GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 6, 2023

Vashu Patel
Hudson's Country Manor, Inc.
9842 Oakland Dr.
Portage, MI 49024

RE: License #: AL390292582
Investigation #: 2023A1024010
Hudson's Country Manor, Inc.

Dear Ms. Patel:

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 (616) 356-0183.

Sincerely,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems
427 East Alcott
Kalamazoo, MI 49001
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL390292582
Investigation #:	2023A1024010
Complaint Receipt Date:	12/12/2022
Investigation Initiation Date:	12/15/2022
Report Due Date:	02/10/2023
Licensee Name:	Hudson's Country Manor, Inc.
Licensee Address:	9842 Oakland Dr. Portage, MI 49024
Licensee Telephone #:	(269) 323-9752
Administrator:	Almetta Ch'loe Whitley
Licensee Designee:	Vashu Patel
Name of Facility:	Hudson's Country Manor, Inc.
Facility Address:	9842 Oakland Dr. Portage, MI 49024
Facility Telephone #:	(269) 323-9752
Original Issuance Date:	08/29/2008
License Status:	REGULAR
Effective Date:	12/01/2021
Expiration Date:	11/30/2023
Capacity:	20
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff members have not provided 1:1 staff supervision during mealtimes as required by Resident A's medical provider.	Yes

III. METHODOLOGY

12/12/2022	Special Investigation Intake 2023A1024010
12/15/2022	Special Investigation Initiated – Telephone with administrator Almetta Ch'loe Whitley
12/15/2022	Contact - Document Received-*Bronson Speech Therapy Report* for Resident A
12/15/2022	Contact - Telephone call made with Recipient Rights Officer (RRO) Lisa Smith
01/18/2023	Contact - Telephone call made with licensee designee Vashu Patel
01/29/2023	Contact - Document Received-*30-Day Discharge Notice*
01/30/2023	Inspection Completed On-site with direct care staff members Sophia Lawrence, Sierra Churchwell and Resident A
01/30/2023	Exit Conference with licensee designee Vashu Patel

ALLEGATION:

Direct care staff members have not provided 1:1 staff supervision during mealtimes as required by Resident A's medical provider.

INVESTIGATION:

On 12/12/2022, I received this complaint through the Bureau of Community and Health Systems (BCHS) online complaint system. According to this complaint, direct care staff members have not provided 1:1 staff supervision during mealtimes as required by Resident A's medical provider.

On 12/15/2022, I conducted an interview with administrator Almetta Ch'loe Whitely. Ms. Whitley stated Resident A has a medical condition that causes him to have issues with

swallowing therefore Resident A's doctor recommended Resident A has 1:1 staff supervision while he is eating to assist him with eating. Ms. Whitley stated Resident A coughs every time he drinks so requires someone to sit close to him to prompt him for safety. Ms. Whitley also stated Resident A requires a mechanical soft diet. Ms. Whitley stated this verbal instruction was received in October 2022 after Resident A was seen by a specialist however direct care staff members recently received the written physician order from Resident A's case manager about three weeks ago in November 2022. Ms. Whitley stated the home does not have enough direct care staff to provide 1:1 staff supervision while Resident A is eating however direct care staff have been monitoring Resident A while he eats while also monitoring the other seven residents in the home to ensure his safety.

On 12/15/2022, I reviewed Resident A's *Bronson Speech Therapy Report* (therapy report) dated 10/31/2022. According to this therapy report, Resident A is diagnosed with Dysphagia and was seen by a speech pathologist on 10/27/2022 for a video fluoroscopic swallow study. This therapy report stated Resident A requires a mechanical soft diet caution with dual consistencies due to risk for aspiration of the liquid portion of the food. This therapy report stated Resident A requires 1:1 staff supervision during mealtimes as Resident A requires cuing for safety and the preliminary results and recommendations were discussed with Resident A and direct care staff members who verbalized an understanding of the instructions.

On 12/15/2022, I conducted an interview with Recipient Rights Officer (RRO) Lisa Smith who stated Resident A has been required to have 1:1 staff supervision during mealtimes since October 2022 as instructed by a specialist who performed a swallow study. Ms. Smith stated direct care staff members have not been able to provide this supervision due to staffing issues.

On 1/18/2023, I conducted an interview with licensee designee Vashu Patel who stated direct care staff members monitor Resident A during his mealtimes while working with other residents however she is not able to provide the specific 1:1 staffing therefore she will be issuing a 30-Day discharge notice since Resident A's needs have changed, and direct care staff members are not able to accommodate his special needs at this time.

On 1/29/2023, I reviewed Resident A's *30-Day Discharge Notice* (notice) dated 1/23/2023. This notice stated due to the recent changes to Resident A's needs a 30-day notice is being issued as direct care staff can no longer able to provide the required care Resident A needs.

On 1/30/2023, I conducted an onsite investigation at the facility with direct care staff members Sophia Lawrence and Sierra Churchwell who both stated that although verbal instruction was provided regarding 1:1 staff supervision during mealtimes, direct care staff members did not receive the written physician's order for this instruction until a month later which was given to direct care staff members by Resident A's case manager. Ms. Lawrence and Ms. Churchwell also both stated direct care staff members have regularly monitored Resident A closely during his mealtimes, however, there have

been days Resident A has not been provided actual 1:1 staff supervision during mealtimes due to not being able to hire additional staffing to accommodate this supervision recommendation. Ms. Churchwell stated she transported Resident A to see a pathologist on 10/27/2022 and spoke to the specialist regarding Resident A's eating care needs which included Resident A having 1:1 staff supervision during mealtimes and a soft diet.

While at the facility, I also conducted an interviewed with Resident A who stated he sometimes has issues with eating mostly when he drinks liquids that cause him to choke. Resident A stated he does not require staff supervision when he eats, and he has never had staff assist him with eating nor has he seen staff observe him while he is eating.

I also reviewed the facility's *Staff Schedule* for months November 2022 and December 2022. According to this schedule, there have been days during the week with only one direct care staff member was scheduled to work since Resident A was verbally ordered to be provided with 1:1 direct care staff supervision during mealtimes on 10/27/2022.

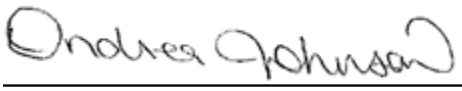
APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(b) Special diets.** **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**

ANALYSIS:	Based on my investigation which included interviews with licensee designee Vashu Patel, administrator Almetta Ch'loe Whitley, direct care staff members Sophia Lawrence and Sierra Churchwell, review of Resident A's therapy report, and the facility's staff schedule for November and December 2022, Resident A was not consistently provided with 1:1 direct care staff supervision during mealtimes as ordered by Resident A's *Bronson Speech Therapy Report.* Verbal instruction was provided to direct care staff members on 10/27/2022 that Resident A required 1:1 direct care staff supervision during mealtimes to assure his safety while eating given his difficulty with swallowing. Per my review of direct care staff schedules and interviews with direct care staff members and licensee designee/administrator Vashu Patel, there has not been enough direct care staff members working to provide this level of supervision since this verbal and/or written physician order was given. Resident A also stated he has never had direct care staff assist him with eating nor has he seen staff observe him while he is eating. Consequently, licensee designee Vashu Patel has not met the specific health care needs of Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 1/30/2023, I conducted an exit conference with licensee designee Vashu Patel. I informed Ms. Patel of my findings and allowed her an opportunity to ask questions and make comments.

IV. RECOMMENDATION

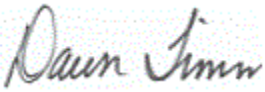
On 01/18/2023 a provisional license was recommended due to violations cited in Special Investigation Report #2023A1024006. On 1/26/2023, licensee designee Vashu Patel submitted an acceptable corrective plan and has enacted that corrective action plan. Consequently, upon receipt of an acceptable corrective action plan for this special investigation report, I recommend the current recommendation of a provisional license status remain unchanged.



02/02/2023

Ondrea Johnson — Date
Licensing Consultant

Approved By:



02/06/2023

Dawn N. Timm — Date
Area Manager