GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 20, 2022

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

RE: License #:	AL250281713
Investigation #:	2022A0872052
	Leighton 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 #:	AL250281713
Investigation #:	2022A0872052
Complaint Receipt Date:	08/23/2022
Investigation Initiation Date:	08/23/2022
Report Due Date:	10/22/2022
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:	Leighton 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

II. ALLEGATION(S)

	Violation Established?
The facility is short staffed.	Yes
Several residents, specifically Resident A, are not getting the care they need due to short staffing.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/23/2022	Special Investigation Intake 2022A0872052
08/23/2022	Special Investigation Initiated - On Site Unannounced
09/12/2022	Contact - Document Sent I emailed Leighton House Inn management requesting information about this complaint
09/14/2022	Contact - Document Received AFC documentation received
09/26/2022	APS Referral I made an APS complaint via email
09/28/2022	Contact - Document Received I received AFC documentation related to this complaint
09/28/2022	Contact - Telephone call made I interviewed Relative A1
09/28/2022	Contact - Telephone call received I spoke to APS Worker, Kelly Clark-Huey about this complaint
09/29/2022	Contact - Document Sent I made a health facility complaint via online regarding Turner House Inn
09/29/2022	Contact - Document Sent I emailed the licensee designee requesting additional information about this complaint

10/07/2022	Contact - Telephone call made I interviewed former staff, Paige Turner
10/07/2022	Contact - Telephone call made I interviewed former staff, Layla Alotabi
10/17/2022	Contact - Telephone call made I interviewed Resident A's former hospice nurse, Julie Tidwell
10/17/2022	Contact - Telephone call made I interviewed staff Audraya Forrest
10/18/2022	Contact - Telephone call made I interviewed staff Molly Vandriessche
10/18/2022	Contact - Document Received I received documentation regarding Resident A
10/18/2022	Exit Conference I conducted an exit conference with the licensee designee, Kimberly Gee
10/18/2022	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

- **The facility is short staffed**
- **Several residents, specifically Resident A, are not getting the care they need due to short staffing.**

INVESTIGATION: On 8/23/22, I conducted an unannounced onsite inspection of Leighton House Inn Adult Foster Care facility. I interviewed the director of assisted living, Amanda Walworth (ALD), the general manager, Ronda Pipe, and the assistant assisted living director, Raelynn Fonger. I also conducted a visual inspection of the facility.

I reviewed the allegations with all individuals, and they said that the facility has been facing 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 currently, there are two residents in Leighton House Inn who have or have had bed sores, but they are both receiving treatment. Resident A is on hospice, and she is actively dying. She has a hospice nurse who comes out every day and provides care for her sore. Resident C had a bed sore in the past, but it was treated, and he no longer has any sores. The resident in room 511 does not have any sores.

On 08/23/22, I observed Resident A, in room 518. She was lying in bed and appeared to be clean and dressed appropriately. I did not interview her because she was sleeping and is at the end stages of life.

On 08/23/22, I met with Resident B, in room 511. Resident B was resting in his room and Relative B1 was with him. I asked them if they have any concerns about the staffing level at this facility. Relative B1 said that staff checks on Resident B "when they can" and said that Resident B does not have any bed sores or other medical needs that are not being met.

On 08/23/22, I met with Resident C, in room 507. Resident C was also resting in his room and Relative C1 was with him. Resident C was clean and dressed appropriately. I asked them if they had any concerns about the staffing level at this facility and Relative C1 said that Resident C is being taken care of but there are not many staff. Resident C and Relative C1 said that Resident C does not have any sores or any other medical concerns that are not being met.

On 09/14/22, I received AFC documentation regarding this complaint. According to the Resident Register, as of 08/25/22, there were 13 residents at Leighton House Inn, and 9 of them wear briefs.

According to the documentation I reviewed, Resident A was seen by the Leighton House Inn PA-C, Kristen Dziadula, on 8/16/22 due to readmission and weakness. According to PA Dziadula's notes, Resident A was admitted to Leighton House Inn after being discharged from the hospital. She was still taking antibiotics as prescribed by the hospital due to an infection. PA Dziadula noted that Resident A was "lying comfortably in bed in no acute distress." She appeared "comfortable and stable."

I reviewed a progress note regarding Resident C completed by DO Michael Samluk, dated 9/14/22. According to DO Samluk's notes, Resident C was seen for an annual health care appraisal. He has numerous medical conditions but at the time of his exam, he appeared comfortable in his wheelchair with Relative C1 by his side. DO Samluk noted, "Patient is receiving wound care to the right heel wound which shows no current signs of infection." Resident C was stable, and "in no acute distress." No other wounds were noted except for the heel wound and no further recommendations were made.

On 9/28/22, I interviewed Relative A1 via telephone. Relative A1 said that Resident A resided at Leighton House Inn and also at Turner House Inn which is a rehabilitation center. Resident A had mild dementia and she could not hear very well. According to Relative A1, she had concerns about the care that Resident A received while at Turner House Inn, so I made a health facility complaint online, regarding the allegations. Relative A1 also had concerns regarding Resident A's care while a resident of Leighton House Inn.

Relative A1 said that Leighton House Inn was often short-staffed. She said that Resident A was originally admitted to Leighton House Inn in 2020. In/around April 2022, Resident A fell in her room and broke her ribs. Relative A1 asked Resident A what had happened. Resident A told her that she had fallen so she was pressing her call button, but no staff came to assist her, so she tried to get up by herself which doctors later said probably made her injury worse. Leighton House Inn staff eventually discovered that she had fallen, and she was transported to Genesys Medical Center.

Relative A1 said that on 07/03/22, Resident A again fell while in her room. She was transported to Genesys Medical Center and diagnosed with a broken hip. She had hip surgery and was released to Turner House Inn rehabilitation center on 07/11/22. Resident A developed Covid-19 while there and did not return to Leighton House Inn until 08/01/22.

On 08/02/22, Relative A1 said that staff contacted her and told her that Resident A had a serious bed sore that needed medical attention. Therefore, Relative A1 consented to have Resident A transported to Genesys Medical Center once again. While there, doctors determined that Resident A was septic and needed intravenous antibiotics. Resident A was eventually stabilized, and she returned to Leighton House Inn under hospice care. She passed away on 08/27/22.

On 10/07/22, I interviewed former staff, Paige Turner, via telephone. Ms. Turner 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. Turner said that she worked in all the Inns, wherever she was needed, as did most staff.

Ms. Turner stated that all the facilities were very short staffed. She said that most of the Inns, including Leighton House Inn, had 10-20 residents and often, one staff was responsible for caring for up to 15 residents at a time, by themselves. Ms. Turner 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.

On 10/07/22, I interviewed former staff, Layla Alotabi via telephone. Ms. Alotabi said that she only worked at this facility for a few weeks, and she quit over a month ago. According to Ms. Alotabi, 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."

On 10/10/22, I reviewed the staffing assignments for Leighton 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 one to two staff to be on shift for every waking hour 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 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, leaving only one full staff to care for all residents.

On 10/17/22, I interviewed Resident A’s former hospice nurse, Julie Tidwell. RN Tidwell said that she started providing care for Resident A in July 2022 after her hip surgery. When Resident A eventually returned to Leighton House Inn, she was basically bedbound. She was not eating and was only minimally responsive. RN Tidwell confirmed that Resident A had sores on her body that needed wound care. She said that on several occasions, she tried to educate staff in Resident A’s wound care and how to change and apply her dressings, but the staff did not seem to “get it.” RN Tidwell said that for that reason, she went to the facility every day during the week and a nurse saw Resident A both weekend days to make sure that the dressings were being changed properly. RN Tidwell confirmed that there was usually a staffing shortage and said that staff did not have the time to provide the kind of care that Resident A needed.

On 10/17/22, I interviewed staff, Audraya Forrest via telephone. Ms. Forrest said that she has worked for this company for over three years, and she typically works at Leighton House Inn. Ms. Forrest confirmed that at times, the facility has been short staffed. She said that management typically schedules two staff for every hour of the day and sometimes, a third staff will overlap and there will be three people working. However, Ms. Forrest said that if staff calls in sick, there are times that she has to work the entire Inn by herself. She said that currently, there are 15 residents and 5 of them have full-assist briefs. Ms. Forrest said that when she has had to work the Inn alone, it was difficult to provide for all the residents. If she needed assistance with one of the residents, she would contact one of the other Inns and wait for one of the staff to come and help her.

Ms. Forrest said that she worked very closely with Resident A when she resided at Leighton House Inn. Ms. Forrest confirmed that Resident A fell on two separate occasions, once breaking her rib and once breaking her hip. She had hip surgery and when she was released from the hospital, she went to Turner House Inn for rehabilitation. According to Ms. Forrest, Resident A was at the hospital and then Turner House Inn for several weeks before returning to Leighton House Inn during the evening

of 08/01/22. Ms. Forrest said that when she entered Resident A's room on 08/02/22, she immediately noticed a foul odor and discovered that Resident A had a huge wound on her buttocks. Ms. Forrest said that the wound was so severe, she could see Resident A's tailbone. Ms. Forrest contacted Resident A's family and sent her to the hospital. When Resident A returned to Leighton House Inn, her condition had deteriorated significantly, and she was on hospice. Ms. Forrest confirmed that Resident A had a significant wound that required attention. She said that Resident A's hospice nurse came out to the facility every day to change the dressing. Ms. Forrest confirmed that she and the rest of the staff have not been specifically trained in wound care for the type of wound Resident A had.

On 10/18/22, I interviewed staff Molly Vandriessche via telephone. Ms. Vandriessche said that she has worked for this facility for over eight years, and she typically works 1st shift at Leighton House Inn. Ms. Vandriessche confirmed that over the summer, the facility was having staffing problems. Although management would schedule enough staff to work each hour of the day, staff would call in sick, come in late, or leave early which sometimes meant one staff had to work the entire Inn by themselves. Ms. Vandriessche said that at times, she had to care for up to 9-12 residents at a time and although it was challenging, she feels she was able to manage and provide good care to the residents.

Ms. Vandriessche said that she worked closely with Resident A while she resided at Leighton House Inn. Ms. Vandriessche confirmed that Resident A fell on two separate occasions and was hospitalized. She said that she was not present for either one of the falls. According to Ms. Vandriessche, when Resident A fell and broke her hip in July 2022, she did not have any sores or wounds on her body. When she returned to Leighton House Inn during the middle of August 2022, she was bedbound and had a severe wound on her buttocks.

On 10/18/22, I examined documentation related to Resident A. I reviewed an Incident/Accident Report (IR) dated 07/02/22. According to the IR, "Housekeeper went into room and observed guest laying on ground next to recliner chair. Guest stated she was trying to take a walk and didn't want to bother anyone." The corrective action measures taken were, "Frequent checks, labs (UA and full metabolic) ordered and STAT x-ray bilateral hips and legs." On 07/03/22, the facility received the results of Resident A's x-ray which determined she sustained a femur neck fracture. She was sent to the hospital at that time.

I reviewed another IR dated 08/02/22 regarding Resident A. According to the report, "Guest was brought back to assisted living with a bed sore on tailbone. Wound was causing pain and producing gray discharge and foul odor. Guest wasn't responding/not able to speak or eat or drink." Resident A was sent to Genesys Hospital. No corrective measures were noted.

I reviewed Resident A's hospital paperwork from Ascension Genesys Hospital. She was admitted on 08/02/22 due to a sacral ulcer. She was discharged in "fair" condition on 08/09/22 and was placed on hospice.

I reviewed Resident A's death certificate dated 08/27/22. Resident A's cause of death was listed as natural.

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, Raelynn Fonger, Rhonda Pype, Audraya Forrest and Molly Vandriessche and former staff, Paige Turner and Layla Alotabi stated that the facility has been short staffed, and staff has had to work alone at times. According to the Resident Register, as of 08/25/22, there were 13 residents at Leighton House Inn, and 9 of them wear briefs. I examined the staff schedule for June, July, and August 2022 and noted that although the facility scheduled at least two staff to work every waking hour, sometimes due to call-ins only one staff was responsible for working the entire Inn. Relative A1, Relative B1, Relative C1 and Resident A's former hospice nurse, Julie Tidwell said that the facility is short staffed and at times there are not enough staff to care for the residents. I conclude that there is sufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

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	According to Ms. Walworth, Ms. Fonger, and Ms. Pype, staff are responsible for passing medications, providing patient care, checking residents who wear briefs every two hours or more often if necessary, distributing meals to the residents from the sub-kitchen, cleaning up after meals, doing laundry, showering residents, and doing light housekeeping. In/around April 2022, Resident A fell in her room and broke her ribs. She told Relative A1 that she had fallen so she was pressing her call button, but no staff came to assist her. She tried to get up by herself which doctors later said probably made her injury worse. On 07/03/22, Resident A again fell while in her room. According to the Incident/Accident Report, a facility housekeeper went into Resident A's room and observed her laying on the ground next to her recliner chair. Resident A stated she was trying to take a walk and "didn't want to bother anyone." Resident A was hospitalized with a broken hip for which she had surgery. Resident A's former hospice nurse, Julie Tidwell said that on several occasions, she tried to educate staff in Resident A's wound care and how to change and apply her dressings, but the staff did not seem to "get it." RN Tidwell said that for that reason, she went to the facility every day during the week and a nurse saw Resident A both weekend days to make sure that the dressings were being changed properly. She said that staff did not have the time to provide the kind of care that Resident A needed. Staff Audraya Forrest confirmed that when Resident A returned to Leighton House Inn in August 2022, she and the rest of the staff have not been specifically trained in wound care for the type of wound Resident A had.

	Staff Molly Vandriessche confirmed that Resident A fell on two occasions, once breaking her rib and once breaking her hip. She said that when Resident A returned to Leighton House Inn in August 2022, she required total care which hospice mostly provided. Ms. Vandriessche said that she feels she was able to provide good care to Resident A and the other residents. I conclude that there is sufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: Resident A fell in the spring of 2022 and again on 07/02/22. She was sent to the hospital on both occasions. The licensee designee did not send me an Incident/Accident Report (IR) regarding either of these injuries or hospitalizations.

On 8/02/22, Resident A was again sent to the hospital, this time due to bed sore/wound. She was hospitalized and returned to Leighton House Inn the next day. The licensee designee did not send me an IR regarding this hospitalization.

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(a) The death of a resident.** **(b) Any accident or illness that requires hospitalization.** **(c) Incidents that involve any of the following:** **(i) Displays of serious hostility.** **(ii) Hospitalization.** **(iii) Attempts at self-inflicted harm or harm to others.** **(iv) Instances of destruction to property.** **(d) Incidents that involve the arrest or conviction of a resident as required pursuant to the provisions of section 1403 of Act No. 322 of the Public Acts of 1988.**

ANALYSIS:	Resident A fell in the spring of 2022 and again on 07/02/22. She was sent to the hospital on both occasions. The licensee designee did not send me an Incident/Accident Report (IR) regarding either of these injuries or hospitalizations. On 8/02/22, Resident A was again sent to the hospital, this time due to bed sore/wound. She was hospitalized and returned to Leighton House Inn the next day. The licensee designee did not send me an IR regarding this hospitalization. I conclude that there is sufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/18/22, I conducted an exit conference with the licensee designee, Kimberly Gee. I explained which rule violations I am substantiating and asked her to complete and submit a corrective action plan upon the receipt of my investigation report.

IV. RECOMMENDATION

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

Susan Hutchinson October 19, 2022

Susan Hutchinson Licensing Consultant	Date

Approved By:

Mary Holton October 20, 2022

Mary E Holton Area Manager	Date