GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 15, 2021

Roberto Cortes Jr.
Christian Care Inc.
1530 McLaughlin Ave.
Muskegon, MI 49442

RE: License #: AH610299982
Investigation #: 2021A1028045
Christian Care

Dear Mr. Cortes Jr.:

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 (616) 356-0100.

Sincerely,

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
Cell (616) 204-4300

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

I. IDENTIFYING INFORMATION

License #:	AH610299982
Investigation #:	2021A1028045
Complaint Receipt Date:	09/13/2021
Investigation Initiation Date:	09/14/2021
Report Due Date:	10/13/2021
Licensee Name:	Christian Care Inc.
Licensee Address:	1530 McLaughlin Ave. Muskegon, MI 49442
Licensee Telephone #:	(231) 722-7165
Authorized Representative/Administrator:	Roberto Cortes Jr.
Name of Facility:	Christian Care
Facility Address:	2053 S. Sheridan Muskegon, MI 49442
Facility Telephone #:	(231) 722-7165
Original Issuance Date:	05/15/2013
License Status:	REGULAR
Effective Date:	11/12/2020
Expiration Date:	11/11/2021
Capacity:	21
Program Type:	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A incurred a fall resulting in injury due to lack of care staff supervision.	Yes
Resident A's medications were improperly administered by care staff.	Yes

III. METHODOLOGY

09/13/2021	Special Investigation Intake 2021A1028045
09/14/2021	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
09/14/2021	APS Referral APS referral emailed to Centralized Intake
09/27/2021	Contact - Face to Face Interviewed Administrator/Facility Authorized Representative Roberto Cortes at the facility
09/27/2021	Contact - Face to Face Interviewed care staff Shavonne Navarro at the facility
09/27/2021	Contact - Face to Face Interviewed care staff Yasmine Brewster at the facility
09/27/2021	Contact - Face to Face Interviewed memory care director Hannah Bernard at the facility
10/21/2021	Contact – Telephone call made Interviewed complainant by telephone
11/15/2021	Exit Interview

ALLEGATION:

Resident A's medications were improperly administered by care staff.

INVESTIGATION:

On 9/14/2021, the Bureau received the allegations from the online complaint system.

On 9/14//21, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 9/27/21, I interviewed authorized representative/administrator Roberto Cortes at the facility. Mr. Cortes reported Resident A resided at the facility from March 2021 to August 2021. On 8/3/21, Resident A incurred a fall resulting in hospitalization which required rehabilitation and resulted in Resident A not returning to the facility. Mr. Cortes reported Resident A does not have a history of falls. Mr. Cortes reported Resident A's family requested Resident A transfer to the skilled side of the facility for rehabilitation upon return from the hospital, but Mr. Cortes reported there was not enough staff on the skilled side to appropriately provide care for Resident A. Mr. Cortes reported there are only three residents currently on the skilled side and that no one has been admitted to skilled rehab in the facility because of being short staffed. Mr. Cortes reported the facility has been short staffed because of the pandemic, but "we are making it work, continually hiring, and working over to make sure care is provided". Mr. Cortes reported the facility is currently utilizing mandation, an on-call system, agency staff, and that management assists on the floor as well to prevent short staffing. Mr. Cortes reported the facility is actively hiring as well. Mr. Cortes provided a copy of Resident A's service plan, admission contract, incident report, record notes, and working staff schedules for my review.

On 9/27/21, I interviewed care staff person (CSP) Shavonne Navarro at the facility. Ms. Navarro reported the facility is short staffed because of the pandemic, but care staff work together to make sure no shift is short. Ms. Navarro reported there are not a lot call-ins and care staff utilize an on-call system, follow a mandation policy, use agency staff, and management assists as well to prevent shift shortages. Ms. Navarro reported the facility is currently hiring too. Ms. Navarro reported Resident A fell on 8/3 but does not have a history of falls. Ms. Navarro reported wellness checks are completed and documented by care staff every night for residents. Ms. Navarro reported wellness checks should have been completed for Resident A prior to falling on 8/3.

On 9/27/21, I interviewed CSP Yasmine Brewster at the facility. Ms. Brewster reported the facility is "somewhat short staffed because of the pandemic, but we all make it work so shifts get covered". Ms. Brewster reported Resident A would get up on [their] own but did not have a history of falls. Ms. Brewster confirmed wellness checks are completed and documented routinely throughout the day for all residents.

Ms. Brewster's statements are consistent with Mr. Cortes' and Ms. Navarro's statements.

On 9/27/21, I interviewed memory care director Hannah Bernard at the facility. Ms. Bernard reported that while staffing has been tight due to the pandemic, care staff work together to prevent shift shortages. Ms. Bernard reported there are currently 16 care staff and 18 residents in assisted living. Four of the residents are two-person assists. Ms. Bernard reported there are four care staff assigned to first and second shifts and two care staff assigned to third shift. Ms. Bernard reported there are not a lot of call-ins and manadation, an on-call system, agency staff, and management are utilized to prevent shift shortages. Ms. Bernard reported the facility is actively hiring as well. Ms Bernard reported Resident A fell on 8/3 but did not have a prior history of falls but would try to get up on [their] own at times. Ms. Bernard reported wellness checks are completed by staff throughout the day and are documented in the resident record.

On 10/21/21, I interviewed the complainant by telephone. The complainant reported Resident A fell on 8/3 and does not have a prior history of falling. The complainant reported Resident A "was self-sufficient until the fall". The complainant reported Resident A did not return to the facility due to requiring rehabilitation and the facility being unable to provide it. The complainant acknowledged that while Resident A does not have a fall history and "falls are bound to happen", but there was concern as to how long Resident A was on the floor before being found by staff. The complainant reported requesting the fall incident report but was [their] request was declined Mr. Cortes. The complainant reported no one at the facility has been able to provide a timeline as to when the fall occurred or how long Resident A was on the floor before being found by staff. The complainant reported the facility appears to short staffed when [they] visited and expressed concerns that the facility may have been short staffed either the evening prior to or the morning of Resident A's fall.

On 10/21/21, I reviewed working care staff schedules from June 2021 to September 2021 which revealed the use of agency staff, on-call staff, and use of management on the floor to prevent shift shortages due to care staff call-ins.

On 10/22/21, I reviewed Resident A's service plan which revealed Resident A required assist with transfers and with use of walker and/or wheelchair. Resident A required supervision to assist with bathing, grooming, dressing, toileting, and feeding.

On 10/22/21, I reviewed Resident A's record notes and compared them with the working staff schedule for March 2021 to August 2021. The comparison review revealed the following:
March 2021:

The dates of 3/5, 3/6, 310, 3/15, 3/16, 3/20, 3/21, 3/24, 3/27, 3/29, and 3/31 are blank for the third shift wellness check at 05:00am for Resident A.

April 2021:

The dates of 4/3, 4/11, 4/12, 4/17, 4/18, 4/20, 4/21 are blank for the third shift wellness check at 05:00am for Resident A.

For May 2021:

The dates of 5/23 are blank for the third shift wellness check at 01:00am for Resident A.

The dates of 5/3, 5/5, 5/9, 5/10, 5/19, 5/20, 5/23, 5/27, 5/28, and 5/30 are blank for the third shift wellness check at 05:00am for Resident A.

For June 2021:

The dates of 6/2, 6/3, 6/5, 6/7, 6/9, 6/11, 6/20 are blank for the third shift wellness check at 05:00am for Resident A.

For July 2021:

The date of 7/31 is blank for the third shift wellness check at 01:00am for Resident A.

The dates of 7/18, 7/23, 7/28, and 7/31 are blank for the third shift wellness check at 05:00am for Resident A.

For August 2021:

The date of 8/2 is blank for the third shift wellness check at 01:00am for Resident A.

The dates of 8/1, 8/2, and 8/3 are blank for the third shift wellness check at 05:00am for Resident A.

I have been unsuccessful in making contact with care staff Kodi Schutter and Aliesha Williams.

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:	Interviews with the facility authorized representative/ administrator, care staff, and the complainant reveal Resident A fell on 8/3 and does not have a history of falls. It was also revealed the facility provides documented wellness checks throughout the day for Resident A. Interviews along with review of documentation reveal that while the facility is short staffed due to the pandemic, the facility utilizes mandation, an on-call system, agency staff, and management assists on the floor to prevent shift shortages as well. While there were two care staff assigned to the working staff schedule for third shift from the evening of 8/2 to the morning of 8/3 when Resident A fell, it cannot be determined if care staff provided the wellness check at 05:00am as required by the service plan. Comparison of the working staff schedules with Resident A's record reveals the date of 8/3 is blank for the third shift wellness check at 05:00am. Further review also showed there were multiple dates that third shift wellness checks were not documented by care staff for Resident A from March 2021 to August 2021, therefore it cannot be determined if care staff actually completed the wellness checks in accordance with the service plan and facility policy.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A's medications were improperly administered by care staff.

INVESTIGATION:

On 9/27/21, Mr. Cortes reported Resident A incurred a fall on 8/3/21 which resulted in hospitalization and since Resident A required rehabilitation, [they] did not return to the facility after the hospitalization. Mr. Cortes reported upon learning Resident A would not be returning to the facility in August 2021, the family requested the return of Resident A's medications. Mr. Cortes reported the medications were provided to the family upon request and reported no knowledge that Resident A had extra medications that were returned to the family. Mr. Cortes reported Resident A's medications had been ordered and delivered for the month of August 2021 prior to learning Resident A would not be returning to the facility, but that there should have been any extra medications. Mr. Cortes provided Resident A's medication

administration record (MAR) from March 2021 to August 2021 with record notes for my review.

On 9/27/21, CSP Ms. Navarro reported Resident A received medications daily, “some whole, some crushed because of a swallowing issue”. Ms. Navarro reported Resident A would refuse medications sometimes and it was reported to family each time it was refused. Ms. Navarro reported Resident A medications were given as instructed by the medication administration record and that to her knowledge Resident A should not have had any extra medications returned to the family or any recent missed medications.

On 9/27/21, CSP Ms. Brewster reported Resident A’s medication administration record was followed and Resident A had some medications that “were taken whole and some that were crushed”. Ms. Brewster reported Resident A could be difficult as times when taking medications due to a swallowing issue, but it was not often. Ms. Brewster reported Resident A did not have any difficulty taking the crushed medications. Ms. Brewster reported no knowledge of Resident A’s family receiving extra medications when Resident A did not return to the facility.

On 9/27/21, Ms. Bernard reported Resident A could be difficult when taking medications due to a swallowing issue, but there was a crushed order in place so Resident A would not miss a medication. Ms. Brewster reported to her knowledge Resident A did not miss any medication. Ms. Brewster also reported Resident A’s medications were ordered and delivered to the facility for the month of August 2021, but Resident A’s family should not have received extra medications when Resident A did not return to the facility.

On 10/21/21, I interviewed the complainant by telephone. The complainant reported Resident A incurred a fall on 8/3/21 and was hospitalized. After the hospitalization, Resident A required rehabilitation and did not return to the facility. The complainant reported the family requested Resident A’s medications upon notifying the facility on 8/24/21 that Resident A would not be returning to the facility. The complainant reported extra medications were returned to the family, leading family to believe that Resident A did not receive appropriate medication administration. The family subsequently completed a medication audit of their own and found that Resident A did not receive medications correctly, specifically the medications Eliquis and Metoprolol-hydrochlorothiazide. The complainant reported they are aware Resident A’s medications were ordered and delivered for the month of August 2021 to the facility, but the amount that the family “received back was an overabundance of medications.” The complainant reported no knowledge of Resident A refusing medication while at the facility but was aware of some of Resident A’s medications were crushed for easier swallowing. The complainant provided me a copies of pharmacy documentation with family medication audit and pictures of the medication packs returned to the family for my review.

On 10/21/21, I reviewed Resident A's MAR from March 2021 to August 2021 which revealed Resident A was prescribed the following medications:

- Calcium D Tablet 600-400 mg; take one tablet by mouth one time a day for supplement.
- Colace Capsule 100 mg; take one capsule by mouth one time a day for constipation; hold for loose stools.
- Metoprolol-hydrochlorothiazide Tablet 100-25 mg; take one tablet one time a day for HTN.
- Sertraline HCl Tablet 100 mg; take one tablet by mouth one time a day for mood after lunch.
- Vitamin D 1000 Max St. Tablet; take one tablet by mouth one time a day for low vitamin D level.
- Eliquis Tablet 2.5 mg; take one tablet by mouth two times a day for A-Fib.
- Nystatin Powder; apply to under breast rash topically two times a day for rash. Discontinue when healed.
- Acetaminophen Tablet 500 mg; take two tablets by mouth every eight hours as needed for pain or fever.
- Betamethasone Dipropionate Cream 0.05%; apply to lower left leg topically as needed for psoriasis flare up.
- Bisacodyl Suppository 10 mg; insert one suppository retally as needed for constipation. Administer is no results from MOM administered on previous shifts.
- Fleet Enema 7-19 gm/118ml (Sodium Phosphate); insert one application rectally as needed for constipation. Administer if no results from Bisacodyl Suppository administered on previous shifts.
- Milk of Magnesia Suspension 400 mg/5ml (Magnesium Hydroxide); Give 30 milliliter by mouth as needed for constipation. Administer if no BM noted on review of previous 9 shifts.

The review of Resident A's MAR from March 2021 to August 2021 revealed no missed medication administration for any medication for Resident A as documented by care staff. There is no documented evidence Resident A has ever refused medications.

I reviewed the documentation the complainant provided me which revealed the following excess of medications that were returned to Resident A's family:

- March 2021:
  Vitamin D3 1,000 mg tablet pack was returned full.

- April 2021:
  There were 13 tablets of the Eliquis 2.5 Tablet PM pill pack card that were returned.

- May 2021:
  There were 10 tablets of Sertraline 100 mg returned.
  Vitamin D3 1,000 mg tablet pack was returned full.
  Eliquis 2.5 Tablet AM pill pack card was returned full.

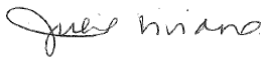
- June 2021:
  There were 20 tablets of Sertraline 100 mg returned.
  Eliquis 2.5 Tablet AM pill pack card had 11 tablets returned and the PM pill pack card was returned full.
  Metoprolol-Hctz was AM pill pack card was returned full.
  There were 12 Docusate tablets returned.
  There were 11 Calc-Carb + Vitamin D tablets returned.
  Sertraline 100 mg was returned full.

- July 2021:
  There were 11 tablets of Vitamin D3 1,000 mg returned.
  Eliquis 2.5 Tablet AM pill pack card was returned full and there 25 returned on the PM pill pack.
  There were 24 Metoprolol-Hctz tablets returned.
  The Docusate Tablets was returned full.
  Calc-Carb + Vitamin D tablets was returned full.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.
ANALYSIS:	Interviews with administrator, care staff, and the complainant reveal Resident A was hospitalized on 8/3 from a fall and did not return to the facility. The family subsequently requested and were provided by the facility Resident A's medications. Review of documentation and Resident A's medication administration records reveals Resident A did not miss any medication and did not refuse any medications from March 2021 to August 2021. However, comparison of the returned medication documentation with Resident A's facility medication administration record from March 2021 to July 2021 revealed significant inconsistency with an excess of Resident A's medication returned to Resident A's family upon Resident A's exit from the facility. Resident A did not appropriately receive medication administration in accordance with the service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

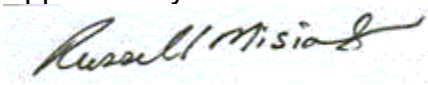
Contingent upon receipt of an acceptable corrective action plan, I recommend the license remain unchanged.



10/22/2021

Julie Viviano — Date
Licensing Staff

Approved By:



11/15/21

Russell B. Misiak — Date
Area Manager