GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 16, 2021

Theresa & John Posey
7550 E. Allen Rd.
Fenton, MI 48430

RE: License #: AS470312588
Investigation #: 2022A0466004
Posey's

Dear Theresa & John Posey:

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 (517) 284-9727.

Sincerely,

Julie Elkins, Licensing Consultant
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 #:	AS470312588
Investigation #:	2022A0466004
Complaint Receipt Date:	10/22/2021
Investigation Initiation Date:	10/22/2021
Report Due Date:	12/21/2021
Licensee Name:	Theresa & John Posey
Licensee Address:	7550 E. Allen Road Fenton, MI 48430
Licensee Telephone #:	(810) 210-8167
Administrator:	Theresa Posey
Licensee Designee:	Theresa & John Posey
Name of Facility:	Posey's
Facility Address:	8194 E. Allen Road Fenton, MI 48430
Facility Telephone #:	(810) 623-2453
Original Issuance Date:	06/20/2012
License Status:	REGULAR
Effective Date:	12/20/2020
Expiration Date:	12/19/2022
Capacity:	6
Program Type:	ALZHEIMERS AGED

II. ALLEGATION

	Violation Established?
Resident A is not being adequately cared for as his foley catheter is infected and he has bruising on his back.	No
Additional Findings	Yes

III. METHODOLOGY

10/22/2021	Special Investigation Intake-2022A0466004.
10/22/2021	Contact - Document Sent to assigned APS worker Sarah Barbee.
10/22/2021	Special Investigation Initiated – Telephone call to APS Sarah Barbee, interviewed.
11/03/2021	Inspection Completed On-site.
12/07/2021	Contact- Telephone Call made to Guardian A1, interviewed.
12/07/2021	Contact- Telephone Call made to Jennifer Young, RN.
12/07/2021	Contact- Telephone Call made to Nancy Posey, interviewed.
12/07/2021	Contact- Telephone Call made to APS Sarah Barbee.
12/15/2021	Exit Conference with licensee Theresa Posey.

ALLEGATION: Resident A is not being adequately cared for as his foley catheter is infected and he has bruising on his back.

INVESTIGATION:
On 10/22/2021, Complainant reported Resident A returned to the hospital on 10/20/21 with the same foley catheter that Resident A left with on 10/6/21. Complainant reported that per nursing assessment "patient admitted with bruising; foley infected with purulent drainage; septic; erythema on buttocks." Complainant reported speaking with bedside nurse about concerns that the foley catheter was not being adequately cared for/cleaned potentially causing infection. Complainant reported Resident A is currently in intensive care. Complainant reported bruising on back and bump on forehead as well.

On 10/22/2021, I contacted assigned adult protective services (APS) worker Sarah Barbee who reported Guardian A1 stated Resident A was well cared for at the adult foster care (AFC) facility. APS Barbee reported Guardian A1 stated the AFC facility was not responsible for changing the foley catheter but that the assigned home nurse Jennifer Young was responsible for this task. APS Barbee reported Guardian A1 described Resident A as depressed and not motivated to be healthy again since his wife passed about a year ago. APS Barbee reported Guardian A1 stated she was not aware of Resident A having any falls and she did not suspect any abuse by any of the caretakers at the facility.

On 11/03/2021, I conducted an unannounced investigation and DCW Alexandra Korshak was working and reported Resident A was not at the facility as he was still in the hospital. DCW Korshak reported Resident A started declining and had a fall coming out of the bathroom which resulted in his first hospitalization around 10/6/2021. DCW Korshak reported Resident A had difficulty keeping his balance with the walker and was more reliant on the wheelchair after the first hospitalization. DCW Korshak reported Resident A does have a foley catheter which a home health care nurse came out to the AFC facility to assist with cleaning and monitoring. DCW Korshak reported DCWs at the facility were responsible to drain and dispose of urine from the catheter and clean the nozzle. DCW Korshak reported when Resident A returned from the hospital he had bruising on his body and a big bruise on his upper arm but she could not remember which arm. DCW Korshak reported AFC facility direct care staff members completed skin assessments and that his bruising should be documented on that sheet. DCW Korshak reported she thought Resident A was hospitalized for the second time around 10/20/2021.

On 11/03/2021, I reviewed Resident A's record which contained an *Assessment Plan for AFC Residents* which did not document that Resident A had a catheter. Under the "toileting" part of the assessment it stated Resident A, "wears pull ups/briefs somewhat continent."

On 11/03/2021, I reviewed Resident A's *Skin Assessment and Special Treatment Procedure* which was dated 10/06/2021 and signed by Samantha Coleman. The report documented to notify Theresa/Nancy and :

- "Skin assessment/return hospital.
- Severe bruising on left under arm pit to elbow. 1 large lump by armpit.
- Sore on right elbow.
- Sore on left foot.
- Sore on buttocks.
- Multiple bruises on arms and legs."

Resident A's record did not contain any incident reports for being hospitalized on 10/06/2021 or 10/20/2021. Resident A's record did not contain any instructions or treatment plan for the foley catheter.

Resident A was not at the facility at the time of the unannounced investigation and therefore could not be interviewed.

On 12/07/2021, I interviewed Guardian A1 who reported that she did not have any concerns about the care Resident A received while living at the facility. Guardian A1 reported Resident A does have a folly catheter and needed a super pubic catheter however his physician would not approve the surgery due to his heart condition. Guardian A1 reported AFC direct care staff members drained urine and cleaned the nozzle of the catheter and Resident A had home health care registered nurse Young that came out to the facility to monitor the catheter. Guardian A1 reported nurse Young reported to her Resident A was being well-cared for at the facility. Guardian A1 reported nurse Young was responsible to change the catheter, not direct care staff members at the AFC facility.

On 12/07/2021, I interviewed nurse Young who reported Resident A was hospitalized twice in October 2021, once at the beginning of the month and then again at the end of the month. Nurse Young could not report the dates Resident A was hospitalized as she did not have Resident A's chart with her. Nurse Young reported that after Resident A's first hospitalization she only saw Resident A three or four times at the facility before Resident A was hospitalized again. Nurse Young reported she did not change Resident A's catheter because catheters are only changed monthly and Resident A did not have it in long enough to have it changed. Nurse Young reported facility direct care staff members were responsible for normal peri care and reported facility direct care staff members did a good job draining the urine and keeping the catheter clean. Nurse Young reported after Resident A's first hospitalization in October he did return to the facility with a large bruise on his left upper arm. Nurse Young reported Resident A was on blood thinners and that it is typical for a patient after being hospitalized to have bruising from IV tape and other things that are done while hospitalized. Nurse Young reported she did not have any concerns regarding the marks and or bruising on Resident A's body. Nurse Young reported that she did not suspect any abuse at the facility.

On 12/07/2021, I interviewed Nancy Posey who reported that Resident A has had a catheter for the past 6-8 months. Ms. Posey reported that Resident A has needed a super pubic catheter, but it has been delayed due to Resident A's heart condition. Ms. Posey reported that the facility has been following a treatment plan with nurse Young where they empty the urine and clean the nozzle. Ms. Posey reported that nurse Young is responsible for changing the catheter. Ms. Posey reported that after Resident A was discharged from the hospital the first time in October 2021, he was covered in bruises. Ms. Posey reported that Resident A is very strong willed and independent and that he runs into things which could have caused the bruising on his body. Ms. Posey also reported that Resident A did have a fall.

On 12/07/2021, I interviewed APS Barbee who reported that she was not substantiating as she did not have any evidence facility direct care staff members had committed any wrongdoing.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.**
ANALYSIS:	Resident A's home health care Nurse Young reported direct care staff members were responsible for providing daily peri-care for Resident A along with draining/disposing urine from Resident A's foley catheter and cleaning the nozzle. Nurse Young reported direct care staff performed these tasks more than satisfactorily while she monitored Resident A's foley catheter. Based on interviews with direct care staff members, Resident A's and home health care nurse, there is no evidence Resident A's foley catheter was not attended to by direct care staff members. With regard to the bruising located on Resident A, DCW Korshak and Nurse Young reported that when Resident A returned from the first hospitalization he had bruising on his body and a big bruise on his upper arm. The facility had a *Skin Assessment and Special Treatment Procedure* which was dated 10/06/2021 and coincided with Resident A's hospitalization date. The skin assessment documented several bruises and sores on Resident A which were determined to have occurred during his hospitalization. Nurse Young stated it was not unusual for bruising to occur from IV's especially for residents on blood thinning medications.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
Complainant and DCW Korshak reported that Resident A was hospitalized on 10/06/2021 and again on 10/20/21. Nurse Young and Ms. Posey reported that Resident A was hospitalized twice in October 2021 but neither had the exact dates available. On 11/03/2021, I reviewed Resident A's record which at the time of the

unannounced investigation did not contain any incident reports from Resident A's October 2021 hospitalizations. Additionally, the facility did not provide any incident reports on Resident A's behalf for his October hospitalizations to the adult foster care division.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(b) Any accident or illness that requires hospitalization**.
ANALYSIS:	Complainant, DCW Korshak, nurse Young and Ms. Posey all reported that Resident A was hospitalized twice in October 2021. The adult foster care licensing division was not notified of Resident A's hospitalizations as a written incident report was not submitted as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 11/03/2021, I reviewed Resident A's record which contained an *Assessment Plan for AFC Residents* which did not document that Resident A had a catheter. Under the "toileting" part of the assessment it stated Resident A, "wears pull ups/briefs somewhat continent." Although Resident A's assessment plan was dated 7/22/2020 and signed by Resident A's designated representative there is no documentation in the *Assessment Plan for AFC Residents* that Resident A had a foley catheter nor was there any written direction for how to care for the catheter.

Additionally, although Resident A had a home health nurse overseeing his care at the facility, at the time of the unannounced investigation, Resident A's record did not contain any home health care documents. Resident A's record did not contain any documentation that he had a foley catheter nor the care responsibilities for the catheter.

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 assessment plan did not contain any documentation that Resident A had a foley catheter nor was there any direction documented on care for the catheter. Resident A's assessment plan did not document his current self-care needs including what Resident A was capable of doing nor the responsibilities of the direct care workers for the foley catheter therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

12/15/2021

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Julie Elkins Date
Licensing Consultant

Approved By:

12/16/2021

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Dawn N. Timm Date
Area Manager