GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 7, 2021

Andrew Akunne
Mary Rose Corporation
Unit A
3879 Packard Rd.
Ann Arbor, MI 48108

RE: License #: AM820010013
Investigation #: 2021A0901023
Mary Rose Residence

Dear Mr. Akunne:

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 (313) 456-0380.

Sincerely,

Regina Buchanan, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 949-3029

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM820010013
Investigation #:	2021A0901023
Complaint Receipt Date:	05/24/2021
Investigation Initiation Date:	05/26/2021
Report Due Date:	07/23/2021
Licensee Name:	Mary Rose Corporation
Licensee Address:	Unit A 3879 Packard Rd. Ann Arbor, MI 48108
Licensee Telephone #:	(313) 479-4652
Administrator:	Andrew Akunne
Licensee Designee:	Andrew Akunne
Name of Facility:	Mary Rose Residence
Facility Address:	22293 Sibley Road Brownstown Township, MI 48192
Facility Telephone #:	(734) 479-4652
Original Issuance Date:	12/01/1986
License Status:	REGULAR
Effective Date:	02/26/2020
Expiration Date:	02/25/2022
Capacity:	12
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was diagnosed with Gangrene on his left foot that required surgery. There are worries that the staff was not addressing the wound despite dressing and bathing him daily.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/24/2021	Special Investigation Intake 2021A0901023
05/24/2021	APS Referral
05/26/2021	Special Investigation Initiated - Telephone APS, Tracey Anderson
05/26/2021	Contact - Telephone call made Staff, Cherice Clanton Home Manager, Diane Lemuel
06/08/2021	Contact - Telephone call made Resident A's daughter
06/08/2021	Contact - Telephone call made Home Manager, Diane Lemuel
06/08/2021	Contact - Document Received Fax
06/18/2021	Contact - Telephone call made Resident A

06/23/2021	Contact - Document Received Fax
06/29/2021	Contact - Telephone call made Resident A
06/30/2021	Contact - Face to Face Resident A
07/01/2021	Contact - Telephone call made Home Manager, Diane Lemuel
07/01/2021	Contact - Telephone call made Resident A's daughter
07/01/2021	Contact - Document Received Fax
07/02/2021	Inspection Completed-BCAL Sub. Compliance
07/03/2021	Exit Conference Andrew Akunne

ALLEGATION:

Resident A was diagnosed with Gangrene on his left foot that required surgery. There are worries that the staff was not addressing the wound despite dressing and bathing him daily.

INVESTIGATION:

An onsite inspection was not completed due to the COVID-19 Pandemic.

On 05/26/2021, I made a telephone call to Tracey Anderson, from APS. She stated Resident A was hospitalized 5/3/2021-5/4/2021 and during that time was diagnosed with Gangrene on his left foot and had to have surgery. She was very concerned as to how his foot got so infected and went unnoticed, considering staff at the home were responsible for bathing and dressing him daily. He is currently in the hospital due to falling out the bed on 05/08/2021 and will not be returning to the facility upon discharge but would be going to a nursing home. Ms. Anderson indicated that due to his health problems and issues with his feet and legs he tends to fall. She specified that the issue with the home was not supervision but the care they provided.

On 05/26/2021, I made a telephone call to the facility and spoke with staff, Cherice Clanton. She stated Resident A moved into the facility in January 2021 and has always had issues with his foot and legs. He has also been in and out of the hospital since his placement there due to his foot and leg issues. She suggested that I speak with the home manager, Diane Lemuel.

On 05/26/2021, I interviewed Ms. Lemuel. She indicated they did not know Resident A's foot was hurting or infected because he never complained about it. She explained that he had a cut underneath his foot that they were not aware of. Ms. Lemuel stated staff should have been checking his feet but were not and that this was something they needed to start doing for all residents. She also said they did not notice it because they stood him up when giving him showers. Ms. Lemuel further indicated that Resident A was receiving in-home care from Henry Ford due to the cellulitis in his legs and he did not complain to them either nor did they notice it. Ms. Lemuel explained that he went to the hospital on 05/03/2021 due to not eating and drinking and that is when the infection was discovered, resulting in surgery. He returned to the home on 05/05/2021 and hospitalized again 05/09/2021 after falling. Due to his numerous health issues, he will be going to a nursing home.

On 06/08/2021, I made a telephone call to Resident A's daughter, who is also his Power of Attorney. She was very concerned that staff allowed his foot to get so infected that he needed surgery. She stated they are supposed to bathe him at least twice a week and if this was being done, there is no excuse for it being unnoticed. She further stated that Resident A has neuropathy, which the home was aware of, therefore, he would not have known there was a problem with his foot because he

cannot feel anything. She indicated that he was currently at Applewood Nursing Center.

On 06/08/2021, I made a telephone call to Ms. Lemuel. She stated they were not aware that Resident A had neuropathy until after his surgery. She explained that she noticed on his discharge paperwork from the hospital that he was prescribed Neurontin and since she was familiar with it, she knew what it was for. She also indicated that staff bathed him 2-3 times a week.

On 06/08/2021, I received a fax from Ms. Lemuel. It consisted of his admission face sheet, a health care appraisal, and podiatry consult. He was admitted to the facility 01/20/2021. A health care appraisal was completed 01/29/2021 and no abnormalities with his feet were noted. He saw the podiatrist on 02/23/2021. The purpose of the visit was mycotic nails. He was diagnosed with ouchomycosis and treated for thickened, yellow, painful, elongated nails. Ms. Lemuel explained that this was his first visit with the podiatrist since his placement at the facility. During the time he was supposed to have his 2nd visit, he had surgery and his daughter wanted him to follow-up with the podiatrist that did the surgery. The fax also included verification of the in-home care he received from Henry Ford and discharge and admission paperwork from a previous hospitalization at Henry Ford on 02/23/2021 and a stay at Applewood nursing home on 03/05/2021. That paperwork listed a host of medical conditions with most of them being chronic. None of the paperwork indicated a foot infection.

On 06/18/2021, I made a telephone call to Applewood in an attempt to speak with Resident A but was told he was napping.

On 06/23/23021, I received a fax from Ms. Lemuel. It consisted of Resident A's assessment plan and incident reports that was completed during his stay at the facility.

On 06/29/2021, I attempted to contact Resident A again at Applewood, but was told I would have to visit him in-person because the residents do not have telephones in their rooms.

On 06/30/2021, I met with Resident A face-to-face at Applewood. He stated he liked the facility and got along well with everyone. He indicated he fell a lot due to his legs being weak and problems with his feet. Resident A stated he did not know his foot was so bad. He reported he has neuropathy but was not sure if staff knew. When asked about being bathed, he stated staff bathed him weekly. They always stood him up to bathe him but did not wash his feet.

On 07/01/2021, I made a telephone call to Ms. Lemuel. I requested that she re-send the fax due to some of the pages overlapping. I could not read them all.

On 07/01/2021, I made a telephone call to Resident A's daughter. She did not recall if she told staff about Resident A having neuropathy but stated they should have known due to his diabetes.

On 07/01/2021, I received a fax from Ms. Lemuel. It was another copy of Resident A's assessment plan and the discharge paperwork from his hospitalization 05/03/2021-05/05/2021. His assessment plan indicated that he always required assistance with bathing. He also required assistance with dressing and personal hygiene. During his hospitalization he was diagnosed with pressure injury on his left foot, acute brain disorder, chronic kidney failure, chronic airway obstruction, depressive disorder, high blood pressure, and irregular heartbeat. On 05/04/2021 he had a procedure done titled debridement bilateral feet.

APPLICABLE RULE	
R 400.14310	**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:	Based on the information obtained during this investigation, Resident A did not receive immediate medical care as needed. Resident A's foot was so infected that he required surgery. The infection went undetected by staff due to the lack of attention given to his feet. Staff failed to check his feet on a regular basis. They were also negligent with bathing his feet. Resident A stated and Ms. Lemuel admitted that staff did not wash his feet. They stood him up for showers but did not give attention to his feet. Considering Resident A required assistance with bathing and dressing, if done properly, the infection should have been observed sooner and care obtained immediately.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 07/01/2021, I made a telephone call to Ms. Lemuel. I requested that she re-send me Resident A's assessment plan. Due to some of the pages overlapping I could not read them all. She informed me that due to COVID, the assessment plan was not signed by Resident A's daughter. I explained that it could have been completed with her by phone, faxed, mailed or emailed for her review and signature. She also

informed me that she completes the assessment plans after the residents move in and she has had time to assess them.

On 07/01/2021, I made a telephone call to Resident A's daughter. She stated someone from the office completed an assessment before Resident A came to the home, but no one from the home contacted her for an assessment after his placement. She also did not recall being sent a copy of an assessment to sign.

On 07/01/2021, I received a copy of Resident A assessment plan. He was admitted to the home on 01/20/2021. It was completed by Ms. Lemuel on 02/10/2021 and was not signed by Resident A's daughter.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Based on the information obtained during this investigation, Resident A's assessment plan was not completed at the time of admission and was not completed with Resident A's daughter, who is his designative representative.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remains unchanged.

_____07/02/2021
Regina Buchanan Date
Licensing Consultant

Approved By:

_____07/07/2021
Ardra Hunter Date
Area Manager