GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 14, 2023

Steven Tyshka
Waltonwood at Carriage Park II
2000 Canton Center Rd
Canton, MI 48187

RE: License #: AH820336526
Waltonwood at Carriage Park II
2000 Canton Center Rd
Canton, MI 48187

Dear Steven Tyshka:

Attached is the Renewal Licensing Study Report for the facility referenced above. The violations cited in the report require the submission of a written corrective action plan. 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 dates 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 home for the aged authorized representative and a date.

Upon receipt of an acceptable corrective action plan, a regular license will be issued. If you fail to submit an acceptable corrective action plan, disciplinary action will result. 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 feel free to contact the local office at 877-458-2757.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
RENEWAL INSPECTION REPORT

I. IDENTIFYING INFORMATION

License#:	AH820336526
Licensee Name:	Waltonwood at Carriage Park II, L.L.C.
Licensee Address:	#200 7125 Orchard Lake Rd West Bloomfield, MI 48322
Licensee Telephone #:	(248) 865-1012
Authorized Representative:	Steven Tyshka
Administrator/Licensee Designee:	Angie Hanson
Name of Facility:	Waltonwood at Carriage Park II
Facility Address:	2000 Canton Center Rd Canton, MI 48187
Facility Telephone #:	(734) 844-3060
Original Issuance Date:	10/18/2012
Capacity:	61
Program Type:	AGED

II. METHODS OF INSPECTION

Date of On-site Inspection(s): 07/12/2023

Date of Bureau of Fire Services Inspection if applicable: 12/1/2022 C Rating

Inspection Type: ☐ Interview and Observation ☒ Worksheet ☐ Combination

Date of Exit Conference: 7/17/2023

No. of staff interviewed and/or observed 15
No. of residents interviewed and/or observed 20
No. of others interviewed One Role Resident's daughter

- Medication pass / simulated pass observed? Yes ☒ No ☐ If no, explain.

- Medication(s) and medication records(s) reviewed? Yes ☒ No ☐ If no, explain.
- Resident funds and associated documents reviewed for at least one resident? Yes ☐ No ☒ If no, explain. No resident funds held.
- Meal preparation / service observed? Yes ☒ No ☐ If no, explain.

- Fire drills reviewed? Yes ☐ No ☒ If no, explain.
  Bureau of Fire Services reviews fire drills. Disaster plan reviewed and staff interviewed regarding disaster plan.
- Water temperatures checked? Yes ☒ No ☐ If no, explain.

- Incident report follow-up? Yes ☐ IR date/s: N/A ☒
- Corrective action plan compliance verified? Yes ☒ CAP date/s and rule/s: CAP dated 8/6/2021 to Renewal LSR dated 7/22/2021: R 325.1922(5), R 325.1932(1), R 325.1979
- Number of excluded employees followed up? Two N/A ☐

III. DESCRIPTION OF FINDINGS & CONCLUSIONS

This facility was found to be in non-compliance with the following rules:

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.

Administrator Angie Hanson stated respite resident, Resident A, was residing in the assisted living with a bedside assistive device commonly referred to as “Halo Ring.”

Observations of Resident A’s apartment revealed there was a Halo Ring secured tightly to each side of the bed frame; however, they lacked covers.

Employee #1 stated Resident A did not have a physician order for the Halo Rings. Employee #1 stated the facility did not maintain the manufacturer guidelines for the halo rings. Employee #1 stated she checked Resident A’s Halo Rings weekly to ensure proper placement and her ability to used them appropriately; however the facility lacked staff training for the devices.

Review of Resident A’s service plan updated on 7/12/2023 read consistent with statements from Employee #1. Resident A’s service plan omitted or lacked sufficient information for specific use, care, and maintenance of the devices including a means for the resident to summon staff, methods for on-going monitoring of the resident, methods of monitoring the equipment by trained staff for maintenance of the device and for monitoring measurements of gaps per the manufacturing guidelines to protect the resident from the possibility of physical harm related to entrapment, entanglement, strangulation, etc.

Given the observations listed above and the lack of an organized plan the facility has not provided reasonable protective measures to ensure resident well-being and safety during the use of a bedside assistive device.

VIOLATION ESTABLISHED.

R 325.1932 Resident medications.

(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions,

orders and by the prescribing licensed health care professional.

Review of Resident A's medication administrator records (MARs) dated May and June 2023 revealed she was prescribed Acetaminophen 325 mg, take two tablets by mouth every four hours as needed for pain. Review of the reasons for medication administration read in part "wants before she has pt."

Review of Resident B's MARs dated May 2023 revealed she was prescribed Lorazepam 0.5 mg, take one tablet by mouth every six hours as needed for agitation/anxiety. Review of the reasons for medication administration read in part "keep [sp] trying to get up out [sp] her wheelchair" dated 5/13/2023, 5/18/2023, 5/26/2023 and 5/30/2023, as well as "fighting staff" dated 5/14/2023.

Review of Resident C's MARs dated May and June 2023 revealed he was prescribed Lorazepam 0.5 mg, take one tablet by mouth four times a day as needed for anxiety in which the reason for medication administration was "keep [sp] trying to get out wheelchair" dated 5/26/2023. The MARs read in part Hyoscyamine 0.125 mg tablet, take one tablet by mouth under tongue every four hours as needed was prescribed in which lacked a reason for administration.

Documentation of reasons for administration of as needed medications were not consistent with the prescribed licensed health care professional's order. Additionally, Resident C's MARs lacked a prescribed reason for administration or diagnosis for as needed Hyoscyamine.

VIOLATION ESTABLISHED.

R 325.1964 Interiors.

(9) Ventilation shall be provided throughout the facility in the following manner:

(a) A room shall be provided with a type and amount of ventilation that will control odors and contribute to the comfort of occupants.

(b) Bathing rooms, beauty shops, toilet rooms, soiled linen rooms, janitor closets, and trash holding rooms shall be provided with a minimum of 10 air changes per hour of continuously operated exhaust ventilation that provide discernable air flow into each of these rooms.

The second floor "Service Center" closet which maintained trash, soiled linens, and cleaning supplies lacked ventilation with adequate and discernable air flow.

The first-floor soiled linen room, beauty salon, the first-floor men and women's public restrooms, and the second-floor public restroom lacked adequate and discernable air flow.

VIOLATION ESTABLISHED.

R 325.1976 Kitchen and dietary.

(13) A multi-use utensil used in food storage, preparation, transport, or serving shall be thoroughly cleaned and sanitized after each use and shall be handled and stored in a manner which will protect it from contamination.

Inspection of the kitchen revealed utilization of a dishwasher in which the temperature was to be tested daily then recorded, however the April and May 2023 records were incomplete. For example, the dishwater temperature test strip log was left blank on the following dates: 4/21/2023 through 4/30/2023, and 5/19/2023 through 5/31/2023. Inspection of the kitchen also revealed chemical sanitization was utilized and tested daily then recorded to demonstrate the task was completed, however the April 2023 records were incomplete. For example, the three-compartment sink test strip log was left blank on the following dates: 4/24/2023 through 4/30/2023. Thus, it could not be confirmed if proper and adequate sanitization of dishware was completed.

VIOLATION ESTABLISHED.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, renewal of the license is recommended.

7/17/2023

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Date

Licensing Consultant