GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 25, 2022

Nancy Bennett
330 Hamilton St.
Caro, MI 48723

RE: License #: AF790006111
Investigation #: 2022A0871013
That Touch Of Class

Dear Ms. Bennett:

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 (989) 732-8062.

Sincerely,

Kathryn A. Huber, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(989) 293-3234

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF790006111
Investigation #:	2022A0871013
Complaint Receipt Date:	12/03/2021
Investigation Initiation Date:	12/08/2021
Report Due Date:	02/01/2022
Licensee Name:	Nancy Bennett
Licensee Address:	330 Hamilton St. Caro, MI 48723
Licensee Telephone #:	(989) 673-5685
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	That Touch Of Class
Facility Address:	330 Hamilton St Caro, MI 48723
Facility Telephone #:	(989) 673-5685
Original Issuance Date:	07/21/1987
License **Status:**	REGULAR
Effective Date:	02/13/2020
Expiration Date:	02/12/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED TRAUMATICALLY BRAIN INJURED AGED

	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A started exhibiting unusual behavior such as being combative and attempting to elope. Nurse Practitioner Steven Holman ordered urine labs on 11/11, 11/12, and 11/23 due to Resident A exhibiting bizarre behaviors but the facility did not honor the request. Resident A was found to have a severe UTI that due to failure to lab orders went untreated for an extended time causing Resident A to become bizarre and combative. Facility filed for emergency relocation.	Yes
Additional findings:	Yes

III. METHODOLOGY

12/03/2021	Special Investigation Intake 2022A0871013
12/03/2021	APS Referral Denied to Tuscola County MDHHS
12/08/2021	Special Investigation Initiated - On Site
12/15/2021	Inspection Completed On-site Interviewed Licensee Nancy Bennett
01/12/2022	Contact - Telephone call made Telephone call to Family Member 1
01/12/2022	Contact - Telephone call made Telephone call to Nurse Practitioner Steven Holman
01/13/2022	Inspection Completed-BCAL Sub. Compliance
01/19/2022	Exit Conference Telephone exit conference with Licensee Nancy Bennett
01/25/2022	Document Received Review of Resident A's file.

ALLEGATION:

Resident A started exhibiting unusual behavior such as being combative and attempting to elope. Nurse Practitioner Steven Holman ordered urine labs on 11/11, 11/12, and 11/23 due to Resident A exhibiting bizarre behaviors but the facility did not honor the request. Resident A was found to have a severe UTI that due to failure to lab orders went untreated for an extended time causing Resident A to become bizarre and combative. Facility filed for emergency relocation.

INVESTIGATION:

On December 15, 2021, I conducted an unannounced onsite investigation and interviewed Licensee Nancy Bennett. I asked Licensee Bennett about Resident A eloping and Licensee Bennett stated that Resident A got out of the facility two times but only was on the sidewalk and never left the property. Licensee Bennett said that Resident A would watch staff and then "would bolt for the door" and Resident A knew how to turn off the alarm. Licensee Bennett indicated Resident A would swing at staff but never hit anybody.

Licensee Bennett said that on November 11, 2021, Nurse Practitioner Steven Holman ordered a urine specimen because of Resident A's behaviors. Licensee Bennett stated Resident A had a bowel movement in the specimen and it then became contaminated. Licensee Bennett indicated she that if she did get a good urine sample, could not use the one order, and could not take it to McLaren Hospital for the results. Licensee Bennett said that once Nurse Practitioner leaves the facility, she has nothing because everything is on the computer. Licensee Bennett said that on the second and third tries to obtain a urine sample, Resident A defecated in the sample. Licensee Bennett indicated she did get a sample on 11/29/2021 and the result was that Resident A had a UTI. Licensee Bennett said that Family Member 1 knew that Resident A needed more care than she could provide. Resident A moved out on December 1, 2021.

On January 12, 2022, I telephoned Family Member 1. Family Member 1 stated that Resident A was placed at A Touch of Class in August. Family Member 1 indicated that Resident A's behaviors were getting worse, and Nurse Practitioner ordered a urine screen on 11/11/2021. Family Member 1 said Licensee Bennett failed to get it done until 11/29/2021. Family Member 1 stated Licensee Bennett had 18 days to get it done. Family Member 1 said Licensee Bennett portrayed herself as the victim because she slept in a chair next to Resident A's bedroom because Resident A would try to elope. Family Member 1 said Licensee Bennett "should have tried every day" to get a urine sample. Family Member 1 said that Resident A's behaviors would not have been worse had Licensee Bennett got the urine sample and the antibiotics to treat the UTI.

On January 12, 2022, I telephone Nurse Practitioner Steven Holman. Mr. Holman stated Resident A was ordered a urine analysis on November 11, 2021. He also indicated the order was good and would stay in the computer until the urine sample was brought into McLaren Hospital in Caro. Mr. Holman said because of Resident A's dementia, "she was a sundowner." Mr. Holman also stated the sample was not brought into the hospital until 11/29/2021. Mr. Holman said, "it is unusual for Nancy not to follow through."

On January 18, 2021, I conducted an onsite investigation and interviewed Licensee Nancy Bennett. I asked Licensee Bennett if she had given a written 24-hour notice to Resident A's Family Member 1 and she replied "no, I called [Family Member 2] and told her to find a place for [Resident A]." Licensee Bennett said "I just couldn't do it anymore" because of Resident A's behaviors. Licensee Bennett said that "she [Resident A] just had to leave" and that she could not handle her anymore.

On January 19, 2021, I conducted a telephone exit conference with Licensee Nancy Bennett. She was advised that she had 18 days to collect a urine sample but failed to do so and was advised this is a rule violation. I also advised Licensee Bennett she must complete the appropriate paperwork when she discharges a resident and when a resident becomes aggressive.

On January 25, 2022, I reviewed Resident A's file. There was not a written discharge notice in the file. There were no *AFC Licensing Division – Incident/Accident Reports* in the file. There was an *AFC-Resident Information and Identification Record, Assessment Plan for AFC Residents, Resident Care Agreement,* and *Resident Funds and Valuables Parts I and II*. These forms were all completed upon the admission of Resident A on 08/05/2021.

APPLICABLE RULE	
R 400.1416	**Resident health care.**
	(1) A licensee, in conjunction with a resident's cooperation, shall follow the instructions and recommendations of a

	resident's physician with regard to such items as medications, special diets, and other resident health care needs that can be provided in the home.
ANALYSIS:	Resident A was ordered to have a urine sample tested to see if she had a UTI. This was done on 11/11/2021 and Licensee Nancy Bennett did not get it done until 11/29/2021. Licensee Bennett had 18 days to provide a urine sample. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
Rule 400.1407	**Resident admission and discharge criteria; resident assessment plan; resident care agreement; house guidelines; fee schedule; physicians' instructions; health care appraisal.**
	(14) A licensee who discharges a resident pursuant to subrule (13) of this rule shall notify the resident's designated representative and responsible agency within 24 hours before discharge. Such notification shall be followed by a written notice to the resident's designated representative and responsible agency stating the reasons for discharge.
ANALYSIS:	Licensee Nancy Bennett called Family Member 2 and told her that Resident A needed to be moved. Licensee Bennett said that she did not provide a written discharge notice. There was no written discharge notice in Resident A's record. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On January 18, 2021, I asked Licensee Bennett it she had written an *AFC Licensing Division- Incident/Accident Report* regarding Resident A's aggressive behavior. Licensee Bennet indicated she wrote it down but did not complete an incident report.

APPLICABLE RULE

R 400.1416	**Resident health care.**
	(4) A licensee shall make a reasonable attempt to contact the resident's next of kin, designated representative, and responsible agency by telephone, followed by a written report to the resident's designated representative and responsible agency within 48 hours of any of the following; (c) Incidents involving displays of serious hostility, hospitalization, attempts at self-inflicted harm or harm to others, and instances of destruction to property.
ANALYSIS:	Licensee Nancy Bennett said Resident A was aggressive and swung at her. Licensee Bennett said she did not complete an *AFC Licensing Division – Incident/Accident Report.* I confirm violation of this rule
CONCLUSION:	**VIOLATION ESTABLISHED**

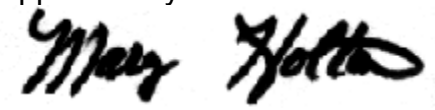
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of this adult foster care family home remain unchanged (capacity 1-6).

01/25/2022

Kathryn A. Huber Date
Licensing Consultant

Approved By:



01/25/2022

Mary E Holton Date
Area Manager