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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 29, 2021

Stephanie Hildebrant
Wood Care X, Inc., d/b/a Caretel Inns of Linden
910 S. Washington Ave.
Royal Oak, MI 48067

RE: License #: AL250281713
Investigation #: 2021A0221004
Leighton House Inn

Dear Mrs. Hildebrant:

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 (906) 226-4171.

Sincerely,

Theresa Norton, Licensing Consultant
Bureau of Community and Health Systems
234 West Baraga
Marquette, MI 49855
(906) 280-2519

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL250281713
Investigation #:	2021A0221004
Complaint Receipt Date:	01/25/2021
Investigation Initiation Date:	01/26/2021
Report Due Date:	03/26/2021
Licensee Name:	Wood Care X, Inc., d/b/a Caretel Inns of Linden
Licensee Address:	910 S. Washington Ave. Royal Oak, MI 48067
Licensee Telephone #:	(248) 543-7300
Administrator:	Stephanie Hildebrant
Licensee Designee:	Stephanie Hildebrant
Name of Facility:	Leighton House Inn
Facility Address:	202 S. Bridge Street Linden, MI 48451
Facility Telephone #:	(810) 735-9400
Original Issuance Date:	06/25/2008
License **Status:**	REGULAR
Effective Date:	08/08/2019
Expiration Date:	08/07/2021
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Staff are sleeping on the night shift.	No
There are not enough staff on duty to care for residents and keep the facility clean.	Yes
Staff did not obtain proper medical attention for Resident A when he fell several times.	No
Food service and meals are sometime inedible.	Yes

III. METHODOLOGY

01/25/2021	Special Investigation Intake 2021A0221004
01/26/2021	Special Investigation Initiated - Telephone Phone call to complainant.
01/27/2021	Contact - Telephone call made Phone call to complainant.
02/02/2021	Contact - Telephone call made Email to Administrator Stephanie Hildebrant.
02/04/2021	Contact - Telephone call made Interview and request for documents from Administrator Hildebrant.
02/08/2021	Contact - Telephone call made Interview with Stephanie Hildebrant, VP of Operations.
02/24/2021	Contact - Document Received Staff schedule, menus, progress notes received.
03/03/2021	Contact - Telephone call made Interview with Rebecca Kiesling, Assistant Director of Assisted Living,
03/03/2021	Contact - Telephone call made Interview with Michelle Moore, General Manager, Administrator.
03/03/2021	Contact - Telephone call made Interview with Staff Molly Vandriessche.

03/04/2021	Contact - Telephone call made Interview with Staff Audraya Forrest and Staff Valerie Dzapo.
03/16/2021	Contact - Telephone call made Telephone call to complainant.
03/23/2021	Exit Conference Exit interview with Licensee Designee Stephanie Hildebrant.
03/29/2021	Contact- Telephone call made Virtual inspection of facility.
03/29/2021	Exit Conference Second exit interview with Ms. Stephanie Hildebrant.

ALLEGATION: Staff are sleeping on the night shift

INVESTIGATION: The complainant states that there are staff sleeping on the night shift.

An onsite inspection was not conducted due to COVID-19.

The complainant states that she 'heard' that staff were sleeping on the night shift at the facility. The complainant did not know who the staff were or when this allegation occurred.

I interviewed 5 staff and 2 administrators regarding this allegation. Out of the 5 staff and 2 administrators interviewed, none had heard nor witnessed any staff sleeping on the night shift.

On March 3, 2021, Director of Admissions, Michelle Moore stated staff are not permitted to sleep during the night shift. She also stated that there are cameras that cover all common areas of the facility and there has been no allegations or recorded images of staff sleeping during the night shift. Ms. Moore also added that night shift staff have specific duties that need to be performed and there has been no complaints that staff have not completed these tasks nor failed to care for residents during the night shift.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	There is no evidence or knowledge of staff sleeping during the night shift nor being suitable to care for residents during sleeping hours.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: There are not enough staff on duty to care for residents and keep the facility clean.

INVESTIGATION: The complainant stated that 'there are not enough staff' at the facility to care for the residents or keep the rooms clean.

The complainant stated there was only 2 staff on duty to care for 20 residents and clean their rooms. The complainant stated the facility did not have a housekeeper for 'months.' The complainant stated the rooms were 'filthy' with human waste 'smears' present on carpets in Resident A's room. The complainant stated rooms were dusty and trash was not emptied daily in Resident A's room. The complainant stated she complained to General Manager Rodney Roberson, but Mr. Roberson was "rude" to her and said, "He would not answer my questions."

On 03/29/2021, a virtual inspection (via FaceTime) was conducted through the Leighton Inn facility. The entire facility plus two resident rooms were observed and found to be very clean. Staff, residents, and family members were observed. Director of Admissions, Michelle Moore led this inspection and stated that there is a full-time housekeeper on staff at this time and no longer are staff required to clean rooms in addition to resident care.

All staff interviewed stated that there was no housekeeping staff for 'months' during 2020. The staff all reported that they were to not only do resident care and personal care, but also clean the rooms of residents. All staff agreed there were not enough staff to care for residents and clean rooms. All staff state there is adequate staff now (at the time of the interviews) to care for residents and there is a now a housekeeper on staff for cleaning rooms.

VP of Operations, Stephanie Hildebrant stated that General Manager Rodney Roberson was no longer employed by the facility (as of January 2021). Ms. Hildebrant stated that last year, the facility did not have a housekeeper for 'some

time' and GA's (Guest Assistants = staff) did have to clean resident rooms. Ms. Hildebrant stated the facility staff ratios are 2:20 waking hours and 1.5:20 during sleeping hours. The facility now has a full-time housekeeper in charge of cleaning resident rooms. Ms. Hildebrant also stated changes have been made in staff schedules from 8 hr. shifts to 12 hr. shifts.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Interviews of staff and management corroborate that there had not been sufficient staff to provide proper care to residents in 2020. There was not a housekeeper on staff for months and GA's (Guest Assistants – staff) were required to clean rooms in addition to caring for residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff did not obtain proper medical attention for Resident A when he fell several times.

INVESTIGATION: The complainant stated that Resident A fell 'several times' and proper medical attention was not obtained for him at the facility. Complainant could not provide dates of falls.

All staff interviewed denied that in 2020 Resident A had falls that required emergency response to be contacted. Staff stated that Resident A had a cane, but did not like to use it and would fall and trip into walls, corners of tables, etc. Staff stated Resident A would be treated with general first aid.

Progress Notes were requested and received for Resident A from 11/2019 through 11/2020. On 11/25/2019, Resident A fell breaking his hip and was transported to the VA in Ann Arbor for treatment. No significant falls were recorded for Resident A in the progress note log after returning from the hospital. There were 3 recorded falls on 06/11/20, 10/19/20 and 11/10/20 (scrapes and minor skin tears) that required general first aid which was provided by staff.

Resident A was placed on Hospice care on 10/23/2020 due to chronic kidney disease, extensive cardiac history, and other medical issues. Resident A passed away at the facility on 11/15/2020.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Through interviews and case log notes, the facility did obtain medical attention when necessary for Resident A. In 2020, there were 3 documented trips and falls (scrapes and skin tears) by Resident A in which first aid which was provided by staff of the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Food service and meals are sometime inedible.

INVESTIGATION: The complainant stated that the food at the facility “was horrible”. The complainant explained that food was observed as “unidentifiable” on certain occasions and inedible. The complainant gave several instances of food being unrecognizable, cold, and ‘burnt to a crisp’.

All staff interviewed stated there were issues with the food service at the facility. One staff stated that the food was burnt, unappetizing, mushy, and not tasteful. One staff reported that a resident moved out of the facility recently because of the “terrible food”.

Ms. Hildebrant stated the facility has change food service providers in the last few months due to the complaints concerning the meal services.

Michelle Moore, Director of Admissions stated she was aware of the food service issue and the facility is now trying ala carte menus along with other “extras” for accentuating the current food services.

Menus were submitted and were found to be nutritionally adequate. However, according to witnesses, the food was not always proper form, consistency, or temperature.

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	According to interviews with staff and administration, the food served at the facility had many complaints including food being cold, burnt, unappetizing, unrecognizable dishes, and vegetables mushy. Meals have not been of quality consistency, form, or temperature on several occasions.
CONCLUSION:	**VIOLATION ESTABLISHED**

An exit conference was conducted with Licensee Designee Stephanie Hildebrant on 03/25/2021. Ms. Hildebrant was told of the findings of this report and the expectation of a corrective action plan.

On 03/29/2021, a virtual inspection was conducted through the facility. A second exit conference was conducted with Licensee Designee Stephanie Hildebrant with no change to the findings of this report.

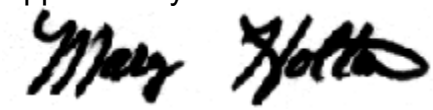
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change to the status of this license.

03/29/2021

Theresa Norton Date
Licensing Consultant

Approved By:



03/29/2021

Mary E Holton Date
Area Manager