STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 18, 2023

Jennifer Huetter
Brookridge Heights Assist
1901 Division
Marquette, MI 49855

RE: License #: AH520337520
Investigation #: 2023A1021088
Brookridge Heights Assist

Dear Mrs. Huetter:

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) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH520337520
Investigation #:	2023A1021088
Complaint Receipt Date:	09/20/2023
Investigation Initiation Date:	09/20/2023
Report Due Date:	11/20/2023
Licensee Name:	CHT Brookridge Heights MI Tenant Corp
Licensee Address:	Suite 500 1423 Clarkview Road Baltimore, MD 21209
Licensee Telephone #:	(410) 427-2700
Authorized Representative/ Administrator:	Jennifer Huetter
Name of Facility:	Brookridge Heights Assist
Facility Address:	1901 Division Marquette, MI 49855
Facility Telephone #:	(906) 225-4488
Original Issuance Date:	01/08/2013
License Status:	REGULAR
Effective Date:	11/13/2022
Expiration Date:	11/12/2023
Capacity:	126
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Residents are left soiled and have skin breakdown.	No
Facility has insufficient staff.	Yes
Resident do not have Depends.	No
Residents unable to eat meals in room.	No
Additional Findings	No

III. METHODOLOGY

09/20/2023	Special Investigation Intake 2023A1021088
09/20/2023	Special Investigation Initiated - Letter email sent to APS for additional information
10/05/2023	Inspection Completed On-site
10/10/2023	Contact-Documents received Received facility documents
10/18/2023	Exit Conference

ALLEGATION:

Residents are left soiled and have skin breakdown.

INVESTIGATION:

On 09/20/2023, the licensing department received an intake from Adult Protective Services (APS) with reports residents are left soiled and have skin breakdown. The APS reporting source alleged that Resident A and Resident B have skin breakdown.

On 10/05/2023, I interviewed staff person 1 (SP1) at the facility. SP1 reported Resident A does have skin breakdown on his buttocks. SP1 reported Resident A is incontinent and wears Depends. SP1 reported staff members are to encourage Resident A to have pressure relief off his buttocks, are to assist Resident A to the bathroom, and are to apply prescription creams to promote healing. SP1 reported the facility is working with Resident A's physician to arrange for wound care. SP1

reported Resident B does not have any skin breakdown on his buttocks. SP1 reported residents are not left soiled for extended periods of time.

On 10/05/2023, I interviewed SP2 at the facility. SP2 reported a few times she has observed residents that are wet from urine, but it is not a common occurrence. SP1 reported at times the residents refuse to be changed. SP2 reported caregivers are responsible to rotate residents, check residents for incontinence, and assist residents to the bathroom.

On 10/05/2023, I interviewed SP3 at the facility. SP3 reported residents are changed appropriately and are not left soiled or wet. SP3 reported a few residents have skin breakdown but the facility has implemented interventions to assist with the healing of the skin breakdown.

On 10/05/2023, I observed the memory care and assisted living unit. I observed multiple residents located in their room and in common areas of the facility. The residents I observed were well kept as observed by them were not in soiled clothes and I did not smell any urine.

I reviewed Resident A’s service plan. The service plan read,

> *“Resident has skin breakdown on his bottom and has creams applied daily. Provide oversight of current skin breakdown and treatment per Health Care Provider Orders.”*

I reviewed Resident A’s medication administration record (MAR) for September and October. The MAR read,

> *“Aquaphor ointment: apply 1 application twice a day by topical route as directed for rash.”*
> *Wound treatment: clean buttocks with water and pat dry. Apply nystatin and place ABD pad on buttocks to prevent direct skin contact with depend.”*

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:	Interviews conducted, observations made, and review of documentation revealed lack of evidence to support the allegation residents are left soiled.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Facility has insufficient staff.

INVESTIGATION:

APS reporting source reported there is insufficient staff at the facility. APS reporting source alleged residents are neglected because of lack of staff.

On 09/20/2023, I interviewed APS worker Garrett Peters by telephone. Mr. Peters reported the facility is doing the best they can with the number of staff they have. Mr. Peters reported he did not see any neglect of residents.

SP1 reported there are 47 residents in assisted living and 47 residents in memory support. SP1 reported on first and second shift there are to be two medication technicians and at least two caregivers per unit. SP1 reported on third shift there is to be one medication technician and one caregiver on assisted living and one mediation technician and two caregivers in memory support. SP1 reported the facility does not have a mandation policy for staff shortages. SP1 reported when there is a staff shortage, caregivers are offered double time. SP1 reported management will also work the floor. SP1 reported the facility is currently hiring.

On 10/05/2023, I interviewed SP2 at the facility. SP2 reported that the facility typically works below their staffing ratios at least once a week. SP2 reported she is usually responsible for approximately 20 residents. SP2 reported it is difficult to provide good care to the residents.

On 10/05/2023, I interviewed SP3 at the facility. SP3 reported that the facility works below their staffing ratios multiple times a week. SP3 reported when there is an emergency, such as a fall, it takes a caregiver off the floor and then other residents receive inadequate care. SP3 reported residents are not changed appropriately and have increased risk of falls due to the lack of staff.

On 10/09/2023, I interviewed authorized representative Jennifer Huetter by telephone. Ms. Huetter reported the facility is currently hiring. Ms. Huetter reported it is difficult to get reliable employees.

I reviewed the medication variance report for 10/01/2023-10/08/2023. The document revealed the following were noted:

10/8: Resident R and Resident B given medications over two hours late
10/07: Resident C given medications one hour late
10/06: Resident D given medication over one hour late
10/05: Resident D E, F, G, H, given medications over one hour late and up to three hours late
10/03: Resident E, D, J, K, L, M given medications over one hour late

10/02: Resident R, E, H, M, N, O, P given medications over one hour late and up to three hours late
10/01: R J,F, Q given medications over one hour late

I reviewed the staff schedule for 09/24-10/04. The following were noted:

09/24: 1st shift in assisted living only one caregiver
09/24: 2nd shift in assisted living one caregiver worked from 5:00-9:00pm
09/25/2023: 2nd shift in assisted living only one caregiver; only medication technician 3:00p-7:00pm
09/26: 2nd shift in memory support only two caregivers 3:00p-7:00p
09/27: 1st shift in memory support only two caregivers 12:00-3:00p
09/28: 1st shift in memory support only two caregivers 11:00a-3:00p
09/28: 2nd shift in memory support there were only one medication technician 3:00-5:00p and 7:00p-11:00p.
09/29: 1st shift in assisted living only two caregivers
09/29: 1st shift in memory support only one medication technician 11:00am-3:00pm
09/29: 2nd shift in memory support until one medication technician 3:00-7:00p
09/30: 2nd shift in assisted living only one medication technician 3:00-7:00pm; only one caregiver
09/30: 2nd shift in memory support only two caregivers
10/1: 1st shift in assisted living only one medication technician 12:00p-3:00p
10/1: 1st shift in memory support only two caregivers 11:00a-3:00p
10/2: 2nd shift in assisted living only one caregiver
10/4: 2nd shift in assisted living only one caregiver
10/4: 3rd shift in memory support only one caregiver

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 does not have adequate staffing levels as evidenced by: Review of daily staff assignment sheets revealed the facility operated below their staffing levels on multiple occurrences. Review of medication variance report revealed multiple days and times in which resident medications were late.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident do not have Depends.

INVESTIGATION:

The APS reporting source alleged residents do not have Depends.

SP1 reported residents that require Depends are on the facility Medline system in which Depends are purchased for them. SP1 reported in addition some resident's families provide Depends. If a resident runs out of Depends, there is an overstock supply that is available. SP1 reported no knowledge of the facility running out of supplies.

SP2 and SP3 statements were consistent with those made by SP1.

I viewed a supply closet located in the facility. The supply closet had a significant supply of Depends available for the residents to use.

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:	Interviews conducted and observations made revealed lack of evidence to support the allegation there is a lack of Depends for the residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents unable to eat meals in room.

INVESTIGATION:

The APS reporting source alleged bedridden residents will have meal trays delivered to their room, but the tray is dropped off not close to the residents and therefore the resident is unable to eat the meal.

SP1 reported there are a few residents that request to eat meals in their room. SP1 reported when a meal tray is delivered to the resident's room, culinary staff will place it near the resident. SP1 reported caregivers will also check to ensure the resident is eating the meal.

On 10/05/2023, I interviewed SP4 at the facility. SP4 reported kitchen staff and the floor staff both assist with bringing room trays to the residents. SP4 reported in the morning caregivers take residents food orders and their preference to eat in the dining room or in their room. SP4 reported this is then communicated to the kitchen staff. SP4 reported when mealtime occurs, care staff will deliver the room trays if they have time. SP4 reported if care staff do not have time, then kitchen staff will take the room tray to the resident. SP4 reported when a room tray is dropped off, kitchen staff will communicate this to caregivers so that they are aware. SP4 reported kitchen staff are always able to find the caregivers as they are centrally located during mealtimes, or they can communicate via walkie-talkie. SP4 reported no knowledge of residents unable to eat meals in room.

APPLICABLE RULE	
R 325.1952	**Meals and special diets.**
	(3) A home shall assure that the temporary needs for meals delivered to a resident's room are met.
ANALYSIS:	Interviews conducted revealed lack of evidence to support the allegation residents are unable to eat meals in their room.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

Kimberly Horst 10/12/2023

Kimberly Horst Date
Licensing Staff

Approved By:

Andrea L. Moore 10/18/2023

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