GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 5, 2022

Dominique Groenveld
MCAP Clare Opco, LLC
4386 14 Mile Rd
Rockford, MI 49341

RE: License #: AL180404676
Investigation #: 2022A0783026
Prestige Place I

Dear Mr. Groenveld:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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) 284-9730.

Sincerely,

Leslie Herrguth, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 256-2181

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL180404676
Investigation #:	2022A0783026
Complaint Receipt Date:	02/08/2022
Investigation Initiation Date:	02/09/2022
Report Due Date:	04/09/2022
Licensee Name:	MCAP Clare Opco, LLC
Licensee Address:	4386 14 Mile Rd Rockford, MI 49341
Licensee Telephone #:	(989) 386-7524
Administrator:	Chelsea Blain
Licensee Designee:	Dominique Groenveld
Name of Facility:	Prestige Place I
Facility Address:	684 Ann Arbor Trail Clare, MI 48617
Facility Telephone #:	(989) 386-7524
Original Issuance Date:	02/01/2021
License Status:	REGULAR
Effective Date:	08/01/2021
Expiration Date:	07/31/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A had pressure ulcers that were not properly treated at the facility.	Yes
Resident A fell and did not receive prompt medical attention.	No
Resident A's special diet was not followed, and she was malnourished and dehydrated.	No

III. METHODOLOGY

02/08/2022	Special Investigation Intake – 2022A0783026
02/08/2022	APS Referral- Denied intake transferred from APS
02/09/2022	Special Investigation Initiated – Telephone call with Complainant
02/18/2022	Contact - Document Received –Written discharge summary from University of Michigan Health
03/02/2022	Inspection Completed On-site
03/02/2022	Contact - Face to Face interviews with facility staff Chelsea Blain, Ervanna Brugger, Carmen Onweller, Mary Jacobs, and Jennie Jones
03/02/2022	Contact - Document Received – Resident A's resident record
04/01/2022	Contact - Telephone call made to PACE (Program of All – Inclusive Care for the Elderly) Nurse Practitioner Mary Beach
04/04/2022	Exit Conference with Chelsea Blain

ALLEGATION:

Resident A had pressure ulcers that were not properly treated at the facility.

INVESTIGATION:

On February 8, 2022, I received a denied APS complaint via centralized intake that stated Resident A passed away on January 20, 2022, due to bed sores. The complaint stated the bed sores were stage 4, exposing Resident A's bone. The complaint stated physicians treating Resident A said surgery would not help. The complaint stated Resident A received medical care through Central Michigan PACE Program and the nurse noted that Resident A's pressure ulcers were not bandaged on multiple occasions. The complaint said PACE staff asked facility staff members if they had the supplies needed to care for the wound and the answer was yes.

On February 9, 2022, I spoke to Complainant who said when Resident A was admitted to the facility in April 2021, she had no pressure ulcers and when she discharged in December 2021 Resident A had severe pressure ulcers that were to the bone and could not be treated according to Complainant. Complainant said Resident A was seen and treated at two different hospitals and both treating physicians advised the pressure ulcers were too advanced for Resident A to be a good candidate for treatment. Complainant said Resident A passed away on January 20, 2022, from infection related to the bed sores she sustained while living at the facility. Complainant said she never saw the pressure ulcers on Resident A and that every time she visited Resident A at the facility the wounds were covered with bandages.

On April 1, 2022, I spoke to Mary Beach who is the nurse practitioner for PACE who was assigned to care for Resident A. Ms. Beach said when she began treating Resident A she was only scheduled to see her twice annually unless staff members at the facility reported concerns, which they did not. Ms. Beach said a PACE staff member telephoned the facility weekly to inquire about Resident A and no staff member from the facility ever expressed that Resident A had a pressure ulcer, rather, it was reported by a PACE nurse that was completing routine monitoring of Resident A on November 2, 2022. Ms. Beach said when it was brought to her attention that Resident A had pressure ulcers on her hip and sacrum area on November 2, 2021, and she completed a written order for wound care. Ms. Beach said the order was dated November 2, 2021 and stated, "cleanse area once daily and cover with dressing. Apply medi – honey every three days or as needed." Ms. Beach said on November 3, 2021, facility nurse Ervanna Brugger reported that Resident A was "doing well and walking with her walker for short distances." Ms. Beach said on November 8, 2022, Ms. Brugger reported that Resident A had sores on her "thigh, hip, and bottom." Ms. Beach said on November 17, 2022, staff member Tammy (last name not listed) reported that the wounds were being cleaned and covered daily and that the medi – honey was being used three times weekly. Ms. Beach said on November 26, 2021, staff member Laura (last name not listed)

reported that Resident A was “doing well,” and there were no concerns to report. Ms. Beach said on December 3, 2022, Resident A was seen by a PACE nurse and the wounds were not healing but rather advancing and a physician’s order for Resident A to be evaluated at a wound clinic was written. Ms. Beach said on December 9, 2022, a nurse from PACE documented that she observed Resident A’s pressure ulcers were not covered according to the written physician’s order as they were not bandaged at all. Ms. Beach added that the nurse documented that Resident A presented as if her pain was not being controlled and staff said they would administer a Tylenol ASAP, for which Resident A had a written order to take as – needed (PRN). Ms. Beach said on December 21, 2021, Resident A was seen at a wound care clinic and referred to a hospital due to the advanced nature of the wound. Ms. Beach said Resident A was referred from the wound care clinic to the hospital where it was determined that Resident A’s pressure ulcers would require an operation, however, Resident A’s designated representative declined the operation and Resident A was discharged from the hospital on hospice care to another facility. Ms. Beach said Resident A’s death certificate listed Lewy Body Dementia as the cause of death and the secondary cause was listed as “infection related to unstageable left hip ulcer.” Ms. Beach said multiple staff members at the facility reported on multiple occasions that Resident A’s wounds were healing when they clearly were not healing.

On March 2, 2022, I interviewed facility administrator Chelsea Blain who said when Resident A was admitted to the facility on April 5, 2021 she did not have any pressure ulcers. Ms. Blain said at that time Resident A was ambulatory with a walker and had a wheelchair to be used as – needed. Ms. Blain said Resident A “declined fast” and stopped using her walker and only used the wheelchair. Ms. Blain said Resident A had severe knee pain and ultimately began spending most of the time in bed. Ms. Blain said she could not recall where, but Resident A developed a pressure ulcer that worsened over time and ultimately Resident A discharged from the facility because staff members at the facility “could not get [the pressure ulcer] under control.” Ms. Blain said she had to remind staff members to reposition Resident A. Ms. Blain said Resident A’s nurse practitioner from PACE completed a written order explaining how the wound was to be cared for. Ms. Blain said she could not recall what the written order directed staff members to do in terms of caring for Resident A’s wound. Ms. Blain said she observed that at times the wound was covered and at times it was not.

On March 2, 2022, I interviewed facility nurse Ervanna Brugger who said Resident A had a pressure ulcer on her sacrum when she admitted to the facility on April 5, 2021, that required topical treatment. Ms. Brugger said when Resident A admitted to the facility, she was ambulatory with a walker and had a wheelchair to use as – needed. Ms. Brugger said Resident A quickly declined and began using the wheelchair with staff assistance to push the wheelchair. Ms. Brugger said Resident A “became bed bound” due to severe knee pain and staff members repositioned Resident A every two hours. Ms. Brugger said due to being “bed bound” Resident A developed a pressure ulcer on her left hip and the nurse practitioner from PACE who

was Resident A's medical provider issued a written order related to Resident A's wound care in November 2021. Ms. Brugger said the written order stated two different topical creams were to be applied and the wound was to be always covered. Ms. Brugger said a nurse from PACE came to the facility and changed the dressing once or twice weekly during the weekdays and staff members at the facility changed the dressing "every third day or every other day" primarily on weekends. Ms. Brugger said the wounds became worse over time because of Resident A's "poor intake," and Resident A discharged from the facility.

On March 2, 2022, I interviewed facility manager and direct care staff member Carmen Onweller who said Resident A developed a pressure ulcer on her hip after her condition declined and she began spending the majority of her time in bed. Ms. Onweller said all staff members consistently repositioned Resident A every two hours. Ms. Onweller said staff members did not perform any wound care for Resident A and that all wound care was completed by a nurse from PACE. Ms. Onweller denied that she ever saw Resident A's wound without a bandage.

On March 2, 2022, I interviewed direct care staff member Mary Jacobs who said Resident A developed a pressure ulcer after she moved into the facility and her condition declined and she began spending most of her time in bed. Ms. Jacobs said staff members consistently repositioned Resident A every two hours. Ms. Jacobs said a nurse from PACE visited Resident A at the facility weekly to assess and address her wound and that staff members were change the bandage on the wound twice daily. Ms. Jacobs said she never observed Resident A's wound without a bandage.

On March 2, 2022, I interviewed direct care staff member Jennie Jones who said Resident A developed a pressure ulcer "on her backside" that developed after she admitted to the facility due to a decline in her condition and a tendency to spend more time in bed. Ms. Jones said staff members repositioned Resident A every two hours. Ms. Jones said staff members were to clean the wound with soap and water, apply a topical cream, and then place a bandage on the wound daily. Ms. Jones said there were occasions where she saw Resident A's wound without a bandage as third shift staff members especially did not always apply a bandage to the wound. Ms. Jones said before Resident A discharged from the facility staff members stopped doing all wound care and PACE did all wound care.

On March 2, 2022, I received and reviewed a written physician's order for Resident A dated November 2, 2021. The written order stated, "apply dime size amount of Santyl to left hip wound bed and cover with optifoam 2 X 2. Change dressing daily and pm. Apply MediHoney to wound bed of left buttock wound, apply optifoam 2 X 2. Change every 3 days and pm." The written order stated Santyl 250 unit/gram topical ointment was to be applied to the cleaned affected area by topical route once daily and as needed. The order stated the wound should be covered with optifoam dressing. The written order stated MediHoney topical gel was to be applied to affected area by topical route every three days.

On March 2, 2022, I received and reviewed Resident A's written *Health Care Appraisal* dated April 5, 2021. The written *Health Care Appraisal* indicated Resident A was diagnosed with hypertension, heart disease, depression, cancer, migraines, and Lewy Body Dementia. The written document indicated Resident A used a walker and a wheelchair for ambulation and had arthritis in both knees. The only skin abnormality documented on the written *Health Care Appraisal* was yeast under Resident A's breast and abdominal folds.

On March 2, 2022, I received and reviewed Resident A's written *Health and Service Evaluation* completed by facility nurse Ervanna Brugger and dated April 2, 2021. The written evaluation stated Resident A had "an active wound and care is provided by an outside agency."

On March 2, 2022, I received and reviewed written *Charting Notes* for Resident A and noted that on October 11, 2022, PACE was "notified of resident having a warm, enflamed area on her outer left thigh. Picture sent with signed consent."

On March 2, 2022, I reviewed Resident A's written *Resident Service Plan* dated April 5, 2021. The service plan indicated Resident A had an open wound on her left hip with redness and hardness and treatment was rendered.

On February 18, 2022, I received a written *Discharge Summary* for Resident A from University of Michigan Health where Resident A was admitted from December 28, 2021 – January 3, 2022. The written summary stated, "Admitted for management and work-up of acute metabolic encephalopathy found to be likely secondary to deep infected multiple sacral decubitus ulcers and left anterior thigh wound. She was treated for hypernatremia, hypertonic, hypervolemia. She was started on broad-spectrum antibiotics for sepsis. We had a difficult time keeping patient's blood sugar up, multiple episodes of hypoglycemia, needed IV dextrose most of admission. She was DNR upon admission. General surgery was consulted for likely need of extensive debridement. Infectious diseases consulted, PICC line was placed. Before surgical intervention, the surgeon Dr. Pilkington had a long conversation with [Relative A1]. It was felt due to the extent of the surgery that she would likely not heal and this would become a recurrent bout of hospitalizations and infections with inability to change ultimate poor prognosis. I personally discussed with [Relative A1], reconfirmed DNR and she ultimately decided that [Resident A] should be comfort care which we implemented in the hospital. Per request from family we discontinued IV antibiotics, IV dextrose and blood draws/sugar checks. No subcu heparin. After discussion with [Relative A1] and case management today, we transferred [Resident A to another facility] on hospice. She was nondistressed without any pain. No hospice medications were needed inpatient to provide comfort."

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	According to Resident A's written *Health Care Appraisal* and statements from those interviewed Resident A did not have severe pressure ulcers when she admitted to the facility on April 5, 2021. Ms. Brugger documented that Resident A had a wound that was cared for by an outside agency on April 2, 2021, and Resident A's medical provider said she was never alerted by the facility that Resident A had a pressure ulcer and rather a nurse from PACE informed her of Resident A's pressure ulcers. Though facility nurse Evanna Brugger documented that she reported a "warm enflamed area" on Resident A's outer left thigh on October 12, 2021, by December 21, 2021, Resident A had severe pressure ulcers for which she required hospitalization but was not an appropriate candidate for surgery. Infection related to the pressure ulcer on her left hip was listed as the secondary cause of death for Resident A who passed away on January 20, 2022. The written physician's order regarding the pressure ulcer stated, "apply dime size amount of Santyl to left hip wound bed and cover with Opti foam 2 X 2. Change dressing daily and pm" and Ms. Beach explained that the wound was to be cleaned daily and always covered with a bandage. Based on statements from Ms. Beach, Ms. Blain, Ms. Jones, and Ms. Onweller there were instances where Resident A's wound was not covered as directed in the written physician's order, and staff members interviewed did not consistently report cleaning the wound as ordered.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A fell and did not receive prompt medical attention.

INVESTIGATION:

On February 8, 2022, I received a complaint via centralized intake that stated on an unknown date at approximately 2:30am complainant received a call from a facility staff member who told her Resident A fell out of bed but was fine. The complaint stated Resident A went to the PACE clinic the following day for a scheduled checkup and was observed with a very large bruise across her forehead. The complaint stated facility staff members stated Resident A had a small bruise on her temple and told Complainant Resident A was “wonderful.”

On February 9, 2022, I spoke to Complainant who confirmed the allegations in the complaint and added that according to staff members from PACE, the whole side of Resident A’s face was bruised from the fall and Resident A needed a CT scan to rule out any internal injuries from hitting her head. Complainant said Resident A only received medical attention the following day because she went to PACE for an appointment that was already scheduled.

On April 1, 2021, I spoke to Mary Beach who is the nurse practitioner for PACE who was assigned to care for Resident A. Ms. Beach said on December 13, 2022, she received a telephone call from facility nurse Ervanna Brugger who told her that Resident A “rolled out of bed and hit her head.” Ms. Beach said Ms. Brugger told her Resident A had a small bruise on her left temple but there were no other injuries. Ms. Beach said Ms. Brugger told her Resident A did not lose consciousness, displayed no change in mentation, nor did she complain of no pain, and was eating and drinking normally. Ms. Beach said based on that information she did not recommend, nor did the facility seek medical treatment for Resident A after she fell out of bed. Ms. Beach said the following day on December 14, 2021, she saw Resident A for an already scheduled routine exam and noted that “the whole side of [Resident A’s] face was black and blue,” and Resident A needed immediate medical attention for the injury to rule out bleeding/swelling of the brain, etc. Ms. Beach said she instantly referred Resident A for a CT scan of her head, which was negative. Nevertheless, Ms. Beach stated because the severe bruising was near Resident A’s brow and temple area, she should have had more timely medical attention.

On March 2, 2022, I received and reviewed all written *AFC Licensing Division Incident/Accident Reports* for Resident A and noted a written incident report dated December 13, 2021, that stated, “observed resident on bedroom floor during rounds. Resident observed to have baseball [sized] bruised area on right side frontal/temporal region. No observed bruising elsewhere.” In the “action taken by staff” section of the written report it stated, “Vitals taken. Resident assisted with two assist to bed. PACE, family, and management notified.” In the “corrective measures taken” section of the written report it stated, “Observed every 15 minutes X 4, every

30 minutes X 2, every 1 hour X 2. Report any signs or symptoms of nausea, vomiting, change in mental status, increased grimacing or shouting out in pain. Bed alarm in place. Discuss hospital bed with half – rails for positioning in bed." The incident report indicated staff members Jennie Jones and Crystal Hamacher were working at the time of the incident. The written incident report indicted PACE was notified on December 13, 2021, at 2:20 am, which was approximately 25 minutes after Resident A fell, according to the written report.

On March 2, 2022, I spoke to facility administrator Chelsea Blain who said Resident A fell as many as five times from April – December 2021. Ms. Blain said the falls were addressed by encouraging Resident A to use her wheelchair full time, assuring that Resident A had at least one staff member present for transferring and toileting, requesting a prescription for a hospital bed with half rails, encouraging Resident A to spend time in the common area and by using bed and chair alarms. Ms. Blain said she did not recall seeing Resident A with anything except for "a small bruise" on Resident A's eye. Ms. Blain denied that she ever saw Resident A with a large bruise on her forehead.

On March 2, 2022, I interviewed facility nurse Ervanna Brugger who said Resident A fell approximately four times between April and December 2021. Ms. Brugger said to address the falls Resident A's wheelchair was changed from as – needed to full time, at least one staff member began assisting Resident A with transferring, mobility, and toileting, a hospital bed with half rails for positioning was requested, and bed and chair alarms were used. Ms. Brugger said none of Resident A's falls required hospitalization and Resident A was slightly injured when she fell on December 13, 2021. Ms. Brugger said when Resident A fell on December 13, 2021, she sustained "a black eye" as well as bruising to her abdomen and shoulder. Ms. Brugger said she notified PACE, which is Resident A's medical provider, and it was not recommended that Resident A go to the hospital. Ms. Brugger said staff members closely monitored Resident A by making visual contact with her every 15 minutes for an hour, then every 30 minutes for an hour, then every hour for two hours. Ms. Brugger said staff members monitored Resident A for signs or symptoms of nausea, vomiting, change in mental status, and for signs of pain and Resident A did not display any symptoms.

On March 2, 2022, I interviewed direct care staff member Jennie Jones who said she was working on December 13, 2021, when Resident A evidently fell when trying to get out of bed. Ms. Jones said Resident A had a bruise approximately the size of a baseball on her temple/forehead area after the fall but had no other bruising or injury. Ms. Jones said facility nurse Ervanna Brugger was notified who advised staff members to closely monitor Resident A by making visual contact with her every 15 minutes for an hour, then every 30 minutes for an hour, then every hour for two hours. Ms. Jones said staff members monitored Resident A for signs or symptoms of nausea, vomiting, change in mental status, and for signs of pain and Resident A did not display any symptoms. Ms. Jones said Resident A had fallen a couple of times previously and that the falls were addressed by changing Resident A's wheelchair

status from as – needed to full time, at least one staff member began assisting Resident A with transferring, mobility, and toileting, a hospital bed with half rails for positioning was requested, and bed and chair alarms were used.

On March 2, 2022 I interviewed facility manager and direct care staff member Carmen Onweller who said Resident A fell several times during the months she was admitted to the facility which was addressed by encouraging Resident A to use her wheelchair full time; assuring that Resident A had at least one staff member present for transferring, mobility, and toileting; requesting a prescription for a hospital bed with half rails; encouraging Resident A to spend time in the common area and by using bed and chair alarms. Ms. Onweller denied that Resident A was seriously injured during any of the falls. Ms. Onweller said she saw Resident A with "a bruise on her forehead," but she did not know what happened as Resident A could not explain.

On March 2, 2022, I interviewed direct care staff member Mary Jacobs who said Resident A never fell during the day shift when she typically works but she was aware that Resident A fell a number of times during the afternoon and night shifts. Ms. Jacobs said Resident A's tendency to fall was addressed by encouraging Resident A to use her wheelchair full time; assuring that Resident A had at least one staff member present for transferring, mobility, and toileting; use of a gait belt; requesting a prescription for a hospital bed with half rails; encouraging Resident A to spend time in the common area and by using bed and chair alarms. Ms. Jacobs denied that she ever saw Resident A with a bruise on her face/forehead. Ms. Jacobs denied that Resident A required outside medical attention for any fall.

On March 2, 2022, I reviewed Resident A's written *Resident Service Plan* dated April 5, 2021. The service plan indicated "fall precautions" were implemented for Resident A such as a wheelchair with alarm, bed alarm, chair alarm, and assistance from one staff member for all activities of daily living.

On March 2, 2022, I received and reviewed Resident A's written *Fall Risk Assessment* dated April 5, 2021, that stated Resident A had a history of falls, required assistive devices for ambulation, required supervision for gait monitoring, and that Resident A had contributing conditions and medications that affected her tendency to fall.

APPLICABLE RULE	
R 400.15310	**Resident health care**
	(4) In case of sudden or adverse change in a resident's physical condition or adjustment, a group home shall obtain the needed care immediately.

ANALYSIS:	Based on statements from Ms. Beach, Ms. Brugger, Ms. Onweller, Ms. Jacobs and Ms. Jones as well as written documentation at the facility it can be determined that Resident A fell on December 13, 2021 and sustained a bruise to her temple/forehead area. Based on the written documentation in Resident A's resident record and statements from those interviewed, PACE, which is Resident A's medical provider, was notified 25 minutes after Resident A fell on December 13, 2021, and facility staff members were not directed to send Resident A to the hospital. Based on the interviews conducted and written documentation at the facility, reasonable efforts were made by the licensee to address Resident A's tendency to fall, and reasonable actions were taken to assess and monitor Resident A after she fell on December 13, 2021.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's special diet was not followed, and she was malnourished and dehydrated.

INVESTIGATION:

On February 8, 2022, I received a complaint via centralized intake that stated according to PACE Resident A was prescribed a special diet of high calorie boost but she did not receive the Boost and lost over 40 pounds in a short amount of time. The complaint stated facility staff misreported Resident A's weight to PACE and told staff there that Resident A was weighed on an old scale from a physician's office. The complaint said a PACE staff member told Complainant took three people to help Resident A get onto a wheelchair scale to get weighed.

On February 9, 2022, I spoke to Complainant who confirmed the allegations in the written complaint and added that a surgeon at University of Michigan Health explained that due to Resident A's malnourishment and dehydration, her body's ability to fight the infection related to the pressure ulcers was compromised. Complainant said a staff member from PACE told her that Resident A was prescribed a Boost drink "a few times" daily and that since she was rapidly losing weight it did not appear as if Resident A was being offered the Boost drink.

On April 1, 2021, I spoke to Mary Beach who is the nurse practitioner for PACE who was assigned to care for Resident A. Ms. Beach said a PACE staff member spoke to a facility staff member weekly and was told that Resident A was eating and drinking well until November 26, 2021, when it was reported that Resident A was not eating well so an order was written for daily Boost drink supplement. Ms. Beach said a

PACE staff member began making weekly contact with Resident A at that time and continued to make frequent telephone calls where staff members reported that Resident A was “doing well.” Ms. Beach said on December 8, 2022, staff members reported that Resident A was consuming two Boost drinks daily and eating well, however, PACE determined Resident A was weak and losing weight so an order was written for high calorie Boost. Ms. Beach said Resident A continued to lose weight and staff at the facility reported that at times Resident A declined the Boost drink, but “she was OK otherwise.” Ms. Beach said Resident A “lost a lot of weight and it was not brought to my attention by [the facility].” Ms. Beach said Resident A was diagnosed with Lewy Body Dementia which “causes all over body breakdown,” including malnutrition.

On March 2, 2022, I interviewed facility administrator Chelsea Blain who stated she did not recall if Resident A was on a special diet but if she was it would have been documented in a written physician’s order and provided to staff members in the kitchen who prepared Resident A’s meals. Ms. Blain said Resident A did lose weight over the several months that she was admitted to the facility which was attributed to a problem with her dentures and the fact she was in pain. Ms. Blain said the weight loss was reported to Resident A’s medical provider which was PACE. Ms. Blain said Resident A was weighed monthly by weighing her in her wheelchair on a wheelchair scale and then subtracting the weight of the wheelchair.

On March 2, 2022, I interviewed facility nurse Ervanna Brugger who said Resident A’s appetite decreased over the months that she resided at the facility. Ms. Brugger said Resident A weighed 191 pounds when she moved into the facility in April 2021 and by December 2021 Resident A weighed 153 pounds. Ms. Brugger said the weight loss was reported to PACE. Ms. Brugger said Resident A was ordered to be on a special diabetic diet and while “a lot of sugar free” food is served at the facility; Resident A was not specifically given a diabetic diet. Ms. Brugger said staff members offered Resident A a drink every time they went into her room to reposition her which was every two hours. Ms. Brugger said Resident A was weighed monthly by weighing her in her wheelchair on a wheelchair scale and then subtracting the weight of the wheelchair.

On March 2, 2022, I interviewed facility manager and direct care staff member Carmen Onweller who said she formerly worked in the kitchen and prepared meals for Resident A. Ms. Onweller said Resident A was on a diabetic diet that included increased protein, low carbohydrates, and low sugar. Ms. Onweller said Resident A was served a diabetic diet and was complaint with following the diet. Ms. Onweller said over time Resident A’s appetite decreased and she began to lose weight. Ms. Onweller said Resident A refused to eat and would close her mouth and shake her head when staff members tried to encourage her to eat. Ms. Onweller stated she tried making milkshakes for Resident A and she would not consume them. Ms. Onweller said ultimately Resident A’s physician ordered two Boost nutritional drinks daily after facility staff members consistently reported that Resident A’s appetite and weight were decreasing. Ms. Onweller said Resident A was provided with the special

diet ordered by her medical provider which was PACE. Ms. Onweller said Resident A was weighed monthly by weighing her in her wheelchair on a wheelchair scale and then subtracting the weight of the wheelchair.

On March 2, 2022, I interviewed direct care staff member Mary Jacobs who said when Resident A first admitted to the facility, she had a healthy appetite but as Resident A's condition declined so did Resident A's appetite. Ms. Jacobs said when staff members noticed that Resident A was not eating well, they began assisting her with eating, but Resident A still did not consume adequate food. Ms. Jacobs said Resident A's weight loss and lack of food consumption were reported to PACE and Resident A was prescribed two Boost nutritional drinks daily which she was provided. Ms. Jacobs said Resident A was weighed monthly by weighing her in her wheelchair on a wheelchair scale and then subtracting the weight of the wheelchair. Ms. Jacobs said Resident A was assisted with and encouraged to drink every two hours when staff members came to reposition Resident A.

On March 2, 2022, I interviewed direct care staff member Jennie Jones who said staff members noted that as Resident A's condition declined, so did her appetite and willingness to consume food. Ms. Jones said staff members began assisting Resident A with eating and drinking but Resident A still did not consume adequate food. Ms. Jones said Resident A's weight loss and lack of appetite were reported to PACE and Resident A was prescribed two Boost nutritional drinks daily which she was provided. Ms. Jones said Resident A was weighed monthly by weighing her in her wheelchair on a wheelchair scale and then subtracting the weight of the wheelchair. Ms. Jones said Resident A was assisted with and encouraged to drink every two hours when staff members came to reposition Resident A.

On March 2, 2022, I received and reviewed Resident A's written Health Care Appraisal dated April 5, 2021 and described Resident A as "well nourished." The Health Care Appraisal documented Resident A's weight as 189 pounds.

On March 2, 2022, I received and reviewed written Monthly Weights for Resident A from April – December 2021. Resident A's weights were listed as follows:

- April – 191.5
- May – 189
- June – 188
- July – 185
- August – 182
- September – 179
- October – 169
- November – 160
- December – 153

On March 2, 2022, I reviewed *ADL Checklist* for the months of April 2021 December 2021. The ADL Checklist documented the percentage of each meal consumed by Resident A. I noted that for the most part, the ADL Checklist consistently

documented Resident A eating100% of three meals daily until October 2021. During the months of October and November Resident A consistently ate approximately 50% of her meals. In December 2021 Resident A consistently consumed only about 30% of her meals. The ADL Checklist indicated Resident A was also offered three snacks daily.

On March 2, 2022, I received and reviewed written *Charting Notes* for Resident A completed by facility nurse Ervanna Brugger which stated on October 12, 2021, she received a telephone call from a dietician at PACE who reported that Resident A lost 10 pounds and Boost should be considered. The written notes stated on December 3, 2021, the same dietician telephoned the facility and stated Resident A would be prescribed Ensure Plus as it contained more protein. The written note stated Resident A was consuming three Boost nutritional drinks daily.

On March 2, 2022, I received and reviewed a written physician's order for Resident A dated November 9, 2022, which stated, "One Boost shake three times a day with meals."

On March 2, 2022, I received and reviewed Resident A's written *Dietary Profile* which stated Resident A's weight was 198 lbs. and she was to consume a diabetic low salt diet per her physician's order. The documented , was updated with at date of November 9, 2021, and stated, "one Boost shake with meals."

On February 18, 2022, I received a written *Discharge Summary* from University of Michigan Health for Resident A which indicated she was admitted to the hospital with dehydration on December 28, 2021. The written summary did not indicate that Resident A was diagnosed with malnutrition.

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet.

ANALYSIS:	Based on statements from Ms. Beach, Ms. Blain, Ms. Brugger, Ms. Onweller, Ms. Jacobs, and Ms. Jones as well as written documentation at the facility it appears that beginning in October 2021 Resident A began to experience a decline in her general health and her appetite decreased, which was documented in writing at the facility. Resident A's weight loss was documented at the facility and shared with PACE which is Resident A's medical provider. Resident A had a primary diagnosis of Lewy Body dementia which according to her treating nurse practitioner causes "all over body breakdown" and "can cause malnutrition." Written medical records received for Resident A did not indicate she was diagnosed with malnutrition. Based on written documentation at the facility and interviews conducted Resident A was given Boost nutritional drinks as prescribed by her physician.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

Leslie Herrguth

04/04/2022

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Leslie Herrguth Date
Licensing Consultant

Approved By:

Dawn Timm

04/05/2022

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Dawn N. Timm Date
Area Manager