GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 11, 2023

Roger Covill
North-Oakland Residential Services Inc
P. O. Box 216
Oxford, MI 48371

RE: License #: AS630402011
Investigation #: 2023A0605029
Dunwoodie

Dear Mr. Covill:

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:

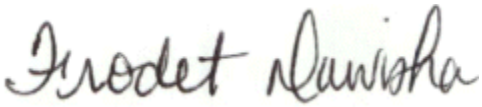
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

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. 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 (248) 975-5053.

Sincerely,



Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
3026 W. Grand Blvd
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630402011
Investigation #:	2023A0605029
Complaint Receipt Date:	05/03/2023
Investigation Initiation Date:	05/03/2023
Report Due Date:	07/02/2023
Licensee Name:	North-Oakland Residential Services Inc
Licensee Address:	106 S. Washington Oxford, MI 48371
Licensee Telephone #:	(248) 969-2392
Administrator/Licensee Designee:	Roger Covill
Name of Facility:	Dunwoodie
Facility Address:	1781 Dunwoodie Ortonville, MI 48462
Facility Telephone #:	(248) 793-3066
Original Issuance Date:	03/27/2020
License Status:	REGULAR
Effective Date:	09/27/2022
Expiration Date:	09/26/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A is currently admitted to Ascension Genesys Hospital due to severe pressure wounds with sepsis. He has multiple wounds down to his bones on his hips and sacrum. He also has black spots on his hands; it cannot be identified what caused this. Resident A's condition can become this severe if he is being left to lay in one spot for too long and not being changed every two hours. Wounds of this magnitude also require a special mattress and it is unknown if Resident A had that at Dunwoodie.	Yes
Resident A appears malnourished and has lost weight.	Yes

III. METHODOLOGY

05/03/2023	Special Investigation Intake 2023A0605029
05/03/2023	Special Investigation Initiated – Letter Email to Oakland County Office of Recipient Rights (ORR) Sarah Rupkus
05/03/2023	APS Referral Referral made to Adult Protective Services (APS)
05/08/2023	Inspection Completed On-site I conducted an unannounced on-site investigation. I interviewed direct care staff (DCS) Shania Robinson and the home manager (HM) Vanessa Jones. I observed Residents B, C, and D. I reviewed documents.
05/16/2023	Contact - Telephone call made I interviewed DCS Mari Morgan and Amelia Walker regarding the allegations. I interviewed Lynn Elling with Harmony Care Hospice regarding Resident B. I interviewed Resident A's legal guardian/sister and brother-in-law. I interviewed the registered nurse (RN) with McLaren Home Health Care (HHC). I left a message with Dr. Cohen's receptionist requesting he return my call. I also left a message for Resident A's supports coordinator Piper Schick with Easterseals.
05/18/2023	Contact - Telephone call received I interviewed Piper Schick regarding the allegations.

05/22/2023	Contact - Telephone call made I interviewed RN Carrie with Dr. Pearl's office regarding Resident A's pressure wounds. I followed up with Resident A's legal guardian/sister. I reviewed McLaren Oakland Hospital and SKLD West Bloomfield discharge papers.
05/24/2023	Contact - Telephone call received Discussed allegations with APS worker Gene Evans
05/31/2023	Contact - Telephone call made Interviewed NORS area supervisor Adrienne Doelle regarding the allegations
06/01/2023	Contact - Document Received Email from the HM
06/12/2023	Contact - Telephone call made Follow-up with DCS Mari Morgan
06/12/2023	Contact - Document Sent Email with HM
06/13/2023	Contact - Telephone call made Followed up with Piper Schick
06/14/2023	Contact - Telephone call made Discussed allegations with Dr. Cohen
06/26/2023	Exit Conference Conducted exit conference via telephone with licensee designee Roger Covill with my findings
07/11/2023	Exit Conference Left message for licensee designee Roger Covill advising him of the provisional recommendation

ALLEGATION:

Resident A is currently admitted to Ascension Genesys Hospital due to severe pressure wounds with sepsis. He has multiple wounds down to his bones on his hips and sacrum. He also has black spots on his hands; it cannot be identified what caused this. Resident A's condition can become this severe if he is being left to lay in one spot for too long and not being changed every two hours. Wounds of this magnitude also require a special mattress and it is unknown if Resident A had that at Dunwoodie.

INVESTIGATION:

On 05/03/2023, intake #194995 was referred by Adult Protective Services (APS) and assigned for investigation on 05/04/2023, regarding Resident A was admitted into Ascension Genesys Hospital due to severe pressure wounds with sepsis. Multiple wounds were down to his bones on his hips and sacrum. Resident A has had four debridement treatments which is a surgical procedure to clean out and change the dressing of the wounds. Resident A's condition can become this severe if he is being left to lay in one spot for too long and not being changed every two hours. There are concerns about Resident A's weight being 90 pounds.

On 05/04/2023, I initiated this special investigation by making a referral to Oakland County Office of Recipient Rights (ORR) worker Sarah Rupkus.

On 05/08/2023, I conducted an unannounced on-site investigation. I interviewed direct care staff (DCS) Shania Robinson and the home manager (HM) Vanessa Jones. I observed Residents B, C, and D. I reviewed documents.

I interviewed DCS Shania Robinson regarding the allegations. Ms. Robinson has been employed with North-Oakland Residential Services (NORS) for about three years. She works day shifts with the HM Vanessa Jones. The HM stepped out to go grocery shopping, but then returned to Dunwoodie when Ms. Robinson called her to inform her that licensing was at the home. Ms. Robinson stated that Resident A has been discharged from the home and that she has information regarding all the other residents and that I should speak with the HM regarding Resident A. I explained to Ms. Robinson that the allegations are regarding Resident A's care when he lived here at Dunwoodie. Ms. Robinson agreed to answer my questions. Ms. Robinson stated when she worked with Resident A, he had a "few sores," one on each side of his hip. She repositioned him every hour and because Resident A had pressure sores on both sides of his hips, so it was difficult keeping him off his sides. Whenever she put him on one side, Resident A would reposition himself on the other side. Resident A would also "pick at his wounds," when staff change the dressing on the wounds. Ms. Robinson stated she would change Resident A's brief when he was soiled and then return to only see he has pulled down his briefs and picked at his wounds. She would check Resident A every two hours and if he needed his briefs change, she would change him. She denied leaving

him soiled for long periods of time. Ms. Robinson and other staff do not document or track when they check or change the residents or document the wounds on residents.

On 05/08/2023, the HM Vanessa Jones returned to Dunwoodie. She stated that I was supposed to inform her within 24 hours of my investigation. I advised her that I was with Adult Foster Care Licensing, not APS. She was interviewed regarding the allegations. Resident A was admitted into Dunwoodie on 11/28/2023. He is non-verbal and requires care from staff. Prior to his admission, he had wounds, but they were not opened. Some staff were repositioning Resident A every one-two hour. Resident A can reposition himself and assist with transferring himself. When he was put in his wheelchair, he would lean forward, making it difficult for him to sit up straight. They were unable to restrain him in the chair, so one staff would hold him up while another staff member fed him. Regarding his wounds, he was receiving wound care from Dr. Pearl. On a monthly basis, she or another staff member was driving him to Dr. Pearl who would care for the wounds and teach her or other staff how to care for the wounds. Dr. Pearl advised the HM that he can no longer see Resident A because “there is nothing more he can do given Resident A's quality of life.” Dr. Pearl prescribed an antibiotic for seven days, but that did not help with the wounds. Harmony Care Home Health Care provided a wound care nurse, Sunshine that was coming out to Dunwoodie weekly but then discharged Resident A after two months. Sunshine’s initial contact was in January 2023 but then discharged Resident A the beginning of February 2023. Again, the HM was advised that there is nothing more Harmony Care can do for Resident A’s wounds, so they signed off. Resident A would reposition himself on his sides where he had wounds on both hips. He would also pick his wounds whenever he could. Dunwoodie was in the process of ordering a mattress to alleviate some of the discomfort, but she believed that would not help because Resident A would just reposition himself and continue to dig his wounds. The HM report whenever she changed Resident A’s brief, she would return to only see he has removed the brief, the bandages on his wounds and blood on the sheets because he has dug into the wounds.

I attempted to interview Resident B who was sitting on a chair next to her bed. Resident B would not respond to any questions asked. She appeared to have good hygiene and no concerns were noted.

I observed Resident D in his bed. He is non-verbal; therefore, he was not interviewed regarding these allegations. He is receiving hospice care services with Harmony Care.

I observed Resident F in his wheelchair. Resident F is also non-verbal; therefore, he was not interviewed. He too appeared to have good hygiene.

Residents C and E were at workshop and not observed or interviewed during this visit.

On 05/16/2023, I contacted via telephone DCS Mari Morgan regarding the allegations. Ms. Morgan has worked for NORS for about one year. She works second shift. Ms. Morgan repositioned Resident A every two hours and then that changed to check every 15 minutes. She cannot recall when it changed to every 15 minutes but reported that

this was changed by the HM. Resident A “moves a lot,” especially when she repositioned him. He had pressure sores on both sides of his hips so whenever she put him on one side, he repositioned himself onto the other side that he was already on. Ms. Morgan would “change his wound bandages as needed.” Ms. Morgan changed Resident A whenever he was soiled. Resident A would dig his wounds when she changed his brief. He would also push everything on the floor. He also takes off his briefs and digs into his wounds. She denied leaving Resident A soiled for long periods of time. She advised that all staff at Dunwoodie did everything they could to care for Resident A. Ms. Morgan does not have any concerns about the staff and the care that staff provide to the residents.

On 05/16/2023, I contacted via telephone DSC Amelia Walker regarding the allegations. Ms. Walker has been with NORS for about one year. She works third shift from 11PM-7AM. Ms. Walker stated, “everything is false. We do the best we can.” Resident A shifts from side to side so when she repositions him on one side, he turns to the other side. Both sides of his hips had pressure wounds. She repositions him every two hours but checks him and all residents every 15 minutes to ensure they are comfortable. One time during her 15-minute check, she noticed Resident A digging into his wounds. Resident A was beginning to do this a lot. Ms. Walker told Dr. Pearl’s office and brought that to his attention and Dr. Pearl stated, “there’s nothing else we can do for him because his wounds won’t heal.” Ms. Walker stated that the wound bandages would be changed when they were soiled so on an “as needed basis or when Resident A had a bowel movement.” Ms. Walker stated there was no care plan for the wounds.

On 05/16/2023, I contacted Harmony Care Hospice regarding Resident D’s care. I spoke with Lynn Elling, the nurse who was providing care at Dunwoodie. Ms. Elling reported that Resident D was receiving “fabulous,” care and that she had no concerns. When Ms. Elling is at Dunwoodie, she observed staff caring for Resident D and stated that staff was “very attentive to all the residents’ needs.” She visits the home two-three times per week. She stated, “I’m very observant to my surroundings so I would report something if I saw it.”

On 05/16/2023, I received an email from ORR worker Sarah Rupkus stating that she will be investigating these allegations.

On 05/17/2023, ORR worker Sarah Rupkus emailed me Resident A’s Easterseals/ MORC individual plan of service (IPOS) and crisis plan. I reviewed both the amended IPOS dated 02/02/2023 and the crisis plan dated 12/08/2022 but went into effect on 11/28/2022 when Resident A was admitted into Dunwoodie. There is no plan of care for Resident A’s wounds in either the IPOS or the Crisis Plan.

On 05/16/2023, I interviewed Resident A’s sister/guardian regarding the allegations via telephone. Resident A was residing at another AFC group home before Dunwoodie. He was admitted at McLaren Oakland on 09/28/2022 and discharged to SKLD in West Bloomfield on 10/07/2022 because the previous AFC home discharged Resident A who required a higher level of care. Resident A was at SKLD from 10/07/2023 until he was

discharged and admitted into Dunwoodie on 11/28/2023. While at SKLD, Resident A only had a right hip stage 3 pressure injury that was closed. Resident A's sister stated that licensee designee Roger Covill assessed Resident A at SKLD prior to admission. Mr. Covill informed Resident A's sister that staff at Dunwoodie can provide for Resident A's needs and assured the sister that Resident A would be cared for properly. Resident A was then admitted into Dunwoodie with only one closed bedsore on his right hip. Resident A is non-verbal, with Downs Syndrome and Dementia. Resident A's sister does not visit regularly, but she is in contact with the HM and staff at Dunwoodie. Resident A was admitted into Dunwoodie as "full assist." He required to be repositioned frequently throughout the day. Resident A's sister stated, "clearly that didn't happen." Resident A's sister advised that on 03/20/2023, Resident A had a seizure and was admitted into McLaren Genesys Hospital. At the hospital, it was discovered that Resident A had nine open pressure wounds. Some were at stage 4 and required debridement treatments. The HM reported to Resident A's sister that Resident A was "picking at the bedsores," but the sister does not believe that "picking at the bedsores," would lead to stage 4 wounds. Resident A's sister stated, "I wish the HM or Roger would have told me before it got to nine bedsores that they can no longer care for Resident A." Resident A's sister stated she was never contacted by the HM or any other staff at Dunwoodie advising her that Resident A had nine bedsores or that the bedsores were down to the bone. Resident A's sister advised that "Roger exuded lots of confidence when admitting Resident A into Dunwoodie and told me he had the care at their home that Resident A required." Resident A's sister reported that Melissa from Dr. Cohen's office called the sister advising her that Sunshine with Harmony Care advised Melissa that the "wounds smelled bad," and that "Resident A needed to go to Urgent Care," because Dr. Cohen could not see Resident A. The HM became "testy with Sunshine and told Sunshine, you don't know what you're talking about, that's gas you smell, not the wounds." Sunshine answered the HM saying, "I do know what I'm talking about and it's not gas." Resident A's sister reached out to Roger Covill who advised the sister "I would take care of it." Resident A's sister stated that Resident A's condition was life-threatening and that he got sepsis because of the nine pressure sores. Resident A is now in a nursing home and all the wounds are healing properly.

On 05/16/2023, I interviewed via telephone Sunshine Ferrero with Harmony Care Home Health Care. Sunshine is no longer employed with Harmony Care. She does not have access to her notes but reported that Resident A would always lay on the effected side where the pressure sore was even when he was told not to. Sunshine advised that staff "new how to do wound care and did it properly." Whenever she arrived at Dunwoodie, the bandages were on and clean. She reported that the first and second time she visited Resident A at Dunwoodie, the wounds were infected, but that staff took Resident A to urgent care and received antibiotics that cleared it up. Resident A would pick at his wounds which she observed as well as observed Resident A repositioning himself. Sunshine reported no concerns with staff.

On 05/18/2023, I received a return call from Easter Seals/Macomb-Oakland Regional Center (MORC) supports coordinator Piper Schick regarding the allegations. Ms. Schick is new to Resident A. She reported that Resident A had wounds prior to being admitted

into Dunwoodie and why that previous home discharged Resident A. Ms. Schick reported that her co-worker Anna has been the only person who has had contact with Resident A. On 01/25/2023, Anna's contact with Resident A was via Zoom. The HM was present with Resident A. The HM reported that Resident A has "MRSA," because of his wounds. The HM also reported that Resident A was slumping over in his wheelchair and not sitting upright. The HM was advised to take Resident A to his wound physician, Dr. Pearl. Anna conducted another Zoom meeting on 02/15/2023 with Resident A and the HM. Ms. Schick reported that the HM advised of similar wound concerns. Ms. Schick stated that Anna then conducted a face-to-face with Resident A on 03/16/2023. According to the notes, Resident A continues to develop more wounds and Anna recommended to the HM to seek medical treatment as the wounds appeared deep. On 03/17/2023, Ms. Schick received an incident report (IR) from Dunwoodie regarding "multiple sores." Resident A was then admitted into McLaren Genesys Hospital on 03/20/2023. Ms. Schick is unclear if Dunwoodie sought immediate care on 03/16/2023 when Anna expressed concerns about the wounds. Ms. Schick is not sure if licensee designee Roger Covill was being informed by the HM or staff of the "severity of the wounds." She reported that Harmony Home Health Care was providing wound care beginning January 2023, but according to the notes, Ms. Schick stated that Sunshine discharged Resident A stating, "I taught the staff how to care for the wounds. There's nothing more I can do." Ms. Schick was working on the script for the mattress but by the time it was approved, Resident A was admitted into the hospital.

On 05/18/2023, ORR Sarah Rupkus emailed incident report (IR) dated 03/15/2023 regarding Resident A. "Resident A have a blister on his left hand. He also breaking out all on his arm and legs and notice that on his groan, he also has a blister on his balls. On the left side of his face, he has a scab and on his left but cheek he has also form into a red pump. Resident A has MRSA." "Clean wounds with Dakin's Solutions." "Staff will continue to monitor change, keep wound clean and all apts."

On 05/22/2023, I contacted Dr. Steven Pearl's office and spoke with registered nurse (RN) Carrie. Carrie advised that Dr. Pearl has only seen Resident A twice. The first time was on 01/23/2023 and the last time was on 02/20/2023. Dunwoodie staff were supposed to bring Resident A back in 4-weeks, but then Resident A was admitted into the hospital. Carrie advised that on 02/20/2023, there was "black tissue in color," and a new wound on the left hip. The HM stated that staff is trying to offload Resident A from the right hip wound. Dr. Pearly had to complete a debridement treatment on the wounds. Carrie advised that infectious disease met with Resident A and felt that "the wound was not healable." Carrie stated that palliative care was discussed as Dr. Pearl agreed with the infectious disease doctor that the "wounds wound not heal." Carrie was unable to state if staff were not caring for the wounds properly.

On 05/22/2023, I followed up with Resident A's sister via telephone. Resident A's sister will email me the hospital discharge papers and Dr. Pearl's notes from the last visit on 02/20/2023. The sister will also email SKLD of West Bloomfield discharge papers that stated that Resident A was discharged with only one open wound on his right hip that was healing.

On 05/22/2023, I reviewed Dr. Pearl's notes dated 01/23/2023 and 02/20/2023 regarding Resident A's visits. According to the notes, Dr. Pearl documented 10 pressure sore wounds on Resident A during his initial visit on 01/23/2023. Dr. Pearl instructed the caregiver who accompanied Resident A to follow the following instructions: "clean wound with Dakin's solution before doing dressing; dressing change twice a day to right hip wound. Patient must be turned every two hours when up in bed. When up in wheelchair, must not have any pressure to hip wound or must not be up longer than for meals." On 02/20/2023, Dr. Pearl's notes stated the following: "Resident A was last seen on 01/23/2023 and now he has a new pressure ulcer to his left hip, as the staff of the group home are trying to offload the right hip." Again, Dr. Pearl's notes continue to reflect 10 pressure sore wounds. Debridement treatment was completed during both visits as the wounds were down to the bones with "black tissue in color."

On 05/24/2023, I received a return call from APS worker Gene Evans. Mr. Evans advised he conducted a face-to-face with Resident A, Resident A's sister/guardian and co-guardian at McLaren Genesys Hospital on 05/03/2023. Resident A is non-verbal; therefore, he was not interviewed. Mr. Evans stated that the sister expressed concerns about Dunwoodie not repositioning Resident A nor caring for his wounds properly. Mr. Evans advised he did not speak with hospital staff regarding Resident A's wounds.

On 05/31/2023, I interviewed NORS area supervisor Adrienne Doelle regarding the allegations. Ms. Doelle stated that there should always be two staff members per shift due to the medical needs of the residents. Ms. Doelle advised that Resident D recently passed away and that Resident F is a two-person assist, but when staff use a Hoyer lift, then Resident F is a one-person assist. Ms. Doelle has never personally met Resident A. She was never informed by the HM or any staff the extend of the wounds on Resident A. Ms. Doelle was contacted by ORR worker Sarah Rupkus regarding pressure wounds. Ms. Doelle initially thought it was regarding Resident E because licensing recently investigated allegations of wounds regarding him. Ms. Doelle was alarmed to hear that another resident at Dunwoodie had open wounds and was concerned about the extent of these wounds on Resident A. Resident A moved into Dunwoodie with only one or two wounds, so having nine open wounds down to the bone is alarming. Ms. Doelle stated that NORS has guidelines regarding "immediate care." She stated that the HM should have immediately taken Resident A to seek medical treatment regarding the wounds since Dunwoodie just had a previous investigation regarding open wounds. Ms. Doelle stated she will be completing an in-service regarding wound care with staff.

On 06/01/2023, the HM Vanessa Jones emailed me Resident A's community living supports logs (CLS) for 02/01/2023 – 03/06/2023. I reviewed the CLS logs and Resident A's wounds were not being changed daily as instructed by Sunshine with Harmony Home Health Care. However, staff did document that occasionally Resident A "picked at his wounds."

On 06/12/2023, I followed up with DCS Mari Morgan via telephone. She reported that Dr. Pearl was the one who advised “as needed,” but she cannot recall for sure. Ms. Morgan advised that when Resident A was discharged from Dunwoodie, he only had two pressure wounds, but then stated, “I’m not sure.”

On 06/12/2023, I followed up with the HM Vanessa Jones via email asking her how many pressure wounds Resident A had prior to his last hospital admission on 03/20/2023. The HM emailed stating, “if I recall correctly, he had one on each hip and one coming on his bottom.”

On 06/13/2023, I followed up with Resident A’s supports coordinator Piper Schick. She went to see Resident A today at Argentine Nursing Home and his wounds are healing properly. She reported that many of the wounds Resident A had while at Dunwoodie Home have closed. Resident A was on intravenous antibiotics so this may have helped with the healing of the wounds.

On 06/14/2023, I made a telephone call with Resident A’s PCP, Dr. Cohen. Dr. Cohen advised when Resident A was discharged from McLaren Oakland Hospital to Dunwoodie, he had a follow-up visit with Resident A. Concerns about Resident A’s wound to his right hip were discussed as it was stage 4. Dr. Cohen ordered wound care nurse to care for the wound to the hip. He does not have any further information regarding the nine wounds Resident A had while at Dunwoodie.

On 06/20/2023, I followed up with Sunshine Ferrero via telephone who advised that when she was providing wound care to Resident A, she only observed the wound to the right hip. She never observed any other wounds on Resident A; however, she did not complete a skin assessment during her visits. Sunshine advised that the staff never reported to her any “new” wounds on Resident A prior to her discharging him on 02/02/2023. Sunshine advised that the plan of care instructions for the hip wound that she advised staff was to “change the dressing daily and as needed if soiled.” She advised that she supervised staff changing the dressings and there were no concerns as she believed staff was following the instructions prior to discharge and would continue to follow the instructions after discharge.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: (a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.

ANALYSIS:	Based on my investigation there was insufficient amount of personal care by staff at Dunwoodie to meet Resident A's medical needs. Resident A was admitted into Dunwoodie the end of November 2022. At that time, he had multiple wounds that were in their healing stages, but only one open wound on his right hip. Resident A received wound care from December 2022 through February 2022 from Harmony Home Health Care. The RN stated she was providing wound care for only the right hip and stated she was never informed by staff that Resident A had more than one open wound and the RN never conducted skin assessments during her visits at Dunwoodie. Dr. Pearl, the wound care physician saw Resident A on 01/23/2023. During this visit, 10 pressure wounds were noted and Resident A received a debridement treatment given the depth of the wounds that were down to the bone. Dr. Pearl instructed the caregiver to change the wound dressings twice weekly, but DCS Mari Morgan stated she was only changing the dressing "as needed," which is collaborated with the CLS logs that I reviewed which indicated that Resident A's wounds were not changed as instructed by the RN or Dr. Pearl; therefore, Resident A's personal care needs were not being met.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: (b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.
ANALYSIS:	Based on my investigation and information gathered, Dunwoodie's staff did not have the skills required to care for Resident A's wounds. Resident A was admitted with only one open wound on 11/28/2022. He was receiving wound care with Sunshine at Harmony Care. Sunshine instructed staff to change the dressing to the wound on the right hip daily and then as needed. Resident A had a total of 10 open wounds on 01/23/2023 when the wound specialist Dr. Pearl examined

	Resident A which resulted in a debridement treatment. Dr. Pearl then instructed staff to change the dressing to twice daily. DCS Maria Morgan stated she changed the dressing as needed only. The staff at Dunwoodie were not meeting the care of Resident A as his dressings were not changed daily when the RN instructed staff when home health care ended on 02/02/2023 and did not follow Dr. Pearl's instructions of twice daily. The staff never expressed to Resident A's guardian or upper management that Resident A required more care than what staff could provide at Dunwoodie. Resident A got sepsis due to his wounds being infected.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 my investigation and information gathered, Resident A's personal care required staff to attend to Resident A's wound care daily from 12/2022-01/2022, but then the instructions were increased to twice daily on 01/23/2023 by Dr. Pearl. According to staff, wound care was provided to Resident A on a "as needed," bases. Therefore, Resident A's personal needs were not attended to at all times in accordance with the provisions of the act.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED SIR 2021A0988012 DATED 02/26/2021; CAP DATED 04/26/2021**

APPLICABLE RULE	
R 400.14310	**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 my investigation and information gathered, staff at Dunwoodie did not seek immediate medical care for Resident A's pressure wounds. On 03/15/2023, an IR was sent to ORR regarding new blisters on Resident A's hands and testicle, but staff did not seek immediate medical care after this sudden adverse change. Also, the supports coordinator Piper Schick stated that on 03/17/2023, it was noted that the supports coordinator assistant, Anna made a face-to-face with Resident A and staff, Anna recommended to staff that Resident A should be taken to urgent care due to the wounds looking infected. Staff did not take Resident A to urgent care. Resident A was admitted into the hospital on 03/28/2023 because he had a seizure. At the hospital, it was discovered that Resident A had sepsis because of his 10 open pressure sores.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATIONS:

Resident A appears malnourished and has lost weight.

INVESTIGATION:

On 05/08/2023, I interviewed Ms. Robinson regarding Resident A's weight loss. She stated Resident A moved in malnourished. They would feed him, and she does not know his weight at admission or how much he weighed at discharge. Ms. Robinson stated she does not know where Resident A's records are kept and that I had to wait for the HM to return to Dunwoodie.

On 05/08/2023, I interviewed the HM regarding Resident A's weight loss. Resident A was admitted into Dunwoodie weighing 95.4 pounds according to the health care appraisal completed on 11/28/2022. Resident A's weight records were not available for my review so the HM will be emailing them to my attention. Resident A was on a pureed diet and was being fed three times per day plus snacks in between. Resident A was losing weight, so they followed up with Resident A's primary care physician (PCP) Dr. Cohen. Dr. Cohen was the PCP who referred Resident A to wound care with Harmony Care.

On 05/16/2023, I interviewed Ms. Walker regarding Resident A's weight loss. Resident A appeared malnourished when he moved into Dunwoodie. He was not a big eater but was being fed pureed food three times a day plus snacks. He was getting fluids too. Ms. Walker stated if I had any further questions to call the HM as the HM can better answer my questions regarding Resident A.

On 05/16/2023, I interviewed Resident A's sister regarding Resident A's weight loss. Resident A stated that Resident A was always on a pureed diet since admission into Dunwoodie. He loves to eat so when the HM told Resident A's sister that Resident A was refusing food, Resident A's sister stated, "that was not credible." Resident A's sister was never told or contacted by the HM or any other staff at Dunwoodie advising her that Resident A was losing weight. According to Resident A's sister, Resident A has gained weight since being admitted into the group home. She believes staff were not feeding Resident A nor were they giving him the Ensure supplements.

On 05/17/2023, I reviewed Resident A's IPOS and Crisis Plan regarding his weight loss. According to the IPOS amended on 02/02/2023, Resident A was prescribed with Simply Thick but Resident A's insurance declined coverage of the supplement. Resident A's weight is being watched as he was 120 pounds before his initial hospitalization and admission to SKLD, but then lost weight and is currently down to 98 pounds. Resident A will work with a home care dietician for weight gain. Resident A should have "weekly weights." After leaving SKLD, Resident A is now fed by staff with a pureed diet and thickened liquids.

On 05/17/2023, I reviewed Resident A's weight records. According to the weight records, Resident A was weighed on 11/10/2022, 11/17/2022 and 11/26/2022 when Resident A was not admitted into Dunwoodie until 11/28/2022. In addition, Resident A was not weighed weekly in January 2023, February 2023, and March 2023. Resident A weighed 95 pounds on 12/04/2022, 93.4 pounds on 12/14/2022, 92 pounds on 12/19/2023, 92 pounds on 12/27/2022, 92.4 pounds on 01/04/2023, 92 pounds on 02/07/2023, and 92 pounds on 03/05/2023.

On 06/12/2023, I received an email from the HM with Resident A's medication logs from January 2023-March 2023 regarding his Ensure supplements. I reviewed the medication logs and Resident A was receiving his Ensure drink twice daily from 01/01/2023-03/20/2023 Simply Thick 6GM/Pump Gel: use 2-3 pumps in beverages until nectar think consistency five times day from 02/01/2023-03/20/2023. The medication logs were not initialed by staff and there were no," times," documented on the medication logs.

On 06/13/2023, I contacted Piper Schick with Easterseals/MORC following up on the IPOS/crisis plan. Ms. Schick stated that Oakland County paid for the prescription of Simply Thick and this should have been given to Resident A and should have been documented on the medication log. Ms. Schick stated she visited with Resident A at Argentine Nursing Home. She was informed that he gained weight after initial admission but has since lost weight due to his medical decline.

On 06/13/2023, the HM responded to my email stating that Resident A was in fact receiving Simply Thick as prescribed.

On 06/14/2023, I contacted Resident A's PCP, Dr. Cohen via telephone. Dr. Cohen's last visit with Resident A was on 01/06/2023 via Telehealth. He stated that the HM Vanessa Jones was present. During this visit, concerns about Resident A were discussed. Dr. Cohen advised that Resident A should be weighed weekly and if there is weight loss, then Dr. Cohen should be contacted. Dr. Cohen reviewed his notes for that day and stated that, "Vanessa said that Resident A was eating well and had a good appetite. He was maintaining his weight." Dr. Cohen advised the HM to follow up with him in three months. Dr. Cohen stated since 01/06/2023, he had not received any telephone calls from the HM or any other staff from Dunwoodie advising him that Resident A had lost weight.

On 06/20/23, I contacted ORR worker Sarah Rupkus who will be substantiating her case.

On 06/26/2023, I conducted the exit conference with licensee designee Roger Covill via telephone with my findings. Mr. Covill completed the assessment for Resident A at the time of admission. He recalls Resident A having multiple wounds but cannot recall how many but advised many were in their healing stages. I advised Mr. Covill of the violations, and he did not have any questions, but indicated he will begin working on a corrective action plan.

On 07/11/2023, left message for licensee designee Roger Covill advising him that the recommendation is to modify the license to a six-month provisional license.

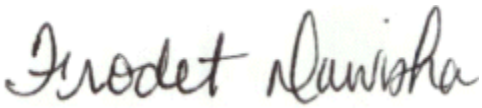
APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on my investigation and information gathered, the staff at Dunwoodie did not provide the personal care as defined in Resident A's IPOS dated 02/02/2023. According to Resident A's IPOS, Resident A is supposed to be weighed weekly. I reviewed Resident A's weight records since admission and Resident A was only weighed monthly from January – March 2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: (d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.
ANALYSIS:	Based on my investigation and information gathered, staff at Dunwoodie did not follow Resident A's health care needs. On 01/06/2023, Resident A's PCP Dr. Cohen instructed staff to weigh Resident A weekly but according to the weight records, Resident A was only weighed monthly from January – March 2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: (b) Complete an individual medication log that contains all of the following information: (iv) Time to be administered. (v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.
ANALYSIS:	Based on my review of Resident A's medication logs I found the following error: • **Simply Thick 6GM/Pump Gel**: use 2-3 pumps in beverages until nectar think consistency five times day from 02/01/2023-03/20/2023. The medication logs were not initialed by staff and there were no, "times" documented on the medication logs.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **LSR DATED 08/31/2020; CAP DATED 09/10/2020**

IV. RECOMMENDATION

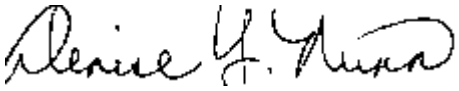
Contingent upon receiving an acceptable corrective action plan, I recommend modification of the license to a six-month provisional license.



07/11/2023

Frodet Dawisha Date
Licensing Consultant

Approved By:



07/11/2023

Denise Y. Nunn Date
Area Manager