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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

Dawn Foulke
Clinton Creek, Inc.
4438 Ramsgate Lane
Bloomfield Hills, MI 48302

October 14, 2022

RE: License #: AH500387884
Investigation #: 2022A1022012
Clinton Creek Assisted Living & Memory Care

Dear Dawn Foulke:

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 authorized representative and a date.

Please review the enclosed documentation for accuracy and contact me with any questions.

Sincerely,

Barbara P. Zabitz, R.D.N., M.Ed.
Health Care Surveyor
Health Facility Licensing, Permits, and Support Division
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Mobile Phone: 313-296-5731
Email: zabitzb@michigan.gov

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500387884
Investigation #:	2022A1022012
Complaint Receipt Date:	07/14/2022
Investigation Initiation Date:	07/14/2022
Report Due Date:	08/13/2022
Licensee Name:	Clinton Creek, Inc.
Licensee Address:	4438 Ramsgate Lane Bloomfield Hills, MI 48302
Licensee Telephone #:	(248) 701-5043
Administrator:	Karrie Dove-Drendall
Authorized Representative:	Dawn Foulke
Name of Facility:	Clinton Creek Assisted Living & Memory Care
Facility Address:	40500 Garfield Road Clinton Township, MI 48038
Facility Telephone #:	(586) 354-2700
Original Issuance Date:	07/18/2019
License Status:	REGULAR
Effective Date:	01/18/2022
Expiration Date:	01/17/2023
Capacity:	62
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The Resident of Concern (ROC) was not provided appropriate skin care and developed a large, deep, pressure sore.	Yes
The ROC was locked in a dining room.	Yes
The ROC did not receive good care, possibly because he was an African American.	No
Additional Findings	Yes

III. METHODOLOGY

07/14/2022	Special Investigation Intake 2022A1022012
07/14/2022	Special Investigation Initiated - Telephone Called complainant and sent an email message asking him to contact me.
07/14/2022	Contact - Telephone call received Spoke with complainant on phone
07/21/2022	Inspection Completed On-site
07/21/2022	APS Referral
09/02/2022	Contact - Telephone call made Additional information requested from the facility by email.
09/07/2022	Contact – Document Received Additional documentation sent by facility
10/14/2022	Exit Conference

ALLEGATION:

The Resident of Concern (ROC) was not provided appropriate skin care and developed a large, deep, pressure sore.

INVESTIGATION:

On 7/14/2022, I interviewed the complainant by phone. According to the complainant, the Resident of Concern (ROC), who was totally dependent on care staff for all activities of daily living had developed a pressure sore. The complainant stated that the facility informed him on 7/11/2022 that a home care nurse would need to come into the facility to treat the pressure sore and they needed the complainant's agreement as he was the ROC's power of attorney (POA). The complainant went on to say that the nurse manager at the facility told him the wound was located on the ROC's buttock where the ROC's "diaper" rubbed against his leg. The complainant went on to say that the ROC was not able to do anything for himself; that he was blind; and had severe dementia. The complainant further said that he did not believe that the facility was providing the ROC with "good care."

On 7/21/2022, a referral was made to Adult Protective Services.

On 7/21/2022, during the onsite visit, I interviewed the administrator and the nurse manager. When asked about the ROC, the nurse manager acknowledged that the ROC had a pressure sore on his buttock and that the facility had arranged for a home health care nurse to provide wound care. The nurse manager stated that the home health care nurse would provide wound care either twice or three times a week, depending on the level of service needed and in the wound care nurse's absence, she, the nurse manager would provide the care. When asked what happened on weekend, the nurse manager stated that frequently, at least one of the wound care nurse's visits would occur on either Saturday or Sunday, and when necessary, the care staff had been trained to provide the necessary care. The nurse manager was then asked to facilitate an observation of the ROC's wound.

The ROC was found seated in a wheelchair in the day area of the Memory Care (MC) unit. According to the care staff, after the ROC had breakfast, he was taken to the day area for activities, and he had been there since. Two caregivers took the ROC in his wheelchair and brought him to his room. They assisted the ROC into bed and began to undress him to remove his brief. As the ROC stood from his wheelchair, it was observed that he had been sitting on a thin, flat cushion as one would find on a dining room chair. The brief was soiled with feces and urine. There

was a dressing on his left buttock that was detached at one corner. The nurse manager began wiping stool from the ROC's anal area and removed the dressing, exposing the wound. The wound appeared to be the size of a 50-cent piece but had "tunneling" that extended into the flesh underneath the outside perimeter of the wound.

According to the caregivers, the ROC had his brief changed prior to being gotten up out of bed for breakfast, about 5:55 am, but not again until the time of this observation, at 10:30 am. When the two caregivers were asked if they had received any specific instructions regarding the ROC's wound, neither caregiver remembered any.

Review of the ROC's electronic heath record revealed the following:

The ROC's service plan was dated 2/28/2021. There were no instructions regarding skin care, or skin breakdown other than a checkmark referencing "See treatment record." The service plan acknowledged that the ROC was incontinent of both bowel and bladder but included no further instructions.

The following charting notes addressing the ROC's pressure sore were found:

- Charting notes dated 6/20/2022, authored by one of the medication technicians indicated "caregiver let me (writer) know that resident is forming a bedsore."
- Charting notes dated 7/5/2022, authored by a second medication technician indicated, "(ROC) has (skin) breakdown on l (left) butt cheek size of 50 cent piece."
- Charting notes dated 7/9/2022, authored by the nurse manager, documented "Resident has a pressure ulcer on coccyx. NP (nurse practitioner) ordered Triad Paste mixed with Calmoseptine to be on coccyx with diaper change and prn (as needed). POA (power of attorney) notified…"
- Charting notes dated 7/12/2022, authored by the nurse manager, documented "writer (nurse manager) notified health POA concerning resident wound care…"
- Charting notes dated 7/14/2022, authored by the nurse manager, documented "Resident was seen by wound care on today and the 11th of July. Treatment in place and completed by wound care nurse… Will continue to follow plan of care."
- Charting notes dated 7/15/2022, authored by the nurse practitioner documented "…Stage 3 pressure ulcer; debridement performed. Patient tolerated well. Continue wound care as per home care instruction…"
- Charting notes dated 7/18/2022, authored by the nurse manager, documented "Resident was seen by the wound care nurse dressing applied. Writer (nurse manager) observed treatment being placed on resident coccyx. Wound care nurse ordered a ROHO (brand name pressure-relieving seat cushion) for resident. Will continue to follow plan of care."

- Charting notes dated 7/19/2022, authored by the nurse manager indicated "nurse manager changed his (ROC's) wound dressing.

There were no additional chart notes for the ROC that addressed the ROC's pressure sore.

There was a treatment record for "Mix equal parts of Triad w/Calmoseptine and apply to wound on coccyx with every brief change every shift," started on the afternoon of 7/7/22, discontinued morning of 7/14/22. The way that this treatment record was documented, it appeared that the treatment was only administered twice daily, once during the morning shift and once during the afternoon. It was not clear that the ROC received this treatment with every brief change.

According to the nurse manager, the ROC was first seen by the home health care wound nurse on 7/11/2022. The nurse's recommendations, dated 7/12/2022, were "Clean with normal saline or wound cleanser and 4 x 4 gauze. Wipe outside of wound with skin barrier wipe. Apply/fill wound with manuka or med honey. Cut to size manuka honey gauze then apply to wound. Cut to size manuka HD super lite then apply to wound. Cover with hydrocolloid. Home care nurse to provide wound care twice a week; Clinton Creek to provide if wound dressing gets soiled due to incontinence." The nurse also recommended a pressure-relieving cushion (ROHO) for the ROC's wheelchair and as well to position the ROC on his side when sleeping, with a pull-on knee cushion in-between his knees. None of the home health nurse's recommendations appeared on either the service plan or any treatment record.

During the onsite visit, 7/21/2022, I interviewed the home health care agency wound nurse. According to the wound nurse, when she first saw the ROC (on 7/11/2022), she measured the wound to 2.2 centimeters by 2.5 centimeters with a depth of 0.8 centimeters. The wound nurse went to say that at her last assessment, 7/14/2022, the wound had deepened. The length and the width of the wound remained 2.2 centimeters by 2.5 centimeters, but the depth had been 1.1 centimeters. The wound nurse stated that she had not assessed the wound since 7/14/2022.

The facility had no further documentation that could be used to explain what measures they had employed to ensure that the ROC did not develop a pressure sore.

APPLICABLE RULE	
R 325.1933	**Personal care of residents.**
	(1) A home shall provide a resident with necessary assistance with personal care such as, but not limited to, care of the skin, mouth and teeth, hands and feet, and the shampooing and grooming of the hair as specified in the resident's service plan.

ANALYSIS:	Between 6/20/2022, when one of the medication technicians first documented the presence of a “bedsore,” and 7/7/2022, when the first treatment as ordered by the NP was applied, a time span of 17 days, the ROC received no treatment or other interventions for a pressure sore. The facility had no documented skin assessments for the ROC. No records were kept of the treatment recommended by the wound nurse on 7/11/2022. There were no records to indicate that the ROC received the recommended treatment if his “wound dressing gets soiled due to incontinence.” There were no records to indicate that the ROC received incontinence care regularly.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The ROC was locked in a dining room.

INVESTIGATION:

According to the complainant, “on June 18th, 2022, I [the complainant] arrived to check in on my father [the ROC]. I [the complainant] was approached by one of the nurses on staff. They reported that my father was getting extremely poor treatment. She relayed to me that my father had been locked in a dining room for approximately 4 hrs. She found him in the dining room alone with the door locked.”

My attempts to interview this facility employee were not successful. The phone number provided by the complainant was not operable. Although the complainant asked the employee to call me, no call was ever received.

When I interviewed the administrator during the onside visit, the administrator stated that residents who lived in the MC unit were to be “checked on” every hour. The administrator went on to say that the medication technician on the unit was to be making rounds on the resident and she expected some kind of charting on each resident. When the administrator was asked how she ensured that care was delivered as specified on the service plan, the administrator again answered that there should be charting of some sort.

At the time of the onsite visit, I asked to see the MC unit dining area. The dining area was situated off one of the main hallways of the unit. There were two doors into the dining area and four windows that opened onto the adjacent hallway. Both doors locked when in the closed position and only employees were able to unlock them. There was a security camera in one corner of the room. When I asked the administrator about the

camera, the administrator admitted that the camera was not monitored and that after 3 days, the footage taken by the camera was no longer available.

Review of the ROC's charting notes revealed that no entries had been made for any shift on any day between 5/6/2022 and 6/20/2022.

According to the ADL log for the month of June 2022, no care was provided to the ROC on the afternoon shift. The entire month was blank. When the administrator was asked if there any other documents or charting that would show that the resident was monitored in the evening by staff, the administrator acknowledged that there none.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
For Reference: R325.1901	**Definitions.**
	(22) "Supervision" means guidance of a resident in the activities of daily living, and includes all of the following: **(d) Being aware of a resident's general whereabouts as indicated in the resident's service plan, even though the resident may travel independently about the community.**
ANALYSIS:	This investigation was not able to determine if the ROC was locked in the dining room during the third week of June 2022; however, there was no evidence that the ROC was properly supervised during this period of time.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The ROC did not receive good care, possibly because he was an African American.

INVESTIGATION:

The complainant stated that he was worried that the ROC faced discrimination in his care, because he was the only resident who was African American. The complainant was not able to provide any additional detail as to why this was his worry.

At the time of the onsite visit, 7/21/2022, although no other residents were identified to be African American, numerous care staff including the nurse manager were observed to be African American. One of these care staff members, caregiver #1 was asked whether it was possible that the ROC was discriminated against because of his race. Caregiver #1 stated that she did not think that was true.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(a) A patient or resident shall not be denied appropriate care on the basis of race, religion, color, national origin, sex, age, disability, marital status, sexual preference, or source of payment.**
ANALYSIS:	There was no evidence that the ROC faced discriminatory treatment because of his race.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

At the time of the onsite visit, 7/14/2022, the only service plan on record was dated 2/28/2021. When the administrator was asked if there had been an annual update of the ROC's service plan in 2022, the administrator acknowledged that there was no update.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	It was more than 16 months since the ROC's service plan had last been established. Despite the development of a pressure sore, no update was made to the ROC's service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the authorized representative (AR) on 10/14/2022. When asked if there were any comments or concerns with the investigation, the AR stated that she agreed with the findings of the report and had already begun to institute corrective actions.

IV. RECOMMENDATION

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

10/14/2022

_____

Barbara Zabitz Date
Licensing Staff

Approved By:

09/16/2022

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