GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June15, 2021

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

RE: License #: AH820336804
Investigation #: 2021A0784024
Waltonwood at Cherry Hill II

Dear Mr. 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.
- 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 (810) 787-7031.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
4809 Clio Road
Flint, MI 48504
(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 #:	2021A0784024
Complaint Receipt Date:	04/12/2021
Investigation Initiation Date:	04/13/2021
Report Due Date:	06/11/2021
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:	08/01/2020
Expiration Date:	07/31/2021
Capacity:	76
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive care in accordance with his service plan	Yes
Additional Findings	No

III. METHODOLOGY

04/12/2021	Special Investigation Intake 2021A0784024
04/13/2021	Special Investigation Initiated - Telephone Contact attempted with Complainant. Message left requesting return call
04/13/2021	Contact - Telephone call made Interview conducted with Relative A1
04/13/2021	Contact - Document Received Email received from Relative A1 with documentation
04/13/2021	Contact - Telephone call made Made with assistant executive director Haylee Hutchison
04/13/2021	Contact - Telephone call received interview conducted with regional director of operations Richard Mabe
04/13/2021	Contact - Document Sent Documentation request sent to administrator Tiffany Tucker, regional director Richard Mabe and assistant executive director Haylee Hutchison
04/14/2021	Contact - Document Received Documentation/Information received from Mr. Mabe by email
05/24/2021	Contact - Telephone call made Attempted with Complainant. Message left requesting return call

05/24/2021	Contact - Telephone call made Message left with Resident A's Guardian requesting return call
05/24/2021	Contact - Document Sent Information request sent to Mr. Mabe by email
05/24/2021	Contact - Telephone call made Attempted with regional director of resident care Lisa Warren. Message left requesting a return call
05/24/2021	Contact - Telephone call made Attempted with administrator Tiffany Tucker at the facility. Message left with staff requesting a call back
05/24/2021	Contact - Telephone call made Interview with Mr. Mabe
05/25/2021	Contact - Document Received Documents received from Relative A1 by email
05/25/2021	Contact - Telephone call made Attempted with former maintenance person Jerome Glombowski. Message left requesting a return call.
05/25/2021	Contact - Telephone call made Attempted with former administrator Karis Wilson-Jones. Message left requesting a return call
05/25/2021	Contact - Telephone call received Interview conducted with Mr. Glombowski
05/26/2021	Contact - Telephone call made Interview with resident care coordinator Lisa Warren
05/26/2021	Contact - Document Sent Document request sent to Mr. Mabe by email
05/27/2021	Contact - Document Received Investigative documents received by email from Mr. Mabe
06/15/2021	Exit Conference – Telephone Conducted with authorized representative Steven Tyshka

Due to the Covid19 pandemic, this investigation was completed remotely.

ALLEGATION:

Resident A did not receive care in accordance with his service plan

INVESTIGATION:

On 4/13/21, the department received this online complaint.

According to the compliant, Resident A lived at the facility until 4/17/20 when he was sent to the hospital and admitted as he was positive for COVID-19. On 4/7/20 Resident A was discovered to have temperature over 100 degrees. The facility reported they were going to test him for COVID-19. It is unknown if this test was ever administered. On 4/10/20, Resident A reported concerns that staff were not wearing masks. Resident A's room phone stopped working on 4/10 so the phone company was contacted to come and fix the room phone. When the phone company arrived on 4/14/20, they did not want to enter the room as Resident A had a sign on his door that read "isolation". When Resident A went to the hospital on 4/17, in addition to being diagnosed positive for COVID-19, he was dehydrated and lethargic, found to have bed sores and was positive for a urinary tract infection (UTI). Resident A passed away on 4/21/20. On 4/22/20, family went to the facility to obtain some or Resident A's clothing and according to Resident A's room cleaning chart, staff had not cleaned his room for at least two weeks prior to his passing on 4/21/20 or at least a week and a half prior to him going to the hospital on 4/17.

Review of the facility licensing file revealed the facility submitted a report to the department for Resident A with an incident date of 4/17/21. Under a section titled Description of *Unusual Occurrence by Observer,* the report reads "Resident was noted to be barley responsive, high blood pressure and exhibiting stroke like symptoms". Under a section titled *Action Taken to Prevent Recurrence/Follow-up Care*, the report reads "Resident transported to SMMH for further eval, writer called to receive update and resident admitted. No further information obtained. Writer will attempt to get diagnosis when nurse is available. Upon resident return from hospital, care staff will adhere to all discharge instructions and encourage visit with PCP and OHC therapy".

On 4/13/21, I interviewed Relative A1 by telephone. Relative A1 stated that on 4/4/20, the facility notified the facility by telephone that Resident A was "doing fine" but gave no details as to what this meant. Relative A1 stated she spoke to (the facility manager, Kara: need to find out who this is) on 4/6/20 who indicated the facility had a resident test positive for COVID-19 on 4/4 which the was the reason for the call stating Resident A was doing fine. Relative A1 stated that on 4/7/20 she found out Resident A had a fever. Relative A1 stated she spoke with Resident A on 4/7 who she stated had a cough as well. Relative A1 stated that on 4/8/20 Resident A was not running a fever anymore but did have a bit of a cough which she stated could have been normal for him during that time of year. Relative A1 stated the last time she spoke with Resident A while he was at the facility was on Good Friday,

4/10/20. Relative A1 stated Resident A1's phone stopped working that day. Relative A1 stated that on 4/12/20, the facility reported Resident A had fallen out of his wheelchair. Relative A1 stated the facility reported he was not injured and that Resident A reported feeling ok. Relative A1 stated Resident A had a second fall later in the day on 4/12. Relative A1 stated the facility contact emergency medical services after the second fall as a reportedly precautionary measure. Relative A1 stated she spoke with EMS by telephone while they were at the facility. Relative A1 stated EMS reported Resident A did not have any apparent injuries and that he had reported feeling fine so Resident A was not sent out to the hospital at that time. Relative A1 stated Resident A's nurse practitioner (NP) contacted Relative A2 on 4/13/20 and reported Resident A was very lethargic. Relative A1 stated the NP stated that due to severe lethargy being a common sign at the time of COVID-19 in older adults, she planned to have Resident A tested for COVID-19 on the morning of 4/14/20. Relative A1 stated Relative A2 was contacted by the facility on 4/17/20 and told Resident A was being taken to the emergency room. Relative A1 stated that when Resident A went to the emergency room on 4/17, he was found to be positive for COVID-19, have a UTI, a bedsore, was dehydrated and very lethargic. Relative A1 stated the last time she or any family member spoke with Resident A at the facility was on 4/10/20. Relative A1 stated Resident A's phone had stopped working on 4/10. Relative A1 stated Resident A's room phone and tv services were contracted through AT&T and that apparently, they stopped working on 4/10 for some reason. Relative A1 stated that on 4/13, she spoke with the facility maintenance person, Jerome Glombowski, regarding the phone not working. Relative A1 stated the Mr. Glombowski attempted to fix the issue but was unable to and suggested AT&T would need to send someone out to fix it. Relative A1 stated that on 4/14 an AT&T Tech did to go the facility to address the issue. Relative A1 stated the Tech reported the issue was with the AT&T "box" located in Resident A's room. Relative A1 stated the Tech was unable to go into Resident A's room that day as Resident A had a sign on his door that stated "Isolation" apparently indicating unauthorized persons could not go into the room. Relative A1 stated the Tech indicated that the box in Resident A's room simply needed to be "rebooted" and that this could be done by staff. Relative A1 stated none of the facility staff would enter Resident A's room to reboot the system. Relative A1 stated that due to this issue, no one in the family was able to contact Resident A between 4/10 and 4/17 when he went to the hospital. Relative A1 stated the last update she had regarding Resident A while at the facility was on 4/13. Relative A1 stated several attempts were made to contact the facility between 4/14 and 4/17 just to get an updated on Resident A and that when someone did answer, staff would report they were unable to check on Resident A at that time. Relative A1 stated that due to staff being unwilling to go into Resident A's room and reporting they did not have time to check on Resident A, as well as Resident A being found on 4/17 to have a UTI, bedsores and extremely dehydrated, she is concerned that staff were not providing Resident A the care he was supposed to receive prior to him going to the hospital.

On 4/13/21, I interviewed regional director of operations Richard Mabe by telephone. Mr. Mabe stated he was not familiar with the events surrounding Resident A in April

2020. Mr. Mabe stated he did serve as the administrator of the facility for a short time starting at the end of April 2020. Mr. Mabe stated that the previous administrator during that time, Karis Wilson-Jones no longer works at the facility. Mr. Mabe stated Ms. Wilson-Jones left her employment shortly before he was appointed administrator. Review of special investigation 2020A1011042 revealed Ms. Wilson-Jones was on leave between 4/8/20 and 4/20/20 and discontinued her employment on 4/22/20 and that Mr. Mabe was appointed the administrator on 4/29/20. Mr. Mable stated regional director of resident care Lisa Warren was working at the facility during the time Ms. Wilson-Jones was off. Mr. Mabe stated Ms. Wilson-Jones did keep in contact with the facility while she was off as she worked remotely. Mr. Mabe stated that during April 2020, staff were provided ample personal protection equipment, including masks, as needed for working with residents. Mr. Mabe stated that due to governors orders in place at the time, staff were only required to wear masks with residents known to be positive with COVID-19. Mr. Mabe stated since he is not familiar with the circumstances of Resident A, he does not know if Resident A was tested for COVID-19 prior to going to the hospital on 4/17/21.

On 4/14/21, I received an email from Mr. Mabe which indicated the facility had no charting notes on file for Resident A for April 2020.

On 5/24/21, I interviewed Mr. Mabe by telephone. Mr. Mabe stated the facility did conduct COVID-19 testing during April 2020. Mr. Mabe stated testing would have been conducted by a home health agency as directed by a physicians order. Mr. Mabe stated that the facility did keep residents who were positive for COVID-19 during April 2020. Mr. Mabe stated any residents who tested positive for COVID-19 and did not need to go to the hospital would have been isolated in their room with a sign on the door which read “isolation”. Mr. Mabe stated staff would have still been expected to adhere to appropriate care for the residents, as indicated by their service plan, while in isolation.

On 5/25/2021, I interviewed former maintenance person Jerome Glombowski. Mr. Glombowski stated he did not specifically recall who Resident A was from his time at the facility. Mr. Glombowski stated he did recall a resident who, during April 2020, had to have AT&T come to the building because his “phone or tv” was not working. Mr. Glombowski stated he recalled having to get “all gowned up” in PPE because the resident was in isolation due to COVID-19. Mr. Glombowski stated he went into the Residents Room because AT&T had been out to the facility and stated that the residents “box” needed to be reset. Mr. Glombowski stated he attempted to reset the box but that it did not work. Mr. Glombowski stated AT&T was contacted again to come back out but would not do so because of active COVID presence in the building.

I reviewed Resident A’s service plan, provided by Mr. Mabe. Under a section titled *Bathing*, the plan reads, in part, “staff will assist [Resident A] with showers 2x a week, helping with hard to reach areas like the lower leg and back areas”. Under a

section titled *Dressing & Grooming*, the plan reads, in part, “Resident A needed “partial assistance with grooming or dressing or putting on shoes”. Under a section titled *Mobility*, the plan reads, in part, “needs assistance getting to and from meals/activities. Occasional assistance with ambulation in his apartment”. Under a section titled *Escort*, the plan reads, in part, “Requires one person assist with transfers”. Under a section titled *Wellness Check*, the plan reads “Wellness check approximately every 2 hours during day/afternoon/night. Ensure prior to entering room knocking on door opening slightly to announce self before entering, ensuring resident privacy”. Under a section titled Toileting, the plan reads, “Needs frequent cueing and/or partial hands on assistance. Care staff should be present in the restroom with [Resident A] to ensure that he is transferred safely from the wheel chair to the toilet”.

I reviewed Resident A’s Resident Care Plan Summary (RCPS) for April 2020, provided by Mr. Mabe. The RCPS is used in combination with the service plan to track specific cares required to be provided to Resident A. The RCPS includes sections highlighted in yellow the cares staff are to provide Resident A. The RCPS also includes three columns, D (Day), E (Evening) and N (Night) to the left of the cares section with space for staff to initial indicating the designated cares have been provided. According to the RCPS, Resident A was to receive bathing on Mondays and Tuesday in the evening; Dressing during “Rounds Every Shift”; Laundry completed on Wednesdays; Housekeeping on Tuesdays. The RCPS includes sections for *Ambulation, Transfer Asist, Personal Hygiene, Dining* and *Activities*, however no specific information is provided regarding times and frequency.

Staff did not document their initials on Resident A’s RCPS to confirm implementation of these items for Resident A in accordance with his service plan on the following dates/shifts:

Day shift: from 4/3; 4/5; and 4/9 to 4/17/20.
Evening Shift: from 4/1; and 4/4 to 4/17/20.
Night Shift: from 4/2 to 4/17/20.

I reviewed a COVID-19 testing document for Resident A from *ACCU REFERNCE MEDICAL LAB* provided by Mr. Mabe. The document indicates a sample was collected from Resident A for testing on 4/14/20 with a positive result discovered on 4/16/20 from the test.

On 5/26/21, I interviewed resident care coordinator Lisa Warren by telephone. Ms. Warren stated Ms. Karis Wilson-Jones in contact with the facility working remotely during April 2020. Ms. Warren stated, however, that Ms. Wilson-Jones focus was not directly on resident care. Ms. Warren stated Ms. Wilson-Jones would have handled duties such as obtaining details on incidents with residents and reporting to the department. Ms. Warren stated she was working onsite at that time Mr. Warren stated she did recall Resident A from that time period prior to him going to the hospital. Ms. Warren stated Resident A was in isolation due to symptoms of COVID-

19 prior to being tested for it on 4/14/20. Ms. Warren stated she also recalled going into his room during that time as she had to put on full PPE in order to enter. Ms. Warren stated Resident A was receiving home health care services from *Oakland Home Care* at the time.

I reviewed April *Home Health/Hospice Field Visit Documentation* for Resident A, provided by Mr. Mabe, which includes notes from a visiting health care service Mr. Mabe indicated had been visiting the facility to provide services to Resident A. The documentation included notes for 4/14/20 and 4/17/20 indicating “time spent with resident today” for 1 hour and 30-40 minutes respectively. The documents further indicated “visit frequency” was done two times per week.

I reviewed Resident A’s hospital admission documentation from *St. Mary Mercy Livonia*, provided by Relative A1, dated 4/17/21. The document indicates Resident A was “admitted to the hospital for further medical management of dehydration, COVID-19". Notes entered by the examining physician read, in part, “Physical exam patient is resting in bed comfortable. Dry Mucous membranes appear dehydrated with delayed cap refill and increases skin turgor. He does have dried food in his mouth and on his shirt. He is very soft spoken but alert and oriented x3 with no focal neurologic deficit”.

I review Resident A’s *Certificate of Death,* provided by Relative A1, which indicated he passed on 4/21/20 of natural causes.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
For Reference: R 325.1901	**Definitions**
	(21) "Service plan" means a written statement prepared by the home in cooperation with a resident and/or the resident's authorized representative or agency responsible for a resident's placement, if any, and that identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical, social, and behavioral needs and well-being and the methods of providing the care and services while taking into account the preferences and competency of the resident.

ANALYSIS:	According to the complaint Resident A did not receive care according to his service plan prior to going to the hospital on 4/17/20. The facility has a method for ensuring staff provide services which adhere to the resident's service plan by having staff document completion of tasks at the end of each shift on RCPS. Review of the RCPS indicated no evidence Resident A received services, in accordance with his service plan, on most dates between 4/1/20 and 4/17, the date which Resident A went to the hospital. Based on the findings the allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/15/21, I discussed the findings of the investigation with authorize representative Steven Tyshka.

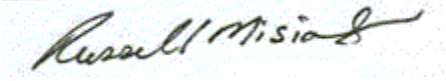
IV. RECOMMENDATION

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

6/9/21

Aaron Clum — Date
Licensing Staff

Approved By:



6/15/21

Russell B. Misiak — Date
Area Manager