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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 21, 2021

Jennia Woodcock
Community Health Care Management
1805 E Jordan
Mt. Pleasant, MI 48858

RE: License #: AM370085652
Investigation #: 2021A1029029
Country Place III

Dear Ms. Woodcock:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On 10/13/2021, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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 (231) 922-5309.

Sincerely,

Jennifer Browning

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
Browningj1@michigan.gov
(989) 444-9614

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

I. IDENTIFYING INFORMATION

License #:	AM370085652
Investigation #:	2021A1029029
Complaint Receipt Date:	08/25/2021
Investigation Initiation Date:	08/25/2021
Report Due Date:	10/24/2021
Licensee Name:	Community Health Care Management
Licensee Address:	2033 Westbrook, Ionia, MI 48846
Licensee Telephone #:	(989) 773-6320
Administrator:	Jennia Woodcock
Licensee Designee:	Jennia Woodcock
Name of Facility:	Country Place III
Facility Address:	1809 E. Jordan, Mount Pleasant, MI 48858
Facility Telephone #:	(989) 773-6320
Original Issuance Date:	05/29/2001
License Status:	REGULAR
Effective Date:	06/08/2020
Expiration Date:	06/07/2022
Capacity:	10
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

ALLEGATION(S)

	Violation Established?
Resident A's feeding bag was empty August 15, 2021 and his lift sling was saturated with urine on August 20, 2021 at Country Place III.	Yes

II. METHODOLOGY

08/25/2021	Special Investigation Intake 2021A1029029
08/25/2021	Special Investigation Initiated – Telephone to complainant
08/26/2021	Contact - Face to Face with Tevin Blizzard, Resident A, Tina Brownridge (home manager)
09/21/2021	Contact - Telephone call made to Jennia Woodcock
10/01/2021	Contact – Telephone to direct care staff member, Paisley Martin
10/01/2021	Contact – Telephone call to Katie Zimmerman, Left message for her.
10/01/2021	Contact – Telephone to direct care staff member, Mackenzie
10/01/2021	Contact – Telephone to Hospice RN Social worker Cindy. Left a message for her.
10/01/2021	Contact – Telephone call to direct care staff member, Shauna Kain. Left a message for her.
10/11/2021	Telephone call to licensee designee, Jennia Woodcock. Left a message.
10/12/2021	Exit conference with licensee designee, Jennia Woodcock.

ALLEGATION:

Resident A's feeding bag was empty August 15, 2021 and his lift sling was saturated with urine on August 20, 2021 at Country Place III.

INVESTIGATION:

On August 25, 2021, a complaint was received via the BCAL online complaint system alleging that Resident was not cared for during the midnight shift on August 14-August 15, 2021, because his feeding was empty and his lift swings were urine soaked leading to skin breakdown on August 20, 2021.

On August 25, 2021, a telephone call was made to Complainant. Complainant gave the telephone numbers for direct care staff members involved in the alleged incident. Complainant stated Ms. Woodcock reported Resident A had no skin breakdown but had redness from the lift swing. The unit manager that was on shift at the time, Katie Zimmerman, told the direct care staff member, Paisley Martin, that the extra food was in the closet next to his bed when she spoke with Ms. Martin at 1:05 a.m.

On August 26, 2021, I interviewed home manager, Kim Waldron at Country Place III. She stated Resident A required total care with eating, dressing, and bathing. Resident A has a Hoyer lift and is fed through tube feeding at a rate of 67 ml per hour. Resident A did not have a one on one assigned staff person and all the direct care staff members provided care to him while working. Ms. Waldron further affirmed Resident A has several boxes of food in the facility when he needs additional food. In order to complete Resident A's feeding routine, Ms. Waldron stated small boxes of Jevity food are emptied into Resident A's feeding bag and the direct care staff member reprograms the pump that controls the rate he receives the food. Ms. Waldron stated she did not know how much food was kept at one time for reserves but stated there was always plenty. Ms. Waldron stated Resident A's tube feeding food is kept in the dresser and closet in Resident A's room. Ms. Waldron stated she received a call during third shift on August 14, 2021, from direct care staff member Paisley Martin stating she could not find the extra food for Resident A. Ms. Waldron told her where the extra food was kept and Ms. Martin told her that she was going to call back if she could not find it. Since Ms. Martin never called back, Ms. Waldron thought the situation was resolved. Ms. Waldron stated Ms. Martin was a newer staff but was trained how to replace the feedings as well as where to find the extra food when Resident A runs out. Ms. Waldron thought perhaps there was no extra food in Resident A's drawer but knew there was plenty of extra in his closet. Regardless, Ms. Waldron stated she did not receive a call back from direct care staff member Ms. Paisley stating she could not locate Resident A's food. Ms. Waldron stated Resident A does not leave the facility and is currently on Hospice. Ms. Waldron stated that Resident A has had skin irritation where the Hoyer lift straps connect with his skin but the direct care staff members rotate baby powder, Vaseline, and a barrier cream which helps reduce the redness.

Ms. Waldron has not observed the Hoyer lift swing to be soaked in urine. The swing has been damp in the past and will be changed out when he receives assistance with dressing and personal care. There are two extra swings for the Hoyer lift which are used when the others are in the wash. She has never observed a dirty one to be left on him.

I interviewed direct care staff member and home manager, Tina Brownridge. She stated direct care staff member Paisley Martin texted her asking about the extra food. She received the text on Sunday morning August 15, 2021, at 4:59 a.m. Ms. Brownridge stated when direct care staff member Shauna Kain came into work the morning of August 15, 2021, she was able to find the food that was in the dresser next to Resident A's bed and two additional cases in the closet. After the incident with Ms. Martin, Ms. Brownridge stated a sign was placed on the door indicating the extra food was in the closet. Ms. Brownridge stated Resident A's tube feeding setting is on twenty four hours a day continuously and they set the machine to always feed him. The machine will go off when it gets to zero however, there will usually be some food in the bag so he is never without. They try to fill the bag with only two cartons if he is going to go outside because the food will get hot. Since this incident, there have been no further issues with direct care staff members not being able to find the food. She stated during this incident on August 15, 2021, Resident A went without food from 5:00 am-7:00 a.m. and he was sleeping during this time.

Ms. Brownridge stated that Hospice has been involved since October 2020 with Resident A. At times, the brief will not be positioned over the Hoyer sling/strap and will cause some skin breakdown if the strap goes on his leg near his left thigh. Sometimes this will leave a pinch mark on his skin from the sling. They have been using barrier creams to alleviate this and Resident A does not have any current sores on him.

During the onsite investigation, I was able to review Resident A's resident record. He currently was receiving care through Visiting Physician's Dr. Shihab Rabh and he had a guardian. The last *Resident Health Care Appraisal BCAL-3947* was completed on July 26, 2021, and it was documented he receives J-tube feedings twenty four hours continuous and is in a wheelchair.

All medications are also given through a jejunostomy (J-Tube). Since starting the Jevity food, he gained 42 pounds and there was a meeting with a nutritionist to see what to do to alleviate further weight gain. The feeding bag gives Resident A 67 ml per hour so one can of Jevity lasts for almost four hours since each container has 237 ml in it.

I interviewed direct care staff member, Tevin Blizzard. Mr. Blizzard stated that he filled Resident A's feeding bag during his shift on August 14, 2021. He would never leave his shift without knowing that there was food for Resident A. He stated that he remembers filling the feeding bag but did not remember what time. When he arrived at work, Resident A had three more boxes in the drawer next to the bed. He did not look in the closet for boxes but they are always in the closet so there was no reason to believe the next shift would not have food available. He had no knowledge of Resident A not having food other than the incident on August 14, 2021.

Mr. Blizzard did not recall a time where Resident A needed assistance with bathing or dressing and he did not receive care. He has never run out of food for Resident A on his shift but if he did, then he would look in the closet first. All the direct care staff members know this is where the food is kept. When they are trained how to do complete the

feedings, this was one point they made sure to cover. They have three slings for the Hoyer lift they can use but there are two they prefer and they alternate those when the other is in the wash. He has never observed the sling to be wet and not be washed right away. He stated that Resident A will sometimes get a sore on his thigh but they have Vaseline and a barrier cream they use.

Resident A was observed to be in his wheelchair with a ½ bag of food in the bag connected to his wheelchair. He was dressed appropriately for the weather. He did not have any stains on his clothing or any odor. The Hoyer lift straps were under him and appeared to be clean and free from any staining. Resident A stated there has never been a time that he has had to wait for assistance from the direct care staff members and is happy with his care at Country Place III. He seemed happy to be listening to his Johnny Cash CD and appeared to be in good spirits.

On September 21, 2021, I interviewed licensee designee, Jennia Woodcock. She stated there was a time that he did not get his feeding when Ms. Martin could not find the food on August 15, 2021. By the time that other staff went up there to get more food, the supervisor Ms. Brownridge found it in the closet and it was connected to the feeding bag. The extra Jevity food was in the closet the whole time. She stated they always had plenty of food for him in the bedroom and there is usually some in the supply room. There have not been any further issues with Ms. Martin since that incident.

Ms. Woodcock stated there have been times that Resident A does urinate through his clothes and the sling but that he is always changed and cleaned promptly. She denied noticing an odor on him. The slings stay on him when he is in his wheelchair and they have two that they alternate when one is dirty. If he does get redness on him, they will use the barrier cream. Ms. Woodcock sent over verification that he was changed and dressed on a regular schedule for August 20 and 21, 2021.

On September 29, 2021, I spoke to Jennia Woodcock who informed me that Resident A passed away on September 23, 2021, after receiving Hospice services for a year. Ms. Woodcock sent Resident A's Assessment Plan for AFC Residents dated and signed by Ms. Woodcock on March 20, 2021, for review. On Resident A's Assessment Plan for AFC Residents, under section "A. Eating/ Feeding," there is documentation that Resident A is on a 24 hour continuous feed via J-Tube and he's on a full assist with checking and changing for toileting, bathing, grooming, dressing, and personal hygiene with one direct care staff member to complete this task. His 24 hour J-Tube is also documented under special diets on the Assessment Plan. There is also documentation that Resident A receives all medications through the J-Tube. His treatment plan from Community Mental Health for Central Michigan dated September 23, 2021, included documentation that Resident A had surgery in early 2021 with a feeding tube inserted in his stomach due to the inability to swallow and that the feeding was delivered continuously via a food pump.

On October 1, 2021, I interviewed direct care staff member, Paisley Martin who stated she started working at Country Place III in the beginning of July 2021. Ms. Martin stated

a little before shift change around August 15, 2021, she noticed that the food was empty in Resident A's bag and she knew that he was supposed to be on 24 hour feedings. Ms. Martin stated she looked for the extra food and when she could not find it, she called the on call manager looking for food and they did not respond immediately. The home manager, Ms. Brownridge, responded that morning and found the food. Ms. Brownridge told her by text where she kept the food and she was able to find it. Ms. Martin said that it was in the closet but there were clothes over it so she did not see it. There was another box by the door but she did not see it because there were clothes near it also. Ms. Martin stated she did not think to move the clothes out of the way to further look for the food.

Ms. Martin stated the Hoyer lift swings were wet with urine on August 20, 2021, and she found dirty clothes on the floor next to the bed. Typically, one would be washed and they would use the backup sling but that day they were both with urine. On August 20, 2021, when she went to work she smelled urine and she changed him with a clean sling. Ms. Martin stated that sometimes Resident A would have abrasions on him which were caused by him having weight gain and the brief being too tight. They used the Vaseline and ointment along with baby powder to alleviate some of this. The direct care staff member ended up using a personal care tracking sheet in order to maintain his hygiene better.

When Ms. Martin started working at Country Place III, she affirmed she received training related to his feedings and how to start the bag but she did not know where the backup food is. Ms. Martin stated Resident A was sleeping during this time and was not aware there was no food in his bag. She kept the door cracked and walked down the hall frequently to check on Resident A. She stated she was not aware how long he did not have food for but thinks it was a couple hours.

On October 1, 2021, I interviewed direct care staff member, Makenzie Callison. She has been working there since the beginning of August 2021. She was familiar with Resident A and stated he needed assistance with changing, feeding, and monitoring him. She stated she normally worked second shift and during her shift she adds food to his bag almost every two hours. She stated she was instructed how to complete the tube feeding when she started. She did not remember which home manager trained her but she knew that she was informed where the extra food was kept during this training. During her shift, whoever had time went to fill his food bag so sometimes it was Mr. Blizzard and sometimes it was her. She denied that there was ever a time that he needed to be changed and was not. She changed him about every two hours while she was working. Ms. Callison stated there were two slings for the Hoyer lift and they would switch it out if any urine got onto the Hoyer lift. During the midnight shift, she checks on the residents every two hours and they are changed then if needed.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Resident A's written assessment plan was not followed during the midnight shift on August 14, 2021, which led to Resident A's continuous 24 hour feeding through his J-Tube to not be received from 5:00 a.m. – 7:00 a.m. the morning of August 15, 2021. Direct care staff member, Ms. Martin stated that she could not find the backup Jevity food for Resident A and his feeding bags were empty. She stated that he did not have food during this time since she could not find the food required for Resident A feeding tube. Ms. Martin stated that she did eventually find the food after Ms. Brownridge told her where it was but stated there was clothes over it since it was in the closet and she did not see it initially. Due to this situation, Resident A went without the Jevity food and he requires a continuous feeding for 24 hours. On Resident A's *Assessment Plan for AFC Residents*, under section "A. Eating/ Feeding," there is documentation that Resident A is on a 24 hour continuous feed via J-Tube. There is no indication that his personal care needs were not attended to leading to his sling being saturated with urine. According to the *Assessment Plan for AFC Residents*, Resident A requires a full assist with checking and changing for toileting, bathing, grooming, dressing, and personal hygiene with one direct care staff member to complete this task. Resident A had two back up slings that could be used for the Hoyer lift. None of the interviews indicated that Resident A was left in an unwashed sling that was urine soaked. During the onsite inspection on August 26, 2021, Resident A was found to be clean and free of odors.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change in the license status.

__ _____10/13/2021_____

Jennifer Browning — Date
Licensing Consultant

Approved By:

10/21/2021

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Dawn N. Timm — Date
Area Manager