RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

June 28, 2018

Winifred Heighton
118 E. Westwood Drive
Kalamazoo, MI 49006

RE: License #: AF390297391
Investigation #: **2018A0578031**
Comforts of Facility

Dear Ms. Heighton:

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

Sincerely,

Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
322 E. Stockbridge Ave
Kalamazoo, MI 49001
(269) 251-4091

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF390297391
Investigation #:	2018A0578031
Complaint Receipt Date:	05/02/2018
Investigation Initiation Date:	05/02/2018
Report Due Date:	07/01/2018
Licensee Name:	Winifred Heighton
Licensee Address:	118 E. Westwood Drive Kalamazoo, MI 49006
Licensee Telephone #:	(269) 388-8863
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	Comforts of Facility
Facility Address:	118 E. Westwood Drive Kalamazoo, MI 49006
Facility Telephone #:	(269) 388-8863
Original Issuance Date:	01/30/2009
License Status:	REGULAR
Effective Date:	04/08/2018
Expiration Date:	04/07/2020
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A developed bed sores and bruises and was totally incontinent within 8 days. Direct care staff were not able to meet Resident A's needs.	Yes
Resident A was not provided medications properly.	No
Resident A was not provided with water.	No
Resident A was not allowed to use the phone.	No

III. METHODOLOGY

05/02/2018	Special Investigation Intake 2018A0578031
05/02/2018	Special Investigation Initiated - Face to Face APS
05/08/2018	Contact- Telephone Interview With Relative A1
05/21/2018	Investigation Completed On-Site Interviewed Resident A and the licensee
06/20/2018	Contact-Interview by Phone With Relative A2
06/20/2018	Contact-Interview by Phone With Relative A3
06/20/2018	Contact-Interview by Phone-Visiting Physicians
06/22/2018	Contact-Interview by Phone-Gull Point Pharmacy
06/22/2018	Exit Conference With the licensee Winifred Heighton

ALLEGATION:
Resident A developed bed sores and was totally incontinent within eight days. Direct care staff were not able to meet Resident A's needs.

INVESTIGATION:
On 05/02/2018, I received this complaint through the BCAL on-line complaint system. Complainant alleged that Resident A was cared for appropriately prior to

being admitted to this facility and developed bed sores and became totally incontinent within eight days of living at the facility.

On 05/02/2018, I interviewed Complainant regarding the allegations. Complainant stated he believed the family was upset that a deposit was not returned by the licensee. Complainant did not believe Resident A was abused or neglected in anyway but added that he did not believe the licensee was prepared to provide the level of personal care Resident A required at the time of admission.

On 05/08/2018, I interviewed Relative A1 regarding the allegations. Relative A1 reported that Resident A had been in the facility for only eight days before her family decided to remove her from the facility. Relative A1 did not have direct observations of the allegations but stated that another relative had visited Resident A at the facility and reported the allegations to her. Relative A1 reported the family had paid $1100 for the eight days and paid an additional $3000 for the following month. Relative A1 reported Resident A did not reside at the facility the following month and the licensee had not returned the money.

On 05/21/2018 I completed an unannounced on-site investigation at the facility and interviewed the licensee Winifred Heighton regarding the allegations. Ms. Heighton stated Resident A had resided at the facility for less than eight days. Ms. Heighton explained that when she first went to see Resident A prior to her admission, Ms. Heighton observed her to be sitting down and talking, and was given no indication that Resident A had difficulties walking and required the use of a wheelchair. Ms. Heighton stated she informed the family that her home was not handicap accessible and could not accommodate a wheelchair or walker and the family responded that mobility was not an issue and Resident A was doing much better since her discharge from the hospital. Ms. Heighton stated that once Resident A arrived at the facility on the day of her admission, the family had used a wheelchair to bring her into the facility. Ms. Heighton stated that shortly thereafter she noticed that Resident A could not ambulate without assistance or the use of a wheelchair, Ms. Heighton stated that she notified the family that her facility was not appropriate and would not be able to provide the care Resident A required. Ms. Heighton denied providing a written emergency discharge notice to Resident A or Resident A's Guardian.

Ms. Heighton stated Resident A had been previously hospitalized with clostridium difficile colitis. Ms. Heighton stated this illness was responsible for Resident A having loose stool, requiring the frequent use of bathroom and requiring frequent assistance that was difficult for one staff at the facility to provide.

Ms. Heighton stated that she did not complete the *Assessment Plan for AFC Residents* or *Resident Care Agreement* for Resident A, stating that Resident A's guardian had quickly left the day of Resident A's admission without signing the required paperwork.

Ms. Heighton reported the family had informed her during the initial assessment interview that Resident A had a history of bed sores. Ms. Heighton stated when Resident A arrived from the hospital she had two bedsores. Ms. Heighton denied any knowledge or responsibility for Resident A's bruising and denied having any hospital documentation related to any bed sores and/or bruising.

On 05/29/2018, I interviewed Resident A regarding the allegations at the facility where she currently resides. Resident A acknowledged having a history of bed sores but stated she could only go off what other people told her because she could not see them. Resident A acknowledged that while living at Comforts of Facility AFC she frequently needed to use the bathroom and at the time was having difficulty walking and required the assistance of a walker or wheelchair. Resident A stated that when she had the sensation that she needed to use the bathroom, she needed to have assistance immediately or it would result in being incontinent. Resident A stated often it would be anywhere from 5 to 15 minutes before she was provided the assistance she needed. Resident A denied knowledge of any bruising and how it may have occurred but reported that she may have obtained them from falling. Resident A reported she was afraid of falling when she had difficulty walking however could not recall when she experienced a fall last.

On 06/20/2018, I interviewed Relative A2 regarding the allegations. Relative A2 reported that Resident A had been in the facility for only eight days before her family decided to remove her from the facility. Relative A2 did not have direct observations of the allegations but stated that her daughter had visited Resident A at the facility and reported the allegations to her. Relative A2 reported the family had paid $1100 for the eight days and paid an additional $3000 for the following month. Relative A2 reported Resident A did not reside at the facility the following month and the licensee had not returned the money. Relative A2 acknowledged Resident A had a history of incontinence but reported this had improved since leaving this facility. Relative A2 reported that she had called the licensee several times to obtain a return on money deposited with no response. Relative A2 denied completing any type of refund agreement with the licensee.

Relative A2 stated nurse "Melissa", last name not given, from Visiting Physicians expressed concerns to her about the level of personal care Resident A was being provided and how it wasn't enough.

On 05/23/2018, I received and reviewed electronic images provided by Relative A1. Relative A1 reported the images were of Resident A and demonstrated bruising and bedsores. The images did not have any image information, such as Resident A's face, or identifying information, like a date or time the picture was taken. I observed no discernable bruising in the three pictures beyond potential skin mottling and a red mark from pressure. I observed two bed or pressure sores that were clean and covered by a bandage. This bandage was peeled back to take the image.

On 06/20/2018, I called the Kalamazoo office of Visiting Physicians and spoke with RN Melissa Louden regarding the allegations. Ms. Louden denied that any other staff named Melissa were employed by the office but acknowledged that Dr. Deitmer Grentz is a current physician employed by their organization. Ms. Louden denied that she had called the family with concerns related to Resident A's care and denied that anyone from the office had called the family with concerns base on medical notes. Rather, Ms. Louden stated the family had called the office on 05/21/2018 with concerns related to Resident A being possibly dehydrated with cracked lips. Ms. Louden stated the family called their office again to report that Resident A was looking weak, had no privacy and that her phone and water was kept across her room where she couldn't reach it. Ms. Louden reported that Dr. Grentz documented that he had told the family that if they have medical concerns to call 911 or go to the ER. The family was instructed to call adult protective services if they had any other treatment concerns.

On 06/20/2018, I interviewed Relative A3 regarding the allegations. Relative A3 reported that she had visited Resident A due to family members concern that Resident A sounded weak on the phone. Relative A3 reported Resident A was lying in bed and had been incontinent of bladder. Relative A3 reported Resident A could not walk and was not mobile. Relative A3 reported she provided Resident A with assistance to the bathroom with a walker but the walker would not fit in the bathroom. Relative A3 reported that as she was changing Resident A into dry clothing she observed one bruise and two bedsores on Resident A's back, which she recorded with a cell phone camera.

APPLICABLE RULE	
R 400.1407	**Resident admission and discharge criteria; resident assessment plan; resident care agreement; house guidelines; fee schedule; physicians instructions; health care appraisal.**
	(5) At the time of a resident's admission, a licensee shall complete a written resident care agreement which shall be established between the resident or the resident's designated representative, the responsible agency, and the licensee. A department form shall be used unless prior authorization for a substitute form has been granted in writing by the department. A resident shall be provided the care and services as stated in the written resident care agreement.

ANALYSIS:	Resident A was admitted to the facility on 4/20/2018. Per licensing rules, licensee Ms. Heighton was required to complete a written resident care agreement for Resident A at the time of her admission outlining the personal care and services needed by Resident A. On 5/21/2018, Ms. Heighton acknowledged that she had not yet completed a written resident care agreement for Resident A outlining what specific personal care and services Resident A required. Therefore the licensee was unable to provide the care and services required by Resident A as written in the completed resident care agreement.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14301	**Resident Admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the facility.
ANALYSIS:	Resident A was admitted to the facility on 4/20/2018. Per licensing rules, Ms. Heighton was required to complete a written assessment plan for Resident A at the time of her admission. On 5/21/2018, Ms. Heighton admitted that she had not yet completed a written assessment plan for Resident A and acknowledged not knowing that Resident A relied heavily on a wheelchair and walker to ambulate at the time of admission.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.1407	**Resident admission and discharge criteria; resident assessment plan; resident care agreement; house guidelines; fee schedule; physician's instructions; health care appraisal.**
	(12) A licensee shall provide a resident with a 30-day written notice before discharge from the home. The written notice shall state the reasons for discharge. A copy of the

	written notice shall be sent to the resident's designated representative and responsible agency.
ANALYSIS:	On 5/21/2018, Ms. Heighton admitted that she had not provided Resident A's designated representative or responsible agency with a 30-day written notice before discharge from the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:
Resident A was not provided medications properly.

INVESTIGATION:
On 06/20/2018, Relative A2 stated a nurse and physician from visiting physicians had called her with concerns regarding Resident A's medications and how they were being administered. Relative A2 identified the nurse as "Melissa", last name not given, and identified the physician as Dr. Grentz. Relative A2 stated the physician called her and reported that Resident A was not receiving her medications appropriately and Resident A's medications were a "mess." Relative A2 stated this resulted in the physician starting Resident A's medications "over from scratch."

ON 05/21/2018, Ms. Heighton denied that Resident A's medications were administered improperly, and stated these complaints were made in an effort to "shut her down." While at the facility I reviewed medication administration records for Resident A and compared them to medications prescribed for Resident A present in the facility. There was no evidence Resident A missed any medications for any reason during the month of May 2018.

On 05/29/2018, Resident A denied having any concerns with how her medications were administered and denied ever missing medications or not being provided medications according to her medication routine.

On 06/22/2018, I called Gull Pointe Pharmacy to compare medication administration records with prescriptions they had recorded for Resident A. Mr. Chris Rousch was able to confirm the medication administration record for Resident A was accurate for the month of May 2018 and still current with Resident A's daily medication routine.

On 06/20/2018, I called the Kalamazoo office of Visiting Physicians and spoke with Melissa Louden regarding the allegations. Ms. Louden denied that she had called the family with concerns related to Resident A's medications and denied that anyone from the office had called the family with concerns base on medical notes.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	Rule 18. (1) Prescription medication, including tranquilizers, sedatives, dietary supplements, or individual special medical procedures, shall be given or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy container which shall be labeled for the specific 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.
ANALYSIS:	During an unannounced interview on 05/29/2018, Resident A denied missing medications or not receiving her medications while at the facility. Interviews with RN Ms. Melissa Louden from Visiting Physicians determined that Resident A's primary physician did not express concerns about medications and how they were administered as alleged. I also reviewed Resident A's May 2018 medication administration record and medications and did not find any errors. Information obtained from Resident A's pharmacy, Gull Pointe Pharmacy, determined the medications the licensee had records of administering in the facility matched Resident A's currently prescribed medications. Therefore, there is no evidence Resident A did not receive their daily medication routine as prescribed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:
Resident A was not provided with water.

INVESTIGATION:
On 06/20/2018, Relative A3 reported that when she went to visit Resident A, a glass of water was on a nightstand in Resident A's bedroom but was out of Resident A's reach.

On 05/21/2018, licensee Ms. Heighton denied that Resident A was ever denied water, stating this was a false allegation conceived by Resident A's family in attempt to "shut her down."

On 05/29/2018, Resident A denied that she was ever refused water or denied access to clean water for bathing or drinking.

During the unannounced investigation on 05/21/2018, I inspected the faucets in the bathrooms and kitchen of the facility and found them to have hot and cold water under pressure.

APPLICABLE RULE	
R 400.1424	**Environmental health.**
	The water supply shall be adequate, of a safe and sanitary quality, and from an approved source. Hot and cold running water under pressure shall be provided.
ANALYSIS:	During an unannounced interview on 05/29/2018 of Resident A, Resident A denied not having access to water for bathing or drinking while at the facility. The licensee, Ms. Winifred Heighton denied refusing Resident A access to water, and during an unannounced investigation at the facility I observed running hot and cold water readily available. Therefore, there is no evidence that Resident A was not provided access to hot or cold water.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:
Resident A was not allowed to use the phone.

INVESTIGATION:
On 05/21/2018, Ms. Heighton denied that Resident A was ever denied access to her personal phone or restricted in her ability to make phone calls.

On 06/20/2018, Relative A3 reported that when she visited Resident A at the home, she observed her personal desk phone to be out of reach of Resident A.

On 05/29/2018, Resident A denied that she was ever not allowed access to her personal phone or restricted in her ability to make phone calls. Resident A reported she has her own phone in order to facilitate making her own phone calls. While visiting the current facility were Resident A resides, I observed Resident A's personal phone to be a large "land line" desk phone.

APPLICABLE RULE	
R 400.1409	**Resident rights; licensee responsibilities.**
	(e) The right of reasonable access to a telephone for private communications. A licensee may charge a resident for long distance telephone calls. A pay telephone shall not be considered as meeting this requirement.

ANALYSIS:	During an unannounced interview on 05/29/2018 of Resident A, Resident A denied not having access to her personal telephone or being allowed to make telephone calls from any telephone. The licensee, Ms. Winifred Heighton denied refusing Resident A access to a telephone or denying Resident A to the ability to make phone calls. Therefore, there is no evidence that Resident A was not provided reasonable access to a telephone.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

06/22/2018

Eli DeLeon Date
Licensing Consultant

Approved By:

06/28/2018

Dawn N. Timm Date
Area Manager