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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 6, 2020

Marcia Curtiss
Homestead Management
Suite 115
21800 Haggerty Rd.
Northville, MI 48167

RE: License #: AL410305473
Investigation #: 2020A0579007
Addington Place at East Paris #5

Dear Mrs. Curtiss:

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,

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
322 E. Stockbridge Ave
Kalamazoo, MI 49001
(269) 615-5050

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410305473
Investigation #:	2020A0579007
Complaint Receipt Date:	11/14/2019
Investigation Initiation Date:	11/14/2019
Report Due Date:	01/13/2020
Licensee Name:	Homestead Management
Licensee Address:	Suite 115, 21800 Haggerty Rd., Northville, MI 48167
Licensee Telephone #:	(616) 949-9500
Administrator:	Marcia Curtiss
Licensee Designee:	Marcia Curtiss
Name of Facility:	Addington Place at East Paris #5
Facility Address:	3964 Whispering Way, Grand Rapids, MI 49546
Facility Telephone #:	(616) 949-9500
Original Issuance Date:	03/22/2011
License Status:	REGULAR
Effective Date:	10/07/2019
Expiration Date:	10/06/2021
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED, AGED

II. ALLEGATION(S)

	Violation Established?
In 2018, Resident A's feet were not monitored resulting in him having two of his toes amputated. Resident A also has missed dialysis 4 times since residing at Addington Place.	Yes
The facility ran out of Resident A's medication three times in the last two months.	Yes
Additional Finding	Yes

III. METHODOLOGY

11/14/2019	Special Investigation Intake 2020A0579007
11/14/2019	APS Referral
11/14/2019	Special Investigation Initiated - Face to Face Pentrilla Shannon, Direct Care Worker
11/14/2019	Contact- Documentation received Audra Rein, Direct Care Worker
11/14/2019	Contact- Documentation received Kat Hartley, Administrator
12/17/2019	Contact- Documentation sent Audra Rein, Kat Hartley
12/18/2019	Contact- Documentation received Kat Hartley
12/18/2019	Contact- Documentation sent Audra Rein, Kat Hartley
12/20/2019	Contact- Documentation received Kat Hartley
12/20/2019	Contact- Documentation sent Audra Rein, Kat Hartley
01/06/2020	Exit Conference Marcia Curtiss, Licensee Designee

ALLEGATION: In 2018, Resident A's feet were not monitored resulting in him having two of his toes amputated. Resident A also has missed dialysis 4 times since residing at Addington Place.

INVESTIGATION: On 11/14/2019, I received this complaint through the Bureau of Community Health Systems. The complaint alleged that “last year” the facility staff forgot to monitor Resident A’s toes which resulted in him having two toes amputated. Resident A has also missed his scheduled dialysis appointments four times since moving into Addington Place in 2018. Resident A missed dialysis on 11/05/2019 which resulted in him being found unresponsive on 11/07/2019.

On 11/14/2019, I exchanged emails with Ms. Chelsea Towns from Adult Protective Services who confirmed APS would be investigating the allegations as well.

On 11/14/2019, I completed on-site interviews with direct care workers, Ms. Pentrilla Shannon and Ms. Audra Rein. Ms. Towns was present for the interviews. Interviews were completed one-on-one. Resident A was out of the facility and unavailable for interviewing on this date.

On 11/14/2019, Ms. Shannon stated she was not aware of Resident A’s feet not being monitored in 2018. She stated Resident A had two toes amputated in 2018 but she did not have direct knowledge as to why the toes were amputated. She stated direct care workers currently put lotion on Resident A’s feet and legs. She stated Resident A’s feet are being monitored regularly at this time.

Ms. Shannon stated Resident A did miss dialysis on 11/05/2019. She stated she believes this occurred because newer staff were working and did not get Resident A ready for the Go-Bus prior to the Go-Bus arriving and that the Go-Bus ended up leaving without Resident A. She stated Resident A was hospitalized on 11/07/2019 but she is not certain it was related to his missing dialysis on 11/05/2019.

On 11/14/2019, Ms. Rein stated over a year ago, Resident A did have two toes amputated. She stated at that time, Resident A had a wound on the heel of his left foot due to complications with diabetes. She stated Resident A’s wound was treated and he had follow-up care with Kindred Healthcare who were monitoring his feet in addition to a bath aide who was bathing him. She stated the wound on his heel was the only complication with his feet she was aware of when Kindred Healthcare began providing his wound and bathing care. She stated one day, Resident A was outside in his wheelchair and told staff that he had bumped his toes. Ms. Rein stated she personally observed his toes and realized that the injury and decay to his toes was not something that could have occurred while he was outside. She stated also, the wound on his heel was on his left foot and the injured toes were on his right foot. She stated Resident A was immediately taken in for treatment and his toes were ultimately amputated. Ms. Rein denied that staff had failed to provide adequate care for Resident A at that time and reported it was Kindred Healthcare providing foot care and bathing for Resident A at the time.

Ms. Rein stated she believes Resident A has missed dialysis on four occasions since residing at Addington Place. She stated two times were due to Resident A having a cold and reporting he did not feel well enough to go to dialysis. She stated

both of those appointments were rescheduled. She stated onetime Resident A missed because the Go-Bus reported they could not make it to the facility due to weather. She stated on 11/05/2019, Resident A missed dialysis because staff were dealing with a sick resident and were not able to get Resident A ready to go prior to the Go-Bus arriving. She stated staff reported once the bus arrived, they were finishing getting Resident A ready, but the bus would not wait and left without Resident A and reported they would not return that day. She stated Resident A's dialysis was rescheduled for 11/06/2019 but he was not feeling well and refused to go. She stated Resident A was sent to the hospital on 11/07/2019 but he was found to have respiratory failure which was not related to him missing dialysis.

On 12/17/2019, I requested any documentation relating to Resident A's foot care, wound care, or procedure to have his toes amputated in 2018. The documentation was not received. I also requested Resident A's Medication Administration Record, Incident/Accident Reports, and discharge summary.

On 12/18/2019, I reviewed Resident A's discharge paperwork from Mercy Health St. Mary's which reported he was hospitalized on 11/07/2019 to 11/11/2019 for acute respiratory failure.

On 12/18/2019, I reviewed the Incident/Accident Report form relating to Resident A's hospitalization on 11/07/2019 which reported Resident A appeared weak and was not breathing well so an ambulance was contacted, and he was transported to the hospital.

On 12/20/2019, I received Resident A's Medication Administration Record for September, October and November 2019 which noted Resident A is prescribed Silvadene cream topically to his right foot every other day. It was reported the order was written on 05/01/2019 and Resident A was receiving the cream as prescribed.

On 12/20/2019, I requested Resident A's Assessment Plan for AFC Residents and Health Care Appraisal from 2018 which is the year Resident A's toes were amputated.

On 12/23/2019, I received Resident A's Assessment Plan for AFC Residents. Regarding bathing it was noted Resident A needs assistance and that his needs will be met by "staff and home health nurse". Regarding grooming (including nail care, teeth, hair care, etc.), personal hygiene, dressing it was noted Resident A needs assistance but did not document how those needs would be met.

On 01/02/2019, I re-reviewed Resident A's Assessment Plan for AFC Residents from 2019. Regarding bathing, toileting, and grooming, it was noted Resident A needs assistance from at least one staff member.

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:	Ms. Shannon confirmed Resident A is currently prescribed a topical medication for his feet and he receives it as prescribed. Ms. Shannon confirmed Resident A missed dialysis on 11/05/2019 due to staff not getting Resident A ready on time. Ms. Rein confirmed Resident A had two toes amputated in 2018. She stated Resident A reported he injured his toes and she observed them to be decaying and sought medical treatment immediately. She stated at that time, Resident A was receiving home health care for a wound on his foot and a bath aide was providing his hygiene care. Ms. Rein confirmed Resident A currently has a topical ointment that facility staff apply. I observed Resident A's MAR from September, October, and November 2019. These confirmed Resident A was receiving his prescription Silvadene ointment on his right foot as prescribed. Ms. Rein confirmed Resident A did miss dialysis twice due to illness and once due to his transportation refusing to pick him up at the facility. She stated he missed dialysis on 11/05/2019 due to facility staff being delayed in getting Resident A up and ready for his appointment on time and therefore his transportation refused to wait to take him to the appointment. Ms. Rein stated Resident A's dialysis was rescheduled for 11/06/2019 but he became ill and was hospitalized for acute respiratory failure on 11/07/2019 which was not related to missing dialysis. I observed Resident A's discharge paperwork from Mercy Health St. Mary's on 11/11/2019 which reported he was hospitalized from 11/07/2019 to 11/11/2019 for acute respiratory failure. Resident A's Assessment Plan for AFC Residents noted Resident A was receiving bathing assistance from staff and a home health nurse in 2018. Regarding grooming, it was noted Resident A needs assistance, but it was not specified how those needs would be meet.

	Resident A's Assessment Plan for AFC Residents noted Resident A requires assistance from at least one staff member with toileting, bathing, dressing, personal hygiene, and grooming. Due to Resident A's needing assistance from at least one staff member with toileting, bathing, dressing, personal hygiene, and grooming, Resident A having foot decay that lead to his toes being amputated in 2018 and missing dialysis due to staff failing to get him ready for the appointment on time, there is sufficient evidence to support the allegation that Resident A was not being provided supervision, protection, and personal care as established by his written assessment plan.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** SIR# 2018A0356049, LSR 08/23/2019, CAP 11/05/2018

ALLEGATION: The facility ran out of Resident A's medication three times in the last two months.

INVESTIGATION: On 11/14/2019, I reviewed this complaint through the Bureau of Community Health Systems. The complaint alleged the facility ran out of Resident A's medication three times in the last two months due to the facility receiving the wrong prescription or the prescription not being submitted. Resident A has been in pain for multiple days because the facility did not have his pain medication. The name of the medication was not listed.

On 11/14/2019, Ms. Shannon denied knowledge that Resident A had run out of medication while at the facility. She stated Resident A typically refuses his powdered and liquid medication because he reports it makes his stomach upset. She stated that is the only medication issue she is aware of regarding Resident A.

On 11/14/2019, Ms. Rein denied that the facility has run out of Resident A's medication. She stated Resident A does not like his liquid medication and his powder medication and will at times refuse. She stated that is the challenge they have with Resident A's medication and why it may be reported he was not receiving his medication.

On 12/20/2019, I received Resident A's Medication Administration Record (MAR) for September, October, November 2019 which noted Resident A did not receive his CINACALCET TAB 30MG one tablet one time daily on 09/01/2019 and 10/17/2019, CALC ACETATE CAP 667MG two tablets three times daily on 09/13/2019 and 09/14/2019, HYDROCO/APAP TAB 5-325MG one tablet three times daily on 10/09/2019, 10/10/2019, 10/11/2019, and 11/14/2019, POLYETH GLY POW 3350 one capful one time daily on 10/31/2019, HumaLOG one injection three times daily

on 10/31/2019 due to the medications not being available on-site and/or not in the medication cart. The MAR noted the HYDROCO/APAP TAB 5-325MG was a daily medication and an as needed medication for pain. It was also confirmed that Resident A often refused his medication.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(a) Medications.**
ANALYSIS:	Ms. Shannon and Ms. Rein confirmed Resident A frequently refuses medication, especially his powdered and liquid medication. Ms. Shannon and Ms. Rein denied that the facility has not had Resident A's medication available. Resident A's Medication Administration Record for September, October and November 2019 noted that there were 10 incidents during those months that Resident A did not receive his medication as prescribed due to the medication not being available in the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

On 12/23/2019, I reviewed Resident A's Assessment Plan for AFC Residents from 2018 which noted Resident A needed assistance with grooming, personal hygiene, and dressing but did not specify how Resident A's personal care needs would be met in the home.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions:

	(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.
ANALYSIS:	Resident A's Assessment Plan for AFC Residents did not specify how his personal care grooming needs would be met in the home in 2018.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 01/06/2019, I completed an exit conference with licensee designee, Ms. Curtiss, who did not dispute my findings or recommendations.

IV. RECOMMENDATION

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

Cassandra Duursma 01/06/2020

Cassandra Duursma Date
Licensing Consultant

Approved By:

Jerry Hendrick 01/06/2020

Jerry Hendrick Date
Area Manager