GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 5, 2024

Jennifer Huetter
Brookridge Heights Assist
1901 Division
Marquette, MI 49855

RE: License #: AH520337520
Investigation #: 2024A1010005
Brookridge Heights Assist

Dear Licensee:

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 authorized representative 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 that I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,
Lauren Wohlfert

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa NW Unit 13, 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH520337520
Investigation #:	2024A1010005
Complaint Receipt Date:	10/12/2023
Investigation Initiation Date:	10/13/2023
Report Due Date:	12/11/2023
Licensee Name:	CHT Brookridge Heights MI Tenant Corp
Licensee Address:	Suite 500 1423 Clarkview Road Baltimore, MD 21209
Licensee Telephone #:	(410) 427-2700
Authorized Representative:	Jennifer Huetter, Authorized Repr.
Name of Facility:	Brookridge Heights Assist
Facility Address:	1901 Division Marquette, MI 49855
Facility Telephone #:	(906) 225-4488
Original Issuance Date:	01/08/2013
License Status:	REGULAR
Effective Date:	11/13/2022
Expiration Date:	11/12/2023
Capacity:	126
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
When residents are injured in the facility, they go hours without emergency medical attention.	No
The facility does not follow the appropriate diet for residents who are gluten free.	No
Additional Finding	Yes

III. METHODOLOGY

10/12/2023	Special Investigation Intake 2024A1010005
10/13/2023	Special Investigation Initiated - Letter Emailed licensing staff person Kimberly Horst
11/02/2023	Inspection Completed On-site
11/07/2023	Contact - Document Received Resident incident reports, staff progress notes, and resident service plans received via email from Ms. Huetter
11/17/2023	Contact – Document Received Received the facility's always available menu, snack menu, and meal menu
01/05/2024	Exit Conference

Allegations regarding staffing in the facility and residents being left soiled were investigated in Special Investigation Report (SIR) number 2023A1021088.

ALLEGATION:

When residents are injured in the facility, they go hours without emergency medical attention.

INVESTIGATION:

On 10/12/23, The Bureau received the allegations from Adult Protective Services (APS). The complaint was not assigned for APS investigation. The complaint read, "On 10/03/2023, two residents fell and broke a hip because there was not a staff

available to assist them with moving. One resident went several hours without oxygen. When injured residents go hours without emergency medical attention."

On 10/13/23, I emailed licensing staff person Kimberly Horst. Ms. Horst confirmed she investigated allegations regarding staffing at the facility under SIR 2023A1021088.

On 11/2/23, I interviewed administrator Jennifer Huetter via Teams. Ms. Huetter stated Resident A fell and fractured her hip on 10/3/23. Ms. Huetter stated Resident A was on hospice and hospice staff were called after staff found her on the floor. Ms. Huetter reported Resident A called out for help after she fell, and staff responded. Ms. Huetter said Resident A resided in the secured memory care unit in the facility.

Ms. Huetter explained hospice staff advised staff at the facility to administer morphine to Resident A. Ms. Huetter stated hospice staff also gave permission to facility staff to contact emergency medical services (EMS). Ms. Huetter reported staff called EMS and Resident A was transported to the hospital. Ms. Huetter said staff at the facility contact EMS anytime a resident reports pain after an incident so EMS staff can respond and evaluate the resident. Ms. Huetter denied knowledge regarding any incidents in which a resident did not get immediate emergency medical attention when needed.

Ms. Huetter reported Resident A was on oxygen when she resided in the facility. Ms. Huetter stated Resident A had a history of removing her oxygen. Ms. Huetter explained Resident A did not have her oxygen on when staff responded after she fell on 10/3/23. Ms. Huetter said Resident A did not return to the facility after the incident. Ms. Huetter reported Resident A had surgery and died shortly after. Ms. Huetter stated Resident A received hospice services through Lake Superior Hospice.

Ms. Huetter stated Resident B also resided in the secured memory care unit in the facility. Ms. Huetter reported Resident B fell on 10/3/23 in her room. Ms. Huetter said staff contacted EMS and Resident B was transported to the hospital. Ms. Huetter stated Resident B fractured her femur and had surgery. Ms. Huetter explained Resident B went to a skilled nursing facility for rehab after her surgery.

Ms. Huetter stated that if a resident does not report being in pain after an incident, staff are trained to monitor them for 72 hours after the incident. Ms. Huetter reported this process is called "alert charting." Ms. Huetter said a medication technician (med tech) must respond and take the resident's vitals after the incident. Ms. Huetter stated the med tech then determines whether EMS needs to be contacted. Ms. Huetter explained the med tech then completes an incident report and contacts the resident's physician and their responsible person. Ms. Huetter denied knowledge regarding the facility's resident incident policy and procedure not being followed.

On 11/7/23, Ms. Huetter emailed me a copy of Resident A's incident report dated 10/3/23 for my review. The *Describe what you saw and heard* section of the report read, "She was yelling from the hallway, I came into room and the resident did not have her oxygen on, she was in the middle of the floor sitting on her butt/left hip leaning back, asking us to get her off the floor. Her glasses were across the room on the floor." The *What did you do? Describe all the assistance given* section of the report read, "I took her vitals and her 02 was at 70. I applied oxygen via concentrator in her room and contacted Hospice. Resident was unable to move left leg without yelling out in extreme pain. Hospice told us to give her her PRN dose of Morphine and later told us to give her scheduled 8pm dose of Morphine before she left. Hospice evaluated her when they arrived and stayed with her until EMS arrived. We contacted family and they approved EMS call through Hospice. We called 911 and they picked her up via ambulance." The *did the resident receive medical care?* section of the report read, "Yes: I gave her her PRN dose of Morphine (2.5mg) at 6:47pm and gave her scheduled Morphine (5mg) at 8:09pm per Hospice Nurse; Called Hospice and EMS for additional cares."

The report read the incident occurred at 6:35 pm and hospice staff were notified at 6:45 pm. The facility followed hospice instructions and administered Resident A's prescribed Morphine. Hospice staff evaluated Resident A at the facility and the report read EMS staff were contacted at 8:05 pm and arrived at the facility at 8:19 pm.

Ms. Huetter provided me with a copy of Resident A's service plan for my review. The *O2: Order and Admin* section of the plan read, "Order O2 as needed. She is on 2L. Keep O2 above 92%. Assist resident with oxygen, check oxygen rate, assist to place oxygen cannula. See MAR for specific instructions. Community to provide support and assistance with the resident's management of oxygen use."

Ms. Huetter provided me with a copy of Resident A's incident report dated 10/3/23 for my review. The *Describe what you saw and heard* section of the report read, "When bringing evening medications to resident she was found lying on floor near her bed. Called for assistance." The *What did you do? Describe all assistance given* section of the report read, "Resident was unable to move left leg without severe pain. EMS was called and resident was taken to ER." The *Did the resident receive medical care* section of the report read, "Yes: bleeding was stopped on small abrasion on left arm. EMS was called for left leg/hip."

The report read the incident occurred at 9:53 pm and EMS was called at 9:58pm. The report read EMS arrived at the facility at 10:12 pm. Resident A's physician was notified at 11:30 pm. Resident A's responsible person was notified at 10:02 pm.

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: **(c) Assure the availability of emergency medical care required by a resident.**
ANALYSIS:	The interview with Ms. Huetter, along with review of Resident A and Resident B's incident reports revealed medical attention was sought for Resident A and Resident B after they fell on 10/3/23 during separate incidents. Resident A was on hospice at the time of her incident and staff appropriately contacted hospice staff after she fell. There is insufficient evidence to suggest the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility does not follow the appropriate diet for residents who are gluten free.

INVESTIGATION:

On 10/12/23, the complaint read, "The kitchen staff refuses to comply with the dietary needs of some residents such as gluten free residents for snack so their gluten free residents will go without food from the time dinner end till breakfast starts while the residents with no dietary restrictions receive a snack in between meals."

On 11/2/23, Ms. Huetter Resident C, Resident D, and Resident E are on gluten free diets. Ms. Huetter stated the facility's dietary director provides the same meals as residents who are on a regular diet, however gluten free substitutions are made for Resident C, Resident D, and Resident E. Ms. Huetter said the facility's dietary director Bre Hetzel is also on a gluten free diet. Ms. Huetter reported as a result, Ms. Hetzel has a good understanding of what gluten free foods Resident C, Resident D, and Resident E can be served.

Ms. Huetter said residents are offered snacks in between meals. Ms. Huetter reported staff go around the facility with a cart of snacks for residents to choose at 2:30 pm and 7:30 pm. Ms. Huetter stated residents can also request snacks at any time during the day. Ms. Huetter said staff have access to the kitchen 24 hours and can accommodate resident snack requests.

Ms. Huetter reported she has not received any concerns or complaints regarding Resident C, Resident D, and Resident E not getting meals consistent with a gluten free diet.

On 11/2/23, I interviewed Ms. Hetzel via Teams. Ms. Hetzel's statements were consistent with Ms. Huetter.

On 11/17/23, I received a copy of the facility's *Alternative Selections* and *Snack Menu* via email from Ms. Huetter for my review. The *Snack Menu* read the snacks are served at 10:30 am, 2:30 pm, and 7:30 pm. The *Snack Menu* included items such as grapes, chex mix, pudding, bananas, muffins, and finger sandwiches. The *Alternative Selections* menu included items such as a salad, hot dog, hamburger, grilled chicken breast, pasts, deli sandwich, fish, and grilled cheese.

Ms. Huetter also provided me with a copy of the resident *Weekly Menu* for 10/1/23 through 11/18/23 for my review. The menu provided the food items served for breakfast, lunch, and dinner.

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 interviews with Ms. Huetter and Ms. Hetzel revealed there are three residents currently in the facility who receive a gluten free diet. Ms. Huetter and Ms. Hetzel reported gluten free food items are substituted on the resident regular menus. There is insufficient evidence to suggest the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 11/2/23, Ms. Hetzel stated that although gluten free substitutions are made to the resident regular menus, the substitutions made are not documented. Ms. Hetzel was

unable to provide the gluten free menus for Resident C, Resident D, and Resident E, therefore it is unknown what meal substitutions they received.

APPLICABLE RULE	
R 325.1953	**Menus.**
	(1) A home shall prepare and post the menu for regular and therapeutic or special diets for the current week. Changes shall be written on the planned menu to show the menu as actually served.
ANALYSIS:	The interview with Ms. Hetzel revealed a separate gluten free menu that contains the gluten free food substitutions made for Resident C, Resident D, and Resident E is not kept. Ms. Hetzel was unable to provide what gluten free meal substitutions Resident C, Resident D, and Resident E were served. The facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Jennifer Huetter on 1/5/24.

IV. RECOMMENDATION

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

11/20/2023

Lauren Wohlfert Date
Licensing Staff

Approved By:

01/04/2024

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