GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 29, 2023

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

RE: License #: AH500387884
Investigation #: 2023A0585061
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 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 (517) 284-9730.

Sincerely,

Brender L. Howard

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street, P.O. Box 30664
Lansing, MI 48909
(313) 268-1788
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500387884
Investigation #:	2023A0585061
Complaint Receipt Date:	05/18/2023
Investigation Initiation Date:	05/19/2023
Report Due Date:	07/17/2023
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:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Call lights are not answered timely. Staff are forced to take care of COVID residents with no PPE.	Yes
Resident D had a fall which resulted in a fracture and the POA was not notified.	No
Residents are not getting their medication.	No
Residents are not getting regular showers.	No
Bed covers are not changed regularly.	No
Residents' rooms are not being cleaned.	No
Additional Findings	No

III. METHODOLOGY

05/18/2023	Special Investigation Intake 2023A0585061
05/19/2023	Special Investigation Initiated - Letter Emailed allegations to Adult Protective Services (APS).
05/19/2023	Inspection Completed On-site Completed with observation, interview and record review.

ALLEGATION:

Call lights are not answered timely. Staff are forced to take care of COVID residents with no PPE.

INVESTIGATION:

On 5/17/2023, the department received the allegations via the BCHS Online Complaint website. The complaint alleged that residents are being neglected and staff does not answer call lights. The complaint alleged that the caregivers are

forced by management to take care of covid patients with no PPE equipment and much of the staff is sick because they keep spreading it to the residents. These allegations were sent anonymous, therefore additional information could not be obtained.

On 5/19/2023, a referral was made to Adult Protective Services.

On 5/19/2023, an onsite was completed at the facility. I interviewed administrator Geralyn Cummings at the facility. Ms. Cummings stated that the expected response time to call light was within ten minutes. She said that sometimes it takes longer depends on situations. She said that they were hiring extra staff. She explained that there are three shifts, and each shift staff overlap of a half hour: 7:00 a.m. – 3:30 p.m., 3:00 p.m. – 11:30 p.m., 11:00 p.m. – 7:30 a.m. Ms. Cummings said that medication technician also assists with personal care when they are not administering medication. Ms. Cummings stated that the facility has lots of PPE for the staff. She stated that a sign was put on the door alerting visitors to COVID present. She stated that no one at the facility at the time is positive for COVID.

During the onsite, I interviewed Employee #1. Employee #1 stated when she is not administering medication, she assists with caring for the residents. She stated that call lights are answered as soon as possible because sometimes staff is assisting another resident. Employee #1's statement was consistent with Ms. Cummings regarding COVID.

During the onsite, I interviewed Employee #2. Employee #2 stated that call lights are answered. She stated that sometimes it might take a little longer because they may be in another resident's room. Her statement was consistent with Ms. Cummings regarding staffing. Employee #1's statement was consistent with Ms. Cummings and Employee #1 regarding COVID.

During the onsite, I interviewed Relative A1 at the facility. Relative A1 stated that they are at the facility around the clock. Relative A1 stated that staff are supposed to roll Resident A over every two hours. She stated that day before yesterday (5/17/23), Resident A was fidgety, and she put the call light on at 5:00 and it was 5:45 before anyone came to see what the problem was.

During the onsite, I interviewed Resident A, Resident B at the facility. They all said that everything was good and call lights are answered by staff and they don't have any issues.

During the onsite, I interviewed Resident C at the facility. Resident C stated that staffing is a big problem because she sat on the toilet, and no one came. She said that staff left her on the toilet, and she yelled and pounded on the wall.

During the onsite, I observed PPE available throughout the building.

Resident A call light pendant audit shows the following:

Date	Time	Elapsed Time
5/1/2023	9:37:03 AM	34:49
5/1/2023	6:59:35 PM	39:09
5/1/2023	8:08:16 PM	1:15:41
5/2/2023	4:28:35 PM	50:16
5/2/2023	7:22:06 PM	36:58
5/2/2023	9:45:59 PM	48:14
5/3/2023	2:37:41 PM	52:04
5/3/2023	6:37:48 PM	1:04:48
5/3/2023	9:25:50 PM	52:50
5/4/2023	3:13:01 PM	54:22
5/6/2023	2:04:45 AM	1:27:40
5/7/2023	11:40:25 AM	30:03
5/7/2023	2:55:14 PM	41:21
5/9/2023	8:12:04 PM	36:47
5/10/2023	8:43:19 AM	38:15
5/11/2023	7:37:23 PM	59.37
5/12/2023	9:02:39 AM	47:24
5/13/2023	7:33:34 PM	1:07:08
5/17/2023	8:33:02 AM	39:48
5/18/2023	8:12:24 PM	1:05:11

Resident B call light pendant audit shows the following:

Date	Time	Elapsed Time
5/1/2023	8:01:50 PM	1:12:58
5/2/2023	6:16:22 PM	42:55
5/2/2023	9:40:12 PM	34:44
5/3/2023	5:24:16 PM	33:24
5/3/2023	1:37:24 PM	48:42
5/03/2023	2:41:08 PM	59:06
5/3/2023	6:43:10 PM	1:49:24
5/4/2023	7:02:36 AM	38:15
5/4/2023	8:06:17 AM	36:40
5/4/2023	2:14:21 PM	58:12
5/4/2023	10:44:03 PM	39:55
5/6/2023	2:11:02 AM	1:06:02
5/6/2023	7:05:34 AM	1:15:11
5/7/2023	8:44:44 AM	1:52:56
5/8/2023	2:09:23 AM	1:40:40

5/9/2023	4:39:10 PM	35:29
5/12/2023	7:12:12 AM	56:34
5/12/2023	7:26:41 PM	46:08
5/12/2023	9:24:08 PM	1:22:17
5/13/2023	3:45:37 AM	43:35
5/13/2023	4:52:29 PM	57:42
5/14/2023	9:03:21 AM	44:17
5/15/2023	1:35:13 AM	39:32
5/15/2023	2:28:47 AM	54:09
5/16/2023	12:47:33 PM	56:38
5/17/2023	7:57:42 AM	1:15:08

Resident C call light pendant audit shows the following:

Date	Time	Elapsed Time
5/1/2023	1:05:24 PM	1:10:40
5/1/2023	5:21:52 PM	31:48
5/1/2023	9:20:33 PM	2:02:54
5/2/2023	2:48:56 PM	40:01
5/4/2023	12:17:10 PM	34:31
5/4/2023	4:04:15 PM	48:33
5/4/2023	8:54:45 PM	50:45
5/6/2023	2:30:04 AM	1:08:15
5/6/2023	7:26:39 AM	39:30
5/7/2023	9:10:28 AM	1:23:51
5/8/2023	1:08:09 PM	42:08
5/9/2023	7:29:46 AM	52:43
5/9/2023	8:44:21 AM	50:03
5/10/2023	3:18:30 PM	37:32
5/11/2023	7:27:17 AM	57:17
5/11/2023	1:20:19 PM	33:05
5/12/2023	8:25:01 AM	1:14:33
5/12/2023	9:13:49 PM	1:08:50
5/13/2023	5:14:03 PM	40:33
5/14/2023	12:50:36 AM	46:33
5/14/2023	3:17:56 AM	37:17
5/14/2023	12:22:55 PM	36:07
5/14/2023	1:43:35 PM	41:51
5/14/2023	7:48:39 PM	39:28
5/15/2023	12:37:56 PM	43:49
5/17/2023	7:46:47 AM	1:26:03
5/17/2023	5:51:39 PM	2:07:49

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: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	The complaint alleged that staff are not answering call lights and staff does not have PPE to use when the residents have COVID. During the onsite, I observed PPE available for the staff. The call light audit revealed that staff did not always response to the call light. There was time where the call light pendant response time was over two hours. Therefore, the claim of this claim of not answering call lights was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident D had a fall which resulted in a fracture and the POA was not notified.

INVESTIGATION:

On 5/22/2023, additional allegations were received from Adult Protective Services (APS). The complaint alleged that Resident D had a fall which resulted in a femur fracture and Resident D's POA was not notified. The complaint alleged that POA does not have any paperwork from the facility regarding the fall.

Ms. Cummings stated that they noticed that Resident D's leg was bruised up. She explained that they didn't know how it happened. She stated that Resident D was never found on the floor but when the staff noticed that her knee was swollen, they had her knee X-rayed. She stated that they do not have any incident report of a fall for Resident D. She explained that she went through all the chart notes and no fall was charted. She stated that resident's POA are contacted whenever there is an incident.

Employee #1 and Employee #2 said that they did not know anything about a fall.

R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	There is no evidence that suggest Resident D had a fall. Staff interviewed did not know anything about a fall. Documentation does not show a fall or any injuries. Therefore, this claim could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents are not getting their medication.

INVESTIGATION:

Ms. Cummings state that all medications are given to the residents and any refusals are documented, doctors and POA is notified. Ms. Cummings explained that the procedure for resident refusal of medication is to re-attempt several times within the hour, document the date, time, medication with dosage and reason for refusal. She said that staff are to call resident's POA each time a refusal takes place and if the refusal continues then they call the resident's physician to consult on options.

Employee #1 and Employee #2's statement was consistent with Ms. Cummings regarding medication.

A review of the medication administration record (MAR) for Resident A, Resident B, Resident C and Resident D, shows that medication was given as prescribed, and any refusals were documented.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.

ANALYSIS:	MAR shows that medication was given as prescribed and there is a procedure in place for all refusals of medication.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents are not getting regular showers.

INVESTIGATION:

Ms. Cummings stated that all showers are given, and any refusals are documented. She stated that some residents have favorite staff. She stated that sometimes if residents refuse showers, they get a different staff to offer the shower to them.

Employee #1 and Employee #2's statements were consistent with Ms. Cummings concerning showers.

Shower sheets shows that showers are given as scheduled and any refusals are documented.

APPLICABLE RULE	
R 325.1933	**Personal care of residents.**
	(2) A home shall afford a resident the opportunity and instructions when necessary for daily bathing, oral and personal hygiene, daily shaving, and hand washing before meals. A home shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	This claim could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Bed covers are not changed regularly.

INVESTIGATION:

Ms. Cummings stated that sheets and covers are changed weekly on shower days.

Employee #1's statement was consistent with Ms. Cummings.

During the onsite, I inspected several rooms, looking at residents' beds throughout the facility. The bedding and sheets were found to be clean. There were no issues with the bed cover or sheets.

APPLICABLE RULE	
R 325.1935	**Bedding, linens, and clothing.**
	(1) Bedding shall be washable, in good condition, and clean, and shall be changed at least weekly or more often as required.
ANALYSIS:	During the onsite, the beds inspected were found to be clean and in good condition.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents' rooms are not being cleaned.

INVESTIGATION:

Ms. Cummings stated that the residents' rooms are cleaned once a week and more if needed. She stated that there are two housekeepers who are responsible for cleaning the facility.

Resident A, Resident B, and Resident C stated that staff are always cleaning their room, and everything was good.

During the onsite, I inspected the facility and found that the facility was cleaned throughout, including the residents' rooms.

Facility cleaning schedule showed that regular housekeeping was completed. The schedule also shows a carpet cleaning schedule.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.

ANALYSIS:	During the onsite, the facility was found to be clean throughout. Therefore, this claim could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remains unchanged.

08/29/2023

Brender Howard Date
Licensing Staff

Approved By:

08/29/2023

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