GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 14, 2023

June Nadolny
Traditions of Saginaw - Main
3785 North Center Road
Saginaw, MI 48603

RE: License #: AH730413810
Investigation #: 2024A0784014
Traditions of Saginaw - Main

Dear June Nadolny:

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.

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 (517) 284-9730.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH730413810
Investigation #:	2024A0784014
Complaint Receipt Date:	11/12/2023
Investigation Initiation Date:	11/13/2023
Report Due Date:	01/11/2023
Licensee Name:	Sabra Midwest Operations IV, LLC
Licensee Address:	Suite 550 18500 Von Karman Ave Irvine, CA 92612
Licensee Telephone #:	(888) 393-8248
Administrator/Authorized Representative:	June Nadolny, Authorized Repr.
Name of Facility:	Traditions of Saginaw - Main
Facility Address:	3785 North Center Road Saginaw, MI 48603
Facility Telephone #:	(989) 498-4000
Original Issuance Date:	09/11/2023
License Status:	TEMPORARY
Effective Date:	09/11/2023
Expiration Date:	03/10/2024
Capacity:	93
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Inadequate care of Resident A.	Yes
Insufficient laundry provisions for Resident A.	Yes
Resident A's specialty diet was not followed.	Yes
Additional Findings	No

III. METHODOLOGY

11/12/2023	Special Investigation Intake 2024A0784014
11/13/2023	Special Investigation Initiated - Telephone Interview with complainant
11/13/2023	APS Referral
11/14/2023	Inspection Completed On-site
11/14/2023	Exit Conference Conducted with administrator/authorized representative June Nadolny

ALLEGATION:

Inadequate care of Resident A.

INVESTIGATION:

On 11/12/2023, the department received this complaint. A referral was made to adult protective services.

According to the complaint, on 9/21/2023, 10/02/2023 and 10/08/2023, Resident A's oxygen tank was deliberately turned off.

On 11/13/2023, I interviewed Complainant by telephone. Complainant stated that Resident A had an order for oxygen which was changed from an as needed (PRN) order to continuous on 9/19/2023. Complainant stated that on 9/21/2023, Resident A's oxygen tank was observed to be turned off. Complainant stated director of

resident Care Josh Coleman was notified of the issue and asked why the oxygen tank was turned off and he reportedly stated he was not aware that it was turned off or why anyone would turn it off. Complainant stated that on 10/02/2023, Resident A's hospice nurse reported that upon arriving at the facility to provide care to Resident A, her oxygen hose was completely disconnected, rolled up, and neatly placed on the top of the oxygen machine. Complainant stated that when this was addressed with the facility Nurse (N1), N1 stated she had no idea why the hose would have been disconnected. Complainant stated that during a visit on 10/08/2023, between approximately 4:30 and 5pm, Resident A's oxygen was again observed to be turned off. Complainant stated that when Associate 1 was informed of the oxygen tank being off, Associate 1 reported she was not aware and unsure why it would be off.

On 11/14/2023, I interviewed administrator/authorized representative June Nadolny at the facility. Ms. Nadolny stated that on 10/09/2023, Relative A came to her and reported concerns that on 10/08/2023, Resident A's oxygen tank was observed to be turned off during a visit in the evening time. Ms. Nadolny stated Relative A did mention this was not the first there was an issue with the oxygen, but that she was not aware of any previous issues prior to Relative A reporting this to her on 10/09/2023. Ms. Nadolny stated also followed up with Mr. Coleman who confirmed there had been previous concerns noted about Resident A's oxygen being turned off. Ms. Nadolny stated Resident A did have her oxygen order changed from PRN [as needed] to continuous but could not recall the specific date this was done. Ms. Nadolny stated Resident A was a restless person and would sometimes pull her oxygen tube off her nose. Ms. Nadolny stated she could not explain why Resident A's oxygen would be turned off as she did not believe Resident A would have the capability to turn it off herself and that it would be unlikely Resident A would have been capable of pulling her tube and placing it neatly on her oxygen machine.

On 11/14/2023, I interviewed director of resident care Josh Coleman at the facility. Mr. Coleman stated he was made aware of concerns, by a family member, that on or about 9/21/2023 Resident A's oxygen tank was turned off. Mr. Coleman stated he was informed of a second time this happened by N1 who apparently had been notified that Resident A's oxygen tank had again been discovered to be off on or about 10/02/2023. Mr. Coleman stated he did not recall the specific date of the third reported instance, on 10/08/2023 as reported by Complainant, but did recall Relative A had reported the issue to him a couple times. Mr. Coleman stated that he did try to address the issue by speaking with staff and sending out a group text message informing them that Resident A's order had changed from PRN to continuous. Mr. Coleman stated he was unable to determine who or why anyone would turn the oxygen off. Mr. Coleman stated he did not believe Resident A would have been capable of turning the oxygen tank off herself. Mr. Coleman stated he could not recall specifically when Resident A's oxygen order was changed from PRN to continuous, but believed it was sometime in early to mid-September 2023, prior to 9/21/2023.

I reviewed physician's orders for Resident A, provided by Ms. Nadolny. An order dated 9/19/2023 reads, in part, "Oxygen via nasal cannula 2L-4L continuous for low Spo2 related to cardiac".

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	The complaint alleged that on several occasions, Resident A's oxygen tank was turned off deliberately. While intent could not be confirmed, the investigation did reveal that Resident A's oxygen was reported to be turned off completely on several occasions after the date at which she was supposed to be receiving continuous oxygen per physician's orders. Based on the findings, the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Insufficient laundry provisions for Resident A.

INVESTIGATION:

According to the complaint, on 10/07/2023, Resident A was observed to be in bed with linens that had urine and feces on them sometime during the early morning. The linens were not changed until later in the day as no linens were available.

When interviewed, Complainant stated that Associate 2 was asked why Resident A's linens had not been changed he reported that it was because Resident A had no clean linens. Complainant stated Resident A had provided at least three sets of linens to the facility and that when Associate 2 was informed of this, he stated none of them were clean. Complainant stated the facility is supposed to clean Resident A's laundry and that when asked why Resident A did not have any clean linens, Associate 2 reported "laundry is not done on the weekends". Complainant stated the soiled linens were on the floor in Resident A's bathroom. Complainant stated that family members gathered Resident A's laundry to take it home and clean it and were stopped by Associate 3 who asked why the laundry was being taken out since the facility was responsible for cleaning it. Complainant stated that when the situation was explained to Associate 3, she took the laundry and stated she would make sure

the laundry was cleaned. Complainant stated this happened early in the day on 10/07/2023 and then during a return visit the same day, at approximately 5pm Associate 1 was observed changing Resident A's sheets for the first time that day as they had apparently just been cleaned.

When interviewed, Ms. Nadolny stated she was aware of the 10/07/2023 issue regarding the soiled linens. Ms. Nadolny she was informed through the facilities "care and concern" process. Ms. Nadolny explained that if a staff member has something they need to report to administration, they can do so by filling out a "care and concern form" and sending it along with an email detailing the issue. Ms. Nadolny stated these reports are sent directly to the Mr. Coleman and N1 and that she is Cc'd on all those email communications. Ms. Nadolny stated Associate 3 was the reporting person on this particular instance and that the care and concern report provided by Associate 3 was consistent with what the complaint alleged. Ms. Nadolny stated she was not made aware of the sheets not being cleaned and changed until several hours later in the day, but that she did speak to Relative A about this issue on 10/09/2023. Ms. Nadolny stated staff are supposed to wash soiled linens right away and that no resident is supposed to be left to lay in soiled linens. Ms. Nadolny stated it is not true that staff do not have to do laundry on the weekends. Ms. Nadolny stated she did follow up with Associate 2 to see if he had made a statement that the facility does not do laundry on the weekend and that Associate 2 denied making such a statement. Ms. Nadolny stated Associate 2 has been a good employee, however, based on the situation, she believes Associate 2 did communicate the message that laundry is not done on the weekends regardless of how it was stated. Ms. Nadolny stated the facility also keeps plenty of extra clean linens in the linen closet so there should have been clean linens available to change the bedding right away. During the onsite inspection I observed the linen closet to have several clean linens as described by Ms. Nadolny. Ms. Nadolny stated the housekeeping staff also work Friday through Saturday and that since 10/07/2023 was a Saturday, housekeeping would have been available to help out so she could not explain why this situation occurred.

I reviewed a *CARE AND CONCERN FORM*, provided by Ms. Nadolny. The form was dated 10/07/2023 with a noted time of 1:30pm. The form read consistently with statements provided by Ms. Nadolny regarding the concerns and events related to Resident A's linens.

APPLICABLE RULE	
R 325.1935	**Bedding, linens, and clothing.**
	(1) Bedding shall be washable, in good condition, and clean, and shall be changed at least weekly or more often as required. **(3) The home shall make adequate provision for the laundering of a resident's personal laundry.**
ANALYSIS:	The complaint alleged that on 10/07/2023, Resident A was observed to be in bed with soiled linens and that no clean linens were made available to change Resident A's sheets. The investigation revealed sufficient evidence to support this allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A's specialty diet was not followed.

INVESTIGATION:

According to the complaint, on many occasions inappropriate food was offered to Resident A such as potato chips, deep fried crunchy shrimp. Resident A was on a soft food diet and not supposed to be given these types of foods.

When interviewed, Complainant stated that on several occasions Resident A was offered foods such as hamburgers and crunchy fried foods which she was not supposed to have as she could not chew the food. Complainant stated Resident A had an order for soft foods to be served to her. Complainant stated this issue was brought to the attention of supervision, Josh Coleman and N1, on several occasions and that each time they would say it would be addressed and get better.

When interviewed, Ms. Nadolny stated she was only aware of one instance in which Resident A was not served food in the manner directed by her physician's order. Ms. Nadolny stated it is possible she had been served food on more occasions outside of her orders since staff ask residents what they would like to eat and allow them to make the choice to which Resident A could have chosen differently. Ms. Nadolny stated Resident A was not known to be disagreeable to the food she was served so if staff had just offered her what was available to her, according to her orders, she likely would have eaten it. Ms. Nadolny stated, as it pertains to the specific instance, she was aware of, she was included on a care and concern notification, on

9/20/2023, informing Mr. Coleman and N1 that at 3:51pm, Resident A's lunch plate was observed to still be in her room with hamburger that was not cut up. Ms. Nadolny stated the report was originated by Associate 4 who was working the front desk that day and received the information from Relative A who was visiting at that time. Ms. Nadolny stated the issue was also forwarded to the Associate 5, the kitchen manager, who confirmed Resident A did have an order for "cut up soft meats" and that Resident A should not have been served the hamburger in that manner.

When interviewed, Mr. Coleman provided statements consistent with Ms. Nadolny. Mr. Coleman stated he addressed the issue with Associate 5. Mr. Coleman stated he discussed the importance of making sure staff provide Resident A food consistent with her physician's order rather than including options that are not consistent with those orders.

I reviewed physician's orders for Resident A, provided by Ms. Nadolny. Orders dated 9/19/2023 read, in part, "mechanical soft diet". Subsequent orders dated 9/20/2023 read, in part, "soft diet, ground meats".

APPLICABLE RULE	
R 325.1952	**Meals and special diets.**
	(4) Medical nutrition therapy, as prescribed by a licensed health care professional and which may include therapeutic diets or special diets, supplemental nourishments or fluids to meet the resident's nutritional and hydration needs, shall be provided in accordance with the resident's service plan unless waived in writing by a resident or a resident's authorized representative.
ANALYSIS:	The complaint alleged that Resident A was offered food which was not consistent with her specialty diet. Review of Resident A's physician orders confirmed Resident A had an order for a soft diet, which specified meats be ground. The investigation revealed that, on at least one occasion, Resident as served food which did not meet the specifications of the orders. Additionally, while staff were made aware of Resident A's dietary needs, reporting from Ms. Coleman indicated staff still provided Resident A food options outside of her specified diet.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan. It is recommended that the status of the license remain unchanged.

12/13/2023

Aaron Clum — Date
Licensing Staff

Approved By:

12/13/2023

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