GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 30, 2024

Steven Tyshka
Waltonwood at Cherry Hill II
42500 Cherry Hill
Canton, MI 48187

RE: License #: AH820336804
Investigation #: 2024A0784078
Waltonwood at Cherry Hill II

Dear Steven Tyshka:

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 #:	AH820336804
Investigation #:	2024A0784078
Complaint Receipt Date:	07/24/2024
Investigation Initiation Date:	07/29/2024
Report Due Date:	09/22/2024
Licensee Name:	Waltonwood at Cherry Hill II, L.L.C
Licensee Address:	7125 Orchard Lake Rd #200 West Bloomfield, MI 48322
Licensee Telephone #:	(248) 865-1012
Administrator:	Tiffiany Tucker
Authorized Representative:	Steven Tyshka
Name of Facility:	Waltonwood at Cherry Hill II
Facility Address:	42500 Cherry Hill Canton, MI 48187
Facility Telephone #:	(734) 981-5070
Original Issuance Date:	12/27/2012
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	76
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Lack of proper communication regarding Resident A's medical condition and treatment	Yes
Resident A's service plan was not updated to reflect his NPO order	Yes
Additional Findings	No

III. METHODOLOGY

07/24/2024	Special Investigation Intake 2024A0784078
07/29/2024	Special Investigation Initiated - On Site
07/29/2024	Inspection Completed On-site
08/20/2024	Contact - Document Sent Email sent to administrator Tiffany Tucker with request for documentation
08/20/2024	Contact - Document Received Email response received from Ms. Tucker regarding document request
08/30/2024	Exit - Email Report sent to authorized representative Steven Tyshka and administrator Tiffany Tucker

ALLEGATION:

Lack of proper communication regarding Resident A's medical condition and treatment

INVESTIGATION:

On 7/24/2024, the department received this online complaint.

According to the complaint, on 6/10/2024, Resident A suffered a stroke. Resident A was on hospice services at the time and hospice decided not to provide treatment.

The facility was aware of Resident A's change in medical condition and did not notify Resident A's power of attorney (POA) when Resident A had his stroke or communicate medical information pertaining to Resident A's ongoing health. Resident AR did not receive a message until 6/11/2024, from LPN1, regarding Resident A's change in medical condition delaying the Resident AR's ability to make medical decisions on Resident A's behalf.

On 7/29/2024, I interviewed administrator Tiffany Tucker at the facility. Ms. Tucker stated she could not recall the specifics of the circumstances surrounding Resident A's last days at the facility, but that Resident A had declined in health quickly. Ms. Tucker stated she was unsure if Resident A had a stroke but was confident that the facility was in contact with Resident A's authorized representative/POA (Resident AR) as information was available. Ms. Tucker stated resident care manager Katrina Duby would have more details regarding this matter.

On 7/29/2024, I Interviewed resident care manager Katrina Duby at the facility. Ms. Tucker was present during the interview. Ms. Duby stated Resident A was never diagnosed with a stroke. Ms. Duby stated that in order to truly diagnose a stroke, a person needs to be sent to the hospital for scans that cannot be done at the facility. Ms. Duby stated hospice did evaluated Resident A but did not have him sent out to the hospital. Ms. Duby stated she did not know the exact date when staff reported a change of condition to hospice, but that it was some date around 6/10/2024 or shortly thereafter. Ms. Duby stated when a resident is on hospice, usually hospice will communicate changes in health to a residents authorized representative or sometimes a medication technician (med tech) at the facility will. Ms. Duby stated she did not recall making direct contact with Resident AR regarding Resident A's initial change in condition. Ms. Duby stated she believed hospice did make contact with Resident AR. Ms. Duby stated the patient care coordinator/LPN (LPN1) would be able to provide more specific information regarding Resident A's evaluations and health decline. Ms. Duby stated hospice maintains notation related to each visit they make with a resident. Ms. Duby stated the facility also has visit documentation that visiting services such as hospice and home care fill out summarizing their visits. Ms. Duby stated that Resident A's quick decline was unexpected as he was doing well and that just prior to this, he was being considered for discharge from hospice service.

On 7/29/2024, I interviewed LPN1 at the facility. LPN1 stated she had received a call from associate 1 on or about 6/10/2024 due to what appeared to be a change in condition for Resident A. LPN1 stated notes taken regarding the visit would confirm the date of Resident's reported change of condition. LPN1 stated that upon initial evaluation, Resident A showed signs of weakness in his left arm as he was unable to give a high five like he normally could and appeared to have stiffness while appearing to protect his left arm. LPN1 stated Resident A also had facial weakness and decreased strength overall in his upper body. LPN1 stated that at that time, based on the symptoms, it was believed that Resident A may have had a small stroke. LPN1 stated these issues were communicated with facility staff, as normal

upon each visit, so they were aware of the changes and the keep watch for any further changes in baseline. LPN1 stated she attempted to contact Resident AR on that day and was unable to reach him. LPN1 stated she had a follow up visit the next day. LPN1 stated that upon this follow up visit, Resident A's condition was not greatly different though he did show signs of additional decrease in strength with some darkness to his urine. LPN1 stated staff also reported Resident A had not been smiling which staff reportedly said is not like him. LPN1 stated a follow up visit was made then next day by hospice nurse 1 (RN1). LPN1 stated that RN1 confirmed that it appeared Resident A may have had a small stroke in previous days. LPN1 stated Resident A's health was continuing to decline at this point and that Resident AR was present during this time having come from out of town. LPN1 stated that she had been in communication with Resident AR during this time who she stated expressed concerns that the facility had not been in contact with them regarding Resident A. LPN1 stated that on 6/13/2024, she sent an email to administrative staff at the facility communicating the concerns of Resident AR regarding the lack of communication on the part of the facility and the desire to move Resident A to a hospice home.

I reviewed facility visit notes for Resident A titled *Home/Hospice Care Field Staff per Visit Documentation*, provided by Ms. Duby. Under a section titled Communication, notes dated 6/09/2024, written by LPN1, read, in part, Resident A "does not show reason for hospice for 6-month mortality. He is on the watch list for discharge".

I reviewed hospice notes for Resident A, titled *Visit Note Report*, dated between 6/10/2024 and 6/14/2024, provided by LPN1. Under a section titled *OTHER COMMENTS REGARDING PAINT ASSESSMENT*, of notes dated 6/10/2024, the notes read "PT [Patient] having symptoms that he had a TIA [transient ischemic attack: a stroke lasting a few minutes occurring when the blood supply to part of the brain is briefly interrupted]. Stiffness and guarding his left arm". Under a section titled ABNORMAL *NEUOLOGICAL FINDINGS, NOTES DATED* 6/10/2024 read "facial weakness". Under a section titled IN WHAT *EXTREMITIES DOES DECREASED STRENGTH EXITS*, notes dated 6/10/2024 read "upper left extremity". Under a section titled *REASON FOR VISIT*, notes dated 6/10/2024 read "Patient care due to unexpected status change". Under a section titled *ABNORMAL MUSCULOSKELETAL FINDINGS*, notes dated 6/11/2024 read, "Decreased strength, limited range of motion". Under section titled *IN WHAT EXTREMETIES DOES DECREASED STRENGTH EXIST*, notes dated 6/11/2024 read, "upper left extremity, lower bilat extremities". Under a section titled Narrative, notes dated 6/11/2024 read, in part, "Urine dark and concentrated in brief". Under a section titled *Narrative*, notes dated 6/12/2024 read, in part, "Visit made for report of patient being in severe pain upon RN arrival patient had been put in bed he was awake and mumbling nonsensical words per [Resident AR] who was present". Under a section titled Intervention Provided, notes dated 6/12/2024 read, in part, "Patient having some symptoms of a CVA [cerebrovascular accident: medical term for a stroke]. Under section titled *Narrative*, notes dated 6/13/2024 read, in part, "Patient seen for acute decline. He is now unable to swallow any

food/water/medications, he is unable to speak anymore. He is believed to have had a CVA a few days ago", [Resident AR] present and in agreement with the current POC [plan of care] changes. He is comfortable at this time, new orders include scheduled morphine 5 MG SL/PO Q4 PRN all PO [by mouth] medications D/C's [discontinued] and comfort measures only". Review of notes dated 6/14/2024 indicated Resident A was "to transfer to Angela Hospice inpatient unit 6/15/2024".

I reviewed June 2024 facility *Progress Notes* for Resident provided, provided by Ms. Duby. Review of the note's revealed notes were only available for 6/13/2024, 6/14/2024 and 6/15/2024.

On 8/20/2024, I emailed Ms. Tucker with a request for any additional Progress Notes dated between 6/01/2024 and 6/12/2024.

On 8/20/2024, Ms. Tucker provided an email response to my request for additional *Progress Notes.* Ms. Tuckers response read, in part, "We do not have any progress notes for the requested timeframe".

I reviewed an email, provided by LPN1, sent from LPN1 on 6/13/2024 to several recipients which included two facility staff, Ms. Duby and associate 2. The email read, in part, "Recently, I had a conversation with the family, who expressed concerns regarding the communication process with the (WWCH) community. They mentioned that they were expecting a call from the facility regarding [Resident A's] condition even if hospice was called", "I am reaching out to you to offer the opportunity to connect with the family directly and address any concerns they may have. Your input and collaboration are invaluable as we strive to provide [Resident A] with the highest quality of care possible. Together, we can ensure that he receives the attention and support he deserves during this challenging time. Please feel free to reach out to me at your convenience to discuss this matter further or to coordinate a meeting with the family".

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents**
	(2)(e) A patient or resident is entitled to receive adequate and appropriate care, and to receive, from the appropriate individual within the health facility or agency, information about his or her medical condition, proposed course of treatment, and prospects for recovery, in terms that the patient or resident can understand, unless medically contraindicated as documented in the medical record by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services.

ANALYSIS:	The complaint alleged that on 6/10/2024, Resident A had a stroke which significantly change his medical condition, and that the facility did not ensure contact was made with Resident AR, who was also the legal POA, delaying Resident AR's ability to make medical decisions on Resident A's behalf. Review of documented notes from hospice revealed that on 6/10/2024, Resident A was believed to have had a small stroke and did have a significant change in his health. Statements provided by Ms. Duby and LPN1, as well as review of an email from LPN1 to facility administration, indicate the facility did not directly contact Resident AR at least prior to 6/13/2024. While hospice notation indicates Resident AR was at the facility by 6/12/2024, there was no evidence to indicate facility administration or staff had contact with Resident AR prior to that date. Based on the findings, the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A's service plan was not updated to reflect his NPO order

INVESTIGATION:

According to the complaint, on 6/13/2024, due to Resident A's declining health, the decision was made to put Resident A on comfort measures which included an order for NPO [Nothing by Mouth] except for comfort measures. Over the following 48 hours, approximately 6/13/2024 to 6/15/2024, staff had to be reminded several times of Resident A's NPO order.

Facility *Progress notes* dated 6/13/2024 read, in part, "Per hospice the resident is NPO only comfort meds".

I reviewed *Physician's Orders* for Resident A which included an order for "comfort measures only" with an originating date of 6/13/2024.

I reviewed Resident A's service plan, provided by Ms. Duby. The service plan did not include updated information regarding Resident A's dietary changes or NPO status as ordered by his physician. Review of the last assessment date noted on the plan revealed no changes had been made on the plan since 3/05/2024.

APPLICABLE RULES	
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.
R 325.1932	**Resident medications.**
	(1)A service plan must identify prescribed medication to be self-administered or managed by the home.
ANALYSIS:	According to the complaint, between 6/13/2024 and 6/15/2024, staff had to be constantly reminded of Resident A's NPO order. While Resident A had a significant change in his health on 6/10/2024 constituting continuing changes in his care needs between 6/10 /2024 and 6/15/2024, including the NPO order and specific dietary changes, review of the service plan revealed no inclusion of this information and indicated that the last time any changes were made to the plan was on 3/05/2024. Based on the findings, this allegation is substantiated.
CONCLUSION:	**VIOLATIONS ESTABLISHED**

IV. RECOMMENDATION

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

Aaron L Clum 8/29/2024

_____

Aaron Clum Date
Licensing Staff

Approved By:

Andrea Moore 08/30/2024

_____

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