring for Residents A and B, "cleaning, doing laundry, feeding (Resident B), help(ing) (Resident B) shower and dress" and staff did not check on them every two hours as they were told staff would do.
- As Resident B's condition deteriorated and he could not get up on his own, family had to ask staff to check or change his briefs rather than staff doing it without prompting.
- Resident B was prescribed a medicated patch by his doctor that had to be administered every 24-hours. The patch was supposed to be dated and placed on Resident A's body in rotating areas. Family noted on numerous occasions that staff had not changed and/or not placed Resident B's patch in a different place on his upper body as instructed by his doctor.
- Staff brought the wrong medication to Resident A on several occasions. In addition, she had to wait over an hour for staff to administer her Tylenol.
- On 7/21/22-7/22/22, staff administered too much of the medication Ativan to Resident B.
- Resident B was discharged from Genesys Medical Center on 07/25/22. He was sent back to Degas House Inn with oxygen. Resident B went several days without his oxygen. Family had to ask staff to begin administering the oxygen as ordered by his doctor.
- On 08/16/22, staff was unable to locate the blood sugar monitor to check Resident A's blood sugar at lunch time.
- On 08/20/22, at 4am, Resident A pressed her call button because she felt her blood sugar drop. Staff did not respond until 8am and did not check her blood sugar until 9:30am.

On 09/23/22, I interviewed Relative AB1 via telephone. Relative AB1 confirmed that she and other family members have been concerned about the care that Residents A and B

received while residing at Degas House Inn. Relative AB1 also confirmed that Resident B passed away at the facility on 08/26/22 while under the care of hospice. Relative AB1 told me that because of the family concerns, Resident A will be moving to a new AFC facility on 10/01/22.

According to Relative AB1, there were a lot of medication errors made regarding Residents A and B. On a couple of occasions, staff brought Resident A the wrong medication which Resident A had to point out and refuse. Resident B's doctor prescribed him an Exelon patch for his dementia which was supposed to be changed every 24-hours. On 07/29/22, staff put his Exelon patch on and failed to remove the patch from 07/28/22 so family removed it later that afternoon when they discovered it. Relative AB1 stated that on 07/21/22 and 07/24/22, staff administered too many doses of Ativan to Resident B.

On 09/28/22, I received AFC documentation from the licensee designee related to Residents A and B. According to Resident A's Assessment Plan, she is diagnosed with hypothyroidism, Type 2 diabetes, vitamin D deficiency, anxiety disorder, restless leg syndrome, insomnia, hypertension, constipation, and joint pain. She uses a walker but is independent with bathing, toileting, personal hygiene, and transfers. Her Health Care Appraisal states that she is on a "standard diet, mechanical soft texture, thin consistency."

I reviewed Resident A's medication record for June – September 2022. I noted the following:

- Resident A was prescribed 0.25mg of Xanax 2x's per day beginning on 07/21/22 at 5pm. Staff did not begin administering the medication until 07/22/22 at 5pm.
- On 08/15/22 and 08/19/22 at bedtime, staff failed to initial that she was given her Type 2 diabetes injection.
- On 8/23/22 at 9am, staff failed to initial if she was given her Type 2 diabetes injection and failed to initial that she was administered the following medications: cholecalciferol, levothyroxine sodium, lisinopril, metoprolol tartrate, multivitamin, oscal D-3, primidone, spironolactone, and Xanax.
- On 09/19/22 at bedtime, staff failed to initial that she was administered the medication ropinirole HCL.
- In September 2022, staff failed to initial on numerous dates at both times of day, that Resident A was administered Biofreeze gel topically to her neck. On 08/03/22, Resident A's doctor prescribed this medication to be applied 2x's per day.

According to Resident B's Assessment Plan dated 06/17/22, he was diagnosed with Alzheimer's Disease, hypertension, and hypothyroidism. It was also noted that he has a cardiac pacemaker. Resident B was independent with eating, walking, bathing, personal hygiene, and dressing. He needed limited assistance with toileting, he used briefs, and used a walker and cane for mobility. Resident B had some impaired cognitive abilities and intermittent confusion due to Alzheimer's.

I reviewed Resident B's medication record for June – July 2022 and noted the following:

- On 06/18/22, Resident B was prescribed a 24-hour Exelon patch transdermally that was to be administered every day at 9am and the old one removed at 8:59am.
- On 06/26/22, the staff times for administration and removal of the patch were 9am and 10:23am. On 06/28/22, the staff times were 8:59am and 10:15am. On 06/30/22, the staff times were 8:59am and 12:28pm. All other staff initials fell within 55 minutes of the 9am order.
- On 07/16/22, staff failed to initial that they passed Rosuvastatin Calcium at bedtime.
- In July, on 10 occasions the staff times for administration and removal of Resident B's Exelon patch fell outside of the one-hour perimeter of the 9am order.

I reviewed the staff progress notes for Resident B from June – July 2022 and noted the following:

- On 07/07/22, Resident B was prescribed 0.5mg of Ativan (Lorazepam) to be administered every 8 hours as needed for agitation. On 07/07/22, staff administered this medication at 4:53pm and 9:28pm. On 07/09/22, staff administered this medication at 3:29am and 7:52am. On 07/11/22, staff administered this medication at 12:07am and 5:15am. On 07/14/22, staff administered this medication at 5:40am and 9:01am On 07/18/22, staff administered this medication at 5:14pm and 08:03pm.
- On 07/14/22, Resident B was prescribed 2.5mg of Zyprexa (Olanzapine) to be administered every 8 hours as needed "for agitation associated with dementia." On 07/18/22, staff administered this medication at 6:18am, 9:18am, 5:14pm, and 8:03pm.
- On 07/17/22, family complained of Resident B having an odor and asked staff to give him a shower. When staff undressed him in the bathroom, staff found that he had "stuffed 3 socks soiled in fecal matter into his brief."
- On 07/18/22, Resident B was prescribed 5mg of Zyprexa (Olanzapine) to be administered every 8 hours as needed for agitation. Staff administered the medication at 5:14pm.

On 10/07/22, I interviewed staff Melissa White via telephone. Ms. White said that she has worked at Symphony Inns for over seven years, and she typically works 1st shift at Degas House Inn. Ms. White said that there have been times when the facility has been short staffed, and Residents A and B may not have been attended to in a timely manner. She said that Residents A and B's family members have expressed concerns about them not receiving proper care. I asked Ms. White if she knew of any medication errors concerning either Resident A or Resident B and she said that she did hear that 3rd shift made some medication errors.

On 10/11/22, I interviewed staff Trinidy Tomlin via telephone. Ms. Tomlin said that she has worked at Symphony Inns since 2019 and she typically works at Degas House Inn. According to Ms. Tomlin, this past summer the Inns were often short staffed which led

to staff not being able to attend to the residents' needs. Some staff would double brief the residents and sometimes residents would have to sit in wet briefs for a while.

On 03/03/22, I completed an SIR #2022A0872019 at this facility and substantiated R 400.303(2) and R 400.312(2). I concluded that staff failed to bathe one of the residents on a regular basis, did not assist her with meals, and she was left in a soiled brief for an extended period of time. I also concluded that staff failed to administer several of a resident's medications on several days in October 2021. The licensee designee, Kimberly Gee submitted a corrective action plan (CAP) dated 03/09/22. Mrs. Gee stated that she would provide education to the assisted living director and staff to prevent these rule violations in the future.

On 11/04/22, I conducted an exit conference with the licensee designee, Kimberly Gee. I discussed the results of my investigation and told her which rule violations I am substantiating. I also told her that I am recommending a provisional license. Mrs. Gee told me that she has implemented the following changes in an attempt to improve services at Degas House Inn:

- Revamped the staff scheduling process for better coverage and clarity
- Increased referral bonus for internal staff to refer quality employees for consideration
- Incorporated regional support for better resources and audits
- Three times a week, management walks through the facility, talking with staff and residents to ensure quality of care
- Preparing to schedule a holiday meal for family, management, and staff to come together and discuss any concerns

Mrs. Gee told me that she will continue to increase monitoring at Degas House Inn and implement changes to improve quality of care.

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:	According to Resident A, on one occasion it took over five hours for staff to respond to her call light and during that time, Resident B was sitting in a wet brief. She said that there were several occasions that she contacted staff for assistance, but staff was too busy to help her and would not assist her for hours. Family spent 8-12 hours a day caring for Residents A and B, "cleaning, doing laundry, feeding (Resident B), help(ing) (Resident B) shower and dress." As Resident B's condition deteriorated and he could not get up on his own, family had to

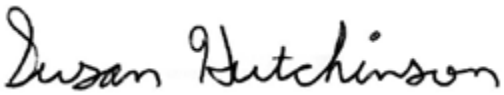
	ask staff to check or change his briefs rather than staff doing it without prompting. On 07/17/22, family complained of Resident B having an odor and asked staff to give him a shower. When staff undressed him in the bathroom, staff found that he had “stuffed 3 socks soiled in fecal matter into his brief.” Staff Melissa White said that there have been times that Residents A and B’s needs were not tended to in a timely manner. She also said that Residents A and B’s family members have expressed concerns about them not receiving proper care. Staff Trinidy Tomlin said that on occasion, staff were not able to attend to resident’s needs. I conclude that there is sufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Ref: SIR #2022A0872019 dated 3/2/19.**

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident A told me that staff made several medication errors with her medications and with Resident B’s medications. According to family, Resident B was prescribed a medicated patch by his doctor that had to be administered every 24-hours. The patch was supposed to be dated and placed on Resident A’s body in rotating areas. Family noted on numerous occasions that staff had not changed and/or not placed Resident B’s patch in a different place on his upper body as instructed by his doctor. I reviewed Resident A’s medication logs and determined that on numerous occasions, in July, August, and September 2022 staff failed to initial her medication log and/or failed to administer her medication.

	I reviewed Resident B's medication logs and staff progress notes and determined that on several occasions, staff failed to administer and/or remove his 24-hour Exelon patch within one hour of the doctor's 9am order. In July 2022, staff failed to follow doctor's orders regarding Resident B's Ativan (Lorazepam) and Zyprexa (Olanzapine) on more than one occasion. I conclude that there is sufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Ref: SIR #2022A0872019 dated 3/2/19.**

IV. RECOMMENDATION

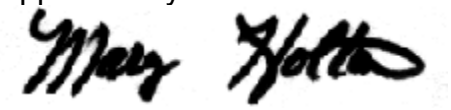
Contingent upon receipt of an acceptable corrective action plan, issuance of a provisional license is recommended.



November 7, 2022

Susan Hutchinson Licensing Consultant	Date

Approved By:



November 7, 2022

Mary E. Holton Area Manager	Date