GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

Crystal Caldwell
Brightside Assisted Living LLC
2140 Robinson Road
Jackson, MI 49203

June 9, 2023

RE: License #: AH380381401
Investigation #: 2023A1022020
Brightside Assisted Living & Memory Care

Dear Crystal Caldwell:

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
(313) 296-5731

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH380381401
Investigation #:	2023A1022020
Complaint Receipt Date:	12/08/2022
Investigation Initiation Date:	12/08/2022
Report Due Date:	02/07/2023
Licensee Name:	Brightside Assisted Living LLC
Licensee Address:	2140 Robinson Road Jackson, MI 49203
Licensee Telephone #:	(517) 787-4150
Administrator:	Maegen Lowder
Authorized Representative:	Crystal Caldwell
Name of Facility:	Brightside Assisted Living & Memory Care
Facility Address:	2388 Robinson Road Jackson, MI 49203
Facility Telephone #:	(517) 787-4150
Original Issuance Date:	09/01/2017
License **Status:**	REGULAR
Effective Date:	03/01/2022
Expiration Date:	02/28/2023
Capacity:	38
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Residents who are incontinent are not getting proper care, resulting in the development of urinary tract infections (UTIs).	No
The facility is understaffed.	Yes
Medications are not being administered properly.	No
Resident medical needs are not being addressed.	No

III. METHODOLOGY

12/08/2022	Special Investigation Intake 2023A1022020
12/08/2022	Special Investigation Initiated - Letter Request for information sent to facility.
01/04/2023	Inspection Completed On-site
01/04/2023	APS Referral
06/09/2023	Exit Conference

ALLEGATION:

Residents who are incontinent are not getting proper care, resulting in the development of urinary tract infections (UTIs).

INVESTIGATION:

On 12/08/2022, the Bureau of Community and Health Systems received an anonymous referral from Adult Protective Services (APS). The APS investigation status was marked as “denied.” According to the referral, “Residents are not treated

properly. Multiple residents have UTIs… residents do not get changed for hours at a time, residents are double, briefed, staff are not taking care of dirty items after cleaning up urine or feces… Urine has been left on counters and tables in residents' rooms… resident [unnamed] urinates in cup because staff has taken their urinal and placed it across the room."

On 1/4/2023, at the time of the onsite visit, I asked the administrator about the complainant's allegations regarding incontinence care of residents. The administrator stated that practices such as "double briefing" (that is, placing two incontinence briefs on an individual to cut down on the amount of incontinence care needed) or not cleaning up after a resident has experience an episode of incontinence was "not appropriate" and not acceptable. The administrator stated that she was sure that if such an incident occurred in the facility, she would have heard about it.

When the administrator was asked about residents who had been treated for urinary tract infections (UTIs), the administrator identified Resident A and Resident B. Both residents had urinalyses completed after they displayed symptoms of the UTI. Resident A was treated with the antibiotic Ciprofloxacin for 5 days in December 2022 and Resident B also treated with Ciprofloxacin for 5 days in November 2022. Neither Resident A nor Resident B were present in the facility at the time of the visit.

During a tour of the facility, the administrator was asked to identify residents who were incontinent and not able to ask for toileting. The administrator identified Resident E and Resident H. During direct observation of toileting for both Resident E and Resident H demonstrated that both residents were wearing single briefs and neither resident was either wet with urine or soiled with feces. During this same facility tour, observations were made in approximately 10 resident apartments. There was no evidence to indicate that staff had neglected to clean after providing incontinence care to residents and no evidence of urinals sitting on counters.

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:	There was no evidence that residents were not receiving appropriate toileting and incontinence care.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility is understaffed.

INVESTIGATION:

According to the anonymous referral, “The facility does not have enough staff.”

At the time of the onsite visit, the administrator was asked to describe optimal staffing for the facility. The administrator stated that for the AM shift, the facility needed 4 caregivers plus a medication passer/supervisor, for the PM shift, 3 caregivers plus a medication passer/supervisor, but just 2 caregivers for the overnight shift with one of those caregivers assuming the shift supervisor responsibilities.

Review of staffing sheets for dates 11/27/2022 through 12/3/2022 revealed that on the weekend day shifts, that is Sunday, 11/27/2022 and Saturday, 12/3/2022, there were only 3 caregivers and the one medication passer/supervisor. According to the administrator, the facility intentionally did not schedule full optimal staffing on weekend days, but that “one shift supervisor and 3 working on the floor providing care… is short but adequate.”

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	The facility intentionally did not schedule full staffing for weekend day shifts.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Medications are not being administered properly.

INVESTIGATION:

According to the anonymous referral, “residents are not getting their medications… One resident has a broken leg and is in a lot of pain. The resident is supposed to get narcotics multiple times a day and they are only receiving narcotics once a day… Another resident has a fentanyl patch and kitchen staff are signing off on witnessing the patch being changed.”

At the time of the onsite visit, the administrator was asked to identify residents who were to receive narcotic medication for pain relief. The administrator identified Resident C, who was ordered a Fentanyl patch; Resident D, who was ordered tramadol for pain; and Resident E, who was also ordered tramadol for pain. The medication administration record (MAR) for each of these residents were reviewed.

The November 2022 MAR for Resident C indicated that he had been ordered a Fentanyl patch to be topically applied to his upper torso every 72 hours for pain. According to the MAR, the patch was consistently applied as the prescriber ordered. There were no Fentanyl exceptions recorded in the MAR.

Resident D was ordered Tramadol 50 mg tablet to be taken every 6 hours as needed for pain. According to the November 2022 MAR, no Tramadol was administered to Resident D, but she was administered acetaminophen 325 mg 2 tablets 3 times daily for mild pain. The acetaminophen was administered as ordered by the prescriber and there were no acetaminophen exceptions recorded.

Resident E was not prescribed a pain medication until 11/30/2022, when her prescriber ordered Tramadol 50 mg tablet to be taken once daily for pain. According to the MAR for December 2022, Resident E was administered the pain medication as ordered. There were no Tramadol exceptions recorded in the MAR.

When the administrator was asked if there had been any resident with a broken bone, especially in the time period of November or December 2022, the administrator identified Resident F, who had been prescribed the medication Norco. According to the administrator, the medication order for Resident F was to receive this medication 3 times daily from 10/13/2022 until 11/11/2022. At that point, the medication order was changed so that Resident F was to receive the medication only in the morning but could be administered another dose as needed once daily. On 11/14/2022, the medication was discontinued completely. Review of the November 2022 MAR for Resident F confirmed this.

When the administrator was asked about the facility’s expectation for the application and removal of a Fentanyl patch, the administrator stated the facility used a “proof of use” sheet for each residents receiving this medication. Both the application and removal were witnessed and signed-off by staff. The administrator acknowledged that for a period of time, the direct care supervisor had allowed a kitchen employee to be the witness for the removal of the patch. The administrator stated that the

direct care supervisor's rational was that the removal was scheduled at a time when was not another caregiver/medication technician easily available to be a witness. Once this practice was brought to the administrator's attention, she directed the staff to change the times of the application and removal such that there would be a member of the care staff to be the witness rather than relying on kitchen staff to perform this function.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	There was no evidence that medications were not being administered as ordered.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident medical needs are not being addressed.

INVESTIGATION:

According to the anonymous referral, "There was one resident who was having a stroke, and nothing was done for them."

According to the administrator, on 12/13/2022 Resident G's private caregiver came to her and told her that Resident G was having "stroke-like" symptoms. Resident G's medical provider, nurse practitioner (NP) #1, was already in the facility and scheduled to examine Resident G on that day, so the administrator informed NP #1 of the private caregiver's concerns. According to NP #1's physical examination notes for neurologic function, no new focal deficits were noted. NP #1 did not diagnose Resident G as "having a stroke." Resident G passed away on 12/27/2022.

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: **(c) Assure the availability of emergency medical care required by a resident.**

ANALYSIS:	There was no evidence that residents did not receive appropriate medical care when needed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

I reviewed the findings of this investigation with the administrator on 06/09/2023. When asked if there were any comments or concerns with the investigation, the administrator stated that there were none.

IV. RECOMMENDATION

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

06/09/2023

_____

Barbara Zabitz Date
Licensing Staff

Approved By:

05/30/2023

_____

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