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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 1, 2021

Dawn Foulke
Clinton Creek, Inc.
4438 Ramsgate Lane
Bloomfield Hills, MI 48302

RE: License #: AH500387884
Investigation #: 2022A1027010
Clinton Creek Assisted Living & Memory Care

Dear Ms. Foulke:

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 licensee authorized representative 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 (517) 241-1970.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500387884
Investigation #:	2022A1027010
Complaint Receipt Date:	11/03/2021
Investigation Initiation Date:	11/03/2021
Report Due Date:	01/03/2022
Licensee Name:	Clinton Creek, Inc.
Licensee Address:	4438 Ramsgate Lane Bloomfield Hills, MI 48302
Licensee Telephone #:	(248) 701-5043
Administrator:	Karrie Dove-Drendall
Authorized Representative:	Dawn Foulke
Name of Facility:	Clinton Creek Assisted Living & Memory Care
Facility Address:	40500 Garfield Road Clinton Township, MI 48038
Facility Telephone #:	(586) 354-2700
Original Issuance Date:	07/18/2019
License Status:	REGULAR
Effective Date:	01/18/2021
Expiration Date:	01/17/2022
Capacity:	62
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive help after pressing her call pendant and received poor care.	Yes
Resident A had three falls in the past month.	No
Additional Findings	No

III. METHODOLOGY

11/03/2021	Special Investigation Intake 2022A1027010
11/03/2021	Special Investigation Initiated - Letter Email sent to AR Dawn Foulke and Administrator Karrie Dove-Drendall requesting the following documentation: service plan, nurses notes (if any), incident reports (both internal and those sent to the department if there are any) and October MARs for Resident A
11/05/2021	Contact - Telephone call made Voicemail left with Administrator Karrie Dove-Drendall inquiring if she received my email request for documentation
11/05/2021	Contact - Document Received Email received from administrator Karrie Dove-Drendall with requested documentation
11/23/2021	Inspection Completed On-site
11/23/2021	Contact - Document Received Email from administrator Karrie Dove-Drendall received with requested physical therapy notes while at on-site inspection
11/24/2021	Contact - Telephone call made Voicemail left with complainant
11/24/2021	Contact - Telephone call made Voicemail left with medication technician Netearia Johnson
11/24/2021	Contact - Telephone call received Telephone interview conducted with complainant.

11/24/2021	Contact - Telephone call made Voicemail left with resident aide Melissa Collier-El
11/24/2021	Contact - Telephone call made Telephone interview conducted with afternoon medication technician Netearia Johnson
11/24/2021	Contact - Telephone call made Telephone call to Karrie Dove-Drendall to request if she can reach out to the Vision Link Call System for a call light log. Ms. Dove-Drendall to follow up next week with documentation if able.
11/29/2021	Contact - Document Received Email received with requested documentation from Karrie Dove-Drendall
11/30/2021	Contact - Telephone call received Email received with requested documentation from Karrie Dove-Drendall
11/30/2021	Contact - Telephone call received Telephone interview conducted with resident aide Melissa Collier-El
12/01/2021	Inspection Completed – BCAL Sub. Compliance
12/14/2021	Exit Conference Conducted with authorized representative Dawn Foulke

ALLEGATION:

Resident A did not receive help after pressing her call pendant and received poor care.

INVESTIGATION:

On 11/3/21, the department received a complaint which read it took one and half hours for Resident A to receive help from staff after the call pendant was pushed, and the facility has an unsafe environment. Additionally, the complaint read care quality is poor.

On 11/23/21, I conducted an on-site inspection at the facility. Ms. Dove-Drendall stated the facility has a wireless call light system through Vision Link. Ms. Dove-Drendall stated residents wear a call pendant necklace or watch and when they

press the button, an alert is sent to staff phones to let them know which resident called. Ms. Dove-Drendall stated staff turn off the call light by touching their magnet to the pendant. Ms. Dove-Drendall demonstrated when a call pendant is pushed, it has red light and when it is turned off, the light turns green. Ms. Dove-Drendall stated sometimes staff have difficulty turning off the call the pendants. Ms. Dove-Drendall stated she can observe on her computer when a resident has pushed their call pendant as well as when the pendants require new batteries. Ms. Dove-Drendall stated she also assists with answering call pendants if she observes that one has not been answered. Ms. Dove-Drendall stated there are two residents that have had issues with their call pendants, including Resident A. Ms. Dove-Drendall stated she has replaced the batteries twice since Resident A moved into the facility on 10/4 and replaced the pendant itself. Ms. Dove-Drendall stated she planned to replace the pendant again. Ms. Dove-Drendall stated Resident A receives care from staff per her service plan including checks every two hours throughout the day, but often more frequently then every two hours. Ms. Dove-Drendall stated she is unable to retrieve a report of documentation of activities of daily living. Ms. Dove-Drendall stated she and staff check on her as well as her spouse frequently throughout the day. Ms. Dove-Drendall stated the facility does not have a call light policy however staff are expected to respond to the call pendant as soon as possible. Ms. Dove-Drendall stated the facility has utilized agency staff, however she is working daily with her human resources department to hire full time staff. Ms. Dove-Drendall stated they currently have eight full time staff in the hiring process at this time. I interviewed Director of Nursing Rhonda Downing whose statements were consistent with Ms. Dove-Drendall. Ms. Downing stated staff provide Resident A with good care and all family concerns have been addressed. I interviewed dayshift resident aide Jasmine Hudgens-Harris. Ms. Hudgens-Harris stated she can observe the call lights on her phone then responds to them as soon as possible, however, sometimes has difficulty turning them off. Ms. Hudgens-Harris stated she has difficulty turning off Resident A's call pendant and sometimes needs to go outside of her room for it to turn off with the magnet. Ms. Hudgens-Harris showed how resident care aides document care in their system such as morning assistance, bathing assistance, oral care, grooming, dressing, hydration, but was unable to pull a report history of the documentation. I interviewed Relative A1 at bedside with Resident A. Relative A1 stated Resident A was a poor historian. Resident A's daughter stated Resident A's call pendant had not worked appropriately since admission. Relative A1 stated she did not have concerns regarding Resident A's care such as showers. Relative A1 stated she had concerns regarding agency staff caring for Resident A when they do not seem familiar with her. Relative A1 stated there was a concern last weekend with an agency staff member and the staff member was sent home, so she feels management addresses family concerns and tries to implement changes.

On 11/24/21, I interviewed the complainant by telephone. The complainant stated she feels staff provide care to Resident A however she feels the facility is short staffed. The complainant stated Resident A's family has expressed their concerns to the facility's management and she feels they try to correct the issues. The complainant stated the major concern is the call light system, specifically Resident

A’s call pendant not working correctly. The complainant stated she has witnessed Resident A push her pendant and not receive assistance for a long period of time.

On 11/24/21, I interviewed afternoon medication technician Netearia Johnson. Ms. Johnson stated she has observed caregivers providing Resident A’s care per her service plan. Ms. Johnson stated one time Resident A’s call pendant was blinking red, but staff did not receive a call on their phones, so Resident A’s family thought staff were not responding to her. Ms. Johnson stated Resident A’s call pendant was fixed. Ms. Johnson stated she has observed Resident A’s call pendant working since that time on her shift.

On 11/30/21, I conducted a telephone interview with midnight resident aide Melissa Collier-El. Ms. Collier-El stated there have been times when Resident A’s pendant did not connect to her phone to inform her a resident had requested assistance, as well as other resident’s pendants in the facility. Ms. Collier-El stated management was informed of the call pendants not working.

I reviewed Resident A’s service plan. The plan read Resident A requires 1 person assist for mobility, transfers, bathing, dressing and toileting. The plan read to check and change Resident A every two hours and to “check more often at night.” The plan was signed and dated 10/4/21 by Ms. Downing and by Resident A authorized representative.

I reviewed the call light report log from 10/4/21 through 11/29 for Resident A. In October, Resident A utilized her call pendant approximately 38 times and in November, approximately 108 times. The call pendant was not utilized on 10/7, 10/18, 10/26 or 10/27.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	Interviews with the complainant, staff, Relative A1 and review of documentation revealed Resident A utilized her call pendant however it cannot be determined if her calls transmitted to staff phones or not, however staff interviews revealed the call pendant has not always worked appropriately. Although Resident A received care per her service plan, the plan was not updated to reflect additional measures to ensure Resident A’s safety and well-being were met due to the malfunctioning call pendant.

CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

Resident A had three falls in the past month.

INVESTIGATION:

On 11/3/21, the department received a complaint which the complainant alleged Resident A had three falls in the past month.

On 11/23/21, I conducted an on-site inspection at the facility. I interviewed administrator Karrie Dove-Drendall. Ms. Dove-Drendall stated the facility has documentation of one fall on 10/6 when Resident A fell without injury. I interviewed Director of Nursing Rhonda Downing whose statements were consistent with Ms. Dove-Drendall. Ms. Downing stated if Resident A had fallen, then she would need assistance getting up and she was not aware of any additional falls other than the one that occurred on 10/6. I interviewed dayshift resident aide Jasmine Hudgens-Harris who stated Resident A had one fall on midnight shift but was not aware of any other falls and had not fallen on her shift. I interviewed Relative A1 at bedside with Resident A. Relative A1 stated Resident A was a poor historian. Relative A1 stated she was only aware of Resident A's one fall during the first week she admitted to the facility in which she thought may be caused from disorientation.

On 11/24/21, I conducted a telephone interview with the complainant. The complainant stated Resident A reported to her that she fell twice. The complainant stated the facility has documentation of only one fall.

On 11/24/21, I conducted a telephone interview with afternoon medication technician Netearia Johnson. Ms. Johnson stated Resident A had not had falls on her shift and if she did fall, then she would have written an incident report.

On 11/30/21, I conducted a telephone interview with midnight resident aide Melissa Collier-El who stated she could recall Resident A having one fall.

I reviewed Resident A's service plan which read Resident A is a one person assist for mobility, transfers, toileting and utilizes a walker as an assistive device.

I reviewed the facility's nurses notes which read on 10/6/21 11:31, a late entry for 10/4/21 from Ms. Downing, "Resident (A) does utilize walker for ambulation however gait is disturbed, resident has neuropathy and tends to lift foot, leg, very high when ambulating. Resident had a fall this early AM." A note on 10/15 at 12:00 AM from Susanne M. Garay FNP-B read "gait disturbance; continue fall precautions."

I reviewed the incident report from 10/6/21 which read “Room 106 called me just before 5:00 AM. I found her on the floor she said that her legs have given out, EMS was called they checked her out, and she refused to go to the hospital.” The report read corrective measures to prevent reoccurrence were to order physical and occupational therapy for strengthening, gait and balance.

I reviewed the home care physical and occupation therapy notes on 10/19/21, 10/21, 10/26, 10/27, 10/28, 11/1, 11/5, 11/9, and 11/18 which read Resident A was a fall risk. The notes did not relay whether Resident A had falls while at the facility or not.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident’s authorized representative, if any, and the resident’s physician.
ANALYSIS:	Interviews with the complainant, staff and review of facility documentation revealed there is not enough evidence to substantiate Resident A had more than one fall since admission to the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 12/14/2021, I shared the findings of this report with authorized representative Dawn Foulke. Ms. Foulke verbalized understanding of the finding.

IV. RECOMMENDATION

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

Jessica Rogers (signature)

12/13/21

Jessica Rogers — Date
Licensing Staff

Approved By:

12/13/21

Russell B. Misiak
Area Manager

Date