GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 24, 2021

Kelly Steffey
Vicinia Gardens Transition
4045 Vicinia Way
Fenton, MI 48430

RE: License #: AH250382445
Investigation #: 2021A0784030
Vicinia Gardens Transition

Dear Ms. Steffey:

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. 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 #:	AH250382445
Investigation #:	2021A0784030
Complaint Receipt Date:	06/09/2021
Investigation Initiation Date:	06/09/2021
Report Due Date:	08/08/2021
Licensee Name:	Vicinia Gardens Transition, LLC
Licensee Address:	1012 N LeRoy Fenton, MI 48430
Licensee Telephone #:	(810) 629-9368
Administrator:	Jessica Mole
Authorized Representative:	Kelly Steffey
Name of Facility:	Vicinia Gardens Transition
Facility Address:	4045 Vicinia Way Fenton, MI 48430
Facility Telephone #:	(810) 629-9368
Original Issuance Date:	09/12/2017
License Status:	REGULAR
Effective Date:	03/12/2021
Expiration Date:	03/11/2022
Capacity:	28
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident B is not being bathed according to her service plan	No
Resident B is not adequately fed or hydrated	No
Additional Findings	Yes

III. METHODOLOGY

06/09/2021	Special Investigation Intake 2021A0784030
06/09/2021	Special Investigation Initiated - Telephone Message left with adult protective services worker Daniel Spalthoff. Call back requested
06/09/2021	Contact - Telephone call received Interview with Mr. Daniel Spalthoff
06/15/2021	Inspection Completed On-site
06/15/2021	Inspection Completed-BCAL Sub. Compliance
06/24/2021	Exit Conference – Telephone Conducted with authorized representative Kelly Steffey

ALLEGATION:

Resident B is not being bathed according to her service plan

INVESTIGATION:

On 6/9/21, the department received this complaint from adult protective services (APS) worker Daniel Spalthoff.

According to the complaint, from 5/31/21 to 6/5/21 Resident B's room smelled like sewage due to a sewage backup in her bathroom. Due to the smell, Resident B also smelled like sewage. Resident B was not bathed during this time due to the sewage problem in her bathroom.

On 6/9/21, I interviewed APS worker Daniel Spalthoff by telephone.
Mr. Spalthoff stated he spoke with resident care director Jessica Mole regarding the allegations. Mr. Spalthoff stated Ms. Mole reported the facility did not have a sewage issue but did have an issue with the toilets in the facility being backed up.
Mr. Spalthoff stated Ms. Mole did not explain how this related to resident bathing, however she reportedly stated that for the period between 5/31/21 and 6/5/21, Resident B had received a sponge bath.

On 6/15/21, I interviewed resident care director Jessica Mole at the facility. Business director Ali Bickford was present during the interview. Ms. Mole stated Resident B did not have a sewage backup in her bathroom at any point in time. Ms. Mole stated that on or about 6/6/21, a staff member reported that Resident B's toilet seemed to be flushing slowly causing an odor in her bathroom. Ms. Mole stated this was reported to maintenance technician Paully Sharewood who she stated addressed the issue. Ms. Mole stated that she is not aware of any sewage backup issues and that whatever the issue was with the toilet has been addressed. Ms. Mole stated Resident B was bathed during this time as scheduled. Ms. Mole, referring to facility records, stated Resident B did receive a sponge bath on 6/4/21 due to Resident B's refusal to take a shower. Ms. Mole stated sometimes Resident B will refuse showers and in order to accommodate her, they will offer sponge baths. Ms. Mole stated that if Resident B refuses both, staff will try to reapproach her at a later time but will not force her. During the onsite inspection I observed Resident B in her room. Resident B appeared to be clean and well groomed. No odors as described within the complaint were present at the time.

On 6/15/21, I interviewed maintenance technician Paully Sharewood at the facility. Mr. Sharewood provided statements consistent with Ms. Mole regarding Resident B's slow flushing toilet. Ms. Sharewood stated he could not recall the exact date, but that it was sometime around the beginning of June 2021. Mr. Sharewood stated Resident B's toilet was flushing but did appear to be doing so slowly.
Mr. Sharewood stated he used a tool called a "snake" to clear out the pipes and the

toilet starting flushing better. Mr. Sharewood stated he has not had any issues since doing this.

I reviewed Resident B's service plan, provided by Ms. Mole. Under a section titled *Bathing,* the plan indicates Resident B's receives two showers a week between 5pm and 8pm.

I reviewed a document titled *Admin History for [Resident B]* - SHOWER, provided by Ms. Mole. Ms. Mole explained that this document is a log of the dates and times staff provided showers to Resident B. I reviewed logs dated between December 2020 and June 2021. According to the logs staff are providing showers to Resident B consistent with her service plan.

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.
ANALYSIS:	The complaint alleged Resident B was not being bathed according to her service plan. Interviews with staff and review of Resident B's service plan and tracking documentation do not support the allegation. Based on the findings the allegation is not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident B is not adequately fed or hydrated.

INVESTIGATION:

On 6/10/21, the department received this complaint in reference to Resident B after it was discovered to have been assigned to the AFC Division incorrectly.

According to the complaint, at some point during March 2021, Resident B was found nonresponsive and taken to the hospital. Her labs came back normal except for dehydration. Additionally, on approximately May 5, 2021, Resident B stopped eating and drinking and became dehydrated. Prior to that she was playing bingo, eating, talking, and calling her family daily. When the facility was asked why she was not

eating they said she needed a swallow study done and it was due to her Parkinson's and stated Resident B needed to puree foods. Resident B's family have brought Resident B solid meals to eat and she appears to consume them just fine with no problems swallowing.

When interviewed, Ms. Bickford explained that she was the resident care director at the facility until approximately April 20, 2021. Ms. Bickford stated she was familiar with the events noted in the complaint from March 2021 and May 2021. Ms. Bickford stated that she did not recall the exact date, but that on a day in March, during or after Resident B was done eating lunch, staff checked on Resident B to see if she needed a brief change. Ms. Bickford stated Resident B was non-responsive to staff and so emergency services (EMS) was called to take her to the hospital. Ms. Bickford stated Resident B stayed overnight at the hospital and was found to be dehydrated. Ms. Bickford stated Resident B receives liquids with her meals and has liquids available to her any time of the day. Ms. Bickford stated the facility also conducts three "water passes" a day for all residents at 7am, 3pm and 7pm to ensure all residents are offered liquids throughout the day. Ms. Bickford stated Resident B generally will drink liquids regularly.

I reviewed the facilities HOME FOR THE AGED – INCIDENT/ACCIDENT REPORT, dated 3/15/21, provided by Ms. Mole. Under a section titled Explain What Happened/Describe Injury, the report read "Resident was eating and when RA came to do brief checks, resident was breathing but non-responsive. Resident was brought to empty hallway and chest rubs were performed. No response was given so family and stat [emergency services]".

When interviewed, Ms. Mole stated that sometime in May 2021, staff began to notice Resident B having difficulty swallowing her food. Ms. Mole and Ms. Bickford stated Resident B has historically been a slow eater, sometimes taking up to an hour to finish her food, and that staff noticed it was becoming more difficult for her and taking longer. Ms. Mole stated the facility requested for Resident B's to have a swallow test conducted from *Careline Physicians Services*, who provide Resident B with her primary medical care. Ms. Mole stated that the recommendation from this evaluation was that Resident B be put on a pureed diet. Ms. Mole stated Resident B's family did not agree with the recommendation. Ms. Mole stated Resident B has been eating and drinking regularly and is assisted by staff. Ms. Mole stated the facility maintains a log to indicate when and how much Resident B is eating.

I reviewed an *Order Form* from *Careline Physician Services,* provided by Ms. Mole and attributed to Resident B. The form indicated a "date of service" of 4/21/21. In a section titled *Services Order*, the form reads "Pureed Diet".

Under a section of Resident B's service plan titled *Eating/Meals*, the plan indicates Resident B receives a "pureed" diet due to "difficulty chewing" and "difficulty swallowing". This section also indicates that "Employees are to assist the resident

with feeding" and that Resident B should be offered fluids "every two hours during waking hours".

I reviewed a document titled *Admin History for [Resident B] - EATING*, provided by Ms. Mole for May and June of 2021. The log reads consistently with statements provided by Ms. Mole. The log provides a "percentage" of food eaten and indicates Resident B is consistently provided three meals a day.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	The complaint alleged Resident B is not being fed or hydrated adequately. While Resident B was apparently found to be dehydrated on two occasions, interviews and document review indicate the facility is appropriately following Resident B's order for a puree diet and providing Resident B with ample opportunities to consume liquids. Based on the findings the allegation is not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

The complaint indicated Resident A suffered an injury between approximately 5/13/21 and 5/15/21 and that the wound had to be soaked because the bandage used to wrap it was stuck to the wound.

When interviewed, Ms. Mole stated that on 5/15/21, associate Madison Nelson was pushing Resident B in her wheelchair to the facilities activities room. Ms. Mole stated Ms. Nelson accidently pushed Resident B too close to the door of the room and her arm caught on the door causing a skin tear to her forearm. Ms. Mole stated Ms. Nelson put medical tape around the wound in an attempt to provide wound care. Ms. Mole stated Ms. Nelson had not been trained for wound care at this time. Ms. Mole stated attempts were made to contact Resident B's primary medical care

service, *Careline Physician Services,* and that no one was available to come to the facility. Ms. Mole stated the NP from Careline did not come to the facility until 5/19/21 to provide wound care. Ms. Mole stated attempts were made each day between 5/15 and 5/19 to contact Careline. Ms. Mole stated that during that time, Resident B was provided wound care by Ms. Nelson on the morning on 5/16/21, 5/17/21 and 5/18/21 while also being provided wound care in the evening of 5/18 by care associate Alexandria Dainty after providing Resident B with a shower. Ms. Mole stated Ms. Dainty also was not trained on proper wound care. Ms. Mole stated staff generally are not trained for wound care the facility will usually request orders for wound care to be provided by outside services. Ms. Mole stated some staff have been trained in wound care, but not Ms. Ms. Madison or Ms. Dianty prior to 5/19 when Ms. Nelson was trained by the Carline NP on how to provide proper wound care. Ms. Mole stated the NP did provide an order for the wound care on 5/19. Ms. Mole stated the NP was upset when she arrived at the facility on 5/19 because Resident B's wound had been wrapped in medical tape which had to be soaked in order to be removed.

When interviewed, Ms. Bickford stated the facility did not pursue alternate methods of providing proper wound care for Resident B prior to 5/19/21 and stated, "I think we just dropped the ball".

I reviewed Resident B's wound care order, provided by Ms. Mole, which indicated that on 5/19/21 the NP ordered "wound care to right arm skin tear". Notes in the order read "Apply Vaseline jelly, cover with telfa, then wrap with coban, Change QD and PRN".

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
For Reference: R 325.1901	**Definitions**
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and

	personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	The complaint indicated Resident B received improper wound care after suffering a skin tear. The investigation revealed that after accidently suffering a skin tear on 5/15/21, staff who were untrained in proper wound care proceeded to attempt wound care for several days until adequate care was obtained on 5/19/21. Based on the findings the allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Review of incident reporting regarding Resident B in relation to 3/15/21 and 5/15/21 indicated Resident B's primary physician and authorized representative were notified, however no such notification was noted to the department.

Review of the facility licensing file revealed no reporting regarding the incidents in question from 3/15/21 and 5/15/21.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.
For Reference: R 325.1901	**Definitions**
	(17) "Reportable incident/accident" means an intentional or unintentional event in which a resident suffers harm or is at risk of more than minimal harm, such as, but not limited to, abuse, neglect, exploitation, or unnatural death.

ANALYSIS:	The investigation revealed that the facility did not report incidents relative to Resident B which fall within the definition of a reportable incident. Based on the findings the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/24/21, I discussed the findings of the investigation with authorize representative Kelly Steffey.

IV. RECOMMENDATION

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

6/24/21

Aaron Clum Date
Licensing Staff

Approved By:

6/24/21

Russell B. Misiak Date
Area Manager