GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 3, 2022

Stephanie Hildebrant
Wood Care X, Inc., d/b/a Caretel Inns of Linden
910 S. Washington Ave.
Royal Oak, MI 48067

RE: License #:	AL250331306
Investigation #:	2022A0872019
	Degas House Inn

Dear Mrs. Hildebrant:

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 (906) 226-4171.

Sincerely,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL250331306
Investigation #:	2022A0872019
Complaint Receipt Date:	01/12/2022
Investigation Initiation Date:	01/12/2022
Report Due Date:	03/13/2022
Licensee Name:	Wood Care X, Inc., d/b/a Caretel Inns of Linden
Licensee Address:	910 S. Washington Ave. Royal Oak, MI 48067
Licensee Telephone #:	(947) 282-7555
Administrator:	Stephanie Hildebrant
Licensee Designee:	Stephanie Hildebrant
Name of Facility:	Degas House Inn
Facility Address:	202 S Bridge Street Linden, MI 48451
Facility Telephone #:	(810) 735-9400
Original Issuance Date:	05/01/2014
License Status:	REGULAR
Effective Date:	11/03/2020
Expiration Date:	11/02/2022
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
There is not enough staff to care for the residents.	Yes
Resident A is not being care for. Staff is not bathing her or assisting her with eating.	Yes
Resident A missed several doses of her medications in October 2021.	Yes

III. METHODOLOGY

01/12/2022	Special Investigation Intake 2022A0872019
01/12/2022	APS Referral This complaint was referred by APS but was not assigned for investigation
01/12/2022	Special Investigation Initiated - Telephone I interviewed Resident A's private nurse
02/01/2022	Inspection Completed On-site Unannounced
02/04/2022	Contact - Document Received Documentation received regarding Resident A
03/01/2022	Contact - Telephone call made I interviewed Relative A1
03/02/2022	Exit Conference I conducted an exit conference with the acting licensee designee, Kimberly Gee, via telephone
03/02/2022	Inspection Completed-BCAL Sub. Compliance

ALLEGATIONS:

- **There is not enough staff to care for the residents.**
- **Resident A is not being care for. Staff is not bathing her or assisting her with eating.**
- **Resident A missed several doses of her medications in October 2021.**

INVESTIGATION: On 02/01/22, I conducted an unannounced onsite inspection at Degas House Inn Adult Foster Care facility. I interviewed Resident A, her private duty care giver, Jill Hedger, and the assisted living director, Elizabeth Cole.

Resident A was lying in bed during my inspection. She told me that she relies on staff for all her personal needs. She requires a 2-person assist and she is completely incontinent. Resident A told me that when she pushes her call button, she "never knows" when staff will respond. She said that she has waited up to an hour for staff to check on her after pushing her call light. According to Resident A, she is unable to move from side to side in bed on her own and requires staff assistance. However, staff is often too busy to help her and oftentimes there is only one staff on shift and that staff is unable to do the shifting or transfer on her own.

Resident A told me that staff does not change her brief consistently and she often relies on Ms. Hedger to do so when she comes to the facility. Resident A said that staff does not bathe her and although they "wash me up" in bed, she has not had a shower in several weeks. According to Resident A, she experiences a lot of pain when being transferred via Hoyer lift and therefore, she often refuses to allow staff to shower her.

Resident A said that she went without her medications for several days in October 2021. She also said that she did not receive breakfast on October 23 and 25. Resident A told me that she has two wounds on her buttocks which requires wound care but as of this date, a wound care nurse has not been out to see her.

On 02/01/22, Private Duty Care Giver, Jill Hedger said that she has been Resident A's private duty care giver for several years. She typically cares for Resident A four days per week, for five hours each day. Ms. Hedger said that most days, Resident A's brief is not changed until she comes to the facility and does it herself. She said that sometimes, Resident A is only changed 2x's in an entire shift. She said that Resident A is bedbound and needs assistance just to move from one side to the other. Staff does not do regular checks on the residents even though they are supposed to. Resident A uses an oxygen cannula which is not being cleaned on a regular basis. Resident A experiences pain with transfers and is a 2-person assist. There is often only one staff and a "floater" per shift, and they are too busy to assist Resident A with bathing or any other personal care needs. Ms. Hedger said that Resident A has not had a shower in two months and has only has sporadic bed baths. Therefore, Ms. Hedger, Resident A, and Relative A1 decided that Ms. Hedger will take care of Resident A's bed baths.

According to Ms. Hedger, Resident A has trouble managing many foods and condiments. Resident A is unable to open condiment packets and she cannot hold on to some foods such as sloppy joes, spaghetti, etc. Ms. Hedger said that she has asked staff to be sure to assist Resident A by cutting up larger foods, opening condiment packets, etc. but not all staff do so. Staff is so busy during mealtimes that it can take up to an hour for staff to respond if Resident A needs anything. Also, by the time the food makes it to Resident A, it is often cold. While I was at the facility, staff served Resident A lunch. She was served a whole bar-b-que rib sandwich with sides and condiments. Staff did not cut up the sandwich nor did staff open the condiments. Ms. Hedger said that in October 2021, Resident A went several days without her medications. When Ms. Hedger asked management about it, she was told that the facility was switching pharmacies and there was a problem with the delivery of medications.

Assisted Living Director, Elizabeth Cole said that currently, Degas House Inn has 10 residents and the connecting Inns have anywhere between 10-20 residents per Inn. I asked Ms. Cole what the staff-to-resident ratio is. She said that currently, during waking hours it is 1-staff-to-15-residents plus a floater who serves two of the Inns and at night it is 1-staff-to-20-residents plus a floater. Ms. Cole confirmed that Resident A is a 2-person-assist and said that there are other residents at Degas House Inn that are 2-person-assists as well.

Ms. Cole confirmed that staff are typically busy during mealtimes. She said that the kitchen brings down a food cart to each Inn's sub-kitchen and staff are responsible for plating the food, serving the dining room residents, and then serving the residents who eat in their rooms. Staff are then responsible for collecting the used plates, cleaning up after the residents, and loading the dishwasher. I asked Ms. Cole how long the meal process typically takes, and she said she believes it takes approximately ½ hour for staff to complete each meal.

Ms. Cole agreed to send me AFC paperwork related to Resident A. On 02/04/22, I received documentation related to this complaint from Ms. Cole.

On 02/28/22, I reviewed Resident A's AFC paperwork. Resident A was admitted to Degas House Inn on 10/05/19. She is diagnosed with multiple medical conditions including thrombocytopenia, hypothyroidism, Parkinson's disease, hypertension, major depressive disorder, cellulitis, and difficulty in walking. She is fully incontinent and relies on staff to change her brief and for all personal care. She uses an oxygen cannula which staff are instructed to check and clean every night and change every week. She has a history of urinary tract infections, chronic pain, and wounds to her buttocks. She uses a wheelchair and Hoyer lift and experiences pain with movement. She is a 2-person assist. Resident A refuses showers due to the pain it causes her when transferring from the Hoyer lift, so staff are to give her bed baths every evening shift.

I reviewed several physician notes from September 2021 through January 2022 regarding Resident A's medical visits. Resident A was seen on multiple occasions for various reasons including the pressure sore on her buttocks. Medical staff noted that

staff are to continue applying barrier cream to the area and are to “proceed with pressure-point offloading and frequent turns.” Resident A requires 2-staff to assist with turning her and with any transfers. She is basically bed-bound due to “generalized weakness, debility, chronic wounds, and slow, unsteady gait. She is considered a high fall risk. Resident A receives wound care on a regular basis.

I reviewed a progress note dated 1/27/22 completed by Assisted Living Director, Elizabeth Cole. According to the note, Ms. Cole had a phone consultation with Relative A1 and they determined that Resident A’s private duty care giver, Jill Hedger will now be responsible for giving Resident A bed baths and doing her laundry. Ms. Cole noted that she reiterated to staff that they should be cutting up Resident A’s food when they deliver her meals.

I reviewed the staff schedule from December 19-January 29 and noted that this facility was not staffed with at least 2-full time caregivers per shift to care for the residents.

I reviewed Resident A’s mediation log for October 2021. According to the log, staff failed to administer the following medications on the following days:

- Anoro Ellipta Aerosol Powder (1 puff orally, one time per day): 10/12, 10/24, 10/26, and 10/27
- Aspercreme Lidocaine patch 4% (apply to left hip/left knee topically one time a day): 10/24, 10/26, and 10/27
- Aspirin tablet (1 tablet by mouth 1 time per day): 10/12, 10/24, 10/26 and 10/27
- Atorvastatin Calcium tablet (1 tablet by mouth at bedtime): 10/03, 10/08, 10/09, 10/15, 10/23, 10/25, and 10/28
- Citalopram (1 tablet by mouth 1 time per day): 10/12, 10/24, 10/26 and 10/27
- Claritin (1 tablet by mouth at bedtime): 10/03, 10/08, 10/09, 10/15, 10/23, 10/25 and 10/28
- Furosemide (1 tablet by mouth 1 time per day): 10/12, 10/24, 10/26 and 10/27
- Glucema (1 time a day): 10/12, 10/24, 10/26 and 10/27
- Pantoprazole (1 tablet by mouth 1 time per day): 10/12, 10/24, 10/26 and 10/27
- Pepcid (1 tablet by mouth 1 time per day): 10/12, 10/24, 10/26 and 10/27
- Polyethylene glycol powder (17 gram by mouth 1 time a day): 10/12, 10/24, 10/26 and 10/27
- Potassium Chloride (1 tablet by mouth 1 time a day): 10/12, 10/24, 10/26 and 10/27
- Pramipexole (1 tablet by mouth at bedtime): 10/03, 10/08, 10/09, 10/15, 10/23, 10/25 and 10/28
- Seroquel (1/2 tablet by mouth at bedtime): 10/03, 10/08, 10/09, 10/15, 10/23, 10/25 and 10/28
- Synthroid (1 tablet by mouth 1 time per day): 10/12, 10/24, 10/26 and 10/27
- Biofreeze Gel (apply to left hip topically every day and evening shift): 10/12-am, 10/16-pm, 10/24-am, 10/26-am, 10/27-am and 10/31-pm

- Carbidopa-Levodopa (1 tablet by mouth 2 times per day): 10/03-pm, 10/08-pm, 10/12-am, 10/14-pm, 10/15-pm, 10/16-pm, 10/18-pm, 10/22-pm, 10/23-pm, 10/24-am, 10/26-am and 10/27-am
- Cetaphil cream (apply to skin topically every day and evening shift): 10/12-am, 10/16-pm, 10/24-am, 10/26-am and 10/27-am
- Gabapentin (1 capsule by mouth 2 times a day): 10/03-pm, 10/08-pm, 10/12-am, 10/14-pm, 10/15-pm, 10/16-pm, 10/18-pm, 10/22-pm, 10/23-pm, 10/24-am, 10/25-pm, 10/26-am and 10/27-am
- Preparation H ointment (insert 1 application rectally 2 times per day): 10/03-pm, 10/08-pm, 10/09-pm, 10/12-am, 10/15-pm, 10/16-pm, 10/23-pm, 10/24-am, 10/25-pm, 10/26-am, 10/27-am and 10/28-pm
- Medihoney wound/burn dressing gel (apply to buttocks topically every shift): 10/05-pm, 10/10-pm, 10/12-am, 10/13-pm, 10/16-afternoon, 10/16-pm, 10/17-pm, 10/20-pm, 10/21-pm, 10/23-pm, 10/24-am, 10/24-pm, 10/26-am, 10/27-am, 10/28-pm, 10/29-pm, and 10/31-pm
- Norco (give 1 tablet by mouth 3 times per day): 10/03-pm, 10/08-pm, 10/09-pm, 10/12-am, 10/15-pm, 10/23-pm, 10/24-am, 10/25-pm, 10/26-am, 10/27-am and 10/28-pm
- Silver sulfadiazine cream (apply to left leg topically every shift): 10/05-pm, 10/10-pm, 10/12-am, 10/13-pm, 10/16-afternoon, 10/16-pm, 10/17-pm, 10/20-pm, 10/21-pm, 10/23-pm, 10/24-am, 10/24-pm, 10/26-am, 10/27-am, 10/28-pm and 10/29-pm

I reviewed staff notes regarding the checking and cleaning of Resident A's oxygen cannula for October and November 2021. According to staff notes, the oxygen cannula was only checked and/or cleaned on 10/02, 10/09, 10/13 and 10/20 although doctor's orders stated it shall be cleaned/checked every evening shift.

On 03/01/22, I interviewed Relative A1 via telephone. Relative A1 confirmed that Resident A has resided at Degas House Inn for several years. He said that since Symphony took over last fall, the care of the residents has declined significantly. According to Relative A1, he last visited Resident A on 2/24/22. He was there for approximately three hours and saw staff when they brought Resident A's lunch. Relative A1 said that there is a lack of staff at this facility. He said that Resident A has sat in a soiled brief for up to seven hours. He confirmed that Resident A is totally dependent on staff for all her personal needs and is unable to ambulate on her own. Relative A1 told me that Resident A often complains that she presses her call button, and it goes unnoticed.

On 03/02/22, I conducted an exit conference with the acting licensee designee, Kimberly Gee, via telephone. I reviewed the allegations with her and explained which rule violations I am substantiating. Ms. Gee said that Symphony took over Degas House Inn and the other Inns onsite several months ago and she is in the process of making changes and improvements. Ms. Gee told me that she is in the process of hiring a new Assisted Living Director and is hiring more staff. She also said that she is working on the meal process and trying to make it better for the residents and staff. Ms. Gee

agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	According to Resident A, private duty care giver Jill Hedger, and Relative A1, there is not enough staff to care for the residents. According to the assisted living director, Elizabeth Cole, the facility is staffed at 1-staff-per-15-residents during waking hours plus a floater and 1-staff-per-20 residents during sleeping hours plus a floater. I reviewed the staff schedule from December 19-January 29 and noted that this facility was not staffed with at least 2-full time caregivers per shift to care for the residents. Resident A, Ms. Hedger, Relative A1, and Ms. Cole confirmed that Resident A is a 2-person assist. Resident A's Assessment Plan states that she is a 2-person assist and requires full assistance from staff for all personal needs. Ms. Cole said that there are other residents at this facility who are a 2-person assist. Ms. Cole confirmed that that there are not at least 2 full time staff per shift to care for the residents. I conclude that there is sufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15303	**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:	According to Resident A, private duty caregiver Jill Hedger, assisted living director Elizabeth Cole, Relative A1, and

	Resident A's Assessment Plan, Resident A requires full staff assistance with bathing, transferring, and all personal care. Resident A, Ms. Hedger, and Relative A1 said that Resident A is often left in a soiled brief. In addition, staff does not bathe Resident A on a regular basis, and they do not assist her with managing her meals. I conclude that there is insufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	According to Resident A and her private duty care giver, Jill Hedger, Resident A was not given her medications for several days in October 2021. According to Resident A's medication logs, staff failed to administer several of Resident A's medications on several days in October 2021. I conclude that there is sufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

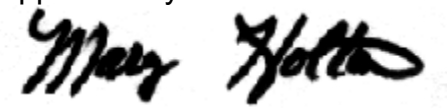
IV. RECOMMENDATION

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

March 2, 2022

Susan Hutchinson Licensing Consultant	Date

Approved By:



March 3, 2022

Mary E Holton Area Manager	Date