GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 1, 2021

Sanjay Rattan
Marys Residential Care for Seniors Inc
Suite
5701 Chicago Road
Warren, MI 48092

RE: License #: AL500007236
Investigation #: 2021A0990009
Marys Senior Center

Dear Mr. Rattan:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 (248) 975-5053.

Sincerely,

LaShonda Reed, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(586) 676-2877

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL500007236
Investigation #:	2021A0990009
Complaint Receipt Date:	05/21/2021
Investigation Initiation Date:	05/21/2021
Report Due Date:	07/20/2021
Licensee Name:	Marys Residential Care for Seniors Inc
Licensee Address:	35225 Silvano Clinton Twp, MI 48035
Licensee Telephone #:	(248) 844-1407
Administrator:	Sanjay Rattan
Licensee Designee:	Sanjay Rattan
Name of Facility:	Marys Senior Center
Facility Address:	35225 Silvano Clinton Twp, MI 48035
Facility Telephone #:	(586) 790-0640
Original Issuance Date:	03/09/1979
License **Status:**	REGULAR
Effective Date:	09/09/2019
Expiration Date:	09/08/2021
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL; AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A came to the hospital with bleeding sores on her back. The sores have a foul odor. Resident A is severely malnourished and dehydrated. Her wound dressings have not been changed since 05/10/2021.	Yes

III. METHODOLOGY

05/21/2021	Special Investigation Intake 2021A0990009
05/21/2021	APS Referral Adult Protective Services (APS) Complaint initiated at intake.
05/21/2021	Special Investigation Initiated - Letter I emailed Sanjay Rattan, licensee designee (LD). I requested several documents related to Resident A.
05/21/2021	Contact - Document Sent I emailed Krystal Shaw, APS investigator. I requested more information about the complaint.
05/21/2021	Contact - Document Received I received an email from Ms. Shaw.
05/24/2021	Contact - Telephone call made I conducted a brief phone interview with Mr. Rattan.
05/27/2021	Contact - Face to Face I conducted an onsite investigation along with Ms. Shaw. I interviewed Mr. Rattan and direct staff Heather Hale. I observed Resident A.
06/07/2021	Contact - Document Received I reviewed Resident A's documents.
06/07/2021	Contact - Telephone call made I conducted a phone interview with Nadia Kent, Nurse Practitioner (NP).

06/07/2021	Contact – Telephone call made I called Andrea Rumbley, direct care staff. Ms. Rumbley said that she was busy and would call back.
06/22/2021	Contact - Telephone call made I conducted a phone interview with Dipa Begam, home health nurse from Mobility Plus Home Care.
06/22/2021	Contact - Telephone call made I left a detailed voice message for Relative A.
06/23/2021	Contact - Telephone call made I conducted a phone interview with Ms. Begam and Ms. Shaw.
07/01/2021	Exit Conference I conducted an exit conference with Mr. Rattan.

ALLEGATION:

Resident A came to the hospital with bleeding sores on her back. The sores have a foul odor. Resident A is severely malnourished and dehydrated. Her wound dressings have not been changed since 05/10/2021.

INVESTIGATION:

On 05/21/2021, I received an email from Krystal Shaw, APS investigator. Ms. Shaw said that she visited Resident A today at Mt. Clemens Regional Hospital and took several pictures that will be forwarded. Ms. Shaw said that Resident A was in bad shape, and they are discussing hospice. Ms. Shaw said that Resident A has resorted to curling up and twisting her legs and is not eating. Ms. Shaw said Resident A is covered bedsores of all different stages and some unstageable. Ms. Shaw said that Resident A arrived at the emergency room (ER) with her eyes crusted shut. Ms. Shaw said that the hospital believes that Resident A was being physically neglected in the home based her condition when she arrived on 05/19/2021. Ms. Shaw said that Resident A is fragile malnourished, and her bones are sticking out of every part of her body. Ms. Shaw said that she was informed by the hospital staff that when Resident A arrived at the ER on 05/19/201 one set of her wound dressings were dated for 05/10/2021.

On 05/24/2021, I conducted a phone interview with Mr. Rattan, licensee designee. Mr. Rattan said that Resident A health has declined, and her appetite has decreased. Mr. Rattan said that prior to Resident A's hospitalization, the family refused hospice care for Resident A. Mr. Rattan said although, Resident A refused to eat they were encouraging three meals per day and fluids. Prior to Resident A being hospitalized, she has a bedsore on her buttock. The bedsore was healing until the family demanded that Resident A stay in bed. Although Resident A was in bed most of the day she was turned every two hours per doctors' orders. On 05/18/2021, staff observed that

Resident A was lethargic although, she was last seen by her physician on that Monday 05/17/2021. Mr. Rattan said that staff observed a new bedsore on the middle of her back on 05/19/2021 and it was decided that she needed to be seen at the ER. Mr. Rattan said that Resident A is very thin. Mr. Rattan said that he would be sending over the requested documents soon as well as the incident report (IR).

On 05/27/2021, I conducted an onsite investigation along with Ms. Shaw. I interviewed Mr. Rattan and direct staff Heather Hale. I observed Resident A. Mr. Rattan said that Resident A returned to the facility on 05/26/2021. Mr. Rattan said that Resident A returned with four new bedsores. The bedsores are located on each hip and each foot. Mr. Rattan said that the family has agreed to hospice care since Resident A has returned. Resident A has been living at the facility since April 2021 and was transferred from one Mr. Rattan's other adult foster homes due to its closure (Dawn's Center closed effective 03/12/2021). Mr. Rattan said that Resident A lived there for three years.

Mr. Rattan said that Resident A's nurse practitioner is Nadia Kent, and her home health nurse is Dipa Begum. Mr. Rattan said that Ms. Begum would change the wound dressings 1-2 times per week. Mr. Rattan said that in between the home health care changes, staff would change the dressing as well as needed. Resident A's wounds were healing until the family decided in early May 2021 that they wanted Resident A in bed most of the day. Mr. Rattan said that Resident A was more susceptible of bedsore because she is very thin. Resident A was turned every two hours. Mr. Rattan said that the second week of May, Resident A stopped eating. Staff would introduce food to her, and she would not eat much and eating at about 50%. Resident A was beginning to lose weight which also increases her risk for bedsores. Mr. Rattan said that they were giving her Ensure nutritional drinks. The family would visit and try to feed Resident A as well, but she would not eat. Mr. Rattan said that Resident A was given baths twice a week.

Ms. Shaw said that she visited Resident A in the hospital and observed that her eyes were crusted shut and she was brought into the ER wearing a hospital gown. The hospital staff reported that Resident A's dressings had written dates on them for 05/10/2021. Ms. Shaw observed the bedsores on 05/20/2021 and has photos and medical documentation to support this.

I interviewed direct care staff Heather Hale. Ms. Hale said that she has worked for the home for 1.5 years. When Ms. Hale returned from vacation on 05/18/2021, she observed that Resident A was not eating or drinking. Ms. Hale said that she tried giving her Ensure and yogurt, but she refused to eat. On 05/19/2021, Ms. Hale observed that Resident A was very lethargic and observed a new wound on her back. Ms. Hale contacted Mr. Rattan to report her condition and it was decided that Resident A needed to go the ER. Ms. Hale was trained to write the dates on the dressings. Ms. Hale said that if the dressings were changed while she was on vacation more than likely there would not have been a date written on her dressings because she is the only person that does this. Ms. Hale could not recall if the dressings were dated when she observed Resident A on 05/18/2021 or 05/19/2021.

Ms. Hale said that she observed four bedsores on Resident A before she was hospitalized. Ms. Hale said that on 05/19/2021 she was going to give Resident A a bed bath but realized that she was too weak and needed medical intervention. Ms. Hale changed Resident A into a hospital gown before the medical transportation services arrive. Ms. Hale said that prior to her vacation Resident A's wounds were pink and healing. Ms. Begum showed her how to do wound care. Ms. Hale said that Resident A's family insisted that she stays in bed because they felt that she was too uncomfortable sitting in her recliner.

During the onsite, I observed Resident A lying in her bed. She had two dressings on both of her feet (heels) and both hips. Mr. Rattan showed areas where bedsores existed before and were healed. Mr. Rattan insisted that the new bedsores were obtained while she was hospitalized. Resident A was not able to be interviewed due to her altered state.

I observed several photos sent by Ms. Shaw that were taken of Resident A on 05/20/2021. I observed the following wounds:

- Large pinkish open wound on right hip.
- Small dark colored wound on right elbow
- Small wounds on left inner lower leg
- Left forearm purple and bluish with a small open wound that was darkening
- Small dark wounds on right inner foot and heal

On 06/07/2021, I reviewed Resident A's documents. Resident A's weight at admission was 106 pounds on 02/25/2021. I observed her last weight on 04/24/2021 was 98 pounds. I observed in the physician contact notes that wound care was done on 04/19/2021 and that on 04/24/2021 hospice was discussed with the family.

I reviewed Resident A's *Assessment Plan* dated 02/25/2021. Resident A is uses a wheel chair and is contracted at the legs. Resident A is a one person assist for all activities of daily living. I reviewed Resident A's May medication administration record (MAR). It was noted on the MAR that Santyl ointment was applied to her left buttock daily at 8AM and was initialed up until 05/20/2021. I observed that the Santyl ointment was started on 04/25/2021.

I reviewed Resident A's medical report from Mt. Clemens Regional Hospital date of service 05/20/2021. According to the medical report, Resident A's general appearance was severely malnourished with bony prominences of her skeletal, her eyes were crusted shut with discharge, her mucous membranes were dry, her lower extremities were atrophied (withered), there were multiple wounds on her heels/lateral toes, unstageable sacral (upper tail bone) wounds, thorax pressure wounds (mid-body) and coccygeal wounds (lower tail bone). It was also noted that Resident A was admitted due to altered mental state and she was wearing a urine-soaked diaper. It was noted in the hospital notes that the attending nurse documented that Resident A's wound dressings were dated 05/10/2021 and appeared as if they had not been changed since.

It was also documented that Relative A informed the hospital that Resident A refuses to eat and has been declining since a femur fracture some years ago. It was documented that the Relative A said that the family visits 2-3 times week and Resident A was observed sitting up in her wheelchair on 05/16/2021.

I reviewed note from Premier Physician Care dated 05/26/2021. Resident A was seen by Nadia Kent, Nurse Practitioner (NP) at the facility. The note documents that Resident A had open ulcers that were healing. The family agreed to hospice care.

I reviewed the hospital discharge paperwork from Mt. Clemens Regional Medical Center dated 05/26/2021. The reason for hospitalization was for advanced Alzheimer dementia with failure to thrive and multiple pressure wounds.

On 06/07/2021, I conducted a phone interview with Nadia Kent, (NP). Ms. Kent said that she visited Resident A today at the facility. Ms. Kent said that she was aware of the allegations. Ms. Kent said that prior to today, she last saw Resident A on 04/26/2021 and she had an ulcer on her left buttock. Ms. Kent said that they begin treating the ulcer. Ms. Kent said that over the last 2.5 months Resident A has declined rapidly and is malnourished. Ms. Kent said that she has talked to the family several times in the past about hospice services, but they declined, and it was decided by the family that they would give Resident A Ensure nutritional drinks. Ms. Kent said that Resident A's body is very contracted, and it is painful for her to be moved. Ms. Kent said that Ms. Begum would have more information about the wound care. Ms. Kent said that if the family had agreed to hospice care sooner that Resident A would not have been hospitalized in that condition.

On 06/22/2021, I conducted a phone interview with Dipa Begum, home health nurse from Mobility Plus Home Care. Ms. Begum said that she no longer is working for Mobility Plus and is living in Canada. Ms. Begum recalls only seeing Resident A a few times along with other residents in the facility. Ms. Begum agreed to call back after receiving access to the system to review the chart.

On 06/23/2021, I conducted a phone interview with Ms. Begum and Ms. Shaw. Ms. Begum said that she could not gain full access to Resident A's medical records. Ms. Begum said that she was told by her prior employer that she last saw Resident A on 05/06/2021. Ms. Begum said on that date she changed her dressings. Ms. Begum said that Resident A had a wound on her left leg that was healing and one on her tailbone that was healing. Ms. Begum said that she would see Resident A 1-2 times per week and in between visits the staff are to change the dressings if there is draining or fecal matter. Ms. Begum said that typically open wounds are changed every two days unless there is drainage or fecal matter.

On 07/01/2021, I conducted and exit conference with Mr. Rattan. I informed Mr. Rattan the findings and the report will be sent for review for finalization. Mr. Rattan was provided technical support regarding more detail needed in *Assessment Plans*. Mr. Rattan was recommended and agreed that the wound dressings should be changed per doctors' orders and dated to keep track.

APPLICABLE RULE	
R 400.15303	**R 400.14310 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: (d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.
ANALYSIS:	Resident A was hospitalized on 05/19/2021 due to altered mental status. According to Mr. Sanjay-LD and Ms. Kent-NP Resident A's health began to decline in April 2021. As a result, home health nursing services were provided to Resident A 1-2 times per week by Mobility Plus nurse Ms. Begum. According to the MAR, Resident A began ointment on her wounds. Ms. Sanjay said that due Resident A's thin structure and contracted legs she was prone to bedsores. According to Ms. Sanjay, the family wanted Resident A in bed all day. Resident A was turned every two hours when in bed however, due to her frailty and lack of movement she was prone to bedsores. According to Ms. Kent-NP, over the last 2.5 months Resident A has declined rapidly and is malnourished. Ms. Kent has talked to the family several times in the past about hospice services, but they declined. If the family had agreed to hospice care sooner, Resident A would not have been hospitalized in that condition. Based on Resident A's thin body structure, contracture lower extremities and refusal to eat, she was prone to bedsores. Some of the bedsores healed and new ones developed. It cannot be determined that the facility did not properly provide for Resident A's health care needs.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions, when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathe at least weekly and more often if necessary.
ANALYSIS:	Resident A was hospitalized on 05/19/2021 due to altered mental status. Upon her admission to the hospital, Resident A was observed to have multiple ulcers, malnourished and her eyes were crusted shut. According to the APS investigator Ms. Shaw and the Mt. Clemens General Hospital records, Resident A dressings for her wounds were dirty and dated for 05/10/2021 which was nine days prior. Ms. Hale, direct care staff could not recall if the wound dressings were dated for 05/10/2021 on 05/19/2021 when she observed Resident A's condition prior to hospitalization. Ms. Hale is the only staff person that writes the dates on the dressing when changed. Ms. Hale has been on vacation until 05/18/2021. There is sufficient evidence to support that Resident A wound dressings were not changed for nine days. According to Ms. Begum home health nurse, wound dressings should be changed at least every two days or more as needed.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend no change the license.

L. Reed 07/01/2021

LaShonda Reed Date
Licensing Consultant

Approved By:

Denise Y. Nunn 07/01/2021

Denise Y. Nunn Date
Area Manager