GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 25, 2024

Kelly Glynn
The Oaks at Woodfield
5370 Baldwin Rd.
Grand Blanc, MI 48439

RE: License #: AH250314824
Investigation #: 2024A1027064
The Oaks at Woodfield

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 877-458-2757.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH250314824
Investigation #:	2024A1027064
Complaint Receipt Date:	05/23/2024
Investigation Initiation Date:	05/24/2024
Report Due Date:	07/22/2024
Licensee Name:	Trilogy Healthcare of Genesee LLC
Licensee Address:	303 N. Hurstbourne Pkwy. Louisville, KY 40222-5185
Licensee Telephone #:	(502) 213-7575
Authorized Representative/ Administrator:	Kelly Glynn
Name of Facility:	The Oaks at Woodfield
Facility Address:	5370 Baldwin Rd. Grand Blanc, MI 48439
Facility Telephone #:	(810) 606-9950
Original Issuance Date:	11/02/2012
License Status:	REGULAR
Effective Date:	09/10/2023
Expiration Date:	09/09/2024
Capacity:	38
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A lacked protection.	No
Additional Findings	Yes

III. METHODOLOGY

05/23/2024	Special Investigation Intake 2024A1027064
05/24/2024	Special Investigation Initiated - Letter Email sent to Kelly Glynn asking for documentation for Resident A
05/30/2024	Contact - Document Received Email received from Kelly Glynn with requested documentation
06/05/2024	Contact - Document Sent Email sent to Kelly Glynn requesting additional information and documentation
06/10/2024	Contact - Document Received Email received from Kelly Glynn with additional information and documentation
06/10/2024	Inspection Completed-BCAL Sub. Compliance
06/25/2024	Exit Conference Conducted with authorized representative Kelly Glynn

ALLEGATION:

Resident A lacked protection.

INVESTIGATION:

On 5/23/2024, the Department received a complaint through the online complaint system which read on 6/25/2023 at 10:30 AM Resident A reached out to Relative A1 in distress reporting she was short of breath with difficulty talking. The complaint read Resident A reported she had increased confusion due to the facility overmedicating her. The complaint read staff told Resident A to urinate in her clothing. The complaint read Relative A1 called the facility five times with no answer.

On 6/5/2024, I interviewed the manager at CenterWell Home Health service who stated Resident A received their services from 5/13/2023 to 6/26/2023 with visits 2-3 times weekly for wound care on her legs. The manager reviewed the nurse's visit notes. The manager stated note dated 5/28/2023 read in part Resident A had difficulty maintaining her breathing during a dressing change. The manager stated from 6/12/2023 to 6/19/2023, Resident A was hospitalized and returned to the facility in which they resumed their services, and she was now on oxygen. The manager stated the nurse visited on 6/24/2023 in which facility staff reported to the nurse Resident A was having difficulty maintaining her oxygen levels and her oxygen was increased. The manager stated Resident A was hospitalized and placed on a ventilator as of 6/26/2023.

On 6/5/2024, I called the facility phone number in which a staff member answered the phone promptly.

I reviewed Resident A's face sheet which read in part she admitted to the facility on 3/1/2022 and was discharged on 7/5/2023 to the hospital. The face sheet read in part Resident A had multiple diagnoses including respiratory. The face sheet read in part Resident A had a wheelchair, oxygen, wound care nurse. The face sheet read in part Resident A was her own responsible party.

I reviewed Resident A's admission evaluation and service plan dated 3/1/2022 which read in part Resident A was independent with ambulation and a wheelchair/walker, as well as transferring, bathing, and dressing. The plan read in part Resident A was cognitively intact, and continent of bowel and bladder. The plan read in part staff were to assist as needed or provide supervision with hygiene and dressing. The plan read in part Resident A required staff to administer her medications and respiratory treatments.

I reviewed Resident A's June 2023 Medication Administration Records (MAR) which read in part she had scheduled and as needed medications prescribed. The MAR read in part staff initialed medications as administered or documented why they were not administered. The MAR read on 3/17/2023, Resident A required 1-2 staff to assist on day shift with changing her clothing and toileting.

The MAR read in part Employee #1 administered Resident A's medications on day shift on 6/25/2023. The MARs read in part Resident A had scheduled Hydrocodone-Acetaminophen prescribed every four hours in which staff initialed as administered or documented the reasons it was not administered. The MAR read in part Resident A was administered her prescribed as needed Albuterol for shortness/wheezing on 6/25/2023 at 4:00 AM and staff documented it was "*somewhat effective*." The MAR read in part a chest x-ray was completed on 6/25/2023. The MAR read in part medications were documented as not administered starting in the evening on 6/25/2023 due to Resident A being sent to the hospital.

I reviewed Resident A's incident report dated 6/25/2023 which read in part Resident A had complaints of shortness of breath, nausea, short periods of confusion and her oxygen levels were not consistent. The report read in part "*Resident asked by med tech to go to hospital for evaluation. Resident agreed*." The report read in part Resident A was sent to the hospital, admitted to the intensive care unit.

I reviewed Resident A's June 2023 chart notes which read in part:

> Note dated 6/19/2023 read in part Resident A was evaluated by the physician assistant and had no new cough or shortness of breath in which her chronic diseases were deemed stable. Additionally, the note read in part Resident A reported her edema had not increased nor had she felt she gained weight.
>
> Note dated 6/23/2023 read in part Resident A was evaluated by the physician assistant and her chronic obstructive pulmonary disease was stable on oxygen. The report read in part she had no respiratory signs or symptoms.
>
> Note dated 6/25/2023 read in part Resident A was complaining of not being able to breath, nausea and not feeling well in which staff monitored her oxygen levels every two hours. The note read in part Resident A agreed to go to the hospital and asked that her sister be notified.

Review of Resident A's MARs revealed Employee #1 provided care on dayshift on 6/25/2023; therefore, I reviewed her records. Email correspondence with Kelly Glynn read Employee #1's date of hire was 1/10/2017. Employee #1's Workforce Background Check dated 12/13/2016 read in part she was eligible for employment. Employee #1's training records read in part she completed training on preventing, recognizing, and reporting abuse and neglect, as well as resident rights and medication administration.

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:	Review of Resident A's medical records revealed she was assessed by a licensed healthcare professionals prior to transitioning to the hospital on 6/25/2023. Interview with Resident A's home care services team revealed they visited her consistently and indicated a notable absence of concern regarding the care provided at the facility. Review of Resident A's June 2023 MARs revealed her medications were administered per the licensed health care professional's orders. Review of Employee #1's records revealed she was eligible for employment and trained. Therefore, this investigation lacked sufficient evidence to support Resident A lacked protection.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

I reviewed Resident A's admission evaluation and service plan dated 3/1/2022 which read in part Resident A was independent with ambulation and a wheelchair/walker, transferring, bathing, dressing, continent and cognitively intact. The plan read in part staff were to assist as needed or provide supervision with hygiene and dressing. The plan read in part she had no skin impairments.

Review of Resident A's medication administration records revealed in March 2023, she required 1-2 staff to assist with dressing and toileting.

Review of Resident A's June 2023 chart notes from her physician assistant revealed she had a fall and required wound care to her lower extremities.

Interview with CenterWell Home Health services revealed they provided wound care services from May to June 2023.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the

	resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	Resident A's service plan was dated 3/1/2022, and she discharged from the facility on 7/5/2023; therefore, it does not meet this regulation. Additionally, upon reviewing Resident A's medical records it was discovered that although she was previously independent, as of March 2023, her care necessitated assistance from 1-2 persons, as well as wound care for bilateral lower extremities. As a result, a violation was identified for this regulation due to the failure to at least annually update her service plan and reflect the changes in her care needs.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

06/12/2024

Jessica Rogers Date
Licensing Staff

Approved By:

06/24/2024

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