GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 1, 2022

Nicole Swart
Clark Retirement Home
1551 Franklin Street, SE
Grand Rapids, MI 49506-8203

RE: License #: AH410236767
Investigation #: 2023A1021009
Clark Retirement Home

Dear Mrs. Swart:

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.

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,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410236767
Investigation #:	2023A1021009
Complaint Receipt Date:	11/01/2022
Investigation Initiation Date:	11/01/2022
Report Due Date:	01/01/2023
Licensee Name:	Clark Retirement Community Inc.
Licensee Address:	1551 Franklin SE Grand Rapids, MI 49506
Licensee Telephone #:	(616) 278-6543
Administrator/ Authorized Representative:	Nicole Swart
Name of Facility:	Clark Retirement Home
Facility Address:	1551 Franklin Street, SE Grand Rapids, MI 49506-8203
Facility Telephone #:	(616) 452-1568
Original Issuance Date:	12/25/1957
License Status:	REGULAR
Effective Date:	08/21/2022
Expiration Date:	08/20/2023
Capacity:	107
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A bed is not made.	No
Resident A does not receive showers.	Yes
Food does not meet nutritional standards.	No
Facility washing machine is broken.	No
Additional Findings	Yes

III. METHODOLOGY

11/01/2022	Special Investigation Intake 2023A1021009
11/01/2022	Special Investigation Initiated - Letter referral sent to centralized intake at APS
11/04/2022	Inspection Completed On-site
11/09/2022	Contact-Document Received Received Resident A's documents
11/18/2022	Contact- Telephone call made Interviewed kitchen manager Michelle Brooks
11/18/2022	Contact-Telephone call made Interviewed director Baylin Binnendyk
12/01/2022	Exit Conference Exit Conference Nicole Swart

ALLEGATION:

Resident A bed is not made.

INVESTIGATION:

On 11/1/22, the licensing department received a complaint with allegations Resident A's bed is not made.

On 11/4/22, I interviewed the administrator Nicole Swart at the facility. Ms. Swart reported the facility encourages resident independence. Ms. Swart reported Resident A attempts and prefers to make her own bed. Ms. Swart reported if the bed is not made by mid-morning, caregivers are to offer to make the bed if they have the time. Ms. Swart reported it is an added hospitality feature for the facility to make the resident's bed. Ms. Swart reported it is not a requirement for the bed to be made.

On 11/4/22, I interviewed Resident A at the facility. Resident A reported her room is tidied up daily and is deep cleaned once a month. Resident A reported she likes when her bed is made. Resident A reported she tries to make her own bed but does have a difficult time making the bed. Resident A reported sometimes caregivers will make her bed.

I observed Resident A's bed. The bed was not fully made as observed by the bed sheets were tucked into the bed, but the bed comforter was not pulled up.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	Interviews conducted revealed it is not a requirement of the facility to make the resident's bed, however, the facility will attempt to make the bed, if time allows.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A does not receive showers.

INVESTIGATION:

The complainant alleged Resident A does not receive showers.

Resident A reported she washes herself up daily. Resident A reported she is to receive a shower twice a week. Resident A reported one time she did not receive a shower as the caregiver came in and she was already washed and dressed for the day. Resident A reported she usually does receive showers.

Ms. Swart reported Resident A is to receive showers weekly. Ms. Swart reported caregivers have stand up meetings on first and second shifts to discuss the showers for the day. Ms. Swart reported Resident A receives her showers.

I reviewed shower schedule and shower sheets for Resident A. Resident A was to receive showers on Wednesday and Saturday. Review of the shower sheets revealed lack of documentation of showers from 9/3/22- 10/22/22.

Resident A's service plan read,
"Resident requires supervision while bathing."

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:	Staff could not demonstrate that Resident A received the required weekly bath.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Food does not meet nutritional standards.

INVESTIGATION:

The complainant alleged the food is disgusting.

Resident A reported she was almost done with breakfast, and it was a pancake, bacon, and coffee. Resident A reported the food is okay but that she does miss her own cooking. Resident A reported she receives three meals a day and the food is decent.

Ms. Swart reported the fourth floor has a satellite kitchen and dining room. Ms. Swart reported last week the air conditioning stopped working which caused disruptions in the refrigerator. Ms. Swart reported the kitchen staff made the executive decision that residents would have to go down to the main dining room on the first floor or get takeout food. Ms. Swart reported this decision was made without management approval. Ms. Swart reported now residents have the option of going to the main dining room, meals delivered to their room, or have meals eaten in the satellite

kitchen. Ms. Swart reported the facility held numerous meetings and had open communication with family and residents on the changes in meal service. Ms. Swart reported residents never went without food and the food was always served appropriately.

I viewed Resident A's room tray. The room tray had leftover bacon and pancake. The food appeared to be cooked well and appetizing.

On 11/18/22, I interviewed dinning manager Michelle Brooks by telephone. Ms. Brooks reported the satellite kitchen air conditioning unit broke which caused the ice machine and refrigerator to break. Ms. Brooks reported residents have the option to eat meals in their room, eat in the satellite dinning room, or go down to the main floor. Ms. Brooks reported the unit has set mealtimes, 8:00, 12:00, and 5:00pm. Ms. Brooks reported the food is transported in a warm box and immediately served to the residents. Ms. Brooks reported even with the disruption in meal service, residents were still provided all meals that were appropriate temperature and good quality. Ms. Brooks reported the kitchen has had numerous conversations with residents and family members with positive feedback.

I reviewed memo that was sent to family members and residents. The memo was dated 10/26/22 and read,

> *"Our Fourth Floor Assisted Living had an unprecedented change recently regarding dining services. Since then, Clark Leadership has been working diligently to ensure residents and families are pleased with their dining experience.*
>
> *We acknowledge and understand the importance of the Fourth Floor Dining Room being available for residents. Unfortunately, there is equipment in the satellite kitchen that is not functioning as it should, thus putting our staff in harm's way. New equipment has been ordered and will be replaced as quickly as possible. Once installation is complete, the Fourth Floor Dining Room will re-open for residents to enjoy. We estimate that may be up to 60 days.*
>
> *In the interim, residents can enjoy their meals in the Main Dining Room located on the first floor, in their own rooms, or they may congregate in the Fourth Floor Dining Room with their room trays. We highly encourage residents to dine in the Main Dining Room, as this will provide opportunities to build community and offer additional menu options. Those who still need to receive meals in their rooms will be free of charge during this time. Clark leadership will continue to provide updates to residents and families as equipment is installed and we resume traditional dining."*

APPLICABLE RULE	
R 325.1952	**Meals and special diets.**
	(1) A home shall offer 3 meals daily to be served to a resident at regular meal times. A home shall make snacks and beverages available to residents.
ANALYSIS:	There is lack of evidence to support the allegation the food does not meet nutritional standards.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Facility washing machine is broken.

INVESTIGATION:

The complainant alleged the resident washer is broken on the fourth floor and the facility has not fixed the washer.

Ms. Swart reported a ticket was placed on 10/18 for the washing machine to be fixed. Ms. Swart reported the washing machine is broken on the fourth floor but was to be fixed on 11/4. Ms. Swart reported residents have the option to do their own laundry or for the facility to do the laundry. Ms. Swart reported it is not an extra charge for the facility to do the laundry. Ms. Swart reported there is a washing machine on the third floor for residents to use. Ms. Swart reported there is a backlog on the part needed for the washing machine and that is why the washing machine has not been fixed sooner.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	The washing machine on the fourth floor has been out of service for an extended period due to a supply chain issue with the part. The facility has worked diligently to fix the washer and residents have been able to use other washers within the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Ms. Swart reported bedrails are not allowed at the facility. Ms. Swart reported Resident A's bed came in with bedrails from Care Linc and a work order has been put in with them to get these removed.

Review of Resident A's room revealed Resident A had a ½ bed rail attached to the right side of the bed. The bedrail was securely attached to the bed. The bed rail did not have a cover on the rail.

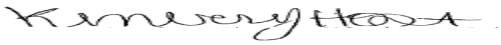
Review of Resident A's service plan revealed lack of information pertaining to the use of the bedrail.

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: R 325.1901	**Definitions**
	16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	The facility has a policy that bedrails are not allowed within the facility. However, Resident A had a ½ bedrail attached to her bed. The facility did not have an order for the bedrail in addition Resident A's service plan lacked information about the devices related to purpose of use, staff responsibility to ensure devices were safe, and ongoing maintenance schedules.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/1/22, I conducted an exit conference with authorized representative Nicole Swart by telephone.

IV. RECOMMENDATION

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



11/21/22

Kimberly Horst — Date
Licensing Staff

Approved By:

11/28/2022

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