GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 15, 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 #:	2022A0872059
	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 #:	2022A0872059
Complaint Receipt Date:	09/26/2022
Investigation Initiation Date:	09/27/2022
Report Due Date:	11/25/2022
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:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
On 08/05/22, Resident A was found dead on the floor in her room. She had a large indentation on her head.	No
Additional Findings	Yes

III. METHODOLOGY

09/26/2022	Special Investigation Intake 2022A0872059
09/27/2022	Special Investigation Initiated - Letter I emailed the licensee requesting information about this complaint
09/28/2022	Contact - Document Received I received AFC documentation related to this complaint
10/13/2022	Inspection Completed On-site Unannounced
11/07/2022	Contact - Telephone call made I called Sharp Funeral Home in Swartz Creek requesting a copy of Resident A's death certificate
11/07/2022	Contact - Telephone call made I called Relative A2 but was unable to leave a message. I sent a SMS message asking her to return my call
11/07/2022	Contact – Telephone call made I called Relative A1 and left a message
11/07/2022	Contact - Telephone call made I contacted Resident A's doctor, Michael Samluk and left a message requesting a return call
11/07/2022	Contact - Telephone call made I interviewed staff De'Zhaney Rice
11/07/2022	Contact - Telephone call made I interviewed former staff, Madison Nelson
11/09/2022	Contact - Telephone call made I interviewed Resident A's physician assistant, Kristen Dziadula

11/09/2022	Contact – Document sent I emailed Relative A1 and Relative A2 requesting one of them return my call
11/09/2022	Exit Conference I conducted an exit conference with the licensee designee, Kimberly Gee
11/09/2022	Inspection Completed-BCAL Sub. Compliance
11/10/2022	Contact – Document received I received additional documentation about this complaint

ALLEGATION: On 08/05/22, Resident A was found dead on the floor in her room. She had a large indentation on her head.

INVESTIGATION: On 09/28/22, I received Adult Foster Care documentation related to Resident A. Resident A was admitted to Monet House Inn on 06/17/22. According to her Health Care Appraisal dated 04/13/22, she was diagnosed with Alzheimer's, dementia, hypertension, and chronic hypothyroidism. Her doctor, Linda Norrell, MD noted that Resident A was not oriented to person, place, or time. She is suffering from "rapidly declining dementia" with an onset in early 2019.

According to Resident A's Assessment Plan, she is 70-years old. She has a poor appetite, nausea/vomiting, and unplanned weight loss. She requires supervision with eating, and assistance with bathing, personal hygiene, and dressing. At the time of her assessment, she was fully ambulatory, did not have any assistive devices and she was able to walk on her own. She walks "occasionally" but spends most of her time in a chair or in her bed. She is partially incontinent, and wears pull ups. She has a history of wandering, but she is not an elopement risk. Resident A does not have a history of falls, but she is frequently confused and has an unsteady, shuffling gait.

I reviewed her weight records and noted that on her date of admission (06/17/22), she weighed 135lbs and as of 07/12/22, she weighed 135lbs.

I reviewed the staff progress notes for July and August 2022. On 07/21/22, staff noted that Resident A has been spitting out her medications and is refusing eating and care. Throughout the rest of July, her behaviors intensified, and she continued to refuse many of her medications. Staff contacted Resident A's physician assistant, Kristen Dzidula on three separate occasions and made her aware of the concerns.

According to the progress noted dated 08/05/22, "Director was called due to resident being found in room passed away. Med passer went down to pass meds and the last time she was checked on was around 6/7pm which resident was laying in bed. Resident hasn't been feeling good the last couple of days and hasn't gotten out of bed per GA.

Resident was still talking to them though. When they went to pass her meds, her lights were off, and they found her on the floor. Attempted BP/pulse 0. Told them to call 911 and family and make them aware. Director came to facility and assisted with situation. Spoke with MEI, they weren't coming out, police cleared the scene. Family was present when director left, GA cleaned up resident and Director called the funeral home and made arrangements for pickup."

I reviewed Resident A's medication logs for July and August 2022 and noted the following:

- Resident A either refused or spit out the medication Levothyroxine 75mcg, 1 tablet 1x per day on 7 occasions in the month of July and 1 occasion in the month of August
- Resident A either refused or spit out the medication Trazadone 50mg, 1 tablet at bedtime on 12 occasions in the month of July and 4 occasions in the month of August
- Resident A either refused or spit out the medication Memantine 10mg, 2x's per day on 13 occasions in the month of July and 5 occasions in the month of August
- Resident A either refused or spit out the medication Lorazepam 0.5mg, 3x's per day on 12 occasions in the month of July
- Beginning on 07/21/22, staff began administering Resident A Lorazepam topically 2x's per day "as needed." Beginning on 07/28/22, staff began administering Resident A Lorazepam topically 3x's per day. In the month of August, she refused this medication on 2 occasions

I reviewed three of PA-C, Kristen Dziadula's progress notes for the month of July and noted the following:

- On 07/19/22, PA-C Dziadula examined Resident A due to "anxiety and medication management per nursing staff request." At the time of the exam, Resident A was relaxing in bed and was not in any distress. PA-C Dziadula refilled her anxiety medication and asked staff to "monitor for efficacy or any adverse side effects."
- On 07/21/22, PA-C Dziadula examined Resident A due to "agitation/combative behavior per nursing staff request. Nursing staff relate resident becomes quite combative at times and is requesting topical medication management." At the time of the exam, Resident A was sitting upright, in no acute distress. PA-C Dziadula put in an order for Lorazepam to be applied topically 2x's per day, as needed.
- On 07/28/22, PA-C Dziadula examined Resident A due to "agitation/combative behavior per nursing staff request." She was sitting upright, in no acute distress. "Nursing staff relay she has been quite combative as of late and are inquiring about scheduling her Ativan (Lorazepam) gel. Nursing staff relates she has been 'spitting out' her Ativan tablets." PA-C Dziadula discontinued Resident A's Ativan tablets and ordered Lorazepam to be applied topically 3x's per day

I reviewed an Incident/Accident Report (IR) dated 08/05/22 at 9:30pm completed by staff, Madison Nelson. According to the report, staff “went into (Resident A’s) room to give medication and (she) was lying on the floor unresponsive. Blood pressure and O2 were taken, both reading 0.” Staff contacted management, family, 911, and EMS.

On 10/13/22, I conducted an unannounced onsite inspection of Monet House Inn Adult Foster Care facility. I interviewed the assistant to the assisted living director, Raelynn Fonger and conducted a visual inspection of the facility. During my inspection, I observed 3 staff and 12 residents. The residents were eating, and staff was interacting with them. All residents of this facility have dementia and/or Alzheimer’s Disease so I did not interview any of them. I noted that all residents appeared to be clean, dressed appropriately, and their needs were being attended to by staff. Ms. Fonger agreed to send me any additional information I may need to investigate this complaint.

On 11/07/22, I interviewed staff De’Zhaney Rice via telephone. She said that on 08/05/22, she was working in one of the other halls but was asked to help pass medications in Monet House Inn. According to Ms. Rice, staff Madison Nelson came up to her at around 9:30pm and said that she thought Resident A had fallen because she was on the floor in her room and appeared to be sleeping. Ms. Rice said that she and Ms. Nelson went down to Resident A’s room and found her laying on the floor, by her bed. Ms. Rice said that Resident A was laying on her back, her mouth was open and one of her hands was on her chest. According to Ms. Rice, she did not see any blood, marks, bruises, or injuries. I asked her if she saw any indentation on Resident A’s head and she said, no. Additionally, nothing was out of order in Resident A’s room indicating she might have fallen against something when she fell to the floor. Ms. Rice said she and other staff contacted management, the police, and Resident A’s family. When the police came to the facility, they told staff that they would not be conducting an investigation and to call the funeral home.

According to Ms. Rice, she was very familiar with Resident A and she worked with her on several occasions. She said that while residing at Monet House Inn, Resident A’s condition rapidly declined. Ms. Rice said that she interacted with Relative A1 and Relative A2, and everyone was aware of her declining condition. Ms. Rice said that near the end of her life, Resident A was combative with staff at times, and she would spit out some of her medications. She also had trouble eating. Ms. Rice said that she and other staff notified PA-C Dziadula who examined Resident A on several occasions and who was aware of her declining health.

Ms. Rice told me that on 08/03/22, she noted that Resident A did not seem to be feeling well but she was not demonstrating any obvious signs of distress that would have prompted her to contact a doctor for a medical exam. Ms. Rice said that Resident A was unable to verbalize if something was wrong, but she was still walking around periodically, and she was still interacting with staff.

On 11/07/22, I interviewed former staff Madison Nelson via telephone. Ms. Nelson confirmed that she was working on 08/05/22 and she initially found Resident A on the floor in her bedroom. According to Ms. Nelson, she went into Resident A's room after 9:00pm to pass her medications. Resident A's light was off, and she was not lying in bed. Ms. Nelson said she turned Resident A's light on and saw that she was laying on her back, on the floor. Ms. Nelson thought she might have fallen and then just went to sleep on the floor. Ms. Nelson told me that she alerted staff De'Zhaney Rice and they both went back in Resident A's room. Ms. Nelson said that upon closer examination, it was obvious that Resident A had passed away based on the appearance of her body but said that there were no marks, bruises, or injuries. Ms. Nelson said that she did not see any blood and there was "nothing out of the ordinary." Ms. Nelson told me that she and other staff alerted management, 911, and Resident A's family.

On 11/07/22, I obtained a copy of Resident A's death certificate from Sharp Funeral Home in Swartz Creek, Michigan. According to the death certificate, Resident A died of natural causes and her cause of death was Alzheimer's Disease. It was signed by Michael Samluk, DO and an autopsy was not performed.

On 11/09/22, I interviewed Resident A's physician assistant, Kristen Dziadula via telephone. PA Dziadula said that she was Resident A's primary care physician while she was a resident of Monet House Inn. According to PA Dziadula, she saw Resident A on 07/19/22, 07/21/22, and 07/28/22. PA Dziadula said that Resident A was suffering from early onset Alzheimer's Disease, and she had many psychiatric issues as a result. PA Dziadula said that Resident A's Alzheimer's was severe, and she had combative behaviors as well as problems with anxiety and trouble eating. I reviewed the allegations with PA Dziadula and discussed her thoughts on Resident A's care.

PA Dziadula said that staff kept her informed of Resident A's problematic behaviors and her medication noncompliance. PA Dziadula said that Resident A's condition declined rapidly but it was a result of her Alzheimer's Disease and there was nothing staff could have done differently. PA Dziadula said that she was contacted when Resident A passed away and she was not told by staff or anyone else that Resident A had an indentation on her head. She said that according to her notes, Resident A did not have any cranial abnormalities or cranial depressions. PA Dziadula said that she did not have any concerns about Resident A's care while she resided at Monet House Inn. PA Dziadula said that she did not suspect that Resident A was being abused or neglected and although she was surprised to hear of her death, she did not find it unusual.

I left several voicemail messages for Relative A1 and Relative A2 requesting a call back. I also emailed Relative A1 and Relative A2 asking them to call me regarding this complaint. As of 11/09/22, neither has returned my calls.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
ANALYSIS:	**(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.**
	On 08/05/22, Resident A was found deceased on the floor in her bedroom. According to staff De'Zhaney Rice and former staff, Madison Nelson, there were no marks, bruises, or injuries on Resident A, there was no blood, and there was no evidence of any disturbance in her room.
	According to Resident A's Health Care Appraisal, Assessment Plan, and her physician's assistant, Kristen Dzidula, Resident A had early onset Alzheimer's Disease and her condition was rapidly deteriorating. According to Resident A's death certificate, she died of natural causes and her cause of death was Alzheimer's Disease. I conclude that there is insufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: I reviewed an Incident/Accident Report (IR) dated 08/05/22 at 9:30pm completed by staff, Madison Nelson regarding Resident A's death. Staff did not send me a copy of this report as required by AFC Licensing rules.

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1)(a) The death of a resident.

ANALYSIS:	I reviewed an Incident/Accident Report (IR) dated 08/05/22 at 9:30pm completed by staff, Madison Nelson regarding Resident A's death. Staff did not send me a copy of this report as required by AFC Licensing rules. I conclude that there is sufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/09/22, I conducted an exit conference with the licensee designee, Kimberly Gee. I told her the results of my investigation and explained which rule violation I am substantiating. I told Mrs. Gee that I need her to send me a corrective action plan upon the receipt of my investigation report.

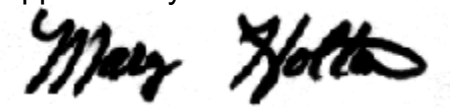
IV. RECOMMENDATION

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

November 15, 2022

Susan Hutchinson Licensing Consultant	Date

Approved By:



November 15, 2022

Mary E. Holton Area Manager	Date