GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 25, 2023

Dawn Foulke
Clinton Creek, Inc.
4438 Ramsgate Lane
Bloomfield Hills, MI 48302

RE: License #: AH500387884
Investigation #: 2023A1027057
Clinton Creek Assisted Living & Memory Care

Dear Ms. Foulke:

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) 241-1970.

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
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AH500387884
Investigation #:	2023A1027057
Complaint Receipt Date:	03/27/2023
Investigation Initiation Date:	04/04/2023
Report Due Date:	05/26/2023
Licensee Name:	Clinton Creek, Inc.
Licensee Address:	4438 Ramsgate Lane Bloomfield Hills, MI 48302
Licensee Telephone #:	(248) 701-5043
Administrator:	Geralyn Cummings
Authorized Representative:	Dawn Foulke
Name of Facility:	Clinton Creek Assisted Living & Memory Care
Facility Address:	40500 Garfield Road Clinton Township, MI 48038
Facility Telephone #:	(586) 354-2700
Original Issuance Date:	07/18/2019
License Status:	REGULAR
Effective Date:	01/18/2023
Expiration Date:	01/17/2024
Capacity:	62
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A lacked care.	Yes
Additional Findings	No

III. METHODOLOGY

03/27/2023	Special Investigation Intake 2023A1027057
04/04/2023	Special Investigation Initiated - Letter Email sent to APS worker informing her the allegations were assigned for investigation by the Department
04/05/2023	Contact - Document Received Email received from APS worker with additional information
04/17/2023	Inspection Completed On-site
04/20/2023	Contact - Document Received Emails received from Ms. Cummings with documentation requested at on-site inspection
04/25/2023	Contact - Document Sent Email sent to Ms. Cummings requesting Resident A's MARs
04/25/2023	Contact - Document Received Email received from Ms. Cummings with requested documentation
04/25/2023	Inspection Completed-BCAL Sub. Compliance
04/27/2023	Exit Conference Conducted by telephone with authorized representative Ms. Foulke, then by email with Ms. Foulke and Ms. Cummings

ALLEGATION:

Resident A lacked care.

INVESTIGATION:

On 3/27/2023, the Department received allegations forwarded from Adult Protective Services (APS) which read Resident A admitted to the memory care at the facility in November 2022. The allegations read Resident A had a history of stage 5 kidney disease, hypothyroidism, and dementia. The allegations read Resident A ambulated with a walker but required a wheelchair due to a “UTI” [urinary tract infection]. The allegations read Resident A was left in soiled briefs for 14-19 hours and had four UTIs since admission. The allegations read Resident A did not receive her medications timely. The allegations read Resident A received hospice services.

On 4/17/2023, I conducted an on-site inspection at the facility. I interviewed administrator Geralyn Cummings who stated Resident A had moved out of the facility last week. Ms. Cummings stated APS had investigated Resident A’s care at the facility. Ms. Cummings stated although staff followed Resident A’s service plan, Resident A’s daughter frequently changed care instructions for her mother which was difficult to manage. Ms. Cummins sated Resident A’s daughter wrote notes for staff in Resident A’s apartment and on her door, as well as maintained a camera in her apartment.

While on-site, I interviewed Employee #1 who stated medications could be passed one hour before or after the administration time. Employee #1 stated Resident A’s daughter requested she be allowed to sleep in the morning and to not wake her for medication administration; however, there would be times she would monitor Resident A’s camera and call the facility when she had not received her medications. Employee #1 stated Resident A’s daughter provided guidance for Resident A’s care, however it sometimes was contradictory such as with medication administration. Employee #1 stated Resident A usually only ate lunch and dinner due to her sleep schedule, in which she was offered room temperature water, per her preference, and snacks. Employee #1 stated Resident A had a good appetite at times, and other times, did not in which Resident A’s daughter informed staff was normal. Employee #1 stated Resident A had declined since admission to the facility in which she was initially continent of bowel and bladder, then became incontinent requiring briefs. Employee #1 stated Resident A had wandered and sometimes would go into other residents’ apartments, however she utilized a wheelchair more often since transitioning to hospice services.

While on-site, I interviewed Employee #2 whose statements were consistent with previous staff interviews. Employee #2 stated memory care residents were often gathered in common spaces between meals, however every memory care resident received two-hour checks.

While on-site, I interviewed Employee #3 whose statements were consistent with previous staff interviews. Employee #3 stated Resident A’s daughter would talk through the camera in her apartment to staff and Resident A. Employee #3 stated the camera caused increased confusion for Resident A because she would look for

her daughter. Employee #3 stated Resident A's briefs were numbered by her daughter in which sometimes staff did not apply briefs in chronological order.

While on-site, I interviewed Employee #4 who statements were consistent with previous staff interviews. Employee #4 stated Resident A's briefs were not always changed in her apartment nor applied in chronological order. Employee #4 stated there were three public restrooms in which contained extra supplies such as briefs. Employee #4 stated sometimes staff would take Resident A into a public restroom because it was closer for her and utilized the extra supply of briefs. Employee #4 stated Resident A did not have skin breakdown on her bottom area.

I reviewed Resident A's face sheet which read she admitted to the facility on 11/3/2022. The face sheet read Relative A1 was her durable power of attorney for finances and health care.

I reviewed Resident A's service plan dated 11/14/2022 which read in part she was orientated to person and her age. The plan read in part her wake up time was 10:00 AM, her sleep time was 9:00 PM and her rest schedule was afternoon. The plan read in part Resident A was independent with mobility, transfers, grooming with reminders, dressing with cueing, and toileting with occasional incontinence. The plan read in part Resident A required cueing and one person assist with bathing. I reviewed Resident A's service plan updated on 1/15/2023 and signed by Relative A1 on 2/29/2023 which read she received Accent Care Hospice services. The plan read in part she was alert, forgetful, confused, combative, resisted care and was orientated to person only. The plan read in part her wake up time, sleep time and rest scheduled varied. The plan read in part to encourage Resident A's water intake while awake. The plan read in part she was one person assist for mobility, transfers, grooming, and dressing. The plan read in part she was two-person assist for toileting and was incontinent of bowel and bladder. The plan read in part she one person assist for bathing on Tuesdays and Fridays. The plan read in part special instructions for morning care were to let her sleep in. The plan read in part to check her briefs during the night. The plan read in part staff were to administer her medications whole.

I reviewed Resident A's licensed healthcare professional orders. Order dated 12/11/2022 read to obtain a "UA & CS" [urine analysis and culture sensitivity] to rule out UTI dysuria. Order dated 1/16/2023 read to obtain UA & CS to rule out UTI. Order dated 1/18/2023 read Keflex 500 mg, 1 capsule by mouth twice daily for seven days for bladder infection. Order dated 1/25/2023 read in part for Resident A to admit to Accent Care hospice for diagnosis: late effect cerebrovascular disease, comfort measures only, fall safety precautions, and regular diet as tolerated or desired.

I reviewed Resident A's hospital discharge summary dated 1/20/2023 to 1/25/2023 which read in part her diagnosis was a urinary tract infection.

I reviewed Resident A's medication administration records (MARs) dated December 2022 through April 2023. The December 2022 MARs read one or more medications were left blank following dates on: 12/25/2022 and 12/28/2022. The January 2023 MARs read one or more medications were left blank following dates on: 1/20/2023 and 1/22/2023. The February 2023 MARs read one or more medications were left blank following dates on: 2/2/2023, 2/7/2023, 2/10/2023, 2/14/2023, 2/26/2023, and 2/27/2023. The March 2023 MARs read one or more medications were left blank following dates on: 3/3/2023 and 3/25/2023. The April 2023 MARs read one or more medications were left blank following dates on: 4/3/2023.

I reviewed Resident A's January, February, March and through April 16, 2023 ADL [Activities of Daily] logs in which staff initialed tasks were completed. The January 2023 logs read Resident A required stand by assistance at bedtime, morning assistance, standby bathing assistance, one person assistance for grooming, oral care twice daily in which she required setup and reminders and rounds every two hours. The February 2023 log read consistent with the January 2023 log, however standby bathing assistance was discontinued and full bathing assistance including washing hair was implemented on 2/21/2023, as well as incontinence checks every two hours. The March and April 2023 logs read Resident A required incontinence checks every two hours, oral care twice daily, and round every two hours. The January through April 16, 2023, logs were left blank on various dates/times for each task.

I reviewed Resident A's chart notes dated 11/14/2022 to 4/12/2023 which read consistent with the licensed healthcare professional orders. Note dated 11/18/2022 completed by the nurse practitioner read in part Resident A's family requested she provide medical care while at the facility and labs were ordered. Note dated 2/28/2023 and completed by hospice agency staff read in part Resident A was doing much better after starting medication Cipro for the suspected UTI. Note dated 3/6/2023 completed by hospice agency staff read in part Resident A's daughter requested Cipro be extended for three days as staff had held the medication a couple of days. The note read in part, the hospice agency staff reviewed medication administration with staff and the need to be complaint with medications especially antibiotics. Note dated 3/25/2023 read and completed by the nurse practitioner read in part Resident A's daughter felt she had a UTI, so an order for medication Cipro was called to the pharmacy. Note dated 4/4/2023 from hospice agency staff read in part Resident A sometimes missed breakfast due to daughter request to let her mother sleep in.

I reviewed Accent Care's hospice plan of care update report dated 3/15/2023 which read in part Resident A was ambulating with a four wheeled walker and one-person standby assistance in which she was now chairbound with two-person assist, dependent for activities of daily living and incontinent of bowl and bladder. The report read Resident A had multiple falls prior to her start of care. The report read her most recent hospitalization was for a diagnosis of urosepsis and treatment with

intravenous antibiotics. The report read on 2/25/2023 there was a suspected UTI in which she was treated with “Cipro” for seven days.

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.
For Reference: R 325.1901	**Definitions.**
	(t) "Service plan" means a written statement prepared by the home in cooperation with a resident, the resident's authorized representative, or the agency responsible for a resident's placement, if any, that identifies the specific care and maintenance, services, and resident activities appropriate for the individual resident's physical, social, and behavioral needs and well-being, and the methods of providing the care and services while taking into account the preferences and competency of the resident.
For Reference: R 325.1932	**Resident’s 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.

ANALYSIS:	Review of Resident A's medical records revealed she had declined since admission to the facility in which she required more staff assistance with her activities of daily living as well as hospice services. Review of Resident A's service plan revealed it was updated to reflect her need of increased staff assistance in which staff were responsible for changing her briefs and medications administration. Review of Resident A's hospice records read consistent with her service plan. Review of Resident A's medication administration records revealed, although medications were documented as administered within the timeframe permitted, there were several dates that were left blank in which it could not be determined if the medications were administered or not. Additionally, review of the ADL logs revealed several dates for each task that were left blank, thus it could not be determined if the task was completed or not. Although Resident A's UTIs could not be correlated with lack of brief changes given her medical history and lack of skin breakdown, review of documentation revealed it could not be determined if care and medications were always provided consistent with her service plan. Based on this information, this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

04/26/2023

Jessica Rogers Date
Licensing Staff

Approved By:

04/26/2023

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