



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 10, 2022

Jennia Woodcock
Community Health Care Management
1805 E Jordan
Mt. Pleasant, MI 48858

RE: License #: AM370085651
Investigation #: 2022A1033026
Country Place II

Dear Ms. Woodcock:

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) 284-9730.

Sincerely,

A handwritten signature in black ink that reads "Jana Lipps". The signature is written in a cursive style with a large initial 'J' and 'L'.

Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM370085651
Investigation #:	2022A1033026
Complaint Receipt Date:	08/16/2022
Investigation Initiation Date:	08/16/2022
Report Due Date:	10/15/2022
Licensee Name:	Community Health Care Management
Licensee Address:	2033 Westbrook Ionia, MI 48846
Licensee Telephone #:	(989) 773-6320
Administrator:	Jennia Woodcock
Licensee Designee:	Jennia Woodcock
Name of Facility:	Country Place II
Facility Address:	1807 E. Jordan Mount Pleasant, MI 48858
Facility Telephone #:	(989) 773-6320
Original Issuance Date:	07/02/2001
License Status:	REGULAR
Effective Date:	07/13/2022
Expiration Date:	07/12/2024
Capacity:	10
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

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II. ALLEGATION(S)

	Violation Established?
Residents A, B, and C are not receiving adequate personal care and are often incontinent of urine and left in wet briefs.	No
Home Manager, Kim Waldron, told Resident E, he could not purchase pizza with his money, because "he was going to get fat."	No
Home Manager, Kim Waldron, allowed Resident D to have scissors and give Resident A a haircut.	No
On 8/4/22, Home Manager, Kim Waldron, took Resident D to town. Resident D's care plan stated she could only leave the facility for medical appointments.	Yes
Direct care staff, Natasha Deline, signed that she had administered a suppository to Resident E that was not administered.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/16/2022	Special Investigation Intake 2022A1033026
08/16/2022	Special Investigation Initiated - Telephone interview with licensing consultant, Jennifer Browning.
08/24/2022	Inspection Completed On-site- Interviews with Home Manager, Kim Waldron, direct care staff, Natasha Deline and Resident A, Resident B and Resident C. Resident record review initiated.
08/25/2022	Contact - Document Sent- Email sent to Assistant Manager, Jamie Callahan, requesting AFC Assessment Plans for Residents A, B, C, Safety Plan for Resident A dated prior to 8/23/22, and employee files for Natasha Deline, Kim Waldron and Nate Bartel.
08/25/2022	Contact - Telephone call received- Voicemail message received from complainant. Attempted to return call, no answer. Left voicemail message.
08/25/2022	Contact - Telephone call received- Interview with complainant, via telephone.
09/07/2022	Contact - Document Sent- Follow-up email sent to Assistant Manager, Jamie Callahan, requesting employee files and resident

	assessment plans that have still not been received after being requested, via email, on 8/25/22.
09/15/2022	Contact - Telephone call made to the facility to obtain copies of employee files and resident assessment plans. No answer and there was a recording noting the voicemail box was full.
09/15/2022	Contact - Telephone call made to home manager, Kim Waldron, requesting assistance obtaining copies of employee files and resident assessment plans. Voicemail message left, awaiting a response.
09/15/2022	Contact - Document Sent- Email sent to LD, Jennia Woodcock, requesting assistance obtaining employee files and resident assessment plans.
09/21/2022	Contact - Telephone call made- Attempt to interview direct care staff, Jasmine Mead. Voicemail message left and awaiting a call back.
09/21/2022	Contact - Telephone call made- Follow up call to Home Manager, Kim Waldron. Voicemail message left, awaiting returned call.
09/21/2022	Inspection Completed-BCAL Sub. Compliance
10/11/2022	Exit Conference with Licensee Designee, Jennia Woodcock, via telephone.

ALLEGATION:

Residents A, B, and C are not receiving adequate personal care and are often incontinent of urine and left in wet briefs.

INVESTIGATION:

On 8/16/22 I received an online complaint which alleged that Residents A, B, and C, of the Country Place II facility (the facility), are not receiving adequate personal care and are often incontinent of urine and left in wet briefs. On 8/24/22 I completed an on-site investigation at the facility. I interviewed Home Manager and direct care staff member, Kim Waldron. Ms. Waldron reported Resident A often refuses care, especially when it comes to toileting. Ms. Waldron reported there are certain direct care staff Resident A is more inclined to receive care from who have an easier time showering Resident A and assisting her with changing her brief. Ms. Waldron reported they offer, in multiple ways, to assist Resident A but she does tend to refuse care. Ms. Waldron reported Resident A does not have any current issues

with skin breakdown or sores due to refusal of care. Ms. Waldron further reported Resident B does not wear a brief at any time of day or night. She reported Resident B uses verbal prompts for toileting, during the day, and usually stays dry. Ms. Waldron reported Resident B does not like to get up at night to use the bathroom. She reported if he needs to urinate, he will wait until morning or have an accident. Ms. Waldron reported when Resident B has an accident during the night, he will refuse to get out of bed to allow staff to provide personal care. Ms. Waldron reported she has never heard of an issue where direct care staff could not get him out of bed for longer than a two-hour period, when he was incontinent. Ms. Waldron reported Resident C is "incontinent by choice." Ms. Waldron reported that there are times Resident C will be incontinent at night and refuse to get out of bed for hours. Ms. Waldron reported Resident C does not wear incontinence briefs and will frequently be incontinent of urine during the day. Ms. Waldron reported Resident C will change herself and her bedding to be cleaned. Ms. Waldron reported she has never witnessed or observed a staff member refuse to provide personal care to Resident A, B, or C. Ms. Waldron reported that neither Resident A, B, or C have issues with skin integrity related to their incontinence.

On 8/24/22, during on-site investigation, I interviewed direct care staff, Natasha Deline. Ms. Deline reported she has worked for the facility for about three years. Ms. Deline reported she works day shift and often she will come in for her shift around 8am and residents are still soiled, with urine, from the night before. Ms. Deline reported this is usually Residents A and C. Ms. Deline reported she is told by third direct care shift staff that these residents have been refusing care. Ms. Deline reported sometimes Resident C will refuse care for multiple hours. Ms. Deline reported Resident A is usually accepting of the care offered and provided during day shift. Ms. Deline reported it is rare to find Resident B incontinent when she is at the facility.

On 8/24/22, during on-site investigation, I interviewed Resident C. Resident C reported that she does not need assistance with personal care from direct care staff and she is able to toilet herself. Resident C reported personal care she receives is suitable for her and she had no complaints about direct care staff at this time.

On 8/24/22, during on-site investigation, I interviewed Resident E. Resident E reported the direct care staff provide for the needs of the residents at the facility. Resident E reported he had no concerns about the care being provided and noted direct care staff help him when he needs assistance.

On 8/24/22, during on-site investigation, I interviewed Resident D who reported she had no concerns about the direct care staff providing for resident personal hygiene. Resident D reported the facility can smell like feces from time to time as Resident A tends to be incontinent of stool and the staff must tend to this need.

On 8/25/22 I interviewed Complainant via telephone. Complainant reported that there are times when Residents A and B are found soiled in the mornings because they have not received proper personal care and assistance by the midnight staff.

During on-site investigation, on 8/24/22, I reviewed *Community Mental Health for Central Michigan, Specialized Residential Progress Note Form A*, for Residents A, B, and C. The documents reviewed were dated from 8/1/22 through 8/23/22. These progress notes all demonstrated that personal care including toileting was being offered to Residents A, B, and C and the care was either refused or accepted by the residents. There were no statements of staff finding Residents A, B, or C in a soiled condition when they arrived for their shifts or that these residents had gone for prolonged periods of time without care. These logs were completed on each shift, morning, afternoon, and midnights.

During on-site investigation, on 8/24/22, I reviewed the document titled, *Resident Showers*, in Resident A, B, and C's files. On Resident A's *Resident Showers* log, I noted in the period of time from 8/1/22 through 8/23/22 Resident A received 7 showers and refused 1 shower. On Resident B's *Resident Showers* log, I noted in the period from 8/1/22 through 8/23/22, Resident B received 10 showers and had 3 documented refused showers. On Resident C's *Resident Showers* log, I noted in the timeframe from 8/1/22 through 8/23/22 Resident C had received 9 showers and had 6 documented refused showers.

On 9/16/22 I reviewed *Assessment Plan for AFC Residents* forms for Residents A and B. Resident A's form under section, *II. Self Care Skill Assessment*, subsection, *B. Toileting*, it states, "Verbal prompt and physical assistance in the bathroom." Resident B's form under section, *II. Self Care Skill Assessment*, subsection, *B. Toileting*, it states, "He needs prompted every 2-3 hrs to toilet. Also have to track bowel movements. He tends to refuse to get up at night when soiled."

On 9/16/22 I received copies of employee files for direct care staff Natasha Deline, Kim Waldron, Nathaniel Bartell, and Sarah Schmittler. I reviewed these employee files and found evidence of completed Michigan Workforce Background Checks and proof of required trainings. I did not find any employee disciplinary actions related to not providing residents with adequate personal care.

APPLICABLE RULE	
R 400.14303	Resident care; licensee responsibilities.
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	Based on interviews with Ms. Waldron, Ms. Deline, Residents C, D, and E, review of resident files and employee files, the facility direct care staff are providing for resident personal care as defined in the residents written assessment plans.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Home Manager, Kim Waldron, told Resident E, he could not purchase pizza with his money, because “he was going to get fat.”

INVESTIGATION:

On 8/16/22 I received an online complaint that alleged Ms. Waldron had denied taking Resident E to the store to spend his money because he was going to buy pizza with his money and “he was going to get fat.” On 8/24/22 I completed an on-site investigation at the facility. I interviewed Ms. Waldron. Ms. Waldron reported that she did not make this statement to Resident E. Ms. Waldron reported she did speak with Resident E about buying pizza because he did not have enough money to purchase a pizza and the snacks he wanted to purchase, and she was trying to explain this to him.

During on-site investigation on 8/24/22 I interviewed Ms. Deline. Ms. Deline reported that she has never witnessed, or overheard Ms. Waldron speak to Resident E in a derogatory manner. She reported she has never heard Ms. Waldron state to Resident E that he could not purchase pizza because “he was going to get fat.” Ms. Deline reported Resident E does like to buy pizza and he will eat an entire pizza in one sitting if unsupervised. She reported direct care staff do try to encourage him not to eat it all at once based upon his special low carb diet.

During on-site investigation, on 8/24/22, I interviewed Resident E. Resident E reported he did not recall Ms. Waldron making a statement about the fact that ‘he was going to get fat’ if he bought pizza. Resident E reported no issues with the current direct care staff members. Resident E reported direct care staff help him when he needs help.

On 9/16/22 I reviewed Resident E’s *Assessment Plan for AFC Residents* form. On this form in section *II. Self Care Skill Assessment*, subsection, *A. Eating/Feeding*, it states, “Courage to eat low sugar/low carb.” In section, *III. Health Care Assessment*, subsection, *B. Special Diets*, it states “low carb-low sugar.”

APPLICABLE RULE	
R 400.14305	Resident protection.
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based upon interviews with Ms. Waldron, Ms. Deline, Resident E and review of Resident E's <i>Assessment Plan for AFC Residents</i> form, the direct care staff are treating Resident E with dignity and respect.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Home Manager, Kim Waldron, allowed Resident D to have scissors and give Resident A a haircut.

INVESTIGATION:

On 8/16/22 I received an online complaint which alleged that Ms. Waldron allowed Resident D to have access to scissors and cut Resident A's hair. On 8/24/22 I completed an on-site investigation at the facility. I interviewed Resident D who reported Ms. Waldron did give her a pair of scissors and asked her to cut Resident A's hair. Resident D reported she has a history working in cosmetology and Ms. Waldron reported Resident A needed a haircut so Resident D offered to assist. Resident D reported she knew this was against her Community Mental Health safety plan as she was not allowed to have any objects that could be considered a weapon in her possession.

On 8/25/22 I interviewed Complainant via telephone. Complainant reported Ms. Waldron gave Resident D a pair of scissors and that direct care staff, Jasmine Mead, was present when this occurred.

On 9/21/22 I attempted to interview Ms. Mead and left a voicemail message. There was no returned call from Ms. Mead.

On 9/22/22 I interviewed Ms. Waldron, via telephone. Ms. Waldron reported she did give Resident D a pair of scissors and asked her to cut Resident A's hair. Ms. Waldron reported that she did receive disciplinary action for this as this action went against what is written in Resident D's safety plan. Ms. Waldron reported that she was present during this time and provided supervision to Resident D. The scissors were returned to Ms. Waldron when Resident D had completed the haircut.

During on-site investigation, on 8/24/22, I reviewed Resident D's *Montcalm Care Network, Adult Foster Care Home Safety Protocol*, dated 8/2/22. Under section, *Medical Necessity*, it states, "This individual is being transitioned from a more restrictive level of care and requires close monitoring to ensure health and safety due to risk to self and/or others." Under section, *Safety Actions*, it notes, "Items that could be used to harm self, such as razors, cords, belts, medications should be voluntarily removed from the room by resident." This form was updated on 8/9/22, 8/12/22, and 8/16/22 and maintained these guidelines through all available updates.

During on-site investigation, on 8/24/22, I was not able to interview Resident A due to impaired memory related to a diagnosis of Alzheimer's Disease.

APPLICABLE RULE	
R 400.14305	Resident protection.
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based upon interviews with Resident D, Ms. Waldron, Complainant and review of Resident D's <i>Montcalm Care Network, Adult Foster Care Home Safety Protocol</i> form, dated 8/2/22, Ms. Waldron allowed Resident D access to a pair of scissors and allowed her to cut Resident A's hair with these scissors. Ms. Waldron provided supervision to Resident A and D during this haircut and the scissors were returned following the event. Resident D's <i>Adult Foster Care Home Safety Protocol</i> form identifies Resident D as the responsible party to ensure she is not in possession of items that could be used to harm herself. Ms. Waldron provided the supervision and protection to ensure safety of Resident A and D.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

On 8/4/22, Home Manager, Kim Waldron, took Resident D to town. Resident D's care plan stated she could only leave the facility for medical appointments.

INVESTIGATION:

On 8/16/22 I received an online complaint which alleged that Ms. Waldron took Resident D on an outing, on 8/4/22, and Resident D had restrictions in place on her safety plan restricting outings. On 8/24/22 I completed an on-site investigation at the

facility. I interviewed Ms. Waldron who reported she took Resident D on an outing on 8/4/22. Ms. Waldron reported that the outing was not for a medical appointment. Ms. Waldron reported she was unaware of the restrictions in Resident D's safety plan, from Community Mental Health, until after she took her on this outing. Ms. Waldron reported that she did not accurately read the safety plan before she took Resident D on this outing.

During on-site investigation, on 8/24/22, I reviewed the facility's *Outing/ Appts/Community Activities* log for the month of August 2022. This form was in Resident D's resident record with Resident D's name written on the top. On the date, 8/4/22, it was noted that Resident D was on a "ride w/mgt" from 9:45 to 10:15. There was no indication whether this was AM or PM.

On 8/25/22 I interviewed the Complainant, via telephone. Complainant reported that on 8/4/22 Ms. Waldron took Resident D on an outing, against the restrictions set forth in her safety plan. Complainant reported that the outing was documented on the "outing log" the facility keeps.

On 9/16/22 I reviewed Resident D's *Montcalm Care Network, Adult Foster Care Home Safety Protocol* form, dated 8/2/22. On this form under section, *Safety Actions*, it states, "[Resident D] will not be going out into the community unless it is a doctor's appointment and then will be accompanied by Staff. When in the community will have Line of Sight Supervision."

APPLICABLE RULE	
R 400.14305	Resident protection.
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based upon interviews with Ms. Waldron & Complainant, as well as review of Resident D's <i>Montcalm Care Network, Adult Foster Care Home Safety Protocol</i> form, dated 8/2/22, and the <i>Outing/ Appts/Community Activities</i> log for the month of August 2022, Ms. Waldron did not ensure Resident D's protection and safety as she did not follow the protocol in place in Resident D's established safety plan.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

Direct care staff, Natasha Deline, signed that she had administered a suppository to Resident E that was not administered.

INVESTIGATION:

On 8/16/22 I received an online complaint which alleged that Ms. Deline had signed that she had administered a suppository to Resident E that was not actually administered. The exact date of this occurrence was not recorded. On 8/24/22 I completed an on-site investigation at the facility. I interviewed Ms. Waldron regarding this allegation. Ms. Waldron reported that this incident occurred on 6/29/22. Ms. Waldron explained that this medication was recently ordered for Resident E and it was to be administered for a period of 10days, at 10am, beginning on 6/29/22. Ms. Waldron reported Ms. Deline must have forgotten to administer the medication as it was a new medication, and she was not used to the new medication on the *Medication Administration Record (MAR)*. Ms. Waldron reported she noticed there was a “hole” or blank in the MAR where the medication had not been signed for and had asked Ms. Deline to sign that the medication was administered. Ms. Waldron reported she had thought Ms. Deline had just failed to sign off that she administered the medication and later found out that Ms. Deline had not actually administered the medication.

On 8/24/22, during on-site investigation, I interviewed Ms. Deline. Ms. Deline reported that for two days prior to 6/29/22 she had not been on the schedule. Ms. Deline reported that when she returned to work on 6/29/22, she was unaware that Resident E was prescribed this new medication. Ms. Deline reported she overlooked the medication on the MAR and did not administer the medication to Resident E. Ms. Deline reported she told Ms. Waldron she had not administered the medication and was told, by Ms. Waldron, to initial the MAR stating the medication had been administered. Ms. Deline reported she took responsibility for not administering the medication and received a written disciplinary action for this incident.

During on-site investigation, on 8/24/22, I reviewed Resident E’s MAR for the month of June 2022. On Resident E’s MAR was a medication that was ordered for “Bisacodyl 10mg Suppository, Insert one suppository into the rectum daily for ten days.” On the date 6/29/22 Ms. Deline initialed that the medication had been administered. On the back of the MAR was a notation stating, “6/29, 10am, suppository, was not passed. ND”

On 9/16/22 I reviewed the employee file for Ms. Deline. There was no record of disciplinary action for the incident on 6/29/22 concerning the missed medication dosage for Resident E.

APPLICABLE RULE	
R 400.14312	Resident medications.
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based upon interviews with Ms. Waldron & Ms. Deline, as well as review of Resident E's MAR, Resident E's Bisacodyl Suppository was not given on 06/29/2022 pursuant to label instructions.
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

During on-site investigation of the facility on 8/24/22 I interviewed Resident D. Resident D reported that the facility is not kept in a clean and sanitary condition. She reported the facility frequently smells of urine and feces due to residents with incontinence issues. Resident D also reported that the bathroom, just off from the kitchen area, has mold and mildew growing on the shower.

I did walk through the facility and did not smell urine or feces while I was in the facility. I did tour the bathroom, near the kitchen, and did note a black substance in the corners of the shower and stretching along the metal trim of the shower door/walls.

APPLICABLE RULE	
R 400.14403	Maintenance of premises.
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	The shower in the bathroom near the kitchen has a black substance building up along the metal trim that needs to be cleaned.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon an approved corrective action plan, no change to the status of the license is recommended at this time.

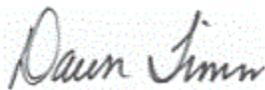


10/10/2022

Jana Lipps
Licensing Consultant

Date

Approved By:



10/10/2022

Dawn N. Timm
Area Manager

Date