GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 26, 2022

Danielle Gill
Christian Care Assisted Living
1530 McLaughlin Avenue
Muskegon, MI 49442-4191

RE: License #: AH610236765
Investigation #: 2022A1010057
Christian Care Assisted Living

Dear Ms. Gill:

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 (517) 241-1970.

Sincerely,
Lauren Wohlfert

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa NW Unit 13, 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH610236765
Investigation #:	2022A1010057
Complaint Receipt Date:	07/11/2022
Investigation Initiation Date:	07/12/2022
Report Due Date:	09/10/2022
Licensee Name:	Christian Care Inc.
Licensee Address:	1530 McLaughlin Ave. Muskegon, MI 49442
Licensee Telephone #:	(231) 722-7165
Authorized Representative/ Administrator:	Danielle Gill
Name of Facility:	Christian Care Assisted Living
Facility Address:	1530 McLaughlin Avenue Muskegon, MI 49442-4191
Facility Telephone #:	(231) 777-3494
Original Issuance Date:	01/01/2000
License Status:	REGULAR
Effective Date:	07/07/2022
Expiration Date:	07/06/2023
Capacity:	105
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Residents are not receiving adequate care.	Yes
Staff are not trained how to administer resident medications.	No
Resident medications are not available when staff go to administer them.	No

III. METHODOLOGY

07/11/2022	Special Investigation Intake 2022A1010057
07/12/2022	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
07/12/2022	APS Referral APS referral emailed to Centralized Intake
07/18/2022	Inspection Completed On-site
07/18/2022	Contact - Document Received Received resident MARs, staff schedule, resident hospice notes
09/26/2022	Exit Conference Completed with licensee authorized representative Danielle Gill

Staffing allegations at the facility are being investigated under special investigation number 2022A1028060.

ALLEGATION:

Residents are not receiving adequate care.

INVESTIGATION:

On 7/11/22, the Bureau received the allegations from the online complaint system. The complaint read, “The residents have skin breakdown due to not having proper care.” The complainant was anonymous; therefore, I was unable to gather additional information.

On 7/12/22, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 7/18/22, I interviewed the facility's clinical care director Natasia Beasley at the facility. Ms. Beasley reported there is one resident at the facility who is receiving wound care treatment at this time. Ms. Beasley explained Resident D has a wound on her ankle that is being treated by her hospice provider. Ms. Beasley stated Resident D receives hospice services through Hospice of Michigan and their staff complete dressing changes on Resident D's ankle.

Ms. Beasley staff are trained to observe resident's skin when assisting with dressing and bathing them. Ms. Beasley said staff are trained to report any resident skin breakdown or wounds to the medication technician (med tech) on the shift and to the "neighborhood director" (shift supervisor). Ms. Beasley said the med tech or "neighborhood director" will then notify the resident's physician. Ms. Beasley reported the resident's skin breakdown or wound(s) are also documented.

Ms. Beasley provided me with a copy of Resident D's service plan for my review. I observed the plan did not address Resident D's wound or its treatment. The plan also did not provide information that the wound is being treated by Resident D's hospice provider.

Ms. Beasley provided me with a copy of Resident D's Hospice of Michigan *SN PROGRESS NOTE ROUTINE VISIT* notes for my review. The notes read the wound on Resident D's ankle was treated and the dressing was changed on 6/17/22, 6/20/22, 6/22/22, 6/27/22, 6/29/22, 7/6/22, 7/11/22, 7/13/22, and 7/15/22. The notes read hospice staff covered the dressing with a "geri sock to assist keeping it in place" during Resident D's wound care, except on 7/11/22 and 7/13/22.

On 7/18/22, I interviewed Staff Person 1 at the facility. Staff Person 1 reported she primarily works on the first floor of the facility. Staff Person 1 denied knowledge regarding any residents on the first floor who have skin breakdown or wounds. Staff Person 1 said Resident D resided on the second floor of the facility. Staff Person 1's statements regarding staff being trained to observe and report resident skin breakdown or wounds were consistent with Ms. Beasley.

On 7/18/22, I interviewed Staff Person 2 at the facility. Staff Person 2's statements were consistent with the Staff Person 1.

On 7/18/22, I interviewed Resident D at the facility. Resident D reported staff change the sock on her wound weekly. Resident D denied concerns regarding the care she received from staff at the facility. Resident D stated staff met her needs. I observed a sock was covering Resident D's left ankle. Resident D said the sock covered her wound.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	The interview with Ms. Beasley revealed Resident D received wound care treatment through Hospice of Michigan. Review of Resident D's service plan revealed her wound and how the wound is to be treated was not outlined. The plan also did not include Resident D's hospice provider information.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff are not trained how to administer resident medications.

INVESTIGATION:

On 7/11/22, the complaint read, "Medications are not being administer [sic] correctly because they hire people that don't have experience with passing medication." The complaint also read, "An employee was poked by a needle and she was told by management to not do anything about it."

On 7/18/22, Ms. Beasley reported med techs received a minimum of five days training before they can administer resident medications. Ms. Beasley stated the med tech training consists of shadowing and completing a training checklist. Ms. Beasley said the med tech in training can receive additional training days as needed. Ms. Beasley reported there have not been any medication errors.

Ms. Beasley stated Staff Person 3 recently poked herself with a needle after she administered a resident's insulin. Ms. Beasley reported a work-related incident report was completed and Staff Person 3 went to get her blood tested to ensure she did not get any ailments after the incident. Ms. Beasley provided me with a copy of Staff Person 3's *Employee's Injury Report to Employer* document for my review. The *Employee's explanation for injury* section of the document read, "While staff was disposing the used syringe staff was poked in left ring finger." The *What actions are being taken to prevent recurrence* section of the document read, "To ensure that proper handling of used needles is followed when deposing [sic] them."

The document read Staff Person 3 was referred to *Workplace Health* for follow up and blood draw. The document was signed and dated by Staff Person 3 on 6/6/22. Ms. Beasley provided me with a copy of Staff Person 3's *Workplace Health*

Muskegon Employer Discharge Summary document for my review. The *Work Status Summary* section of the document read, “Effective 6/8/22 [Staff Person 3] is cleared to perform all job functions associated with regular job duties.” The *Restrictions* section of the document read, “Injury is work related. No restrictions/Return to Full Duty. Take new medications as prescribed.”

The *Diagnosis* section of the document read, “1. Contact with and (suspected) exposure to potentially hazardous body fluids (Z77.21). 2. Contact with hypodermic needle, initial encounter (W46.0XXA). 3. Injury occurred while working per patient history (Y99.0). Contact with hypodermic needle, exposure. Injury occurred while working per patient history.” Staff Person 3 was supposed to return for a “blood draw” on 6/17/22, however she missed this appointment. Ms. Beasley said Staff Person 3 no longer works at the facility.

Ms. Beasley provided me with a copy of Staff Person 3’s medication administration *Team Lead – Orientation Checklist* for my review. The document read Staff Person 3 completed the medication administration training on first shift on 4/19/22 and on second shift on 4/25/22. The *MEDICATION ADMINISTRATION* section of the document read Staff Person 3 completed “Injections” training on 4/25/22. The *MEDICATION* section of the document read Staff Person 3 completed “Insulin, types, Syringes, Drawing/Demo, Injection site map, Injection/Demo, SHARPS CONTAINER, Accu-checks/Demo” training on 4/25/22.

On 7/18/22, Staff Person 1’s statements regarding medication administration training at the facility were consistent with Ms. Beasley. Staff Person 1 stated she received medication administration training when she started at the facility. Staff Person 1 said majority of the residents who are prescribed insulin have “safety syringes” that prevent staff from poking themselves when they dispose the needle. Staff Person 1 explained there was a resident who was not getting “safety syringes” for his insulin because Veteran’s Affairs (the VA) would not pay for them.

On 7/18/22, Staff Person 2’s statements were consistent with Ms. Beasley and Staff Person 1.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following: **(g) Medication administration, if applicable.**

ANALYSIS:	The interviews with staff, along with review of Staff Person 3's medication administration training documents revealed staff receive medication administration training, including how to use syringes, upon hire at the facility. After Staff Person 3 "poked" herself with a used syringe, a work-related incident report was completed, and she received medical follow up. There is insufficient evidence to suggest the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident medications are not available when staff go to administer them.

INVESTIGATION:

On 7/11/22, the complaint read, "Med techs don't have all the residents [sic] medication to give during the med pass."

On 7/18/22, Ms. Beasley reported approximately month ago, the facility switched the packaging of resident medications with their "in house pharmacy." Ms. Beasley explained the resident medications previously came in individual pill "blister packs" that staff had to take out individually to administer. Ms. Beasley said the new packaging contains all of the resident's medication in one "day packet" that are to be administered during their designated timeframe.

Ms. Beasley stated there have been instances when staff found medication missing from the "day packet" because the pharmacy failed to put it in. Ms. Beasley reported when this was found, staff contacted the pharmacy, and the pharmacy delivered the medication the same day so no doses were missed.

Ms. Beasley provided me with a copy of Resident D's June MAR for my review. The MAR read Resident D's prescribed "CIPROFLOXACIN 500 MG TABLET (CIPRO 500 MG TABLET) Take 1 tablet by mouth twice daily" was not administered on 6/8/22, 6/11/22, 6/12/22, and 6/14/22. For these dates the MAR read, "No Pass Reason: Other Problems." The MAR read this medication was not administered on 6/2/22 because "Med unavailable." The MAR read this medication was not administered on 6/13/22 because the med was "not in cart. Will call HTP." The MAR read all other prescribed medications were administered as prescribed.

Ms. Beasley provided me with a copy of Resident E's June MAR for my review. The MAR read Resident E's medications were administered as prescribed.

On 7/18/22, Staff Person 1's statements were consistent with Ms. Beasley. Staff Person 1 reported the system of double checking the medications in the "day packets" with the facility's electronic medication administration record (eMAR) was successful in catching pills that were missing in the "day packets," therefore there were no medication errors.

On 7/18/22, Staff Person 2's statements were consistent with Ms. Beasley and Staff Person 1.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	The interviews with staff revealed the facility recently changed the way resident medications with the facility's "in house" pharmacy is packaged. Staff reported the facility has an effective process in place of identifying when the pharmacy missed putting a resident medication in their "day packets." The facility has the ability to obtain the missing resident dose(s) within the same day.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

I shared the findings of this report with licensee authorized representative Danielle Gill by telephone on 9/26/22.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

07/21/2022

Lauren Wohlfert Date
Licensing Staff

Approved By:

09/26/2022

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Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section