GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 15, 2022

Paula Ott
Central State Community Services, Inc.
Suite 201
2603 W Wackerly Rd
Midland, MI 48640

RE: License #: AS630407345
Investigation #: 2022A0993013
Waterview Home

Dear Ms. Ott:

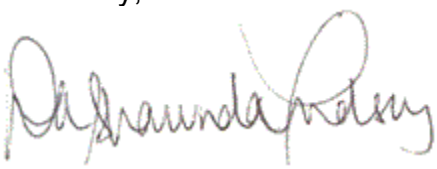
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 505-8036

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630407345
Investigation #:	2022A0993013
Complaint Receipt Date:	02/15/2022
Investigation Initiation Date:	02/15/2022
Report Due Date:	04/16/2022
Licensee Name:	Central State Community Services, Inc.
Licensee Address:	Suite 201 - 2603 W Wackerly Rd Midland, MI 48640
Licensee Telephone #:	(989) 631-6691
Administrator:	Sharon Butler
Licensee Designee:	Paula Ott
Name of Facility:	Waterview Home
Facility Address:	121 Waterview Lake Orion, MI 48362
Facility Telephone #:	(248) 690-9280
Original Issuance Date:	05/18/2021
License Status:	REGULAR
Effective Date:	11/18/2021
Expiration Date:	11/17/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL; AGED

II. ALLEGATION(S)

	Violation Established?
• Resident A was taken to the hospital with gangrene infection in her right foot. Both feet have infections, and she is unable to walk. • It is unknown the last time Resident A had showered. • Resident A is not being cared for because there is a lack of staff.	Yes

III. METHODOLOGY

02/15/2022	Special Investigation Intake 2022A0993013
02/15/2022	APS Referral Received allegations from adult protective services (APS)
02/15/2022	Referral - Recipient Rights Forwarded allegations to recipient rights advocate Rishon Kimble
02/15/2022	Special Investigation Initiated - Telephone Telephone call made to home manager Deja Bennett
02/15/2022	Contact - Document Sent Requested documentation
02/15/2022	Contact - Document Received Received documentation
02/28/2022	Contact - Document Received Received documentation
03/02/2022	Inspection Completed On-site Recipient rights advocate Rishon Kimble and I conducted an announced onsite inspection
03/07/2022	Contact - Document Sent Requested medical records from St. Joseph Mercy Oakland
03/07/2022	Contact - Document Sent Requested documentation

03/07/2022	Contact - Document Sent Requested medical records from St Joseph Mercy Oakland
03/08/2022	Contact - Document Received Received medical records from St Joseph Mercy Oakland
03/08/2022	Contact - Document Received Received documentation
03/14/2022	Exit Conference Attempted to hold with licensee designee Paula Ott. Left a message.

ALLEGATION:

- **Resident A was taken to the hospital with gangrene infection in her right foot. Both feet have infections, and she is unable to walk.**
- **It is unknown the last time Resident A had showered.**
- **Resident A is not being cared for because there is a lack of staff.**

INVESTIGATION:

On 02/15/2022, I received the allegations from adult protective services (APS).

On 02/15/2022, I forwarded the allegations to recipient rights advocate Rishon Kimble.

On 02/15/2022, I conducted a telephone interview with home manager Deja Bennett. Ms. Bennett stated she began working in the facility on 01/4/2022. She verified Resident A is currently hospitalized. Per Ms. Bennett, she went to give Resident A a shower and observed Resident A's feet were blistered and puffy. She observed that Resident A's pinky toe and the back side of her foot was discolored. She took Resident A to urgent care, and Resident A was transferred from urgent care to St. Joseph Mercy Oakland via an ambulance. Ms. Bennett stated she had not worked the few days prior, and staff had not informed her about any concerns with Resident A's feet. Ms. Bennet verified Resident A could not walk, but she stated Resident A has never walked since she began working in the facility. Regarding showers, Ms. Bennett stated the residents are showered daily, but Resident A did not receive a shower the day she was taken to urgent care. Ms. Bennett stated there are two staff scheduled to work per shift. Due to staff shortage, the shifts are now 7am to 7pm and 7pm to 7am. Ms. Bennett denied that there has ever been a time when there was only one staff working on a given shift. She stated the residents are well taken care of. There are six residents in the facility. Ms. Bennett stated all the residents tested positive for COVID, and the facility is currently in quarantine.

On 02/15/2022, I reviewed a copy of the incident report, completed on 02/14/2022 by Ms. Bennett. Per Ms. Bennett, she went to give Resident A her routine shower when she observed Resident A's feet were blistered and puffy. She observed that Resident A's pinky toe and the back side of her foot were turning black as well. Resident A was taken to Beaumont urgent care, but it was recommended that Resident A was transferred to the emergency room due to the severity of the wounds. Resident A was transported to St. Joseph Mercy Oakland and was admitted for further testing. I reviewed Resident A's, Resident D's, and Resident F's assessment plans. Resident A, Resident D, and Resident F require staff assistance with toileting, bathing, grooming, dressing, personal hygiene, and walking/mobility. Resident A also requires assistance with eating/feeding. None of the plans were signed by licensee designee Paula Ott. Resident A's plan expired on 02/02/2021. Resident D's and Resident F's plans were current.

On 02/28/2022, I reviewed a copy of a note from visiting physicians association nurse practitioner Shirley Vicente-Castro. Per the note, Resident A is nonverbal, non-ambulatory, and dependent in activities of daily living (ADLs), including incontinent. Resident A has a chronic gait abnormality, and she uses a wheelchair.

On 03/02/2022, recipient rights advocate Rishon Kimble and I conducted an announced onsite inspection. We interviewed Ms. Bennett, program coordinator LaKenya Jones, staff Cristiane Spencer, supports coordinator Lori Tunnel, assistant home manager Isaiah Thomas, staff Archie Phillips, staff Danielle Williams, and staff Jalyah Coleman. We also interviewed Resident D and Resident E. We were informed that Resident A is no longer a resident in the facility. Resident B died from causes unrelated to this investigation. We observed Resident C in her wheelchair but was unable to interview her as she is nonverbal. Resident C's clothing and wheelchair were not soiled. Resident F was out of the facility with her mother.

Ms. Bennett stated she did not work in the facility from 02/10/2022 until 02/13/2022. She returned to work on 02/14/2022 and observed concerns with Resident A's feet. Ms. Bennett stated there were no concerns with Resident A's feet the last time she worked in the facility (on 02/09/2022). She stated Resident A usually wears footies, but she did not have any on 02/14/2022. No staff reported any concerns about Resident A's feet while she was off work. Ms. Bennett stated Resident A was taken to urgent care and then transported to the hospital. Ms. Bennett stated Resident A was not ambulatory. She used a wheelchair. Ms. Bennett stated staff aim to shower the residents daily. Resident A was last showered in the facility on 02/12/2022. If the residents are not showered, they are cleaned in their beds. The residents are checked and changed every two hours. Ms. Bennett stated Resident A has been discharged from the hospital and is now admitted into a long-term care facility.

Ms. Jones stated she has been the program coordinator since 01/14/2022. She did not know if Resident A was ever able to walk. Ms. Jones stated Ms. Bennett called her the morning of 02/14/2022 to inform her about Resident A's feet. She said Resident A's feet

did not look right and looked discolored. Resident A was taken to the hospital for treatment. Ms. Jones did not know what happened to Resident A's feet. No staff expressed any concerns about Resident A's feet. Ms. Jones stated the only thing she knew was Resident A had ingrown toenails. Per Ms. Jones, Resident A was showered every other day. The other residents were showered daily. The residents are checked on and changed every two hours. There are two staff per shift. First shift may have three staff if the home manager is included. The shifts are 7am to 7pm and 7pm to 7am. Ms. Jones denied there has ever been a time when there was only one staff working on a given shift.

Ms. Spencer stated she has worked the facility since April 2021 She works from 11pm to 7am. Ms. Spencer stated when she went to change Resident A's brief, she noticed that her socks were wet. When she took the socks off, she observed what may have been a fungus on her feet. She informed staff Archie Phillips about what she observed, and she believes Mr. Phillip informed Ms. Bennett about it. Ms. Spencer could not recall the exact date of this incident, but she believed it was approximately two weeks ago. Ms. Spencer verified Resident A was admitted into the hospital. Ms. Bennett stated Resident A has been non-ambulatory since she began working in the facility. She denied ever giving Resident A or any of the other residents a bed or shower. Per Ms. Spencer, the residents are showered or bathed three times per week, but this never occured during her shift. The residents are checked and changed every two to three hours. Ms. Spencer stated none of the residents are neglected. She stated there are two staff per shift. There has never been a time when only one staff worked during a given shift.

Ms. Tunnel stated Ms. Bennett informed her about concerns with Resident A's foot. Resident A was taken to the hospital for treatment. Resident A has been discharged from the hospital and is now in a long-term care facility. Ms. Tunnel stated she became the facility's supports coordinator in late January to early February 2022. She has never had concerns about the care provided to Resident A or any of the other residents in the facility.

Mr. Thomas stated he has worked in the facility for about four weeks. He works all shifts. He verified he worked in the facility the weekend prior to Resident A being transported to the hospital. Per Mr. Thomas, he does not shower/bathe or change Resident A. Resident A's plan specifically states that male staff are not allowed to shower/bathe or change her. He stated Ms. Williams worked with him on 02/12/2022 and 02/13/2022 from 7am to 7pm. Ms. Williams provided care to Resident A, but she did not mention any concerns about Resident A's feet to him. Mr. Thomas stated he learned about concerns with Resident A's feet when he worked on 02/14/2022 with Ms. Bennett. He verified Resident A was taken to urgent care and then transported to the hospital. Mr. Thomas stated the residents are showered/bathed daily. They are checked on and changed every two hours. Mr. Thomas stated there are usually two staff per shift. There has never been a time when only one staff worked a given shift.

Mr. Phillips stated he has worked in the facility for almost one year with a 2-month gap of not working. He works from 7pm to 7am. Mr. Phillips stated male staff are not allowed to go into Resident A's room. He denied that he showered/bathed or changed Resident A. Mr. Phillips verified Ms. Spencer informed him that there was something on Resident A's feet. He stated he told her to write what she observed down and to inform the home manager about it. Mr. Phillips believed this happened on 02/11/2022. Mr. Phillips stated he worked with new staff the following day. He could not recall her name. The new staff did not mention anything to him about Resident A's feet. Per Mr. Phillips the residents are showered/bathed at least twice per week. The residents are checked and changed regularly, sometimes it can be hourly depending on the resident's need. Mr. Phillips stated there are two staff per shift.

Ms. Williams stated she has worked in the facility since 01/07/2022. She verified she worked in the facility on 02/13/2022 from 7am to 7pm with Mr. Thomas. She gave Resident A a bath, but she did not observe anything wrong with her feet. When she returned to work on 02/15/2022, she learned Resident A was hospitalized. Ms. Williams stated the residents are bathed/showered daily. The residents are checked and changed every two hours. Ms. Williams stated there are two staff per shift. There has never been a time when only one staff worked during a given shift.

Ms. Coleman stated she has worked in the facility for approximately three weeks. She mostly works from 7pm to 7am. She changed Resident A on one occasion, but she has never showered/bathed her. She heard Resident A's feet were infected, but she never observed them. The residents are showered/bathed at least every other day. The residents are checked and changed every two hours. There are two staff per shift.

Resident D stated he did not know how long he has lived in the facility. When asked how the staff are, Resident D gestured by pointing his thumbs downwards. He stated staff do not change him when he needs to be changed. He stated staff tells him that they change him every two hours, but he does not think it is that often. Resident D stated sometimes he has a bowel movement, and it leaks out of his brief. However, sometimes staff denies that he had a bowel movement and tell him it is just air. Resident D denied being able to tell the difference. Resident D stated he stays in bed most of the day by choice. He is unable to stand. I observed Resident D's brief as well as linen and bedding. Resident D was not soiled. His linen and bedding were also not soiled.

Resident E stated he has lived in the facility for 17 years. He described staff as good. He does not require assistance with personal care needs. I did not observe Resident E's clothing to be soiled. He stated Resident C and Resident D requires staff assistance with showering/bathing and changing. He stated Resident A requires staff assistance with everything. He denied observing any concerns with Resident A's feet. Resident E did not know how often the residents are showered/bathed, but they are changed as needed. There are two staff per shift.

On 03/07/2022, I reviewed Resident A's medical records from St. Joseph Mercy Oakland. Resident A was admitted to the hospital on 02/14/2022. The final discharge diagnoses were:

- Bilateral lower extremity cellulitis with blisters and necrotic right fifth toe
- Right buttock decubitus ulcer present on admission, status post bedside debridement
- Cerebral palsy
- Debility and weakness
- COVID-19 infection, patient asymptomatic
- Hypokalemia

The record documented that Resident A "was noted to have right fifth toe dry gangrene, blisters on bilateral toes with thickened toenails. Right buttock decubitus ulcer with skin breakdown and black layer partially sloughed with surrounding erythema. Patient was started empirically on Zosyn and Vanco. She was seen by general surgery they did bedside debridement of the sacral ulcer. She was seen by Dr. Dental from podiatry who recommended antibiotics at this time once the blisters and cellulitis healed then patient might benefit from right fifth toe amputation." Resident A was discharged to a skilled nursing facility on 02/22/2022.

On 03/08/2022, I reviewed Resident A's discharge paperwork from Beaumont urgent care. Resident A was seen on 02/14/2022 due to gangrene of toe of right foot and ischemic toe ulcer, right with unspecified severity. There was an ambulatory referral to emergency medicine. I reviewed Resident A's health care chronological. There were no mentions of Resident A's foot until 02/14/2022 when it was documented that Resident A's feet was discolored and both feet were swollen with blisters. Resident A was taken to urgent care and the hospital for treatment. I reviewed the staff schedule from 02/05/2022 until 03/11/2022. I observed the following:

- On 02/05/2022, there was only one staff scheduled from 7am to 3pm.
- On 02/07/2022, there was only one staff scheduled from 9pm to 11pm.
- On 02/11/2022, 03/04/2022, and 03/11/2022, no staff was scheduled from midnight until 7am.
- On 02/16/2022, there was only one staff scheduled from 5pm to 7pm.
- On 02/17/2022, there was only one staff scheduled from 7pm to 7am.
- On 02/21/2022, there was only one staff scheduled from 7am to 7pm.
- On all the other days, at least two staff were scheduled per shift.

As of the date of this report, I have not received a copy of Resident B's, Resident C's, and Resident E's assessment plans.

On 03/14/2022, I attempted to hold the exit conference with licensee designee Paula Ott with no success. I left a message.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.
ANALYSIS:	Per staff, there are two staff per shift. There has never been a time when only one staff worked on a shift.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(1) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.** **(b) Job titles.** **(c) Hours or shifts worked.** **(d) Date of schedule.** **(e) Any scheduling changes.**
ANALYSIS:	Per staff, there are at least two staff working per shift. There has never been a time when only one staff worked during a shift. I reviewed the staff schedule from 02/05/2022 to 03/11/2022. On 02/05/2022, 02/07/2022, 02/11/2022, 02/16/2022, 02/17/2022, 02/21/2022, 03/04/2022, and 03/11/2022, the schedule was not updated to reflect that two staff worked each shift. In addition, the job titles were not listed.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	I reviewed Resident A's, Resident D's, and Resident F's assessment plans. Resident A, Resident D, and Resident F require staff assistance with toileting, bathing, grooming, dressing, personal hygiene, and walking/mobility. Resident A also requires assistance with eating/feeding. None of the plans were signed by licensee designee Paula Ott. Resident A's plan expired on 02/02/2021. Resident D's and Resident F's plans were current. As of the date of this report, I have not received a copy of Resident B's, Resident C's, and Resident E's assessment plans.
CONCLUSION:	**VIOLATION ESTABLISHED**

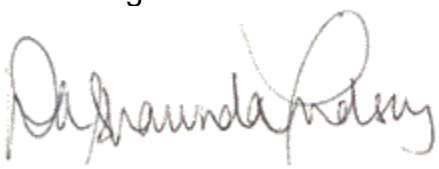
APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	On 02/14/2022, Resident A was taken to Beaumont urgent care and then transported to St. Joseph Mercy Oakland. Resident A's discharge diagnoses were bilateral lower extremity cellulitis with blisters and necrotic right fifth toe, right buttock decubitus ulcer present on admission, status post bedside debridement, cerebral palsy, debility and weakness, COVID-19 infection, patient asymptomatic, and Hypokalemia. Staff failed to document any concerns with Resident A's feet and/or seek treatment in a timely manner. Per staff, the residents are bathed/showered regularly. The residents are checked and changed every two hours. During an unannounced onsite investigation, Resident C, Resident D, and Resident E were not soiled.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain care immediately.

ANALYSIS:	On 02/14/2022, Resident A was taken to Beaumont urgent care and then transported to St. Joseph Mercy Oakland. Resident A's discharge diagnoses were bilateral lower extremity cellulitis with blisters and necrotic right fifth toe, right buttock decubitus ulcer present on admission, status post bedside debridement, cerebral palsy, debility and weakness, COVID-19 infection, patient asymptomatic, and Hypokalemia. Staff failed to document any concerns with Resident A's feet and/or seek treatment in a timely manner.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

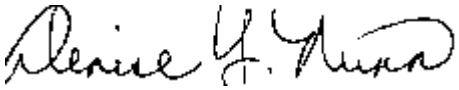
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



03/14/2022

DaShawnda Lindsey Date
Licensing Consultant

Approved By:



03/15/2022

Denise Y. Nunn Date
Area Manager