GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 9, 2022

Tami McKellar
AH Kentwood Subtenant LLC
6755 Telegraph Road Suite
Bloomfield Hills, MI 48301

RE: License #: AL410397694
Investigation #: 2022A0583027
AHSL Kentwood Riverstone

Dear Ms. McKellar:

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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even

if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

If you desire technical assistance in addressing these issues, please 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 (616) 356-0183.

Sincerely,

Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410397694
Investigation #:	2022A0583027
Complaint Receipt Date:	04/27/2022
Investigation Initiation Date:	04/27/2022
Report Due Date:	05/27/2022
Licensee Name:	AH Kentwood Subtenant LLC
Licensee Address:	One SeaGate, Suite 1500 Toledo, OH 43604
Licensee Telephone #:	(248) 203-1800
Administrator:	Tami McKellar
Licensee Designee:	Tami McKellar
Name of Facility:	AHSL Kentwood Riverstone
Facility Address:	5980 Eastern Ave SE. Kentwood, MI 49508
Facility Telephone #:	(248) 309-0257
Original Issuance Date:	01/18/2019
License Status:	REGULAR
Effective Date:	07/18/2021
Expiration Date:	07/17/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Prior to Resident A's death on 01/17/2022, the facility was understaffed.	Yes
Resident A did not receive timely wound care.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/27/2022	Special Investigation Intake 2022A0583027
04/27/2022	Special Investigation Initiated - On Site Licensee Designee Tami McKellar, Resident B, Resident E, Resident F, Resident M, Resident P
05/04/2022	Contact – Email Relative 1
05/06/2022	Contact - Email Licensee Designee Tami McKellar
05/10/2022	Contact - Telephone Relative 1
05/25/2022	APS Referral
05/26/2022	Contact - Telephone Staff Madison Williams
05/26/2022	Contact - Telephone Will Todd, Interim Healthcare
05/26/2022	Contact - Telephone Kaylie Vanengen, Interim Healthcare
05/26/2022	Contact - Telephone Staff Madison Williams
05/27/2022	Contact - Telephone Staff Tommy Stornello
05/27/2022	Contact - Document Will Todd, Interim Healthcare

05/31/2022	Contact - Document Patenna Shannon, American House Office Assistant
06/09/2022	Exit Conference Katrina Aleck, American House Clinical Specialist

ALLEGATION: Prior to Resident A's death on 01/17/2022, the facility was understaffed.

INVESTIGATION: On 04/27/2022 complaint allegations were received and alleged that residents do not receive adequate personal care because the facility is insufficiently staffed. It was specifically alleged that the facility did not have enough staff working approximately one month prior to Resident A's death on 01/17/2022 to adequately meet the needs of facility residents.

On 04/27/2022 I completed an unannounced onsite investigation at the facility. I privately interviewed Licensee Designee Tami McKellar, Resident B, Resident E, Resident F, Resident M, and Resident P.

Licensee Designee Tami McKellar stated the facility "generally" operates with "one med tech and two aides" but admitted there has been instances when the facility operated with only one med tech and one aide due to an overall staffing shortage. Ms. McKellar explained that one staff is identified as a "med tech" and their job responsibilities are to administer resident medications first and then provide resident care as time allows. Ms. McKellar stated that during situations in which the facility staff requires additional staff assistance to perform resident care, such as with lifting non-ambulatory residents, staff from other facilities located on the same campus will "come over for assistance". Ms. McKellar stated she is not aware of any residents' care needs not being met and indicated residents have been provided adequate care.

Resident B stated he does not know how many staff worked at the facility on any previous shift and expressed no concerns regarding the prior or current level of staffing at the facility. Resident B presented as lucid and coherent.

Resident E stated she does not know how many staff worked at the facility on any previous shift and expressed no concerns regarding the prior or current level of staffing at the facility. Resident E presented as lucid and coherent.

Resident F stated she does not know how many staff worked at the facility on any previous shift and expressed no concerns regarding the prior or current level of staffing at the facility. Resident F presented as lucid and coherent.

Resident M stated she is unhappy with the level of care provided. Resident M stated she was unaware of staffing numbers however "there aren't many" staff. Resident M

stated she has been “left in bed all day” without staff assistance and is often left “sitting in wet pants”. Resident M stated she is “not getting personal care” from facility staff as evidenced by not being bathed or showered for “two weeks” because facility staff informed Resident M there was “no help” due to low staffing. Resident M displayed unwashed hair and a slight body odor. Resident M was unable to provide exact dates of being “left in bed all day” however stated the incidents were more than once within the past few months. Resident M presented as lucid and coherent.

Resident P stated, “staff sit on their butts and play with their phones” and she has had to “go eight hours without being checked on” by staff. Resident P stated “staff complain residents are not getting changed at night” however Resident P stated “I’m not naming names” of the staff that complain. Resident P stated she has always received adequate care and could not identify incidents in which her personal care needs were not met. Resident P stated she does not know how many staff worked at the facility on any previous shift. Resident P presented as lucid and coherent.

On 05/06/2022 I received an email from Licensee Designee Tami McKellar with the Resident Register attached. The document indicated that the facility housed between eighteen and nineteen residents from 12/15/2021 until 01/15/2022.

On 05/06/2022 I received a second email from Licensee Designee Tami McKellar which contained Resident Assessment Plans and Staffing Logs. The Resident Assessment Plans indicated the following:

Resident A’s Assessment Plan dated 06/18/2020 is not signed by Resident A, Resident A’s legal decision maker, or the facility’s Licensee Designee. Resident A’s Assessment Plan indicates Resident A has a diagnosis of “Bi polar” and requires reminders for activities of daily living. Resident A’s Assessment Plan did not indicate Resident A required hospice or wound care.

Resident B’s Assessment Plan dated 10/29/2019 is not signed by the facility’s Licensee Designee. Resident B’s Assessment Plan indicates Resident B requires “standby or partial assistance” with activities of daily living and “stand-by assistance while ambulating with assistive device”.

Resident C’s Assessment Plan dated 12/03/2019 is not signed by Resident C, Resident C’s legal decision maker, or the facility’s Licensee Designee. Resident C’s Assessment Plan indicates Resident C requires “two caregiver assistance” with activities of daily living and “requires two staff to transfer”. Resident C’s Assessment Plan indicates Resident C requires “use of 2 assist and Hoyer Lift” and “complete assistance with all care related to incontinence”. Resident C’s Assessment Plan notes Resident C is diagnosed with “Aphasia”.

Resident D’s Assessment Plan dated 09/22/2021 is not signed by Resident D, Resident ADs legal decision maker, or the facility’s Licensee Designee. Resident

D's Assessment Plan indicates Resident D has a diagnosis of "Schizoaffective disorder; Depression" and requires "STANDBY or PARTIAL ASSISTANCE" with activities of daily living. Resident D's Assessment Plan indicates Resident D requires "ESCORT or SUPERVISON to maintain continence" and "requires staff STAND-BY assistance while ambulating with assistance device".
Resident E's Assessment Plan dated 05/18/2021 is not signed by Resident E, Resident E's legal decision maker, or the facility's Licensee Designee. Resident E's Assessment Plan indicates Resident E requires "STANDBY or PARTIAL assistance" and "will call for assistance with transfers on and off commode". Resident E's Assessment Plan indicates Resident E "has an assistance device and requires STAND-BY assistance while ambulating with assistance device"

Resident F's Assessment Plan dated 02/08/2021 is not signed by Resident F, Resident F's legal decision maker, or the facility's Licensee Designee. Resident F's Assessment Plan indicates Resident F has a diagnosis of "Alzheimer's Disease" and "is stress incontinent".

Resident G's Assessment Plan dated 09/09/2021 is not signed by Resident G, Resident G's legal decision maker, or the facility's Licensee Designee. Resident G's Assessment Plan indicates Resident G has a diagnosis of "traumatic subdural hemorrhage" and "cognitive communication disorder". Resident G's Assessment Plan indicates Resident G requires "STANDBY or PARTIAL ASSISTANCE" with activities of daily living and "needs additional supervision/monitoring related to a neurological diagnoses, frequent urinary incontinence, physical limitation, or issues with feet".

Resident H's Assessment Plan dated 10/25/2021 is not signed by Resident H, Resident H's legal decision maker, or the facility's Licensee Designee. Resident H's Assessment Plan indicates Resident H has a diagnosis of "Cerebral infarction" and "Hemiplagia". Resident H's Assessment Plan indicates Resident H requires "COMPELTE ASSISTANCE" with activities of daily living and requires "one person physical assistance to transfer safely".

Resident I's Assessment Plan dated 09/23/2020 is not signed by Resident I, Resident I's legal decision maker, or the facility's Licensee Designee. Resident I's Assessment Plan indicates Resident I has a diagnosis of "mild cognitive disorder" and requires "STANDBY or PARTIAL ASSISTANCE" with activities of daily living and "HANDS-ON ASSISTANCE" with continence care. Resident I's Assessment Plan indicates Resident I requires "STAND-BY assistance while ambulating with assistive device".

Resident J's Assessment Plan dated 09/17/2021 is not signed by Resident J, Resident J's legal decision maker, or the facility's Licensee Designee. Resident J's Assessment Plan indicates Resident J requires "STANDBY or PARTIAL ASSISTANCE" with activities of daily living.

Resident K's Assessment Plan dated 11/03/2017 is not signed by Resident K, Resident K's legal decision maker, or the facility's Licensee Designee. Resident K's Assessment Plan indicates Resident K has a diagnosis of "Morbid Obesity" and requires "one person physical assistance to safely transfer".

Resident L's Assessment Plan dated 04/02/2021 is not signed by Resident L, Resident L's legal decision maker, or the facility's Licensee Designee. Resident L's Assessment Plan indicates Resident L requires "STANDBY or PARTIAL ASSISTANCE" with activities of daily living and "COMPLETE ASSISTANCE" with incontinence care. Resident L's Assessment plan indicates Resident L "requires two staff to transfer; resident may also require the assistance of a mechanical lift or sit to stand or Hoyer lift".

Resident M's Assessment Plan dated 10/28/2020 is not signed by Resident M, Resident M's legal decision maker, or the facility's Licensee Designee. Resident M's Assessment Plan indicates Resident M has a diagnosis of "Cerebral Infarction" and requires "STANDBY or PARTIAL ASSISTANCE" with activities of daily living. Resident M's Assessment Plan indicates Resident M "is generally continent with episodes of incontinence" and requires "assistance with clothes and briefs and reminders to maintain continence". Resident M's Assessment Plan indicates Resident M "requires one person physical assistance to safely transfer".

Resident N's Assessment Plan dated 07/15/2021 is not signed by Resident N, Resident N's legal decision maker, or the facility's Licensee Designee. Resident N's Assessment Plan indicates Resident N requires "STANDBY or PARTIAL ASSISTANCE" with activities of daily living and in incontinent of bowel and bladder thus requiring "COMPLETE ASSISTANCE". Resident N's Assessment Plan indicates Resident N "needs a wheelchair escort".

Resident O's Assessment Plan dated 02/17/2021 is not signed by Resident O, Resident O's legal decision maker, or the facility's Licensee Designee. Resident O's Assessment Plan indicates Resident O is independent with activities of daily living. Resident O's Assessment Plan indicates Resident O utilizes a walker for mobility.

Resident P's Assessment Plan dated 12/23/2019 is not signed by Resident P, Resident P's legal decision maker, or the facility's Licensee Designee. Resident P's Assessment Plan indicates requires "STANDBY or PARTIAL ASSISTANCE" with activities of daily living and is "generally incontinent of bowels or bladder" which requires "HANDS ON ASSISTANCE". Resident P's Assessment Plan indicates Resident P utilizes a wheelchair and requires "2 assist to transfer to wheelchair".

Resident Q's Assessment Plan dated 11/24/2021 is not signed by Resident Q, Resident Q's legal decision maker, or the facility's Licensee Designee. Resident Q's Assessment Plan indicates Resident Q has a diagnosis of "Dementia" and requires "STANDBY or PARTIAL ASSISTANCE" with activities of daily living.

Resident R's Assessment Plan dated 07/22/2021 is not signed by Resident R, Resident R's legal decision maker, or the facility's Licensee Designee. Resident R's Assessment Plan indicates Resident R has a diagnosis of "dementia" and requires "two caregiver assistance" with activities of daily living. Resident R's Assessment Plan indicates Resident R is "incontinent of bowel and bladder" and requires "complete assistance". Resident R's Assessment Plan indicates Resident R requires "a staff member to sit with them and requires FULL ASSISTANCE with eating". Resident R's Assessment Plan indicates Resident R requires "two staff to transfer" and the use of a wheelchair.

On 05/10/2022 I interviewed Relative 1 via telephone. Relative 1 stated Resident A was a resident of the facility until his death on 01/17/2022. Relative 1 stated Resident A passed away after complications of Covid 19 and a coccyx wound discovered on or about 12/24/2021 leading to a rapid decline in Resident A's overall health. Relative 1 stated Resident A received hospice services just prior to Resident A's passing and together with facility staff, hospice was tasked with caring for Resident A's coccyx wound and overall healthcare. Relative 1 stated she visited the facility on 01/14/2022 and 01/15/2022 from around noon until mid to late afternoon and while at the facility observed "twenty residents and only two staff". Relative 1 stated while onsite she observed facility staff reposition Resident A "one time". Relative 1 stated she is concerned that the facility was understaffed given the high needs of facility residents coupled with the high level of care Resident A required given his coccyx wound and rapid health decline.

On 05/25/2022 I emailed complaint allegations to Adult Protective Services Centralized intake.

On 05/26/2022 I interviewed Kaylie Vanengen via telephone. Ms. Vanengen stated she is employed by Interim Healthcare Hospice as a nurse. Ms. Vanengen stated she provided hospice nursing care to Resident A at the facility from approximately 01/07/2022 until his death on 01/17/2022. Ms. Vanengen stated she completed five in person visits with Resident A at the facility and each visit lasted approximately thirty minutes. Ms. Vanengen stated she was unsure of the facility's staffing levels from 01/07/2022 until Resident A's death however Ms. Vanengen did observe one incident in which Resident A's care needs were not met by facility staff. Ms. Vanengen stated that on 01/12/2022 she visited the facility and upon entry was informed from an unknown facility staff that Resident A had just been changed and was "dry". Ms. Vanengen stated after the brief conversion with the staff member, she immediately entered Resident A's bedroom and observed Resident A was lying "in urine-soaked bedding and clothing". Ms. Vanengen stated, "there was no way" facility staff had just changed Resident A because Resident A's bedding was "soaked in urine down to the mattress pad and up (Resident A's) shirt". Ms. Vanengen stated the care she provided to Resident A was some time ago and therefore she could not recall any other examples of Resident A's care needs going unmet while he resided at the facility.

On 05/26/2022 I interviewed former staff Madison Williams. Ms. Williams stated she was previously employed as the facility's Manor Coordinator and staff scheduler "until a couple months ago". Ms. Williams stated the facility "generally" operated with two or three facility staff "and that's if everyone showed up". Ms. Williams stated that from 12/15/2021 until 01/15/2022 there were times the facility housed eighteen or nineteen residents and operated with "only one staff". Ms. Williams stated the low staffing levels affected the quality of resident care as evidenced by "residents could have been washed better and check and changes were not always done every two hours". Ms. Williams stated multiple residents required two-person staff assisted transfers however when the facility operated with one staff "sometimes one staff" would transfer the resident independently or staff from other facilities were called to the facility to assist. Ms. Williams stated multiple times she requested additional staffing from administration however she stated, "I was getting my ass chewed by corporate because I was calling the agency too much and they didn't want to pay for the agency". Ms. Williams explained that "agency" means staffing provided by an outside home health staffing agency.

On 05/27/2022 I interviewed former staff Tommy Stornello via telephone. Mr. Stornello stated he no longer works at the facility but did work closely with Resident A from 12/15/2021 until his death on 01/17/2022. Mr. Stornello stated the facility typically operated with one med tech and two resident care aides per shift and Mr. Stornello "doesn't remember" if the facility operated with less than three staff per shift. Mr. Stornello stated he was on vacation and did not work at the facility from 12/16/2021 until returning 12/25/2021 and stated he is unsure of the facility's staffing during that time frame. Ms. Stornello stated other staff often complained that the facility was too understaffed to meet the care needs of facility residents however Mr. Stornello thought staffing levels were adequate. Mr. Stornello stated facility staff were often "on their cell phones" rather than focusing their attention on resident care. Mr. Stornello stated resident care was not always performed adequately. Mr. Stornello stated at 7:00 am on an unknown date December 2021, Mr. Stornello observed Resident A sitting in his chair "completely soaked in urine" because facility staff did not change residents often enough. Mr. Stornello stated after Resident A developed a coccyx wound facility staff were instructed by hospice staff to "reposition" Resident A every two hours, however, that was "not always being done".

On 05/27/2022 I received an email from Interim Healthcare Hospice Executive Director Will Todd. The email contained "Skilled Nursing Visit" notes referencing Resident A and authored by Interim Healthcare Nurse Hospice Kaylie Vanengen. The documents stated that on 01/12/2022 Ms. Vanengen "found that patients fitted sheet and under pad and shirt were completely soaked with urine". On 01/12/2022 Ms. Vanengen noted that "Madison the MT reported she had been changing the dressing three times a day but on Monday I left only two optifoam at the bedside and only one was used".

On 05/31/2022 I received an email from American House Office Assistant Patenna Shannon. The email stated, "These are the only logs we have for that time frame. If

the previous ED filled in on open shifts, it wasn't noted on the schedule". The email contained the facility's weekly staffing schedule from 12/15/2021 until 01/15/2022. The staffing schedule indicated that on 12/31/2021, one staff was scheduled to work from 11:00 pm until 6:30 am. It also indicated that on 12/16/2021, 12/19/2021, 12/24/2021, 12/28/2021, 01/09/2022 from 7:00 am until 2:30 pm two staff were scheduled to work and on 12/24/2021, 12/29/2021, 12/30/2021, 01/11/2022 from 3:00 pm until 10:30 pm two staff were scheduled to work. The staffing schedule does not identify occasions when staff who were scheduled to work did not report to work.

On 06/09/2022 I completed an Exit Conference with American House Clinical Specialist Katrina Aleck via telephone. Ms. Aleck stated Licensee Designee Tami McKellar is no longer employed at the facility and Ms. Aleck is currently working as a temporary replacement to assist with the completion of the Special Investigations and management of the facility. Ms. Aleck stated she agrees with that a preponderance of evidence indicates a violation regarding Rule 400.15206 (1) was discovered, however AH Kentwood Subtenant LLC requests to read the Special Investigation report in it's entirely before an agreement can be made to accept a Provisional license. Ms. Aleck stated she would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.15206	**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 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours.
ANALYSIS:	The facility's Resident Register indicates there were eighteen or nineteen residents from 12/15/2021 until 01/15/2022. Resident Assessment Plans indicate Resident C, Resident L, Resident P, and Resident R required assistance from two staff with transferring. Licensee Designee Tami McKellar stated the facility "generally" operates with one med tech and two aides but admitted that there have been instances when the facility was understaffed and subsequently operated with only one med tech and one aide. Ms. McKellar stated that during situations in which the facility staff requires additional staff assistance to perform resident care, such as with lifting non-ambulatory residents, staff from other facilities located on the same campus will "come over for assistance".

	Interim Healthcare Hospice nurse Kaylie Vanengen stated there was one incident in which Resident A's care needs were not met by facility staff. Ms. Vanengen stated that on 01/12/2022 she visited the facility and upon entry was informed by facility staff that Resident A had just been changed and was dry. Ms. Vanengen stated she immediately went into Resident A's bedroom and observed Resident A was lying "in urine soaked bedding and clothing". Ms. Vanengen stated, "there was no way" facility staff had just changed Resident A because Resident A's bedding was "soaked in urine down to the mattress pad and up (Resident A's) shirt". Former staff Madison Williams stated the facility "generally" operated with two or three facility staff "and that's if everyone showed up". Ms. Williams stated that from 12/15/2021 until 01/15/2022 there were times the facility housed eighteen or nineteen residents and operated with only one staff. Ms. Williams stated the low staffing levels affected the quality of resident care as evidenced by "residents could have been washed better and check and changes were not always done every two hours". Ms. Williams stated multiple residents required two-person staff assisted transfers however when the facility operated with one facility staff sometimes one staff would transfer the resident independently or staff from other facilities were called to assist. The staff schedule indicated that on 12/31/2021 one staff was scheduled to work from 11:00 pm until 6:30 am. The staff schedule indicated that on 12/16/2021, 12/19/2021, 12/24/2021, 12/28/2021, 01/09/2022 from 7:00 am until 2:30 pm two staff were scheduled to work and on 12/24/2021, 12/29/2021, 12/30/2021, 01/11/2022 from 3:00 pm until 10:30 pm two staff were scheduled to work. A preponderance of evidence was discovered during the Special Investigation to substantiate a violation of the applicable rule. On 12/31/2021 from 11:00 pm until 6:30 am the facility's staff schedule indicated only one staff was scheduled to work and on multiple dates the facility operated with two staff in total. The facility is required to provide care to four residents who require two-person physical assistance to safely transfer. Facility staff interviews reveal that the current staffing ratios of one or two staff working per shift is inadequate as indicated by the resident Assessment Plans and supported by practice of calling staff over from another facility for assistance. Therefore, the current staffing level for this facility is insufficient as determined by the department, to carry out the responsibilities defined in the act

CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: Resident A did not receive timely wound care.

INVESTIGATION: On 04/27/2022 complaint allegations were received and alleged that Resident A did not receive timely care for a diagnosed coccyx wound.

On 05/04/2022 I received an email from Relative 1. The email contained a document labeled “Kentwood Riverstone Observations”. The document contained a 12/24/2021 6:39 am observation note authored by staff Laura Baca that indicated Resident A was observed with a “wound” and “antibiotic ointment” was applied to said wound to “prevent further infection”. A 12/25/2021 2:42 pm observation note authored by staff Tommy Stornello indicated that Resident A “has open area near coccyx” and “also has scrotal/pelvic edema”. The 12/25/2021 observation note also stated that the “area is mapped out if swelling increases or resident doesn’t urinate resident will need to be sent to hospital to be assessed”. I also reviewed a 01/01/2022 10:24 pm observation note authored by staff Tommy Stornello that noted Resident A’s “buttocks appears worse than a few days ago”.

On 05/06/2022 I received an email from Licensee Designee Tami McKellar which contained Resident A’s Assessment Plan. The document was dated 06/18/2020 and is not signed by Resident A, Resident A’s legal decision maker, or the facility’s Licensee Designee. Resident A’s Assessment Plan indicates Resident A has a diagnosis of “Bi polar” and requires reminders for activities of daily living. Resident A’s Assessment Plan did not indicate Resident A required hospice or wound care.

On 05/10/2022 I interviewed Relative 1 via telephone. Relative 1 stated Resident A was a resident of the facility until his death on 01/17/2022. Relative 1 stated Resident A passed away 01/17/2022 while residing at the facility after complications of Covid 19 and a coccyx wound discovered on or about 12/24/2021 leading to a rapid decline in Resident A’s overall health. Relative 1 stated facility staff did not obtain expedient medical treatment for Resident A’s coccyx wound which discovered by facility staff on 12/24/2021. Relative 1 stated Resident A received hospice services just prior to Resident A’s passing and together with facility staff, hospice was tasked with caring for Resident A’s coccyx wound and overall healthcare. Relative 1 stated she visited the facility on 01/14/2022 and 01/15/2022 and while at the facility she observed facility staff reposition Resident A only one time.

On 05/26/2022 I interviewed Will Todd, Executive Director of Interim Hospice. Mr. Todd stated Interim Healthcare Hospice received a referral for Resident A’s care on 01/03/2022, and on 01/05/2022 an in person care assessment was completed.

On 05/26/2022 I interviewed Kaylie Vanengen via telephone. Ms. Vanengen stated she is employed by Interim Healthcare Hospice as a nurse. Ms. Vanengen stated Interim Healthcare’s director completed an initial assessment of Resident A on

01/05/2022 and Ms. Vanengen stated she had “no idea” when the initial referral for hospice services was received from the facility. Ms. Vanengen stated she provided hospice nursing care to Resident A at the facility from approximately 01/07/2022 until his death on 01/17/2022. Ms. Vanengen stated she completed five in-person visits with Resident A at the facility and each visit lasted approximately thirty minutes. Ms. Vanengen stated she did observe one incident in which Resident A’s care needs were not met by facility staff. Ms. Vanengen stated that on 01/12/2022 she visited the facility and upon entry was informed from an unknown facility staff that Resident A had just been changed and was “dry”. Ms. Vanengen stated she immediately went into Resident A’s bedroom and observed Resident A was lying “in urine soaked bedding and clothing”. Ms. Vanengen stated, “there was no way” facility staff had just changed Resident A because Resident A’s bedding was “soaked in urine down to the mattress pad and up (Resident A’s) shirt”. Ms. Vanengen stated upon initiation of hospice services, Resident A’s coccyx wound was “bad” and after every in-person visit Ms. Vanengen educated facility staff regarding Resident A’s wound care needs. Ms. Vanengen stated she educated facility staff regarding the use of Resident A’s wound cream and optifoams dressings. Ms. Vanengen stated she instructed facility staff to reposition Resident A “every two hours” at minimum, keep Resident A's wound clean and dry, and change Resident A’s wound dressing upon soiling or if the dressing fell off. Ms. Vanengen stated she primarily interacted with staff Madison Williams and informed Ms. Williams of Resident A’s wound care needs. Ms. Vanengen stated the care she provided to Resident A was some time ago and she didn’t recall observing Resident A’s wound worsening to the point of requiring additional medical care.

On 05/26/2022 I interviewed former staff Madison Williams. Ms. Williams stated Resident A was diagnosed with a coccyx wound however Ms. Williams was unsure of the exact date facility staff identified the existence of the wound. Ms. Williams stated facility staff were “late” in informing Ms. Williams of Resident A’s wound and Resident A should have received skilled nursing treatment for the wound “earlier”. Ms. Williams stated a referral was made to Interim Healthcare Hospice with Resident A’s coccyx wound identified as a need for skilled care. Ms. Williams stated she had never dealt with a bed sore as large as Resident A’s coccyx wound and stated the facility was not equipped to care for the wound. Ms. Williams stated Interim Healthcare staff told Ms. Williams “not to touch (Resident A’s) wound because we are not skilled care”. Ms. Williams stated Interim Healthcare staff told facility staff “we were not allowed to clean it” and “hospice staff didn’t train facility staff well enough to provide wound care”. Ms. Williams stated “hospice should have come in more” to provide increased wound care. Ms. Williams stated Resident A’s coccyx wound dressing was only changed by facility staff if “BM” was observed on Resident A’s wound because “it’s not something we were supposed to do because we are not skilled care”.

On 05/27/2022 I interviewed former staff Tommy Stornello via telephone. Mr. Stornello stated he no longer works at the facility but did work closely with Resident A from 12/15/2021 until his death on 01/17/2022. Mr. Stornello stated while he was

on vacation, he was notified by a colleague that Resident A presented with a wound, and it was requested that Mr. Stornello observe the wound upon his 12/25/2021 return to work. Mr. Stornello stated on 12/25/2021 he observed Resident A presented with an “ulcer” on his coccyx area and he reported the information to staff Madison Williams. Mr. Stornello stated Ms. Williams reported she would make a referral to hospice wound care. Mr. Stornello stated “multiple staff let Madison know his wound needed care quicker and recommend he go to the hospital or skilled for wound care”, however, Ms. Williams denied their request. Mr. Stornello stated Resident A’s wound was significant and progressed significantly over a 24 hour period as evidenced by the wound increasing in size and “working towards below the small of the back and down the buttocks”. Mr. Stornello stated Interim Healthcare Hospice began services the first week of January 2022. Mr. Stornello stated, hospice staff instructed facility staff to reposition Resident A every two hours however “it was not always happening because most of the time staff were sitting at the desk, complaining of too much work to do, and just laziness”. Mr. Stornello stated he observed Resident A was not repositioned every two hours as evidenced by viewing Resident A in the same position. Mr. Stornello stated facility staff were not trained in Resident A’s wound care and Mr. Stornello stated he performed Resident A’s wound dressing change one time because it needed to get done.

On 05/27/2022 I received an email from Interim Healthcare Hospice Executive Director Wil Todd. The email contained “Skilled Nursing Visit” notes referencing Resident A and authored by Interim Healthcare Nurse Hospice Kaylie Vanengen. The documents stated that on 01/12/2022 Ms. Vanengen “found that patients fitted sheet and under pad and shirt were completely soaked with urine”. On 01/12/2022 Ms. Vanengen noted that “Madison the MT reported she had been changing the dressing three times a day but on Monday I left only two optifoam at the bedside and only one was used”.

On 06/09/2022 I completed an Exit Conference with American House Clinical Specialist Katrina Aleck via telephone. Ms. Aleck stated she neither agrees nor disagrees with substantiation of R 400.15303 (2) and R 400.15310 (4) until Kentwood Subtenant LLC can read the Special Investigation report in it’s entirely.

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:	Facility observation notes indicate that on 12/24/2021 Resident A was observed with a “wound” and “antibiotic ointment” was applied to said wound to prevent further infection. Facility observation notes indicate that on 12/25/2021 Resident A “has open area near coccyx”, “also has scrotal/pelvic edema”, and

	that the “area is mapped out if swelling increases or resident doesn’t urinate resident will need to be sent to hospital to be assessed”. Facility observation notes indicate that on 01/01/2022 Resident A’s “buttocks appears worse than a few days ago”. Interim Healthcare Hospice Kaylie Vanengen stated the initiation of hospice services did not begin until 01/07/2022, and on that ate Resident A’s coccyx “wound was bad”. Ms. Vanengen stated that after every in-person visit Ms. Vanengen educated facility staff regarding Resident A’s wound care needs and instructed facility staff to reposition Resident A every two hours at minimum, keep Resident A's wound clean and dry, and change Resident A’s wounds dressing upon soiling or if the dressing fell off. Ms. Vanengen stated that on 01/12/2022 she visited the facility and observed Resident A was lying “in urine soaked bedding and clothing”. Ms. Vanengen stated, “there was no way” facility staff had just changed Resident A as reported. Interim Healthcare Hospice Skilled Nursing Visit notes referencing Resident A and authored by Interim Healthcare Nurse Hospice Kaylie Vanengen stated that on 01/12/2022 Ms. Vanengen “found that patients fitted sheet and under pad and shirt were completely soaked with urine”. Observation notes further stated that on 01/12/2022 Ms. Vanengen noted that “Madison the MT reported she had been changing the dressing three times a day but on Monday I left only two optifoam at the bedside and only one was used”. Former staff Tommy Stornello stated hospice staff instructed facility staff to reposition Resident A every two hours however “it was not always happening because most of the time staff were sitting at the desk, complaining of too much work to do, and just laziness”. Former staff Mr. Stornello stated he observed Resident A was not repositioned every two hours as evidenced by viewing Resident A in the same position. Resident A’s Assessment Plan did not address the care needs related to his wound. A preponderance of evidence was discovered during the Special Investigation to substantiate a violation of the applicable rule. Facility staff did not provide Resident A with adequate wound care as recommended by Interim Healthcare Hospice.

CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15310	**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 needed care immediately.
ANALYSIS:	Facility observation notes indicate that on 12/24/2021 Resident A was observed with a “wound” and “antibiotic ointment” was applied to said wound to “prevent further infection. Facility observation notes indicate that on 12/25/2021 Resident A “has open area near coccyx”, “also has scrotal/pelvic edema”, and that the “area is mapped out if swelling increases or resident doesn’t urinate resident will need to be sent to hospital to be assessed”. Facility observation notes indicate that on 01/01/2022 Resident A’s “buttocks appears worse than a few days ago”. Former staff Madison Williams stated Resident A was diagnosed with a coccyx wound however Ms. Williams was unsure of the exact date facility staff identified the existence of the wound. Ms. Williams stated facility staff were “late” in informing Ms. Williams of Resident A’s wound and Resident A should have received skilled nursing treatment for the wound “earlier”. Will Todd, Executive Director of Interim Hospice, stated Interim Healthcare Hospice received a referral for care on 01/03/2022 and on 01/05/2022 an in-person care assessment was completed. A preponderance of evidence was discovered during the Special Investigation to substantiate a violation of the applicable rule. Resident A’s coccyx wound was first observed by facility staff on 12/24/2021 however a referral for wound care to Interim Healthcare Hospice was not completed until 01/03/2022 and care was not initiated until 01/07/2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: The facility's Resident Register lacks place and address to which the resident moved, if known.

INVESTIGATION: On 05/06/2022 I received an email from Licensee Designee Tami McKellar with the Resident Register attached. I reviewed that the document lacks the place and address to which any residents previously residing at the facility has moved to.

On 06/09/2022 I completed an Exit Conference with American House Clinical Specialist Katrina Aleck via telephone. Ms. Aleck stated she agrees that a preponderance of evidence supports substantiation of rule violation R 400.15210. Ms. Aleck stated she would submit an acceptable Correctible Action Plan.

APPLICABLE RULE	
R 400.15210	**Resident Register.**
	A licensee shall maintain a chronological register of residents who are admitted to the home. The register shall include all of the following information for each resident: **(a) Date of admission.** **(b) Date of discharge.** **(c) Place and address to which the resident moved, if known.**
ANALYSIS:	I reviewed that the facility's Resident Register lacks the place and address to which any residents previously residing at the facility has moved to. A preponderance of evidence was discovered during the Special Investigation to substantiate a violation of the applicable rule. The facility's Resident Register lacks the place and address to which residents formerly residing at the facility have moved to.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Resident Assessment Plans are not completed annually and are not completed by the licensee and appropriate designated representatives.

INVESTIGATION: On 05/06/2022 I received an email from Licensee Designee Tami McKellar which contained Resident Assessment Plans and Staffing Logs. I reviewed the Resident Assessment Plan indicated the following:

Resident A's Assessment Plan dated 06/18/2020 is not signed by Resident A, Resident A's legal decision maker, or the facility's Licensee Designee.

Resident B's Assessment Plan dated 10/29/2019 is not signed by the facility's Licensee Designee.

Resident C's Assessment Plan dated 12/03/2019 is not signed by Resident C, Resident C's legal decision maker, or the facility's Licensee Designee.

Resident D's Assessment Plan dated 09/22/2021 is not signed by Resident D, Resident ADs legal decision maker, or the facility's Licensee Designee.

Resident E's Assessment Plan dated 05/18/2021 is not signed by Resident E, Resident E's legal decision maker, or the facility's Licensee Designee.

Resident F's Assessment Plan dated 02/08/2021 is not signed by Resident F, Resident F's legal decision maker, or the facility's Licensee Designee.

Resident G's Assessment Plan dated 09/09/2021 is not signed by Resident G, Resident G's legal decision maker, or the facility's Licensee Designee.

Resident H's Assessment Plan dated 10/25/2021 is not signed by Resident H, Resident H's legal decision maker, or the facility's Licensee Designee.

Resident I's Assessment Plan dated 09/23/2020 is not signed by Resident I, Resident I's legal decision maker, or the facility's Licensee Designee.

Resident J's Assessment Plan dated 09/17/2021 is not signed by Resident J, Resident J's legal decision maker, or the facility's Licensee Designee.

Resident K's Assessment Plan dated 11/03/2017 is not signed by Resident K, Resident K's legal decision maker, or the facility's Licensee Designee.

Resident L's Assessment Plan dated 04/02/2021 is not signed by Resident L, Resident L's legal decision maker, or the facility's Licensee Designee.

Resident M's Assessment Plan dated 10/28/2020 is not signed by Resident M, Resident M's legal decision maker, or the facility's Licensee Designee.

Resident N's Assessment Plan dated 07/15/2021 is not signed by Resident N, Resident N's legal decision maker, or the facility's Licensee Designee.

Resident O's Assessment Plan dated 02/17/2021 is not signed by Resident O, Resident O's legal decision maker, or the facility's Licensee Designee.

Resident P's Assessment Plan dated 12/23/2019 is not signed by Resident P, Resident P's legal decision maker, or the facility's Licensee Designee.

Resident Q's Assessment Plan dated 11/24/2021 is not signed by Resident Q, Resident Q's legal decision maker, or the facility's Licensee Designee

Resident R's Assessment Plan dated 07/22/2021 is not signed by Resident R, Resident R's legal decision maker, or the facility's Licensee Designee.

On 06/09/2022 I completed an Exit Conference with American House Clinical Specialist Katrina Aleck via telephone. Ms. Aleck stated she agrees that a preponderance of evidence supports substantiation of rule violation R 400.15301 (4). Ms. Aleck stated she would submit an acceptable Correctible Action Plan.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	A preponderance of evidence was discovered during the Special Investigation to substantiate a violation of the applicable rule. Resident A, B, C, F, I, K, L, M, O, P Assessment Plans are not completed annually and Resident A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R Assessment Plans lack required signatures.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED 2022A0467019**

IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend the issuance of a Provisional License for the above referenced quality of care violations.

Toya Zylstra 06/09/2022

Toya Zylstra Date
Licensing Consultant

Approved By:

06/09/2022

Jerry Hendrick Date
Area Manager