GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 21, 2023

Emily Foster
Sunset Manor
725 Baldwin Street
Jenison, MI 49428-7945

RE: License #: AH700236908
Investigation #: 2023A1028059
Sunset Manor

Dear Emily Foster:

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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AH700236908
Investigation #:	2023A1028059
Complaint Receipt Date:	06/13/2023
Investigation Initiation Date:	06/14/2023
Report Due Date:	08/13/2023
Licensee Name:	Sunset Manor Inc.
Licensee Address:	725 Baldwin St. Jenison, MI 49428
License Telephone #:	(616) 457-2770
Authorized Representative/Administrator:	Emily Foster
Name of Facility:	Sunset Manor
Facility Address:	725 Baldwin Street Jenison, MI 49428-7945
Facility Telephone #:	(616) 457-2770
Original Issuance Date:	12/01/1999
License Status:	REGULAR
Effective Date:	09/19/2022
Expiration Date:	09/18/2023
Capacity:	188
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A's laundry is not washed in a timely manner resulting in Resident A having to wear clothing that was inappropriate for the climate.	Yes
Resident A's laundry is not washed in a timely manner.	No
Additional Findings	Yes

III. METHODOLOGY

06/13/2023	Special Investigation Intake 2023A1028059
06/14/2023	Special Investigation Initiated - Letter
06/14/2023	APS Referral APS referral made to Centralized Intake.
06/15/2023	Contact - Face to Face Interviewed Admin/Emily Foster at the facility.
06/15/2023	Contact - Face to Face Interviewed Employee A at the facility.
06/15/2023	Contact - Face to Face Interviewed Employee B at the facility.
06/15/2023	Contact - Face to Face Interviewed Employee C at the facility.
06/15/2023	Contact - Face to Face Interviewed hospice staff at the facility.
06/15/2023	Contact - Document Received Received Resident A's record from Admin/Emily Foster.
06/15/2023	Inspection Completed On-site Inspection completed onsite due to investigation.

ALLEGATION:

The facility did not provide care consistent in accordance with Resident A's needs or the service plan.

INVESTIGATION:

On 6/13/2023, the Bureau received the allegations from the online complaint system.

On 6/14/12023, a referral was made to Adult Protective Services (APS) through Centralized Intake.

On 6/15/2023, I interviewed the facility administrator, Emily Foster at the facility who reported Resident A has a diagnosis of Parkinson's disease and has declined significantly since May 2023. Resident A resided in independent living but due to recent decline, was first moved to a respite room and then assisted living on 5/9/2023. Resident A is currently receiving hospice services and is nearing the end-of-life stage. Ms. Foster reported no knowledge Resident A had difficulty using the provided call pendant. Resident A's family provided a large call light button due to Resident A's inability to use the call light pendant because of the advanced Parkinson's disease. Ms. Foster reported due to Resident A's functional decline, Resident A was to receive assistance with feeding and reported no knowledge of staff not following this care instruction in Resident A's service plan. Resident A also has pressure sores on the back and buttocks that are monitored and treated by hospice staff. Ms. Foster reported no knowledge of Resident A not receiving pressure relieving assistance from staff to aid in the healing of the pressure sores. Ms. Foster reported there have been no complaints from Resident A, Resident A's family, or staff concerning Resident A's care. Ms. Foster provided me Resident A's record for my review.

On 6/15/2023, I interviewed Employee A at the facility who reported Resident A could not use the call pendant consistently when first admitted to assisted living, so a large call button was provided by the family to use. Employee A reported no knowledge of it not working appropriately. Resident A would use the call button intermittently but is no longer able to use it due to recent significant decline. Employee A reported Resident A did fall twice after moving to assisted living due to getting up on [their] own and not calling staff or waiting for staff assistance. Resident A did not incur any injury from the falls. Employee A reported knowledge that Resident A requires assistance during feeding and with opening food containers. Employee A reported [they] were mindful of opening food containers for Resident A and providing set-up due to Resident A's Parkinson's diagnosis, but not all staff follow the service plan and need reminders to provide set-up for Resident A. Employee A also reported knowledge Resident A requires pressure relieving techniques due to pressure sores on back and buttocks; and that staff are supposed to assist with this, but "there have been times, I think it did not happen on the later

shifts because [Resident A]'s sores were more red at the end of the shift than the beginning".

On 6/15/2023, I interviewed Employee B at the facility who reported knowledge that Resident A had difficulty using the large call pendant, so a call button was provided instead, but Resident A no longer uses the large call button due to decline. Employee B reported Resident A's family will assist in feeding sometimes but was unsure about the service plan instruction for feeding assistance for Resident A when questioned. Employee B had no knowledge of Resident A's falls, but reported knowledge Resident A has pressure sores on the back and buttocks. However, Employee B was unable to report knowledge of pressure relieving techniques when questioned.

On 6/15/2023, I interviewed Employee C at the facility who reported no knowledge of staff not following Resident A's service plan concerning assistance with feeding, opening of containers, or with providing pressure relieving techniques. Employee C reported no knowledge of any complaints concerning the care of Resident A or staff not following the service plan.

On 6/15/2023, I interviewed hospice staff who confirmed Resident A was entering end of life stage and was being provided comfort care. Hospice staff reported observing Resident A with caked baby powder on the front and back private areas which was "indication that [Resident A] is not cleaned thoroughly when changed or turned in bed". Hospice staff also expressed concern about the condition of Resident A's clothing and pressure sore on back. Hospice staff reported the pressure sore on the buttocks is healing but it was caked with baby powder as well.

On 6/15/2023, I completed an on-site investigation and observed Resident A in [their] room with a baby powder caked on the skin between the legs, on and around the pressure sore on the buttocks, and on and in between the buttocks. Resident A's shirt was also observed to be soiled from the pressure sores present on the back.

On 6/15/2023, I reviewed Resident A's service plan which revealed the following:

- Resident is alert and oriented x 2.
- Resident A *is a two-person assist*.
- Resident A *has a foley catheter that is to be emptied every shift and pm.*
- Resident A *is total assist with bathing, Hospice.*
- Resident A is total assist with upper and lower body dressing.
- Resident A requires assistance with brushing lower and upper dentures.
- Resident A requires assistance with feeding each meal.

I reviewed the record notes which revealed the following:

- On 5/22/2023, Resident A was noted with a reddened area to coccyx with scab. PCP notified and order requested.
- On 5/28/2023, Resident A was found on the floor. No pain reported and Resident A was alert. Spouse notified.

- On 5/30/2023, Resident A fell attempting to self-toilet. Pain level was observed to be a 3 due in the knee area. PCP and Resident A's authorized representative notified.
- On 6/2/2023, Resident A's family met with hospice for assessment.
- On 6/5/2023, wound care orders were sent to address Resident A's pressure sore to the right buttock and wound to right knee from fall. Dermatology to assess head lesion and as orders as necessary.
- On 6/6/2023, Resident A's family requested a different hospice company and assessment was completed.
- On 6/7/2023, hospice staff completed visit and noted decline in Resident A's appetite and alertness. Facility to monitor and call physician with any change in condition.
- On 6/8/2023, hospice staff completed visit and noted no concerns. Facility staff and family were educated on non-verbal pain indicators. Hospice plan of care review and updated.
- On 6/9/2023, hospice staff visited and noted Resident A was *pre-actively dying.* Hospice conferenced with facility staff and Resident A's family concerning plan of care and Resident A's uncontrolled pain levels despite pain medication. Hospice sent order for thickened liquids and staff to offer mouth swabs if difficulty swallowing.
- On 6/11/2023, facility staff called hospice due to change catheter placement and output. Resident A demonstrating poor appetite. Resident A to be repositioned every 2 hours.
- On 6/12/2023, hospice conferenced with Resident A's family and facility staff to discuss Resident A's transition and comfort care.
- On 6/13/2023, Resident A was noted to be in pain with hospice reviewing plan of care with family and facility staff.
- On 6/14/2023, hospice reviewed plan of care with family and facility staff to prepare for end-of-life stage. Hospice repositioned Resident A to assist with shaving.
- Evidence of hospice providing family and facility staff education throughout Resident A's end of life care.

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:	It was alleged facility staff were not following Resident A's service plan. Interviews, on-site investigation, and review of documentation reveal the facility consistently communicated with Resident A's physician, hospice staff, and Resident A's authorized representative and family concerning Resident A's care. However, interviews and on-site investigation also revealed an inconsistency in facility staff knowledge and understanding of Resident A's service plan to include feeding set-up and repositioning due to pressure sore on back and buttock. Resident A was also observed with baby powder caked onto the body indicating facility staff did not appropriately assist Resident A in maintaining a clean body. Resident A was also observed wearing a heavily soiled shirt during the on-site investigation. The facility did not provide Resident A care consistent with personal needs or care in accordance with the service plan. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A's laundry is not washed in a timely manner resulting in Resident A having to wear clothing that was inappropriate for the climate.

INVESTIGATION:

On 6/15/2023, Ms. Foster reported no knowledge of issues with Resident A's laundry not being completed and returned in a timely manner.

On 6/15/2023, Employee A reported Resident A came to assisted living with a lot of dirty laundry that required washing. Employee A reported Resident A's initial load of laundry was washed the Monday they were admitted to assisted living and then the laundry was placed on a laundry schedule afterwards. Employee A reported no knowledge of Resident A wearing winter clothes due to laundry not being completed in timely manner. Employee A reported Resident A's laundry is completed every Wednesday.

On 6/15/2023, Employee B reported no knowledge of Resident A's laundry not being completed in a timely manner or Resident A's having to wear winter clothes because laundry was not completed in time. Employee B reported Resident A's laundry is washed every Wednesday and to [their] knowledge, there have been no issues with

it. Employee B reported no knowledge of any complaints concerning Resident A's laundry.
On 6/15/2023, Employee C's statements were consistent with Ms. Foster's statements and Employee B's statements.

On 6/15/2023, I completed an on-site inspection of Resident A's room and noted clean laundry ready and available. Soiled laundry was observed in the appropriate receptacle.

APPLICABLE RULE	
R 325.1935	**Bedding, linens, and clothing.**
	(3) The home shall make adequate provision for the laundering of a resident's personal laundry.
ANALYSIS:	It was alleged Resident A's laundry was not being completed in a timely manner. Interviews and on-site investigation reveal there is no evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

Additional Findings:

On 6/15/2023, I completed an inspection of the facility due to this special investigation and observed an unlocked medication cart with loose medication in an administration container sitting on top of the cart. The resident's private medication administration information and medical record was also displayed on the medication cart computer screen as well. Staff responsible for the medication cart were observed conversing inside of an office nearby with backs turned to the cart.

INVESTIGATION:

APPLICABLE RULE	
R 325.1932	**Resident Medications**
	(5) A home shall take reasonable precautions to ensure or assure that prescription medication is not used by a person other than the resident for whom the medication is prescribed.

ANALYSIS:	A medication cart was observed unlocked with loose medication in an administration cup sitting on top of the medication cart. Staff responsible for the medication cart were in a nearby office with their backs to the medication cart. The medication was easily accessible to anyone in the facility. The resident's private medical information was also displayed on the medication cart computer monitor for anyone to view in the facility as well.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, I recommend the status of this license remains the same.

Julie Viviano

6/29/2023

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Julie Viviano Date
Licensing Staff

Approved By:

Andrea L. Moore

08/21/2023

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