GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 4, 2024

Mary North
Brookdale Portage MC
3150 Old Centre Avenue
Portage, MI 49002

RE: License #: AH390236936
Investigation #: 2023A1028076
Brookdale Portage MC

Dear Mary North:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

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

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action. Please review the enclosed documentation for accuracy and contact me with any questions. In the event I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AH390236936
Investigation #:	2023A1028076
Complaint Receipt Date:	08/07/2023
Investigation Initiation Date:	08/15/2023
Report Due Date:	10/06/2023
Licensee Name:	Brookdale Senior Living Communities, Inc.
Licensee Address:	Suite 2300, 6737 West Washington St. Milwaukee, WI 53214
Licensee Telephone #:	(414) 918-5000
Administrator:	Mary North, Authorized Repr. Kattie LaRose, Designee
Authorized Representative/	Kattie LaRose, Designee
Name of Facility:	Brookdale Portage MC
Facility Address:	3150 Old Centre Avenue, Portage, MI 49002
Facility Telephone #:	(269) 324-3141
Original Issuance Date:	10/01/1999
License Status:	REGULAR
Effective Date:	10/11/2022
Expiration Date:	10/10/2023
Capacity:	38
Program Type:	AGED

	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was found with maggots in an ear wound.	Yes
Additional Findings	Yes

III. METHODOLOGY

/08/07/2023/	Special Investigation Intake 2023A1028076
08/15/2023	APS Referral APS made initial referral to HFA under wrong license number. Resident was in MC not AL.
08/14/2023	Contact - Face to Face Interviewed interim Admin/Percell Smith at the facility.
08/14/2023	Contact - Face to Face Interviewed Employee A at the facility.
08/14/2023	Contact - Face to Face Interviewed Employee B at the facility.
08/14/2023	Contact - Document Received Received Resident A's record from interim Admin/Percell Smith.

ALLEGATION:

Resident A was found with maggots in an ear wound.

INVESTIGATION:

On 8/14/2023, the Bureau received the allegations through Centralized Intake.

On 8/14/2023, Adult Protective Services (APS) made the referral to Homes for the Aged (HFA) through Centralized Intake.

On 8/14/2023, I interviewed interim facility administrator, Percell Smith, at the facility who he is the acting facility administrator and has been at the facility for one week. Mr. Smith reported knowledge that Resident A was on hospice services and passed on 8/4/2023. Resident A had a history of melanoma of the skin with a recent surgery to remove multiple cancerous areas. Mr. Smith reported no knowledge of Resident A being found with maggots in [their] ear wound due to being at the facility for only a week, but Mr. Smith was able to provide me a copy of Resident A's record.

On 8/14/2023, I interviewed Employee A at the facility who reported Resident A was on hospice services and had a history of skin cancer. Employee A reported Resident A also had a history of picking at [their] skin and would remove bandages, scabs, staples, and would cause further irritation to the skin and/or wound due to picking. Employee A reported knowledge that Resident A was found with maggots in [their] ear on 7/22/2023. Resident A had cancerous lesions on and around the ear that Resident A picked at causing further irritation. Employee A reported Resident A liked to sit outside and [they] believe this is where Resident A came into contact with a fly that laid eggs in the ear wound. Employee A reported once the maggots were discovered Resident A was sent to the hospital immediately for evaluation and treatment. Resident A's authorized representative was contacted as well.

On 8/14/2023, I interviewed Employee B at the facility who reported Resident A has a history of skin cancer and that Resident A picked at [their] skin causing further irritation and wound injury. Resident A would remove bandages, stitches, and staples, pick scabs off, and pick at [their] despite cuing and redirection not to. Resident A's family was aware of Resident A's history of picking at the skin causing further injury. Employee B reported Resident A was scheduled to have surgery on 7/24/2023 to address the cancerous lesions on and around the ear but was found by facility staff with maggots in the cancerous lesion on the ear on 7/22/2023. Resident A liked to be outside and staff would provide Resident A time outside. Employee B reported [they] suspect this is probably when a fly laid eggs in Resident A's ear wound, hatching several hours later resulting in the formation of maggots. Resident A's physician and authorized representative were contacted immediately. Resident A was sent to the hospital for further evaluation and treatment. Employee B reported Resident A stayed in the hospital for treatment of the wound and also had the scheduled surgery on 7/24/2023 as well. Resident A returned to the facility from the hospital with home care and therapy treating for seven days afterwards. Resident A was then sent back to the hospital on 7/30/2023 due to demonstrating signs of aspiration and returned to the facility with hospice services in place. On 8/1/2023, Resident A was sent back to the hospital due to a fall in which a laceration to the back of the head occurred. Resident A returned the same day with three staples to the back of the head and hospice treating upon return to the facility. Employee B reported Resident A continued to remove wound dressings from face/ear area and head area and picked at the wounds. Resident A's authorized representative was notified of Resident A's behavior. Employee B reported continued to decline after return from hospital and Resident A later passed away on 8/4/2023.

On 8/14/2023, I reviewed Resident A’s service plan which revealed the following:

- Had a history of skin cancer, Alzheimer's disease, dysphagia, hypothyroidism and other conditions.
- Not oriented to place or time.
- Required assistance and cueing with dressing, grooming, showering, and toileting.
- Required physical assistance due to the inability to stand independently during dressing, grooming, toileting, and showering tasks.
- Required physical assistance to and from dining room due to limited mobility and memory impairment.
- Resident A had a history of falls and was a fall risk.
- Resident A had a lack of safety awareness with the facility implementing for fall risk prevention interventions.
- Has fragile skin. Wound care provided by home health for two or more complex wounds. Has ongoing skin cancer.
- Resident A picks at skin, scabs, causing open areas and bleeding. Will frequently remove bandages. Use lotion routinely to prevent skin breakdown. Gel cushion used in wheelchair to prevent skin breakdown.
- Hospice services managed chronic condition, showering, and skin care.

I reviewed Resident A’s record notes which revealed the following:

- On 5/2/2023, the facility spoke with Resident A’s family about skin cancer on Resident A’s ear. Dermatologist appointment made by family for Resident A.
- On 5/6/2023, the facility contacted the dermatologist to report Resident A picked at the fresh cauterized spot on ear and it had an odor. Facility told to monitor Resident A for infection, fever, and/or pain.
- On 7/17/2023, Resident A’s family notified facility of Resident A’s upcoming surgery on 7/24/2023to treat cancerous areas on and near left ear. Facility notified family that the left ear had an increased odor, and the physician was contacted regarding treatment.
- On 7/22/2023, Resident A was found by staff with maggots in the left ear lesion and was sent to hospital for treatment and evaluation. Family later notified facility that Resident A would remain at the hospital until surgery on 7/24/2023.
- On 7/25/2023, Resident A returned from the hospital with antibiotic and home health services for wound care and therapy in place. Resident A had four surgical sites with sutures to the nose, left ear, left neck, and forehead. Resident A removed dressing from nose site. Physician ordered Vaseline to be applied to all surgical sites. Facility contacted physician about nose site dressing removal along with home health services about wound care. Home Health services reported they could not come out until next week. Resident A continued to pick at nose, and other surgical sites. Family was notified of Resident A’s picking.
- On 7/26/2023, facility called another home health company with family in agreement to come out and treat Resident A for wound care because it could not wait until the next week.

- From 7/26/2023 to 7/27/2023, Resident A demonstrated difficulty breathing and symptoms of aspiration and was admitted to the hospital. It cannot be determined when Resident A returned to facility due to not entry in the record.
- On 7/30/2023, Resident A was admitted to hospice services.
- On 8/1/2023, Resident A incurred a fall at the facility and transported to the hospital. Resident A returned with three staples to the back of the head to close the laceration incurred from the fall. Hospice was in to treat Resident A's new laceration.
- On 8/2/2023, Resident A incurred another fall resulting in a laceration to left elbow with active bleeding. Wound was treated and dressed. Resident A's authorized representative refused to send Resident A to hospital. Hospice was notified of fall with injury and requested nursing visit. Hospice arrived and recommended that Resident A be sent to hospital for sutures to left elbow but the authorized representative refused. Authorized representative and family educated by hospice on risk of infection and healing process without suture closure.
- On 8/3/2023, Resident A did not get up and was not feeling well. Excess secretions were observed, and hospice was notified to request visit and additional dressing supplies. Resident A continued to pick at skin and remove dressings. Authorized representative and family were also notified.
- On 8/4/2023, Resident A passed at the facility.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**

ANALYSIS:	It was alleged Resident A was found with maggots in an ear wound. Interviews, on-site investigation, and review of documentation confirm Resident A was found with live maggots in a left ear lesion. The origin of the maggots could not be determined but interviews revealed Resident A had spent time outside prior to the discovery of the maggots. There is a documented history of Resident A picking at [their] skin causing further injury, however, there is no documented evidence of staff interventions to deter Resident A from this behavior. It could also not be confirmed if staff supervised Resident A during the time outside or if appropriate sun protection was provided in relation to Resident's ongoing history of skin cancer while Resident A was outside, as there is no documented evidence in the record. The facility did not provide appropriate assistance or supervised care to Resident A which placed Resident at great risk resulting in the formation of maggots in a skin lesion on the left ear. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

Additional Findings:

On 8/14/2023, upon arrival at the facility, it was discovered the former administrator was no longer employed by the facility. No communication has been sent to me regarding the appointment of an interim administrator.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(d) Appoint a competent administrator who is responsible for operating the home in accordance with the established policies of the home.**

ANALYSIS:	The facility's prior administrator, Holly Jenkins, resigned from the facility in August 2023. (Resignation date could not be provided by facility staff). As of 8/31/2023, the facility has not submitted the required change of administrator form for the interim administrator, Percell Smith. Therefore, the facility is non-compliant and in violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, I recommend the status of this license remain the same.

Julie Viviano

8/31/2023

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Julie Viviano Date
Licensing Staff

Approved By:

Andrea L Moore

01/03/2024

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