GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 1, 2021

Renae-Marie Kiehler
Innovative Housing Dev Corp
3051 Commerce Drive, Suite 5
Fort Gratiot, MI 48059

RE: License #: AS740253774
Investigation #: 2021A0604015
Mayfield

Dear Ms. Kiehler:

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 (248) 975-5053.

Sincerely,

Kristine Cilluffo, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 285-1703

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS740253774
Investigation #:	2021A0604015
Complaint Receipt Date:	08/23/2021
Investigation Initiation Date:	08/23/2021
Report Due Date:	10/22/2021
Licensee Name:	Innovative Housing Dev Corp
Licensee Address:	Suite 5 3051 Commerce Drive Fort Gratiot, MI 48059
Licensee Telephone #:	(810) 385-4463
Administrator:	Renae-Marie Kiehler
Licensee Designee:	Renae-Marie Kiehler
Name of Facility:	Mayfield
Facility Address:	3055 Mayfield Port Huron, MI 48060
Facility Telephone #:	(810) 982-8968
Original Issuance Date:	03/18/2003
License Status:	REGULAR
Effective Date:	09/18/2019
Expiration Date:	09/17/2021
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A had a stroke and there is concern regarding the length of time it took for her to receive medical treatment. Her activity logs appear to be altered.	Yes

III. METHODOLOGY

08/06/2021	Contact- Document Received Email from St. Clair County Recipient Rights Director, Telly Delor
08/06/2021	Contact- Document Sent Email to and from Administrator, Mindy Wiegand
08/10/2021	Contact- Document Received Email from Administrator, Mindy Wiegand
08/23/2021	Special Investigation Intake 2021A0604015
08/23/2021	Special Investigation Initiated - Letter Email from Telly Delor. Received return email.
08/23/2021	Contact - Document Sent Email to and from Telly Delor.
08/24/2021	Inspection Completed On-site Completed unannounced onsite investigation. Interviewed Home Manager. Lisa Scouton and Staff, Dana Landschoot.
08/24/2021	Contact - Document Sent Email to and from Telly Delor.
08/27/2021	Contact - Document Sent Email to and from Telly Delor.
11/01/2021	Exit Conference Completed exit conference by email with Licensee Designee Renae Kiehler and Administrator, Mindy Wiegand

ALLEGATION:

Resident A had a stroke and there is concern regarding the length of time it took for her to receive medical treatment. Her activity logs appear to be altered.

INVESTIGATION:

On 08/06/2021, I received an email from St. Clair Community Mental Health (CMH) Recipient Rights Director, Telly Delor. She stated that the nurse at CMH, Karen Recker, will be reviewing records for Resident A as it was reported that she may have showed signs of a stroke two days prior to receiving medical treatment. Ms. Delor stated that the nurse would like to review records prior to deciding whether she believed Resident A was taken to the hospital early enough.

On 08/06/2021, I sent an email to Administrator, Mindy Wiegand regarding Resident A and requested a copy of incident report.

On 08/10/2021, I received Resident A's records by email from the Administrator, Mindy Wiegand. Ms. Wiegand sent Resident A's Individual Plan of Service, daily logs, bed checks, Harbor Oaks and MedliLodge records, health care chronological, health care appraisal and VPA appointment record.

On 08/20/2021, I received a copy of registered nurse's (RN) report from Telly Delor by email. On 08/23/2021, I reviewed Karen Recker RN's report and opened an investigation based on the findings.

The nurse's analysis stated the following:

> "(Resident A) began having mobility issues on 8/1/21 at 11:30 am requiring multiple staff to assist in getting her to the restroom. There was no further notation of her difficulty either worsening or resolving until 8/2/21 at 3:30 pm when EMS was requested. Two different physicians at McLaren PH noted (Resident A) to have an onset of stroke symptoms 24 hours or more prior to her coming into the ER for treatment. Stroke symptoms constitute an emergency medical situation that requires immediate medical attention in order to ensure the best possible outcome for the person exhibiting symptoms. Failing to provide prompt, emergency medical care when someone is having stroke symptoms can cause/contribute to less favorable outcomes including increased risk of permanent disability or death, depending on the location and severity of the stroke. The (unaltered) activity log sheets give the appearance of (Resident A) being at her baseline on and before 7/31/21 and there is a notable change in food intake on 8/1/21 in the afternoon. There is no documentation of dietary intake or activity for the midnight or day shift on 8/1/21. She is noted to have refused breakfast on 8/2/21 and ate 50% of her lunch. It is unclear what goals were completed during day shift on 8/2/21 prior to EMS being requested." Ms.

> Recker made the following recommendations, “Recommend that Emergency Medical care be provided at the onset of a medical emergency.
>
> Recommend that when a change in medical or behavioral health condition occurs, contact take place with PCP and guardian at minimum. Recommend when symptoms/behaviors outside of resident’s baseline/norm are observed, ongoing documentation of those symptoms takes place including notation of worsening or resolution of those symptoms and including what staff is doing to mitigate symptoms or otherwise provide care for them. Recommend that documentation be corrected consistent with acceptable practices for correcting legal/healthcare documents—drawing a single line through mistaken entries, writing the correction, and dating, timing, and signing the correction; no use of white out, no use of black marker to line out entries. Recommend using forms specific to a particular resident (Resident A) and date instead of making corrections to a different resident’s documents (Resident B) in order to document the resident’s (Resident A) care”.

On 08/24/2021, I completed an unannounced onsite investigation at the Mayfield Home. I interviewed Home Manger, Lisa Scouton. She stated that Resident A moved into the home on 07/13/2021. Ms. Scouton stated that they were told by CMH that Resident A was moving to the home from the MediLodge, however, she was brought from Harbor Oaks Hospital. When Resident A moved into the home, they received a packet from Harbor Oaks with minimal information. They also received copies of two prescriptions that were due on 07/15/2021. Ms. Scouton stated that they had the prescription for Trazadone filled on 07/14/2021. The second prescription was for an injection, Invega Sustenna 156 mg. Ms. Scouton informed the CMH psychiatrist about the prescription on 07/15/2021, however, were told they did not have supporting documentation to give injection and the doctor would get back to them. Ms. Scouton stated that Resident A used a roller walker, walked on own and was able to toilet herself. Resident A was seen by Visiting Physicians Association (VPA) Nurse Practitioner on 07/30/2021. The Nurse Practitioner did an exam and attempted blood draw. They were told that Resident A was dehydrated and needed fluids. The Nurse Practitioner also gave an order for bloodwork.

Ms. Scouton stated that Resident A appeared to be fine on 07/31/2021 and nothing was reported. Ms. Scouton heard Resident A fell the morning of 08/01/2021 due to being unsteady. Ms. Scouton stated that there was some confusion regarding the fall as to whether staff saw her fall or it was reported to them. Ms. Scouton worked the evening of 08/01/2021 and morning of 08/02/2021. She stated on the morning of 08/01/2021, she assisted Resident A in the restroom. Resident A required assistance from her bed to walker and from her walker to toilet. Resident A seemed more confused, however, did not appear to have any physical ailments. Ms. Scouton thought behavior was due to Resident A’s dehydration and left the home around 7:00 am. Ms. Scouton stated that she received a call from staff at 2:45 pm. Staff was concerned that Resident A appeared to be confused and weak. Resident A had laid on the love seat and defecated. Staff were informed to contact EMS. Resident A was taken to McLaren Hospital and it was determined that she had a stroke. Ms. Scouton stated that she received a call from a

nurse at McLaren Hospital who wanted to know when Resident A received her last injection. Ms. Scouton said the nurse was concerned because an antipsychotic medication should not be stopped suddenly.

On 08/24/2021, I interviewed Staff Dayna Landschoot at the home. She stated that on 08/02/2021, Resident A had a bowel movement accident. Resident A was emotional and weak. Ms. Landschoot stated that Resident A could use a walker when she came in, however, was now not using her walker. She was concerned and EMS was contacted.

I reviewed an incident report dated 08/02/2021 completed by Dayna Landschoot. It indicates that Resident A was displaying difficulties with ambulating and speech with small onset from 08/01/2021. Staff did monitor vitals but became more concerned after she ate and drank throughout the last 24 hours with no changes. Staff notified supervisor of their concerns. Supervisor instructed staff to notify guardian of concerns and have Resident A transported to McLaren of Port Huron for medical evaluation.

I reviewed Resident A's appointment record from 07/30/2021. The nurse practitioner lists Resident A's diagnosis as hypertension and hypokalemia. The record indicates that Resident A needs blood work completed.

I reviewed daily notes for Resident A. The note on 08/01/2021 indicates that Resident A fell and was unable to stand on her own. Note indicates at 11:30 am Resident A fell again on her way to the bathroom. Staff assisted her to the bathroom and she almost fell again. Staff noted that they believe it is because she is dehydrated from not drinking enough fluids and always wanting a Coke. Staff was able to get her to drink some Poweraid but Resident A did not each lunch and was laying on the couch. Staff included a drawing of a sad face with the notes.

On 08/24/2021, I reviewed daily notes and logs. The home has a notebook where staff write daily notes for each resident. I did not observe any areas where the information appeared to be altered. There are also logs completed on a typed form that document daily grooming, sleep, meals, medical and outings for each resident. Some of Resident A's forms had another resident's name and a date typed on them. The typed name and date were crossed out and Resident A's name and date were handwritten. The information contained in the logs did not appear to be altered. The CMH report from Karen Recker, RN states, "Several documents were altered (10 pages which will be provided as paper copies, so the alterations are not obliterated by further scanning and emailing). These appear to be a daily activity log. The name of another resident can be seen through the black marker used to obliterate their name and Dorothy's name was added. The dates were also changed from July 19 to various other dates. One form appeared to have had white out used on it."

I completed an exit conference with Licensee Designee, Renae Kiehler and Administrator, Mindy Wiegand on 11/01/2021. I informed them of the violation found and

that a copy of the special investigation report would be mailed once approved. I also informed them that a corrective action plan would be requested.

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:	On the morning of 08/01/2021, Resident A showed changes in her physical and mental condition. The home did not seek emergency medical treatment until the afternoon of 08/02/2021. Resident A was seen by VPA on 07/30/2021. The appointment record lists her diagnosis as hypertension and hypokalemia. The records also notes that bloodwork is needed. The Home Manager, Lisa Scouton and staff were told that Resident A was dehydrated, and the Nurse Practitioner was unable to draw blood. On the morning of 08/01/2021, Ms. Scouton assisted Resident A in the restroom. Resident A required assistance from her bed to walker and from her walker to toilet. Resident A seemed more confused, however, did not appear to have any physical ailments. Ms. Scouton thought behavior was due to Resident A's dehydration and left the home around 7:00 am. The note on 08/01/2021 indicates that Resident A fell and was unable to stand on her own. Notes indicate at 11:30 am Resident A fell again on her way to the bathroom. Staff assisted her to the bathroom, and she almost fell again. Staff noted that they believe it is because she is dehydrated from not drinking enough fluids and always wanting a coke. According to staff, Dayna Landschoot, Resident A had a bowel movement accident. Resident A was emotional and weak. Ms. Landschoot stated that Resident A could use a walker when she came in, however, was now not using her walker. She was concerned and EMS was contacted. The information in Resident A's logs did not appear to be altered to change events that occurred prior to her stroke. However, it is recommended that clean forms are used, or corrections are clearly documented.
CONCLUSION:	**VIOLATION ESTABLISHED**

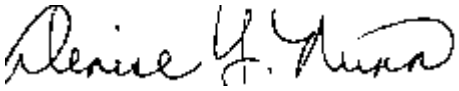
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in license status.

11/01/2021

Kristine Cilluffo — Date
Licensing Consultant

Approved By:



11/01/2021

Denise Y. Nunn — Date
Area Manager