GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 6, 2023

Teresa Murray
Murrays Country View
6201 HWY M-35
Gladstone, MI 49837

RE: License #: AH210396377
Investigation #: 2023A1028063
Murrays Country View

Dear Teresa Murray:

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 #:	AH210396377
Investigation #:	2023A1028063
Complaint Receipt Date:	06/23/2023
Investigation Initiation Date:	06/28/2023
Report Due Date:	08/23/2023
Licensee Name:	Murray's Country View, LLC
Licensee Address:	3670 Blacksmith 20.5 Ln Gladstone, MI 49837
Licensee Telephone #:	(906) 399-7581
Authorized Representative/Administrator:	Teresa Murray
Name of Facility:	Murrays Country View
Facility Address:	6201 HWY M-35 Gladstone, MI 49837
Facility Telephone #:	(906) 428-1334
Original Issuance Date:	12/12/2018
License Status:	REGULAR
Effective Date:	06/12/2023
Expiration Date:	06/11/2024
Capacity:	25
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Residents are unclean and neglected.	Yes
The Additional Findings	Yes

III. METHODOLOGY

06/23/2023	Special Investigation Intake 2023A1028063
06/28/2023	Special Investigation Initiated - Letter
06/28/2023	APS Referral APS referral made to Centralized Intake
07/17/2023	Contact - Telephone call made Interviewed Employee A by telephone.
07/18/2023	Contact - Telephone call made Interviewed AR/Teresa Murray by telephone.
07/26/2023	Contact - Document Received Received requested facility documentation and resident records from AR/Teresa Murray.
07/31/2023	Contact – Document Received Received additional complaint concerning Resident A.
07/31/2023	Contact – Email Sent Emailed AR/Teresa Murray to request Resident A’s medication administration record with notes.
08/01/2023	Contact – Telephone Call Made Called AR/Teresa Murray for interview about additional complaint information.
08/02/2023	Contact – Document Received Received Resident A’s medication administration record with notes.

ALLEGATION:

Residents are unclean and neglected.

INVESTIGATION:

On 6/23/2023 the Bureau received the allegations anonymously through the online complaint system.

On 6/28/2023, an Adult Protective Services (APS) referral was made to the Centralized Intake system.

On 7/17/2023, I interviewed Employee A at the facility by telephone who reported no knowledge of resident neglect or uncleanliness. Employee A reported there are 19 residents at the facility currently and residents are provided care in accordance with the service plans. Residents are provided showers one to two times per week and not all residents require assistance with care. Employee A reported residents and the facility is clean, but Resident A is actively passing from cancer and refuses to go to the hospital, despite intervention from the facility, emergency services and the physician. Employee A reported Resident A is their own person and has a recent history of refusing care. Employee A reported Resident A does smell due to actively passing from cancer and the smell is noticeable in the facility with residents, staff, and visitors complaining of the smell.

On 7/18/2023, I interviewed the facility authorized representative, Teresa Murray, by telephone. Ms. Murray reported residents are not neglected and the facility is clean. Ms. Murray reported the facility showers residents one to two times per week in accordance with the service plan. Ms. Murray confirmed there are 19 residents in the facility. Ms. Murray reported Resident A is actively passing from cancer and due to cancer diagnosis, “there is a strong odor in the facility” and residents have complained about it. Ms. Murray confirmed Resident A is [their] own person and makes [their] own decisions. Resident A demonstrates a recent history of refusal of medical services despite facility staff, physician, and emergency services encouragement to seek treatment at the hospital. Ms. Murray reported it has been difficult to get Resident A to go to the hospital, but Resident A agreed to go to the hospital for treatment on 7/17/2023. Ms. Murray also reported there are a few other residents in the facility that require reminders and assistance with bathing, toileting, grooming etc., but that residents are bathed and cared for appropriately by staff. I requested Ms. Murray provide me Resident A’s, Resident B’s, Resident C’s, Resident D’s, and Resident E’s records for my review.

On 7/26/2023, I received Resident A’s, Resident B’s, Resident C’s, Resident D’s, and Resident E’s record via email for my review.

I reviewed Resident A's service plan and incident reports which revealed the following:

- Resident A is [their] own decision maker and person.
- Demonstrates aggressive behavior.
- Does not appropriately use alcohol.
- Independent with mobility using a cane, dressing, toileting, bathing, grooming, and feeding.
- Requires assistance with medication management.

I reviewed Resident A's incident report from 7/17/2023 which revealed Resident A was weak and could not breath. Resident A was sent to the hospital for further treatment and evaluation.

I reviewed Resident B's service plan which revealed the following:

- Demonstrates aggressive behavior.
- Uses walker but *unsteady feet due to vision and balance.*
- Requires assistance with dressing, toileting, bathing, grooming, feeding and medication management.

I reviewed Resident C's service plan which revealed the following:

- Resident is [their] own decision maker and person.
- Requires assistance with communication, money management, following instructions, and orientation to surroundings.
- Requires assistance with mobility using wheelchair, dressing, toileting, bathing, grooming, feeding, and medication management.

I reviewed Resident D's service plan which revealed the following:

- Requires assistance with money management, following instructions, controlling sexual behaviors, and does not appropriately use alcohol.
- Requires assistance with mobility using wheelchair, dressing, toileting, bathing, grooming, feeding, and medication management.

I reviewed Resident E's service plan which revealed the following:

- Resident is [their] own decision maker and person.
- Requires assistance with money management and orientation to surroundings.
- Demonstrates aggressive behavior.
- Independent with feeding.
- Requires assistance with mobility using walker, dressing, toileting, bathing, grooming, feeding, and medication management.

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 residents were unclean and neglected at the facility. Interviews and review of documentation reveal there are several residents at the facility who require assistance for hygiene, bathing, and toileting. It was also revealed during staff interviews that Resident A has cancer and refuses treatment. Resident A is [their] own person and has the right to refuse treatment and care, but due to refusal of treatment, there is an unpleasant odor at the facility. While the facility has made great effort to attend to Resident A's care and needs, the facility has a duty to be consistent in the care, needs, and protection of all residents at the facility. The unpleasant odor has affected other residents, staff, and visitors to the facility; therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

Additional Findings

INVESTIGATION:

On 7/18/2023, I made a request by telephone to Ms. Murray to appoint a new administrator for the facility because the prior administrator, Carolyn Sargent, resigned on 6/1/2023. Another request was made via email on 7/20/2023 to appointment an administrator. No administrator has been appointed.

APPLICABLE RULE	
R325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(d) Appoint a competent administrator who is responsible for operating the home in a accordance with the established policies of the home.**

ANALYSIS:	The former administrator, Carolyn Sargent, resigned 6/1/2023. (A request to appoint a new administrator was first made to Ms. Murray via email on 6/5/2023 upon initial notification of the administrator's resignation). Another request to appoint a new administrator was made via telephone on 7/18/2023. A third request was made via email on 7/20/2023. As of 7/31/2023, an administrator still has not been appointed for the facility; therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 7/17/2023, Employee A reported by telephone that there was only one care staff member from 1pm to 3pm that day. The other care staff member left for the day at 1pm. Employee A reported one care staff member is scheduled daily from 7am to 1pm and a second care staff member from 7am to 3pm. When questioned about staffing, Employee A reported staff "have walked off or just don't want to work. It's hard to find good people to work and we are trying."

On 7/20/2023, Ms. Murray confirmed there are 19 residents total at the facility and reported the second care staff member went home sick for the afternoon on 7/17/2023. Ms. Murray reported the normal schedule is one care staff member from 7am to 1pm and a second care staff member from 7am to 3pm. Ms. Murray reported it has been difficult to get good staffing and there has been a lot of turn over despite great effort made to secure good staff. I requested the working staff schedules from May 2023 to July 2023 for my review.

On 7/26/2023, I received the working staff schedules from May 2023 to July 2023 for my review.

Review of the May 2023 staff schedule revealed the following:

- May 2023 submitted schedule begins on 5/29/2023. There is no submission for days 5/1/2023 to 5/28/2023.
- On 5/29/2023, there was only one care staff member for hours 3pm to 7pm.
- On 5/30/2023, there was only one care staff member for hours 1pm to 3pm and 9pm to 11pm.
- On 5/31/2023, there was only one care staff member scheduled from 11pm to 7pm.

Review of the June 2023 staff schedule revealed the following:

- From 6/1/2023 to 6/30/2023, there were multiple time frames where there was only one care staff member for hours of 7am to 3pm, 1pm to 3pm, 3pm to 11pm, 9pm to 11pm, and 11pm to 7am.

Review of the July 2023 schedule revealed the following:

- From 6/1/2023 to 6/30/2023, there were multiple time frames where there was only one care staff member for hours of 7am to 3pm, 1pm to 3pm, 3pm to 11pm, 9pm to 11pm, and 11pm to 7am.
- Evidence of staff working a split shift on 7/10/2023, 7/15/2023, and 7/17/2023.

On 7/31/2023, I re-reviewed Resident A's, Resident B's, Resident C's, Resident D's, and Resident E's record which revealed the following:

- All require assistance with medication management.
- Resident B, Resident C, Resident D, and Resident E require assistance with care routines.
- Resident B, Resident C, Resident D, and Resident E require assistance with mobility.
- Resident A, Resident B, Resident D, and Resident E demonstrate behaviors.

APPLICABLE RULE	
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:	Interviews and review of the working staff schedules from May 2023 to July 2023 reveal there are multiple blocks of time in which there is only one care staff member on duty for residents. One care staff member cannot meet the needs of the 19 residents in the facility. This also poses a potential safety risk for both staff and residents; therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 7/27/2023, I received an additional complaint with further information concerning Resident A's medications and alcohol intake.

On 7/31/2023, I requested via email from Ms. Murray Resident A's medication administration records from May 2023 to July 2023 along with record notes.

On 8/1/2023, I spoke with Ms. Murray by telephone who reported Resident A is still in the hospital and is subsequently discharged from the facility. Ms. Murray reported Resident A had issues with abuse of alcohol while at the facility. Resident A was their own person, was modified independent with care, and would leave the facility to purchase alcohol to consume in public because the facility would not provide it to Resident A when requested. Ms. Murray reported staff conferenced with Resident A and Resident A's family on multiple occasions about Resident A's alcohol intake and safety. Staff would also confiscate any alcohol from Resident A when Resident A would return to the facility from a public outing. Ms. Murray reported Resident A has returned from the facility intoxicated on multiple occasions and was verbally inappropriate with staff and residents. Ms. Murray also reported the facility has a supervised happy hour occasionally, but only for those who are not on medications that could react with alcohol. Ms. Murray reported other than the occasional supervised happy hour, residents do not have access to alcohol at the facility. Ms. Murray reported to her knowledge Resident A is not on any medications that react with the consumption of alcohol. I requested Resident A's medication administration record (MAR) from May 2023 to July 2023 with notes for my review.

On 8/2/2023, I received Resident A's MAR with notes for my review from Ms. Murray.

On 8/3/2023, I reviewed Resident A's May 2023 to July 2023 MARs which revealed the facility administered Resident A the following medications that have an interaction with the consumption of alcohol:

- 1 tablet 750mg of Levetiracetam by mouth twice daily for seizure. (Alcohol intake is to be limited with intake of this medication).
- 1 tablet of 75mg of Clopidogrel by mouth everyday for disease of the heart or blood vessels. (Alcohol intake should be avoided with intake of this medication).
- 1 tablet 1mg of folic acid by mouth every day. (This medication reacts negatively with alcohol consumption).
- 1 tablet of 2.5mg of Lisinopril by mouth once daily. (Consumption of alcohol causes serious interactions with Lisinopril).
- 1 tablet 81mg of aspirin one time per day. (Alcohol and aspirin should not be taken together).
- 1 tablet 650mg of Tylenol Arthritis as needed. (Alcohol consumption should be limited with intake of this medication).
- Vitamin B 100mg at 8am each day. (Alcohol consumption depletes this vitamin).
- 2 tablets 100mg of Docusate Sodium by mouth once daily. (Alcohol consumption increases mental and physical distress with intake of this medication).
- The May 2023 to July 2023 MARs were complete and Resident A was administered medication in accordance with medication orders.

I reviewed the record notes which revealed that on 12/1/2022, Resident A returned to the facility intoxicated “again” from a public outing. Resident A demonstrated inappropriate behavior towards staff and other residents. It cannot be determined if or what interventions were implemented by the facility to address this incident due to nothing being noted in the record.

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:	Interview and review of documentation reveal the facility administered Resident A’s medications. Resident A had a history of alcohol abuse and despite the facility conferencing with Resident A about alcohol consumption; and confiscating Resident A’s alcohol purchased outside the facility, Resident A continued to consume alcohol. Resident A also demonstrated inappropriate behaviors towards staff and other residents after the consumption of alcohol. Review of Resident A’s MAR from May 2023 to June 2023 revealed Resident A was administered multiple prescribed medications that interacted negatively with alcohol or should have been avoided with the consumption of alcohol. The facility did not provide appropriate medication administration supervision for Resident A’s safety when it was documented and known by staff that Resident A consumed alcohol. There is also no evidence the facility implemented any interventions or contacted Resident A’s physician to address Resident A’s consumption of alcohol with the intake of medication. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

7/31/2023

Julie Viviano Date
Licensing Staff

Approved By:

10/30/2023

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