GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 12, 2022

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

RE: License #:	AL250281706
Investigation #:	2022A0872051
	Monet House Inn

Dear Mrs. Gee:

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) 643-7960.

Sincerely,

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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL250281706
Investigation #:	2022A0872051
Complaint Receipt Date:	08/22/2022
Investigation Initiation Date:	08/23/2022
Report Due Date:	10/21/2022
Licensee Name:	Wood Care X, Inc., d/b/a Caretel Inns of Linden
Licensee Address:	910 S. Washington Ave. Royal Oak, MI 48067
Licensee Telephone #:	(810) 735-9400
Administrator:	Kimberly Gee
Licensee Designee:	Kimberly Gee
Name of Facility:	Monet House Inn
Facility Address:	202 S. Bridge Street Linden, MI 48451
Facility Telephone #:	(810) 735-9400
Original Issuance Date:	06/25/2008
License Status:	REGULAR
Effective Date:	08/08/2021
Expiration Date:	08/07/2023
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Covid outbreak at the facility. The facility is understaffed. Staff are double briefing the residents due to short staffing.	Yes

III. METHODOLOGY

08/23/2022	Special Investigation Intake 2022A0872051
08/23/2022	Special Investigation Initiated - On Site Unannounced
09/12/2022	Contact - Document Sent I emailed Monet House Inn management requesting information about this complaint
09/12/2022	Contact - Document Sent I emailed the licensee designee requesting information about this complaint
09/14/2022	Inspection Completed On-site Unannounced
09/15/2022	Contact - Document Received AFC documentation received
09/26/2022	APS Referral I made an APS complaint via email
10/07/2022	Contact - Telephone call made I interviewed former staff, Paige Tucker
10/07/2022	Contact - Telephone call made I interviewed former staff, Layla Alotabi
10/10/2022	Contact - Document Received I exchanged emails with Amanda Walworth
10/11/2022	Contact - Telephone call made I interviewed staff Pertrina Golden

10/11/2022	Contact - Telephone call made I interviewed staff Shariah Phifer
10/11/2022	Contact - Telephone call made I interviewed former staff Kenisha Sims
10/11/2022	Contact - Telephone call made I interviewed staff Shanika Thomas
10/11/2022	Contact - Telephone call made I interviewed staff Trinidy Tomlin
10/11/2022	Inspection Completed-BCAL Sub. Compliance
10/11/2022	Exit conference I conducted an exit conference with the licensee designee, Kimberly Gee

ALLEGATION: Covid outbreak at the facility. The facility is understaffed. Staff are double briefing the residents due to short staffing.

INVESTIGATION: On 8/23/22, I conducted an unannounced, onsite inspection of Monet House Inn. I met with the assisted living director, Amanda Walworth, the assistant to the assisted living director, Raelynn Fonger, and the general manager, Rhonda Pype. There was a Covid outbreak at the facility, so I did not visually inspect the facility during this inspection.

I reviewed the allegations with all individuals, and they said that the facility has been having a staffing shortage and because of that, they have been utilizing a staffing agency. They are attempting to consolidate residents from one of the other Inns to help deal with the staffing issue and they are trying to explore other options as well. Ms. Pype said that they schedule two staff to work each shift but if one staff calls in sick, they may not be able to fill his/her position. They will use a “floater” who works between two of the Inns to help the remaining staff work the floor.

I asked about each staff member’s responsibilities per shift and was told that staff pass medications, provide patient care, distribute meals to the residents from the sub-kitchen, clean up after meals, do laundry, shower residents, and do light housekeeping.

Ms. Fonger said that earlier this month, she went on vacation and when she came back, she took a Covid-19 test before returning to work. She tested positive for Covid on 8/15/22 and since she was not experiencing symptoms and was feeling well, she returned to work on 8/20/22, and worked only on the Covid unit. Ms. Fonger said that she wore an N-95 mask and used other appropriate PPE while working.

Ms. Fonger, Ms. Walworth, and Ms. Pype said that they did hear some staff discussing that other staff were double briefing residents. Ms. Walworth said because of this, at the last staff meeting, they addressed this with all staff and reminded them that the policy at Monet House Inn is that staff are not to double brief residents. Ms. Fonger said that they were not told which residents were being double briefed but said that none of the residents currently have any skin breakdowns or skin issues that could be a result of being in wet briefs.

On 09/14/22, I conducted another onsite inspection of Monet House Inn. I inspected the facility and spoke to Ms. Fonger. I also observed nine residents in the common area who were playing bingo. All the residents appeared to be clean and supervised. I examined several resident rooms and found them all to be clean, with no odor. Since the residents in this facility suffer from Alzheimer's and/or dementia, I did not interview any of them. In addition to the nine residents observed in the common area, I also observed one resident who was lying in his bed, in his room. He appeared clean as did his room and bathroom.

On 09/15/22, I received Adult Foster Care paperwork related to this complaint. According to the Resident Register, there are 15 residents at this facility and 13 of them wear briefs for incontinence.

On 10/07/22, I interviewed former staff, Paige Tucker, via telephone. Ms. Tucker said that she quit working at this facility approximately six months ago. Prior to that time, she worked at the facility for approximately two years. Ms. Tucker said that she worked in all the Inns, wherever she was needed, as did most staff.

Ms. Tucker stated that all the facilities were very short staffed. She said that most of the Inns had 10-20 residents and often, one staff was responsible for caring for up to 15 residents at a time, by themselves. Ms. Tucker stated that sometimes, there would be a "floater" who would go between two Inns, but it was very difficult caring for so many residents at a time. She said that whenever staff would call in sick, there were no consequences, so staff continued to do it.

I asked Ms. Tucker if staff ever double briefed the residents, and she said yes, sometimes they would when they were working by themselves. Ms. Tucker told me that staff was responsible for checking on the residents who wore briefs every two hours. Some staff would put a contour liner inside the resident's brief so if the resident wet themselves, staff would only have to pull the liner out and replace it, rather than having to change the entire brief. According to Ms. Tucker, she does not recall being specifically told that staff were not allowed to do this and whenever the facility ran out of contour liners, management would always buy more.

On 10/07/22, I interviewed former staff, Layla Alotaibi via telephone. Ms. Alotaibi said that she only worked for Symphony Inns for a few weeks, and she quit over a month ago. According to Ms. Alotaibi, the entire time she worked at this facility, it was always short staffed, and staff was always stressed. She told me that sometimes, staff had to

care for all the residents by themselves for an entire shift and it was “too much.” Ms. Alotaibi said that some staff would double brief residents because it was easier to care for them that way and staff did not have time to do it any other way.

On 10/10/22, I reviewed the staffing assignments for Monet House Inn for the months of June, July, and August 2022. The staffing schedule hours are as follows:

- 6:00am-2:30pm
- 6:00am-6:30pm
- 2:00pm-10:30pm
- 6:00pm-6:30am
- 10:00pm-6:30am

I noted that the facility typically schedules at least two staff to be on shift for every hour of the day and sometimes, they schedule three staff to be on shift during certain times of the day. However, I also noted that on several occasions during these three months, staff would call in which put the staffing down to one or two staff during certain hours of the day. The facility would sometimes assign a “floater” who would go between two of the Inns for his/her shift.

On 10/11/22, I interviewed staff Pertrina Golden via telephone. Ms. Golden said that she has worked at Symphony Inns “for quite some time” and she works in all the Inns, but specifically Monet House Inn. Ms. Golden said that staff does not have a choice as to which Inn they want to work and said that management, “puts us where they want us.” I asked her about the staffing, and she said that all the Inns have been short staffed “for a long time.” Ms. Golden said that on some occasions, she has had to work an entire floor by herself and on other occasions, she has had a “floater” assigned when she is working. Ms. Golden told me that there have been times that she has been responsible for up to 17 residents at a time and said that she “does the best I can.” I asked Ms. Golden if staff ever double briefs residents and she said that some staff does.

On 10/11/22, I interviewed staff Shariah Phifer via telephone. Ms. Phifer said that she has worked for Symphony Inns since April 2022, and she typically works at Monet House Inn. I asked Ms. Phifer if the facility is ever short staffed, and she said yes. She said that she has had to work by herself with a floater and was responsible for caring for a lot of residents. I asked her if she ever worked the floor all alone and she said, “no, there’s always one other person or a floater.” I asked Ms. Phifer about double briefing the residents and she confirmed that staff used to double brief residents, but management told them this is unacceptable and since that time, staff does not do it anymore.

On 10/11/22, I interviewed former staff, Kenisha Sims via telephone. Ms. Sims said that she worked at this facility under different owners for approximately two years and then started working for Symphony Inns in February 2022. Ms. Sims said that she quit last month due to “everything going on over there.”

According to Ms. Sims, she typically worked at Monet House Inn or Van Gogh House Inn. She said that there were a lot of staffing issues, and all the Inns were often short staffed. Ms. Sims stated that there were occasions that she had to work by herself, and she was responsible for up to 17 residents. On other occasions, a “floater” was assigned to her Inn, but she would still work by herself because the “floater” would work in one of the other “priority” Inns. Ms. Sims said that there were several residents who wore briefs and there were several 2-person assists as well. I asked her what she would do if she had to help any of the 2-person assist residents and she said, “I would try to do it by myself and if I couldn’t, I would call for help and wait for someone to come help me.” I asked Ms. Sims if she ever double briefed the residents and she said sometimes, but management addressed it with staff and staff stopped doing it.

On 10/11/22, I interviewed staff Shanika Thomas via telephone. Ms. Thomas said that she has worked for this facility for almost four years, and she typically works in Monet House Inn. Ms. Thomas said that staff were double briefing residents for a while, but management addressed it with staff and told them not to do it so they’re not. She said that they do use contour pads with some of the residents which is what they prefer.

Ms. Thomas said that typically there are at least two staff scheduled for each shift but there have been times that she has had to work alone, with anywhere from 10-17 residents at a time. Ms. Thomas said that this would only happen if staff called in and management was not able to fill their position. On those occasions, sometimes she would have to work alone for several hours and sometimes a “floater” would be assigned to assist if necessary. I asked Ms. Thomas what she does if she is working alone, and she has to assist a resident who requires 2-people. She said that in that case, she calls the floater for assistance and if the floater is unavailable, she contacts management and asks for help. Ms. Thomas said that she has not had to work alone “in a while” but the facility is still experiencing staffing issues.

On 10/11/22, I interviewed staff Trinidy Tomlin via telephone. Ms. Tomlin said that she has worked at Symphony Inns for over three years, and she typically works at Degas House Inn although she works at any of the Inns if she is needed. Ms. Tomlin confirmed that in the past, there have been staffing issues and said that she has had to work by herself with a floater. I asked her if she ever had to work completely by herself and she said that she does not remember if she ever had to do that in Monet House Inn but again said that she has had to work by herself with a floater if staff calls in and management cannot fill their position. She confirmed that there may be from 10-20 residents at any time, in any Inn and staffing has been a problem in the past.

I asked her if staff ever double briefs the residents and she said that “new people” may not know that they are not supposed to double brief the residents, but management addressed it with staff, and nobody does it anymore.

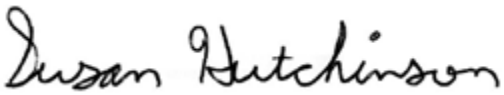
On 10/11/22, I conducted an exit conference with the licensee designee, Kimberly Gee via telephone. I discussed the findings of my investigation and explained which rule

violation I am substantiating. Mrs. Gee agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Staff Amanda Walworth, Rhonda Pype, Raelynn Fonger, Pertrina Golden, Shariah Phifer, Shanika Thomas, and Trinidy Tomlin as well as former staff, Paige Turner, Layla Alotabi, Rhonda Bell, and Kenisha Sims said that at times, there is only one staff plus a floater working at this facility. According to Ms. Pype, staff are responsible for the following: pass medications, provide patient care, distribute meals to the residents from the sub-kitchen, clean up after meals, do laundry, shower residents, and do light housekeeping. According to the Resident Register, as of 08/20/22, there were 15 residents at this facility and 13 of them wore briefs for incontinence. I reviewed the staff assignment logs for June, July, and August 2022. I noted that the facility does schedule at least two staff for every hour of each day. However, I also noted that several times during this three-month period, staff would call in which left the facility with one staff plus a floater. I conclude that there is sufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

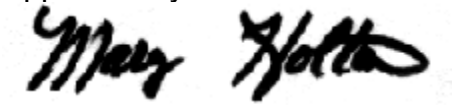
Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.



October 11, 2022

Susan Hutchinson Licensing Consultant	Date

Approved By:



October 12, 2022

Mary E. Holton Area Manager	Date