GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 4, 2024

Jennifer Brown
Hope Network Rehabilitation Serv
1490 E Beltline SE
Grand Rapids, MI 49506

RE: License #: AL410083023
Investigation #: 2024A0583008
Sojourners Transitional Living

Dear Mrs. Brown:

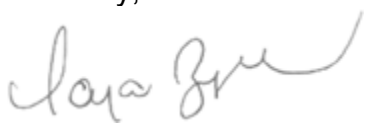
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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,



Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410083023
Investigation #:	2024A0583008
Complaint Receipt Date:	11/21/2023
Investigation Initiation Date:	11/21/2023
Report Due Date:	12/21/2023
Licensee Name:	Hope Network Rehabilitation Serv
Licensee Address:	1490 E Beltline SE Grand Rapids, MI 49506
Licensee Telephone #:	(616) 643-3977
Administrator:	Jennifer Brown
Licensee Designee:	Jennifer Brown
Name of Facility:	Sojourners Transitional Living
Facility Address:	1490 E Beltline Avenue SE Grand Rapids, MI 49506-4336
Facility Telephone #:	(616) 643-3977
Original Issuance Date:	02/19/1999
License Status:	REGULAR
Effective Date:	08/22/2023
Expiration Date:	08/21/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED, DEVELOPMENTALLY DISABLED, MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A does not receive adequate urinary catheter management care from facility staff.	Yes
Resident A did not receive adequate wound care.	No
The facility ran out of the correct size of Resident A's catheters.	No
Additional Findings	Yes

III. METHODOLOGY

11/21/2023	Special Investigation Intake 2024A0583008
11/21/2023	Special Investigation Initiated - Telephone Complainant
11/21/2023	APS Referral
12/04/2023	Contact - Telephone call received Resident A, Complainant
12/05/2023	Contact - Face to Face Staff Lindsey McBride
12/11/2023	Contact - Document Received Staff Lindsey McBride
12/12/2023	Contact - Telephone call Staff Deborah Rueller-Randall
12/13/2023	Contact - Telephone call Staff Didi Nyilibambe
12/19/2023	Contact - Telephone call Staff Perla Ambriz
01/04/2024	Exit Conference Licensee Designee Jennifer Brown

ALLEGATION: Resident A does not receive adequate urinary catheter management care from facility staff.

INVESTIGATION: On 11/21/2023 complaint allegations were received from the BCHS online complaints system. The allegations stated that Resident A, "has to be catheterized to empty her bladder every few hours and they don't have someone

who can do it." It was additionally alleged that facility staff, "are not using the correct catharizing units they are using whatever they have".

On 11/21/2023 I emailed the complaint allegation to Adult Protective Services centralized intake.

On 11/21/2023 I interviewed the complainant via telephone. The complainant stated that Resident A resides at the facility due to a spinal cord injury. The complainant stated that approximately two weeks ago Resident A was seen for an annual checkup by her primary care physician, Dr. David Byrons. While at the appointment, Resident A completed a urinalysis revealing high levels of white blood cells which is indicative of a urinary tract infection. The complainant stated that Resident A returned to the facility after the appointment with Dr. Byrons that same day. The complainant stated that Dr. Byrons contacted Resident A via telephone due to the high white blood cell count and requested a second urinalysis for "confirmation and culture". The complainant stated that Resident A requested that the facility's physician Dr. Talsma order the second urinalysis however facility staff informed Resident A that Resident A's primary care physician, Dr. Byrons, needed to order the second urinalysis. The complainant stated it was approximately one week between the initial urinalysis and second urinalysis being completed. The complainant was concerned that due to Resident A being diagnosed with a severe spinal cord injury it is paramount that Resident A receive medical treatment for any urinary tract infection immediately. The complainant expressed concern regarding the amount of time that elapsed between the initial urinalysis and the second urinalysis. The complainant also expressed concern that facility staff are not adequately educated to perform Resident A's catheter changes. The complainant stated that "several times yesterday" Resident A had to instruct facility staff regarding how to "straight cath" Resident A in a sterile manner.

On 11/22/2023 I completed an unannounced onsite investigation at the facility. While onsite I privately interviewed Resident A and staff Morgan Glascow.

Resident A stated she is currently residing at the facility due to a spinal cord injury. Resident A stated she requires frequent catheter care, and facility staff are not addressing this need adequately. Resident A stated she does not feel that staff are adequately trained to change her catheter as evidenced by not utilizing sterile practices. Resident A stated that facility staff recently attempted to utilize "expired betadine" during her catheter change. Resident A stated that recently during a 2:30 AM catheter change staff Deborah Rueller-Randall placed sterile gloves on her hands but subsequently touched an unsterilized surface before attempting to change Resident A's catheter. Resident A stated that she instructed Ms. Rueller-Randall to put on new gloves after touching the unsterilized surface. Resident A stated that staff Didi Nyilibambe was present during the incident with Ms. Rueller-Randall. Resident A stated she recently had an appointment with her primary care physician, Dr. David Byrons. Resident A stated that during the appointment she provided a urine sample which indicated high levels of white blood cells. Resident A stated that

on that same day, Dr. Byrons requested a second confirmatory screen however he did not order it himself. Resident A stated that she requested the facility staff contact Dr. Talsma, who is a physician that frequents the facility, and requested that Dr. Talsma order a confirmatory urine screen and culture. Resident A stated she was informed by facility staff that Dr. Byrons would have to order the second confirmatory test because Dr. Byrons is her primary care physician who ordered the initial urinalysis. Resident A stated she subsequently contacted Dr. Byrons herself and Dr. Byrons agreed to order the second urinalysis which confirmed a positive urinary tract infection. Resident A stated that Dr. Byrons prescribed the antibiotic "Keflex" to treat the urinary tract infection. Resident A stated that the second confirmatory urine screen took 24 hours to secure and the order for the treating antibiotic "Keflex" took an additional 24 hours to secure. Resident A stated that she was unhappy with the amount of time it required to secure the second confirmatory urinalysis and antibiotic given the severity of her spinal cord injury. Resident A stated it was the responsibility of facility staff to assist her with scheduling the confirmatory urine screen and facility staff were not helpful in doing so.

While on site I interviewed assistant home manager Morgan Glasgow. Ms. Glasgow stated she has worked at the facility for approximately 3 years. Ms. Glasgow denied any knowledge of facility staff attempting to change Resident A's catheter with expired betadine. Ms. Glasgow stated that she has changed Resident A's catheter multiple times and always utilized sterile equipment. Ms. Glascow stated that Resident A is unhappy with the level of care provided, "because staff cannot satisfy her preferences". Ms. Glasgow characterized Resident A as, "unable to be satisfied". Ms. Glasgow stated that all facility staff have been educated on the application of sterile practices while changing Resident A's catheters.

On 12/04/2023 I interviewed Resident A via telephone. The complainant was also present during the telephone interview via three way calling. Resident A stated that on 11/30/2023 facility staff were scheduled to change Resident A's catheter at 6:30 AM however, "no one showed up". Resident A stated that she rang for staff assistance at 6:50 AM however it took facility staff until 7:30 AM to come to Resident A's bedroom to change her catheter. Resident A stated that just recently, Dr. Stoffel of the University of Michigan diagnosed Resident A with a second urinary tract infection. Resident A stated that the first urinary tract infection was positive for "ecoli" while the current urinary tract infection is positive for "Klebsiella".

On 12/05/2023 I completed an unannounced onsite investigation at the facility and privately interviewed staff Lindsey McBride. Ms. McBride stated that during all shifts there are staff scheduled to work that are trained to address Resident A's catheter needs. Ms. McBride stated that Resident A, "does not like certain staff" to change her catheter. Ms. McBride stated that the facility has accommodated Resident A's staff preferences by, "pulling staff from other facilities" located on the same campus to come to the facility to provide Resident A's catheter care. Ms. McBride stated that all staff who perform Resident A's catheter care are adequately trained and to her knowledge utilize sterile procedures. Ms. McBride stated that to her knowledge,

staff have never utilized expired betadine when changing Resident A's catheter. Ms. McBride acknowledged that on 11/30/2023 Resident A's catheter was not changed until 7:30 AM, "due to a miscommunication between programs". Ms. McBride stated that, "Sojourners staff should have gone to relieve Maplewood staff so Maplewood could come here for the treatment" at 6:30 AM. Ms. McBride stated the facility had trained staff working at the facility on 11/30/2023 however Resident A does not prefer that staff change her catheter. Ms. McBride acknowledged that Resident A's current medical order signed by Dr. Jeffrey Kramer on 11/01/2023 states that Resident A is to have her catheter changed every three hours during waking hours and every four hours during sleeping hours. Ms. McBride stated that Resident A's catheter had last been changed on 11/30/2023 at 2:30 AM indicating Resident A went five hours without having her catheter changed.

On 12/11/2023 I received an email from staff Lindsey McBride. The email contained Resident A's Assessment Plan for AFC Residents and a document titled, "Standard Written Order and Letter of Necessity". Resident A's Assessment Plan for AFC Residents, signed 11/03/2023, indicates Resident A requires staff assistance with toileting and states, "staff completes straight cathing q 3 hours during the day and q 4 hours at night". The "Standard Written Order and Letter of Necessity" authored by Jeffrey Kramer M.D. and signed 11/01/2023 indicated Resident A requires catheter changes every three hours while "awake" and every four hours "overnight".

On 12/12/2023 I interviewed staff Deborah Rueller-Randall via telephone. Ms. Rueller-Randall stated the facility is always operated by staff that are trained to competently change Resident A's catheter however Resident A prefers certain staff to do so. Ms. Rueller-Randall stated that the facility will "borrow" staff that Resident A prefers from other facilities located on the same campus and the staff come to the facility to change Resident A's catheter. Ms. Rueller-Randall stated that she has changed Resident A's catheter multiple times and has always done so in a sterile manner. Ms. Rueller-Randall stated that she has never used non-sterile gloves or techniques when changing Resident A's catheter. Ms. Rueller-Randall stated that she has never observed the facility running out of Resident A's correct catheter size and has never observed expired betadine. Ms. Rueller-Randall stated the facility provides quality care however Resident A often refuses care from staff she does not feel comfortable with.

On 12/13/2023 I interviewed staff Didi Nyilibambe via telephone. Ms. Nyilibambe stated that staff are adequately trained to provide appropriate catheter care for Resident A. Ms. Nyilibambe stated that Resident A has preferences for certain staff to provide her catheter care and the facility has tried fulfilling her request. Ms. Nyilibambe stated that she can recall an incident that occurred during third shift in which Ms. Nyilibambe observed staff Deborah Rueller-Randall changing Resident A's catheter. Ms. Nyilibambe stated that Ms. Rueller-Randall placed sterile gloves on her hands and then used the gloves to open Resident A's catheter package. Ms. Nyilibambe stated that Resident A yelled "stop" and Ms. Rueller-Randall was reminded by Resident A that the gloves were no longer sterile and could not be

utilized to change Resident A's catheter. Ms. Nyilibambe stated Ms. Rueller-Randall placed new gloves on her hands and finished changing Resident A's catheter in a sterile manner.

On 12/19/2023 I interviewed staff Perla Ambriz via telephone. Ms. Ambriz stated that she has worked at the facility for approximately one year. Ms. Ambriz stated that on 11/30/2023 she arrived at the facility at 7:00 AM. Ms. Ambriz stated that she changed Resident A's catheter at 7:30 AM. Ms. Ambriz stated that Resident A's catheter should have been changed at 6:30 AM. Ms. Ambriz stated that there are always staff working who are adequately trained to change Resident A's catheter however Resident A has preferences regarding the staff she allows to do so. Ms. Ambriz stated that she has never observed facility staff to utilize expired betadine or non-sterile supplies.

On 01/04/2024 I completed an exit conference via telephone with licensee designee Jennifer Brown. Ms. Brown stated that on 11/30/2023 sufficiently trained staff were working at the facility to provide for Resident A's catheter care however Resident A prefers staff from other facilities provide the care. Ms. Brown stated facility staff have tried to honor Resident A's staffing preferences however on 11/30/2023 there was a staffing miscommunication leading to Resident A not being provided timely catheter care. Ms. Bown stated that she would submit an acceptable corrective action plan.

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:	Resident A's Assessment Plan for AFC Residents, signed 11/03/2023, indicates Resident A requires staff assistance with toileting and states "staff completes straight cathing q 3 hours during the day and q 4 hours at night". Resident A's "Standard Written Order and Letter of Necessity" authored by Jeffrey Kramer M.D. and signed 11/01/2023 indicated Resident A requires catheter changes every three hours while "awake" and every four hours "overnight". Staff Perla Ambriz stated that on 11/30/2023 she arrived at the facility at 7:00 AM. Ms. Ambriz stated that she changed Resident A's catheter at 7:30 AM. Ms. Ambriz stated that Resident A's catheter should have been changed at 6:30 AM.

	Staff Lindsey McBride acknowledged that Resident A's current medical order signed by Dr. Jeffrey Kramer on 11/01/2023 states that Resident A is to have her catheter changed every three hours during waking hours and every four hours during sleeping hours. Ms. McBride stated that Resident A's catheter had last been changed on 11/30/2023 at 2:30 AM indicating Resident A went five hours without having her catheter changed. A preponderance of evidence was discovered during the course of the Special Investigation to substantiate a violation of the applicable rule; Resident A's catheter was changed after five hours.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A did not receive adequate wound care.

INVESTIGATION: On 11/21/2023 complaint allegations were received from the BCHS online complaints system. The allegations stated that Resident A, "has had a pressure sore on her foot that is being ignored" and "the facility was not doing a wound center appointment for her".

On 11/21/2023 I interviewed the complainant via telephone. The complainant stated that Resident A recently presented with an unstageable wound on her left toe. The complainant stated that "a few days passed between" when facility staff were made aware of the pressure sore and when staff secured appropriate medical treatment in the form of an apt with the "wound clinic". The complainant stated she did not know the exact number of days that transpired between when Resident A made facility staff aware of her pressure wound and when staff secured appropriate medical treatment. The complainant stated that after facility staff were made aware of Resident A's need for outside wound care, staff informed Resident A that she needed a referral for outside care. The complainant stated it was later discovered that Resident A did not require a referral for outside wound care treatment because she had already been a patient at Mary Free Bed hospital. The complainant stated that facility staff should have known that Resident A did not require a referral to receive care which ultimately led to a longer wait time for Resident A's wound care to be secured.

On 11/22/2023 I interviewed Resident A at the facility privately. Resident A stated that she presented to the facility at admission with skin breakdown on her left foot. Resident A stated that facility staff had been putting "Mepilex" on the wound however it continued to progress. Resident A stated that she informed facility staff that the wound needed outside wound care assistance on a Tuesday or Wednesday, although she could not confirm the exact dates. Resident A stated that facility staff

initially informed her that she would need a referral to obtain outside wound care assistance at the Mary Free Bed wound clinic or the Corewell Health wound clinic. Resident A stated that she contacted Mary Free Bed hospital's outpatient wound clinic on Thursday of that same week and was informed a referral was not necessary because she was an established patient of the hospital. Resident A stated she was seen by the Mary Free Bed wound clinic the following Monday.
While on site I interviewed assistant home manager Morgan Glasgow. Ms. Glasgow stated Resident A currently has a pressure wound on her foot that is being treated by Mary Free Bed's wound clinic. Ms. Glasgow stated that facility staff are monitoring the wound and she no concerns regarding Resident A's wound care at this time. Ms. Glasgow stated that she had no direct information regarding the timeframe it took Resident A to secure outside wound care.

On 12/05/2023 I privately interviewed staff Lindsey McBride at the facility. Ms. McBride stated Resident A was admitted to the facility with a wound on her left foot which was caused by "chaffing from her shoes". Ms. McBride stated that the wound was monitored by staff and initially "looked like a callous". Ms. McBride stated that facility staff were administering "Mepilex" on the wound until Resident A informed facility staff that the wound progressed further. Ms. McBride stated that facility staff did help Resident A make a timely appointment with Mary Free Bed's wound clinic and it has been treated there. Ms. McBride stated the appointment with Mary Free Bed was made timely and staff are following the medical orders from the wound clinic.

On 12/11/2023 I received an email from staff Lindsey McBride. The email stated: "(*Resident A) arrived to us with a blister on toe in question was being treated with Mepilex. D'cd in 11/6/2023 by wound clinic and ordered to cleanse with saline, pat dry and apply duoderm thin change every other day. Hold AFO's and new shoes with wider toe box were recommended. Hope Network purchased these recommended shoes for (Resident A)".*

The email contained Resident A's Assessment Plan for AFC Residents, "Care Notes", and 11/02/2023 email exchanges. Resident A's Assessment Plan for AFC Resident, signed 11/03/2023, indicates Resident A requires staff assistance with all personal hygiene needs.

An 11/02/2023 care note authored by staff Carol Richard LPN stated the following: *"OT staff reports to nursing consumer has pressure areas on her feet, OT staff states areas appeared to be DT pressure of her shoes" and "nursing contacted MFB wound clinic. MFB wound advised must have a doctor referral fax to them before they would set up an appointment nursing contacted Corewell health CWC accepting self referral appointment" "Nursing contacted Cornwell wound clinic CWC accepting self referral. Appointment scheduled for 11/13/2023 at 2:00 PM consumer status is unconscionable conditional be seized tomorrow Friday".*

I noted an email exchange dated 11/02/2023 between staff Cheryl Martin RN and Mary free bed wound clinic nurse Jennifer Carrier-Masse. The email stated the following:

“Hello

Thank you for sending the images.

I am happy to see her in clinic as soon as scheduling allows.

I have reviewed the images and they do not appear to be acutely infected.

They are correct that her increase tone and spasms are signs of infection so perhaps there could be another source?

Or pain and wounds are enough to cause this as well.

I recommend remove the suspected cause (afo) and protect with prevalon boots pending are follow up on 11/7.

If a more urgent concern you could call clinic or try urgent care or ER

Thanks,

Jen
Jennifer Carrier-Masse RN, MSN, FNP-BC, WCC, OMS, CRRN | Medical Group/MFB Wound Team
Mary Free Bed Rehabilitation Hospital
235 Wealthy St. SE Grand Rapids, MI 49503
office: 616-840-8106
voalte: 58106
maryfreebed.com

From: Martin, Cheryl A <camartin@hopenetwork.org>
Sent: Thursday, November 2, 2023 2:21 PM
To: Jennifer Carrier-Masse <jennifer.carrier-masse@maryfreebed.com>
Cc: Williams, Beverly A <BeverlyWilliams@hopenetwork.org>; Richards, Carol A <carichards@hopenetwork.org>
Subject: [EXTERNAL] SG pictures
Hello,

Here are the images requested of (Resident A’s) feet.

The proximal area on dorsum of left foot was a blister that had opened just prior to admission to HNNR. This has since callused.

I believe this is the area that most concerns (Resident A) and her friend. They are fearful of sepsis and that her increase tone and spasms are signs of infection.
The distal reddened area on dorsum of left foot is fairly new and has not changed.
The reddened area on great toe of right foot was discovered this morning.
The darkened area on 5th digit of right foot is also an old blister that has callused.

OT, PT, nursing and Dr. Kramer believe these pressure areas to be caused by her AFOs making her shoes tight and causing friction on her feet. It has been communicated with Resident A that she may benefit from bigger shoes. She has declined.

Please feel free to contact nursing with any questions. 616-278-7367

Thank you,
Cheryl Martin, RN
HNNR

An 11/03/2023 care note authored by staff Carol Richard LPN stated the following: *"appointment at Cornwell wound care clinic scheduled for 11/13/23 at 2:00 PM cancelled per request of consumer. Consumer has an appointment scheduled with Mary free bed wound clinic 11/6/23*".

I noted an 11/06/2023 care note authored by staff Cheryl Martin Hope RN which stated the following: "(Resident A) returned from wound clinic. Wound care instructions placed in QuickMAR".

On 12/13/2023 I emailed Jennifer Carrier Masse, Registered Nurse at Mary Free Bed's Wound Clinic, requesting information regarding whether Mary Free Bed's clinical wound team had concerns regarding Resident A's timely access to wound care.

On 12/13/2023 I received an email from Emily DeFouw, Vice President of Medical Group Mary Free Bed. Ms. DeFouw stated that Mary Free Bed Hospital would not provide any medical information without a subpoena.

On 12/19/2023 I interviewed staff Perla Ambriz via telephone. Ms. Ambriz stated that Resident A was admitted to the facility, "with a wound on her foot" and facility staff monitored the wound until Resident A observed that it had progressed. Ms. Ambriz stated that the facility's staff nurse was made aware of the wound and assisted Resident A with securing an appointment at the "wound clinic". Ms. Ambriz stated that facility staff are following orders of the wound clinic and the wound is "healing well". Ms. Ambriz stated that Resident A was provided adequate wound care by facility staff.

On 01/04/2024 I completed an exit conference with licensee designee Jennifer Brown via telephone. Ms. Brown stated that she agreed with the special investigation findings.

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:	Resident A and staff Lindsey McBride stated that Resident A was admitted to the facility with skin break down on Resident A's left foot which was managed by staff monitoring and Mepilec bandaging. A review of Resident A's Hope Network Care Notes indicated staff were made aware of wound progression on 11/02/2023 by Resident A and on 11/02/2023 facility staff nurse Cheryl Martin emailed images of Resident A's wounds to the Mary Free Bed Wound Team for their evaluation. These notes indicated Resident A was subsequently treated by Mary Free Bed's Wound Team on 11/06/2023. A preponderance of evidence was not discovered during the course of the Special Investigation to substantiate a violation of the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: **The facility ran out of the correct size of Resident A's catheters.**

INVESTIGATION: On 11/21/2023 complaint allegations were received from the BCHS online complaints system. The allegations stated that facility staff, "are not using the correct catharizing units", "they are using whatever they have," and "are on back order".

On 11/21/2023 I interviewed the complainant via telephone. The complainant expressed concern that facility staff do not have catheterization supplies to adequately address Resident A's care needs. The complainant stated that yesterday at 9:30 AM the facility ran out of Resident A's size 14 catheters and attempted to utilize a size 18 catheter. The complainant stated that the facility staff attempted to use another resident's size 18 catheters however Resident A refused because it is not her correct size. The complainant stated that due to the facility running out of

Resident A's catheter size, the complainant contacted Carelink Durable Medical Equipment Company and secured the correct size.

On 11/22/2023 I interviewed Resident A at the facility privately. Resident A stated that the facility recently ran out of her prescribed “size 14 French tip” catheters. Resident A stated last week at 2:30 AM two staff whose names Resident A could not recall, entered her bedroom to change her catheter but attempted to use a size 16 catheter. Resident A stated she allowed facility staff to utilize the size 16 catheter at 2:30 AM because staff stated that did not have the correct size available. Resident A stated the following morning at 9:30 AM staff Perla Ambriz attempted to use the size 16 catheters because Ms. Ambriz stated that the facility did not have size 14 catheters available. Resident A stated she refused to allow Ms. Ambriz to utilize the size 16 catheters and Ms. Ambriz was subsequently able to find a size 14 catheter “somewhere else” on the campus. Resident A stated Ms. Ambriz reported that Resident A’s size 14 catheters were “backordered” therefore Resident A’s “friend” purchased size 14 catheters from “Carelink”.

While on site I interviewed assistant home manager Morgan Glasgow. Ms. Glasgow stated that to her knowledge the facility has always had the correct size catheter to fulfill Resident A’s medical needs.

While onsite I observed multiple boxes of size 14 French Tip catheters in the facility’s medication storage room.

On 12/05/2023 I privately interviewed staff Lindsey McBride at the facility. Ms. McBride stated the facility has always had Resident A’s size 14 French tip catheters in stock at the facility. Ms. McBride stated there is an additional storage of size 14 catheters located in a separate building on campus and facility staff can access this as needed. Ms. McBride stated that she had no knowledge of staff utilizing an incorrect catheter size for Resident A’s urinary care.

On 12/11/2023 I received an email from staff Lindsey McBride. The email contained a document titled “Standard Written Order and Letter of Necessity”. The “Standard Written Order and Letter of Necessity” authored by Jeffrey Kramer M.D. and signed 11/01/2023 indicated Resident A requires catheter changes every three hours while awake, every four hours overnight, and requires a size 14 “Coloplast Speedicath”.

On 12/12/2023 I interviewed staff Deborah Rueller-Randall via telephone. Ms. Rueller-Randall stated she has no knowledge of the facility running out of Resident A’s correct catheter size. Ms. Rueller-Randall stated that she has always utilized the correct catheter size while changing Resident A’s catheter.

On 12/13/2023 I interviewed staff Didi Nyilibambe via telephone. Ms. Nyilibambe stated that she has never observed the facility run out of Resident A’s correct catheter size. Ms. Nyilibambe stated that the facility has a stockpile of extra size 14

catheters located in a storage room. Ms. Nyilibambe stated that she has no knowledge of facility staff utilizing an incorrect catheter size for Resident A's care.

On 12/19/2023 I interviewed staff Perla Ambriz via telephone. Ms. Ambriz stated that she has never observed the facility not to have Resident A's correct catheter size. Ms. Ambriz stated that there have been instances in which the supply "ran low" on Resident A's correct catheter size however the facility has never run out of stock.

On 01/04/2024 I completed an exit conference with licensee designee Jennifer Brown via telephone. Ms. Brown stated that she agreed with the special investigation findings.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	While onsite I observed multiple boxes of size 14 French Tip catheters in the facility's medication storage room. Staff Morgan Glasgow, staff Lindsey McBride, staff Deborah Rueller-Randall, staff Didi Nyilibambe, and staff Perla Ambriz each reported that the facility has never run out of Resident A's prescribed size 14 French tip catheters. A preponderance of evidence was not discovered during the course of the Special Investigation to substantiate a violation of the applicable rule. The facility did not run out of Resident A's prescribed size 14 French tip catheters.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS: The facility failed to maintain a daily schedule of advance work assignments.

INVESTIGATION: On 12/05/2023 I completed an unannounced onsite investigation at the facility and privately interviewed staff Lindsey McBride. Ms. McBride stated that Resident A, "does not like certain staff" to change her catheter. Ms. McBride stated that the facility has accommodated Resident A's staff preferences by "pulling staff from other facilities" located on the same campus to come to the facility to provide Resident A's catheter care. Ms. McBride stated that she has not updated the staff schedule to include the names, job titles, duties and hours worked by the staff being pulled from other facilities.

On 01/04/2024 I completed an exit conference with licensee designee Jennifer Brown via telephone. Ms. Brown stated that she agreed with the special investigation findings and would submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.15208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.** **(b) Job titles.** **(c) Hours or shifts worked.** **(d) Date of schedule.** **(e) Any scheduling changes.**
ANALYSIS:	Staff Lindsey McBride stated that Resident A does not like certain staff to change her catheter. Ms. McBride stated that the facility has accommodated Resident A's staff preferences by "pulling staff from other facilities" located on the same campus to come to the facility to provide Resident A's catheter care. Ms. McBride stated that she has not updated the staff schedule to include the names, job titles, duties and hours worked by the staff being pulled from other facilities. A preponderance of evidence was discovered during the course of the Special Investigation to substantiate a violation of the applicable rule; the facility staff schedule does not accurately document names of all staff working, job titles, and hours worked.
CONCLUSION:	**VIOLATION ESTABLISHED**

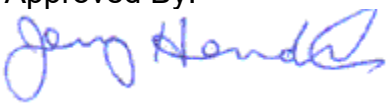
IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend the license remain unchanged.

01/04/2024

Toya Zylstra — Date
Licensing Consultant

Approved By:



01/04/2024

Jerry Hendrick — Date
Area Manager