GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 14, 2023

Mary Marshall
1119 Holyrood Street
Midland, MI 48640

RE: License #: AF560277877
Investigation #: 2023A1033056
Marshall Manor Assisted Living

Dear Ms. Marshall:

Attached is the Special Investigation Report for the above referenced facility. Due to the quality of care violations identified in the report, a six-month provisional license is recommended and 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:

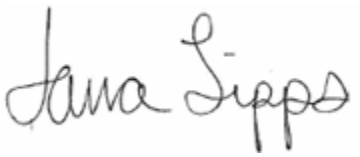
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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,



Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF560277877
Investigation #:	2023A1033056
Complaint Receipt Date:	07/19/2023
Investigation Initiation Date:	07/21/2023
Report Due Date:	09/17/2023
Licensee Name:	Mary Marshall
Licensee Address:	1119 Holyrood Street Midland, MI 48640
Licensee Telephone #:	(989) 631-1266
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	Marshall Manor Assisted Living
Facility Address:	1119 Holyrood Street Midland, MI 48640
Facility Telephone #:	(989) 631-1266
Original Issuance Date:	10/24/2005
License **Status:**	REGULAR
Effective Date:	04/24/2022
Expiration Date:	04/23/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A is frequently found left in his bed soiled in urine and feces. He has been found in this condition on multiple occasions and has a wound on his coccyx that has grown tremendously. The responsible persons are not providing for his personal care needs to aid in healing of this wound.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/19/2023	Special Investigation Intake 2023A1033056
07/21/2023	APS Referral- Active APS investigation at this time.
07/21/2023	Special Investigation Initiated – Letter- Email received from Adult Services Worker, Jill Schmidt, regarding allegations.
08/01/2023	Inspection Completed On-site- Interviews conducted with licensee, Mary Marshall, Responsible Person, Jean Benham, and Residents A & B. Review of Resident A resident record initiated.
08/02/2023	Contact - Telephone call made- Interview with Citizen 1 via telephone.
08/02/2023	Contact - Telephone call made- Interview with The Care Team Hospice, Nurse, Kelly Kobel, via telephone.
08/02/2023	Contact - Telephone call made- Attempt to interview The Care Team Hospice, Nurses Aid, Christal Hoard. Voicemail message left.
08/02/2023	Contact - Document Sent- Email to licensee, Mary Marshall, requesting Assessment Plan and Health Care Appraisal for Resident A, as well as phone numbers for responsible persons.
08/02/2023	Contact - Document Received- Email received from Ms. Kobel including photographs of Resident A's physical condition.

08/04/2023	Contact - Document Received- Email received from Kelle Noxon, Hospice Branch Director, for the Care Team Hospice, containing Resident A patient records.
08/06/2023	Contact - Document Received- Email received from Mary Marshall containing Resident A resident records.
08/07/2023	Contact - Telephone call received- Interview with Amanda Butcher, Nurse Practitioner with Careline Physician Group, via telephone.
08/07/2023	Contact - Document Sent- Email inquiry sent to Nurse Manager at the Wound Treatment Center in Midland, MI, Caryn Leuenberger.
08/08/2023	Contact - Telephone call made- Attempt to interview responsible person, Susan Tice, via telephone. Voicemail message left.
08/08/2023	Contact - Telephone call made- Attempt to interview Caryn Leuenberger, Nurse Manager, with the Midland Wound Clinic. Left message, awaiting response.
08/10/2023	Inspection Completed On-site- Follow up inspection completed. Interviews with responsible persons, Susan Tice & Heather Faunce, Licensee, Mary Marshall, and Citizen 2. Visual observations made of Residents A, B, C, D, & E.
08/10/2023	Contact – Document Received- Email received from Midland Wound Clinic Manager, Caryn Leuenberger.
09/06/2023	Contact – Telephone Call Made- Attempt to interview Monica Judd, RN, with Residential Hospice Services. Message left, awaiting response.
09/06/2023	Contact – Telephone Call Received- Telephone call received from Monica Judd, RN.
09/06/2023	Contact – Telephone Call Received- Interview, via telephone, with Shannon Thompson, RN, with Residential Hospice Services.
09/14/23	Exit Conference Conducted via telephone with licensee, Mary Marshall.

ALLEGATION: Resident A is frequently found left in his bed soiled in urine and feces. He has been found in this condition on multiple occasions and has a wound on his coccyx that has grown tremendously. The responsible persons are not providing for his personal care needs to aid in healing of this wound.

INVESTIGATION:

On 7/20/23 I received an online complaint regarding the Marshall Manor Assisted Living adult foster care home (the facility). The complaint alleged Resident A is frequently found left in his bed soiled in urine and feces. He has been found in this condition on multiple occasions and has a wound on his coccyx that has grown in size. The allegation alleged responsible persons are not providing for adequate personal care to aid in the healing of this wound. On 7/21/23 I received an email message from Adult Services Worker, with Adult Protective Services (APS), Jill Schmidt, regarding the allegation. Ms. Schmidt reported she made an on-site visit to Resident A at the facility on 7/20/23. Ms. Schmidt reported she found Resident A to be in clean bedding, clean clothing, and his skin was clean and dry. Ms. Schmidt reported she interviewed licensee Mary Marshall who denied Resident A has been left in soiled bedding. Ms. Schmidt reported Ms. Marshall stated that a hospice employee provides baths to Resident A twice per week. Ms. Schmidt further reported Ms. Marshall stated the wound on Resident A's coccyx is cleaned and packed every time incontinence care is provided.

On 7/25/23 I received an additional email message from Ms. Schmidt reporting that she had spoken with Resident A's physician (name not specified) who reported that there are no concerns with the care Resident A receives in the home. Ms. Schmidt noted that this physician reported that it is common for wounds on the coccyx to not heal completely since he lays in his bed all day. Ms. Schmidt also reported she spoke with Resident A's wife who reported she visits Resident A every day and has never found him left in feces or urine.

On 8/1/23 I completed an on-site investigation at the facility with Adult Foster Care Licensing Consultant, Johnnie Daniels, Jr. We interviewed Ms. Marshall during this investigation. Ms. Marshall reported she was aware of the complaint as Ms. Schmidt had been to the facility on 7/20/23 to investigate this allegation as well. Ms. Marshall stated Resident A requires total care. She reported Resident A is checked on every 2-3 hours for incontinence care and repositioning. Ms. Marshall reported Resident A has a wound on his coccyx the size of the palm of her hand. She noted the wound is "deep but healthy." Ms. Marshall reported she is currently caring for five residents and has two responsible persons, Jean Benhm and Susan Tice, assisting with resident care.

During on-site investigation Mr. Daniels and I observed Resident A in his bedroom. Resident A was found to be in clean bed linens, clean clothing, and appeared to have been recently bathed. We observed that Resident A had a bruise about the

size of a half dollar, to his right eye, which Ms. Marshall identified as a bee sting. Ms. Marshall reported she presumed it was from a bee sting as the mark just appeared and they had the windows open in his room. Ms. Marshall reported that no one had directly witnessed this alleged bee sting. Mr. Daniels and I attempted to interview Resident A, privately, but due to his diagnosis of Parkinson's Disease with Dementia, it was difficult to conduct an interview. Resident A did not respond to any verbal communication at this time. He was alert and looking around the room, but not verbally responsive.

During on-site investigation, on 8/1/23, Mr. Daniels and I interviewed Resident B. Resident B has been diagnosed with Multiple Sclerosis and is bedbound. Resident B reported she has resided at the facility for almost six years. She reported that she has a bed sore on her buttocks which has been present for "about five years." Resident B reported she has no concerns about the care she is receiving. She reported she has a call button to press for when she needs assistance from a responsible person, and she feels the timeliness of their response is adequate. Resident B reported she has had two surgeries due to the unhealing bedsore on her buttocks. She further reported she feels she has never been left to wait too long for a soiled undergarment to be changed. Resident B was found lying on her back in her hospital bed during this on-site investigation.

During on-site investigation, on 8/1/23, Mr. Daniels and I interviewed responsible person Ms. Benham. Ms. Benham reported she has worked at the facility for about nine years. Ms. Benham reported Resident A's undergarment is changed about every 2-3 hours due to incontinence. She reported Resident A wears an incontinence brief and liners. She reported Resident A's wound care is performed every time he is changed. Ms. Benham reported responsible persons reposition Resident A every time they provide incontinence care. She reported that his wound is slowly healing and "getting better." When asked about repositioning for Resident B Ms. Benham reported responsible persons do not reposition her because she has a special, Ethos Bed, for wound care and they do not need to reposition her due to this special bed.

On 8/6/23, I reviewed Resident A's resident record which included Resident A's *AFC-Resident Care Agreement (RCA), Health Care Appraisal* and *Assessment Plan for AFC Residents (assessment plan).* Resident A's RCA was signed and dated 4/21/2023 by Resident A's designated representative, Citizen 1, and licensee Mary Marshall. I also reviewed Resident A's assessment plan which documented under the section titled "Self-Care Skill Assessment" that "Staff will Assist" Resident A with eating/feed, toileting, bathing, grooming, dressing, and personal hygiene. The assessment plan also listed that Resident A was "on hospice." The assessment plan did not provide any details on how "staff will assist" Resident A with any of the above self-care tasks nor did the assessment plan list any hospice orders for wound care treatment or transfer/positioning.

On 8/2/23 I interviewed Citizen 1 via telephone. Citizen 1 reported she is the spouse of Resident A. Citizen 1 reported she visits Resident A every day at the facility. Citizen 1 reported she was aware of the complaint and allegations being made and she did not agree with the allegations. Citizen 1 reported she is aware Resident A has a wound on his coccyx that is not healing. She reported she visits daily to assist with his feedings and has never found him in soiled incontinence briefs or bedding. She reported she has zero concerns about the facility, and she is pleased with the care. She reported, Ms. Marshall treats Resident A “like family.”

On 8/2/23 I interviewed Ms. Kobel via telephone. She reported that she assumed caring for Resident A in December 2022, after Ms. Marshall had replaced the previous hospice agency, who had been caring for Resident A, with The Care Team Hospice. Ms. Kobel reported that it was mentioned to her, by Ms. Marshall, that the previous hospice was not providing adequate wound care to Resident A as he had wounds on his heels that were not improving. Ms. Kobel reported she has been the primary nurse for Resident A since this transition of care in December 2022. Ms. Kobel reported that when she assumed care for Resident A, he had a wound to his left heel. She reported that within a week of assuming his care he developed a wound on his coccyx which is still present today (8/2/2023). She further reported Resident A has experienced other issues with skin integrity since she assumed his care in December 2022. These issues were reported as a blister that developed on his face, which she reported was due to Resident A not being repositioned in his hospital bed and being left laying on one side of his body for prolonged periods of time. She reported that on the date she discovered this blister to Resident A’s face she had made a visit to the facility and found the resident almost completely face down in his pillow. She reported she repositioned Resident A on this date and noted the redness and blistering to his cheek. Ms. Kobel reported she found it concerning that the directive from Ms. Marshall was to put two incontinence briefs, two incontinence napkins, two incontinence blue pads (chucks), and two cloth bed liners on Resident A after the hospice staff had provided personal care. Ms. Kobel reported this is considered excessive for caregivers who report they are repositioning and providing incontinence care every 2-3 hours. Ms. Kobel reported that on multiple occasions she and the nurses aid with The Care Team Hospice, Christal Hoard, would make joint visits to Resident A and find him completely soiled in urine and feces from head to toe in his bed. Ms. Kobel reported Resident A's wound is extensive and has gone through periods of infection, which required the use of antibiotic therapy. She reported the coccyx wound is tunneling about 4.5 centimeters deep. Ms. Kobel reported she believes Resident A’s personal care needs were not being attended to on a consistent basis which has led to history of infections and a growing non-healing wound on Resident A’s coccyx. Ms. Kobel further reported she has personally witnessed Resident A on two separate occasions with a bruise to his right eye and one to his left eye. Ms. Kobel reported that the first occurrence of facial bruising to his left eye was noticed about three weeks ago and Ms. Marshall, nor either responsible person, had an explanation for the bruising. Ms. Kobel reported the most recent bruise to his right eye was

discovered the week of 7/30/23. She stated it was reported to her by responsible persons that Resident A had been stung by a bee. Ms. Kobel reported there was no eyewitness accounting for this alleged bee sting. Ms. Kobel reported she had attempted to have a conversation with Citizen 1 about her concerns related to Resident A's care and Citizen 1 was not interested in hearing the concerns. Ms. Kobel reported she had taken photographs of Resident A's wound for her own records and would send these photographs to this licensing consultant. Ms. Kobel further reported there was a responsible person, Sky Kryska, who quit because she was upset with the care being provided at the facility. Ms. Kobel had no contact information for this responsible person. Ms. Kobel reported she has cared for two additional residents of this facility, former Residents C and D, who both received hospice care from The Care Team Hospice and both had issues with developing wounds while at the facility. Ms. Kobel reported that Citizen 1 had signed paperwork for Resident A to be switched to a new hospice provider and she was just informed of this on this date. She reported she is not aware of who the new hospice provider is at this time, but she is aware that this is the third hospice agency to work with Resident A.

On 8/7/23 I interviewed Careline Physician Group, Nurse Practitioner, Amanda Butcher, via telephone. Ms. Butcher reported that she has been providing palliative care/primary care physician services to residents of this facility for just over two years. She reported she currently cares for four of the five residents. Ms. Butcher reported that two of the four residents are currently dealing with wounds. Ms. Butcher reported that two of the four residents (Resident A & Resident B) have wounds that are being treated by other agencies. Ms. Butcher reported Resident A has a wound on his coccyx and this wound is currently being managed by hospice staff members. Ms. Butcher reported that she started providing care to Resident A in April 2023 and visualized his wound at that time but has not viewed his wound since his start of care with her services. She reported that when she did visualize the wound in April 2023, she would describe it as a stage IV wound down to the tissue. She reported she had never been made aware that there were concerns the wound was not healing well or not being properly cared for. Ms. Butcher further reported that Resident B has a wound on her buttocks, but she is not providing the wound care for this wound. She reported the Midland Wound Clinic is responsible for Resident B's wound care. She reported Resident B has been battling with her wounds long-term. Ms. Butcher reported she makes scheduled visits to the facility at least one time per month. She reported that she only makes a visit to Resident A about every 8 to 12 weeks as he is being cared for by hospice staff. Ms. Butcher reported that when she visits the facility the residents appear to be clean and well cared for. She reported she has never encountered a resident laying in a soiled bed or incontinence briefs. Ms. Butcher reported she has never observed Resident A with bruising around his eyes. She reported she made a recent visit to Resident A about two weeks ago and did not notice a bruise on or by his eye. Ms. Butcher was asked about her statement that she had never heard of any complaints regarding Resident A's care needs, as I noted conversations with Ms. Marshall and Ms. Kobel. Ms. Butcher reported that she in fact had spoken with Ms. Kobel on 7/13/23, who at

that time expressed concerns about Resident A's personal care needs not being met by responsible persons or Ms. Marshall.

On 8/2/23 I received several email messages from Ms. Kobel, each containing photographs of Resident A's wound on his coccyx dating from January 2023 through the present day. The photographs represent disturbing images of Resident A being found completely saturated in urine and feces on multiple occasions. The dressing over the wound was left saturated with urine and feces as well. The wound appears to be a large, tunneling, wound that has gone through stages of necrosis and infection. The most recent images demonstrated healthier skin tissue around the wound, but the wound remains tunnelling to the point that his bone is exposed when visualizing the photograph. There was a photograph taken of the side profile of Resident A's face demonstrating the red, swollen, blistered skin that Ms. Kobel reported finding when she made a visit to Resident A and found him face down in his pillow. There was also a photo of a wound to Resident A's left heel in these photographs as well as photographs of heel wounds to a previous resident of the facility whom Ms. Kobel had treated under hospice services.

On 8/4/23 a follow up interview was conducted with Ms. Kobel, via email, regarding the photographs received of Resident A's wounds and physical condition. Ms. Kobel reported that the wound on Resident A's coccyx may not have ever completely healed but she would not have expected it to worsen if the resident had been turned every two hours and had his incontinence briefs changed appropriately. Ms. Kobel reported that the expectation set forth for the responsible persons and Ms. Marshall was to reposition and change Resident A, every two hours. She reported that this is written in an order that is given to the facility and noted, verbally, at ongoing visits. Ms. Kobel reported she visited Resident A on Tuesdays and Fridays for complete wound care assessment and treatment. She reported responsible persons and Ms. Marshall were responsible to change the dressing daily and as needed if it was soiled. Ms. Kobel reported that Resident A could have had his incontinence brief changed by the responsible persons and they would not have had to disturb the wound dressing if Resident A had been changed on a regular, consistent basis.

On 8/4/23 I received an email from Kelle Noxon, MSN, RN, CHPN, Hospice Branch Director for The Care Team Hospice. This email contained documentation from The Care Team Hospice staff pertaining to Resident A. This documentation contained skill nursing visit notes which are highlighted as follows:

- 5/30/23, note entered by Kelly Kobel, RN: "Routine skilled nursing visit completed for [Resident A]. Patient appeared more relaxed during this visit and didn't appear to be having the severe muscle spasms like at previous visit. He was cooperative for his bed bath and tolerated well. Upon turning patient to perform wound care, it was noted he had a large amount of stool he was unable to pass. This RN helped with disimpaction and instructed staff to administer a suppository when they turn him next. Senna plus ordered BID R/T constipation. No other questions or concerns for this RN at this time."

- 6/2/23, note entered by Kelly Kobel, RN: “Routine skilled nursing visit completed for [Resident A]. This RN spoke with Mary, owner of Marshall Manor, R/T constipation concerns and wound concerns. Plans for wound care updated to include opticell silver and PRN Senna Plus added to med list to help with constipation issues. Patient was in a great mood and tolerated his bath as well as wound care very well. No other questions or concerns at this time.”
- 6/7/23, note entered by Kelly Kobel, RN: “Routine skilled nursing visit completed for [Resident A]. Patient was much more relaxed during visit today. The medications do appear to be helping with patient comfort. He was noted to be quite soaked in his brief again today. It continues to reach the wound bed causing it to be difficult for wound to heal. Patient was noted to have a loose stool during wound care. The wound bed was also noted to have some more yellow slough as well as some necrotic tissue. It is also concerning that wound is noted to be extending towards rectum and this RN is concerned about a fistula developing. Will continue to monitor and change plan of care on Friday if it is noted to still be growing in size. Wife, [Citizen 1], also asked about decreasing Flexeril so he is more alert, but even though this RN wrote for TID, staff has only been giving at bed time. This RN is concerned with patient discomfort, so will assess on Friday and get a clear outline of how frequently he is receiving medication. No other questions or concerns at this time. Coordinating care with Jeannie [Ms. Benham], Med passer, at Marshall Manor.”
- 6/9/23, note entered by Kelly Kobel, RN: “Routine skilled nursing visit completed for [Resident A]. Patient was asleep when this RN and HHA arrived. Patient did appear more comfortable but it’s noted his color is looking more pale/gray and he does appear much skinnier. Patient was completely soaked in urine and stool through multiple briefs and through chucks on the bed. Patient very clearly hadn’t been changed in quite some time. Wound measurements done and wound care performed. Patient tolerated well. New supplies ordered for wound care with hopes to help it begin to heal. Educated staff on the need to change and turn patient every 2 hours R/T wound being soaked in urine. No other questions or concerns at this time coordinated care with Sky, Med Passer, at Marshall Manor.”
- 6/11/23, note entered by Amanda Dudek, RN: “Pt seen due to cough reported by staff after suspected aspiration a few days ago. Pt has rhonchi in right lower lobe, productive cough, afebrile, respirations even non labored. Order for Mucinex DM and Augmentin 875mg BID x 10 days received from Dr. Jurasek. Educated staff to avoid milk based products, thin liquids and to contact The Care Team with any concerns.”
- 6/15/23, note entered by Sarah Elliott, LMT: “Patient in bed awake. Wife with him. Sore on left heel. Light massage therapy on neck and shoulders arms legs and feet.”
- 6/18/23, note entered by Kelly Kobel, RN: “Routine skilled nursing visit completed for [Resident A]. Patient was in very noticeable spasms. Staff was asked if patient had received morning meds, they stated that he did but Mary

[Ms. Marshall] said to give him a dose of morphine. This RN was able to administer 0.25mls of Morphine but questioned staff again on whether or not he had received his meds. Patient hasn't been this uncomfortable in quite some time so there is questions as to whether meds are being given appropriately. Patient was fairly wet again during this visit and his wound continues to grow in size. Continuing to educate on changing patient frequently and turning patient every 2 hours. No other questions or concerns at this time."

- 6/21/23, note entered by Kelly Kobel, RN: "Routine skilled nursing visit completed for [Resident A]. Patient was lying in bed asleep upon initial arrival. Patient awoke easily to verbal stimuli. Patient is noticeably contracted up in his bilateral lower extremities. Patient has facial grimacing noted when being touched or moved around. 0.25ml does of Morphine was given to aide in patients comfort during bath. Patient was once again found very soiled with urine and stool. Patients wound was packed with Kerlex that was extremely dry and difficult to remove. Patient was given a full bed bath and wound care provided. Patient has a dark purple spot to his right heel developing in to a new wound. Patient's heels are not found to be floating on a regular basis. Instructed staff on importance of floating heels, changing patient every 2 hours, and turning patient. This RN has given orders for Flexeril TID, but it appears facility isn't giving it to him as prescribed. This RN has asked staff it it's being given, but they won't tell this RN the exact amount of times he is receiving it. The patient's wife does want him to be more awake, but this has been at the cost of the patient's comfort. Continuing to educate to the best of this RN's ability. No other questions or concerns at this time. Coordinated care with Jeannie [Ms. Benham], Med Passer, At Marshall Manor."
- 6/25/23, note entered by Kelly Kobel, RN: "Routine skilled nursing visit completed for [Resident A]. Patient was lying in bed asleep upon our arrival. Patient appeared to still be in pain/uncomfortable. Patient was less wet today when being changed but he was covered in stool. This RN assisted Christal, HHA, with bed bath and provided wound care. Patient tolerated fairly well, but this RN is still very concerned that patient isn't receiving medication as prescribed. This RN spoke with Owner, Mary [Ms. Marshall], and discussed continuing to turn patient and float heels. No other questions or concerns at this time."
- 6/27/23, note entered by Kelly Kobel, RN: "Routine skilled nursing visit completed for [Resident A]. Patient was lying in bed getting a bed bath from Christal, HHA. Patient appeared more calm and comfortable during this visit. Patient was still found in a fairly wet brief this morning, and his wound appears to be undermining more in the 9 o'clock position. Patient tolerated wound care well this AM. Coordinated care with Jeannie [Ms. Benham], Med Passer, at Marshall Manor."
- 7/7/23, note entered by Kelle Noxon, RN: "[Resident A] lying in bed getting bed bath by Christal, HHA. Appears generally calm and comfortable with the occasional grimace with movement. B/L lower extremities have intermittent

observable muscle spasms. Skin is pale and extremities are cool to the touch. B/L breath sounds are clear and diminished through and no respiratory distress observed. Soft brown BM and normoactive bowel sounds x 4. Wound care completed to decubitus ulcer as document in ICC. Updated house manager Mary [Ms. Marshall] on patient status and encouraged to continue with wound care as ordered and with reducing pressure to all bony prominences with pillows and frequent position changes. Ordered skin prep, cotton TIP applicators, wipes, medi honey, medium gloves and ensure from Medline per Mary's request."

- 7/11/23, note entered by Kelly Kobel, RN: "Routine skilled nursing visit completed for [Resident A]. Patient was noticeably in pain during his visit. Asked staff to administer a PRN dose of Morphine. Patient tolerated his bath well and this RN assisted Christal, HHA, with getting him bathed and performing wound care."
- 7/18/23, note entered by Kelly Kobel, RN: "Routine skilled nursing visit completed for [Resident A]. Patient was lying in bed with noticeable muscle spasming to bilateral lower extremities. Patient exclaimed "ow" and had facial grimacing when trying to bathe him and turn him. Patient was extremely soaked in urine and his feces. His wound to his bottom was soaked in urine and the ABD covering it was also saturated in urine. The urine had soaked through 2 briefs and 2 liners into a blue chuck and the cloth pad underneath him. He also has new wounds developing on the tip of his penis, on the underside of his penis, his scrotum, and a stage 2 beginning on his left butt cheek. Patient was visibly uncomfortable during his bedbath as facility and family don't want medication given that could make him sleepy. Patient also has sores beginning on medial malleolus which were covered in skin prep to hopefully prevent sores. Spoke with Jeannie [Ms. Benham], worker at Marshall Manor, regarding all of the above. Will continue to monitor."
- 7/20/23, note entered by Kelly Kobel, RN: "Routine skilled nursing visit completed for [Resident A]. Patient was on his left side and has just been changed by facility staff. Patient's coccyx wound had a large amount of drainage and fresh blood. Patient was very uncomfortable again during our isit and had a lot of facial grimacing when moving him around. He did urinate when we turned him to perform wound care as well as a small bowel movement. Patient had calmo placed on stage 2 wound to keep from worsening. Mary, Owner of Marshall Manor, wouldn't speak with this RN today. This RN attempted to update other staff member with minimal response. No other questions or concerns at this time.
- 7/25/23, note entered by Kelly Kobel, RN: This note cited the following regarding current wounds:
    - "Stage 4 (tremendously increased in size) to coccyx
    - /Stage 2 to left buttocks/
- 8/1/23, note entered by Kelly Kobel, RN: "Routine skilled nursing visit completed for [Resident A]. Patient was lying in bed sleeping upon our arrival. It was immediately noticeable that patient had a large amount of bruising on the right eye socket. Staff reported he was stung by a bee, but

> patient also had bruising to his left eye two weeks ago. Reached out to Kelle Noxon, supervisor, regarding concerns. Patient grimaced and grabbed his head throughout almost the entire visit. Patient still doesn't appear comfortable and patient's wife still feels that he is doing better without Flexeril. Patient has noticeable muscle spasming that is involuntary. Coordinated care with Jeannie [Ms. Benham], Med Passer, at Marshall Manor."

On 8/4/23 I received an email message from Ms. Noxon containing a physician's order for wound care for Resident A dated for 6/16/23 and signed by Susan Jurasek, MD, on 6/20/23. The order read, "Cleanse wound thoroughly with wound wash and pat dry. Apply medihoney to wound bed and pack with Kerlex. Cover with ABD. Change daily and PRN if soiled."

On 8/2/23 I sent an email to Ms. Marshall requesting the telephone numbers for the former responsible person, Sky Kryska, and current responsible person, Susan Tice. I received an email response from Ms. Marshall on 8/6/23, providing the telephone number for Ms. Tice, but noting that she had deleted Ms. Kryska's number from her cell phone after she stopped showing up for scheduled shifts and she could not provide this telephone number.

On 8/7/23 I made telephone contact and email contact with the Midland Wound Clinic to discuss Resident B's wound care. I left voicemail and email messages for Caryn Leuenberger, Nurse Manager.

On 8/10/23 I conducted an unannounced follow-up on-site investigation at the facility. I made direct observations of Resident A on this date. Resident A was clean, and his incontinence brief was clean and dry. He was found to be in a clean and well-maintained condition on this date.

On 8/10/23, during on-site investigation, I interviewed Responsible Person, Susan Tice. Ms. Tice reported that she has worked at the facility for about 3.5 years. She reported that she works all shifts, wherever she is needed. Ms. Tice reported that the overnight shift (11p-6am) is primarily staffed by Ms. Marshall or Responsible Person, Doug Tester. Ms. Tice reported that Resident A is usually changed at least four times per day and repositioned when he is changed. She reported that she usually comes in for her morning shift around 8am and has not noticed Resident A being left in soiled undergarments. She reported that Resident A and Resident C are bedbound. She further reported that Resident B spends a good amount of time in bed but she is able to get up into a wheelchair and participate in activities. She reported that of the five current residents, Resident A and Resident C have wounds, the other residents do not have wounds. When asked about Resident A's wound on his coccyx she reported that he has a "large open wound on his back." She additionally reported that the wound is looking better and, "it's not looking so infected." When asked when Resident A's wounds began to develop Ms. Tice reported, "about two months ago." Ms. Tice reported that she had never heard Ms.

Kryska make statements about poor quality of care. She did report that Ms. Kryska worked at the facility for about two to three months before quitting.

During on-site investigation on 8/10/23 I interviewed Responsible Person, Heather Faunce-Tester. Ms. Faunce-Tester reported that she is new to the facility and has only been employed about two weeks. She reported that she works days (6am to 3pm) and some midnight shifts. She reported that she has never found Resident A completely saturated with urine and feces and left in an unclean manner. She further reported that the responsible persons do “double brief” Resident A, referring to placing two incontinence briefs on Resident A at a time. She reported that this is done because Resident A frequently urinates large amounts of urine and they do not want this to soak his bedding and himself. Ms. Faunce-Tester reported that Resident A and Resident B both have wounds. She reported that Resident A’s wound is “the deepest wound I’ve ever seen”. She further reported that the wound appears to be healthy, meaning the tissue around the wound does not appear infected and it seems to be pink and healing.

During on-site investigation on 8/10/23 I interviewed Ms. Marshall. Ms. Marshall reported that Resident A has now signed on with a new hospice provider, All Valley Hospice, on 8/9/23, per Citizen 1’s request. She reported that this is the third hospice provider to provide care to Resident A since he moved to the facility. She reported that the first hospice provider was Residential Hospice Services. Ms. Marshall reported that Resident A’s wound developed while he was under the care of Residential Hospice and there were no warning signs, “it just appeared overnight.”

During on-site investigation on 8/10/23 I interviewed Citizen 2. Citizen 2 is the son of Resident C. Citizen 2 reported that Resident C has resided at the facility for about one year. He reported that he is very pleased with the responsible persons providing care to his mother. Citizen 2 reported that he makes unannounced visits to the facility and has never found his mother to be in a condition where she was soiled and not cared for. He reported that Ms. Marshall prefers when visits are made between the hours of 9am-9pm, but he is welcome whenever he needs to stop by. He reported that he has two sisters who also visit, unannounced and they have not had any reported concerns about the quality of the care being provided to Resident C. Citizen 2 reported that he visits Resident C 3-4 days per week and his sisters visit 2-3 times per month.

On 8/10/23 I received an email correspondence from Caryn Leuenberger, BSN, RN, Clinical Nurse Manager, for the Wound Treatment Center-Midland. Ms. Leuenberger reported that her agency is currently providing care for Resident B and have been providing her care since December 2017. She reported that Resident B’s wound has been healing and looks to heal completely. She reported that she interviewed staff members and Resident B’s providers at the wound center, and they had no concerns about Resident B not receiving adequate care at the facility. She noted that Resident B is found, clean, well kempt, and her peri area is never

soiled when she arrives for her treatments. Ms. Leuenberger reported that Resident B's wound will worsen when she spends too much time in her wheelchair.

On 9/6/23 I interviewed Monica Judd, RN, with Residential Hospice Services. Ms. Judd reported that she had made at least one visit to Resident A at the facility when her hospice program was providing for his care, but she does not have a strong recollection of this visit. She advised for me to interview Shannon Thompson, RN, with Residential Hospice Services, as she had been more involved with Resident A's care needs.

On 9/6/23 I interviewed Ms. Thompson, via telephone. Ms. Thompson reported that she had been caring for multiple residents at the facility in the past. Ms. Thompson reported that Ms. Marshall was difficult to please and went through multiple nursing staff because she did not agree with the care being provided. Ms. Thompson reported that Ms. Marshall had a history of not following physician orders when it came to wound care and would apply dressings and medications to wounds that the physician had not prescribed. Ms. Thompson reported that this conversation was had with Ms. Marshall regarding another resident at the facility. She reported that this resident had bilateral heal ulcers and she discovered that Ms. Marshall was applying the wrong dressings to these wounds. She reported that she had a verbal exchange with Ms. Marshall regarding this issue and did disclose the situation to the family of this resident. Ms. Thompson reported that Ms. Marshall became upset with her and yelled at her in front of Resident A, when Ms. Thompson was at the facility to perform care for Resident A. She reported that Resident A did not have wounds while she was caring for him and this outburst in front of Resident A was related to the other resident Ms. Thompson had been caring for. She reported that the social worker with Residential Hospice arrived during this outburst. Ms. Thompson reported that she then excused herself from the facility and later that week found that Resident A had been transferred to another hospice provider. Ms. Thompson reported that when Residential Hospice was caring for Resident A he had "No open wounds whatsoever." She further reported that she did not see a time when the residents she was providing care for had not been kept clean and dry by the responsible persons in the facility. She reported that the only issue she found was that Ms. Marshall was not following wound care orders from the physician.

I reviewed the nursing documentation provided by Ms. Noxon with the photographs of Resident A's wound and physical state, provided by Ms. Kobel. There are photographs on dates, 6/9/23 & 6/18/23, that verify the unsanitary condition Ms. Kobel found Resident A when she arrived for his wound care. These photographs depict Resident A being left in extremely saturated incontinence briefs and liners, covered with urine and feces. The photographs indicate a lengthy amount of time had elapsed between when Resident A had been changed prior as to the amount of urine and feces present. There was also a photograph dated 6/15/23 which depicted the red blistering on Resident A's face, as described by Ms. Kobel.

APPLICABLE RULE	
R 400.1407	**Resident admission and discharge criteria; resident assessment plan; resident care agreement; house guidelines; fee schedule; physician's instructions; health care appraisal.**
	(5) At the time of a resident's admission, a licensee shall complete a written resident care agreement which shall be established between the resident or the resident's designated representative, the responsible agency, and the licensee. A department form shall be used unless prior authorization for a substitute form has been granted in writing by the department. A resident shall be provided the care and services as stated in the written resident care agreement.
ANALYSIS:	Based upon the interviews conducted, review of Resident A's *AFC-Resident Care Agreement, Assessment Plan for AFC Residents* and the review of The Care Team Hospice nursing documentation, in conjunction with the photographs taken by the hospice providers of the condition, Resident A did not receive the personal care, supervision and protection as agreed to be provided by licensee Mary Marshall in his AFC- Resident Care Agreement and detailed in his assessment plan and hospice orders. Specifically, on 6/9/23 hospice notes detailed educating and reminding responsible persons/licensee (staff) to "change and turn" Resident A every 2 hours however Resident A was found on multiple dates (6/7/23, 6/9/23, 6/13/23, 6/18/23, 6/21/23, 6/25/23, 7/18/23) in excessively soiled undergarments and bedding. By not following this hospice directive and providing this personal care, it became more difficult for the exceptionally large wound on his coccyx to heal. Instead, Resident A was observed with two unexplained black eyes on two separate occasions even though he is not mobile, a large blister on his cheek with no explanation from licensee Mary Marshall and development of new wounds on his penis and scrotum. Further, two different hospice nursing providers reported that conversations were had with responsible persons and Ms. Marshall regarding following wound care orders and providing for regular incontinence care and repositioning. These conversations occurred on 6/9/23, 6/21/23, 6/25/23, and 7/18/23. On 7/20/23, RN Kelly Kobel documented in Resident A's hospice notes that licensee Mary Marshall refused to discuss Resident A's medical care and status with the nurse. Licensee Mary Marshall's refusal does not provide Resident A with personal care as agreed upon either.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.1409	**Resident rights; licensee responsibility.**
	(1) Upon a resident's admission to the home, the licensee shall inform and explain to the resident or the resident's designated representative all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.**
ANALYSIS:	Based upon the interviews conducted and the review of The Care Team Hospice nursing documentation, in conjunction with the photographs taken by the hospice providers of the condition Resident A had been found in on multiple dates (6/7/23, 6/9/23, 6/13/23, 6/18/23, 6/21/23, 6/25/23, 7/18/23) it can be determined that Resident A had not been treated with consideration and respect, with due recognition of personal dignity, as he had been left in excessively soiled undergarments and bedding for prolonged periods of time, aiding in further difficulties providing for adequate wound care and healing of the exceptionally large wound on his coccyx. Two different hospice nursing providers reported that conversations were had with responsible persons and Ms. Marshall regarding following wound care orders and providing for regular incontinence care and repositioning. These conversations were reported to have been met with confrontation and ultimately discharge from these hospice programs.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.1416	**Resident health care.**
	(1) A licensee, in conjunction with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician with regard to such items as medications, special diets, and other resident health care needs that can be provided in the home.

ANALYSIS:	Based upon the interviews conducted and the review of The Care Team Hospice nursing documentation, in conjunction with the photographs taken by the hospice providers of the condition Resident A had been found in on multiple dates (6/7/23, 6/9/23, 6/13/23, 6/18/23, 6/21/23, 6/25/23, 7/18/23) it can be determined that on these dates notated, the responsible persons and licensee were not following directives from hospice nursing staff members to reposition Resident A and change his incontinence briefs every two hours. The photographs reviewed demonstrated that Resident A was left in soiled briefs for longer periods of time judging by the saturation of his briefs and the surrounding bedding, as well as his wound dressing on his coccyx.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 8/1/23 I completed an on-site investigation at the facility with Mr. Daniels. We interviewed Ms. Marshall at this time. Ms. Marshall reported that she knew we were investigating the care at the facility because the hospice nurse with The Care Team Hospice was mad that Ms. Marshall "went above her head" to take Resident A off his Flexeril medication. Ms. Marshall reported she and Citizen 1 had noticed that the Flexeril medication, which was ordered to be administered three times per day, was making Resident A lethargic and unresponsive. She reported Resident A appeared "stoned" when he was taking this medication three times per day. Ms. Marshall reported that Citizen 1 requested that the 3pm daily dose of Flexeril be stopped and instructed Ms. Marshall to just give the morning and evening doses. Ms. Marshall reported that since Citizen 1 is the Power of Attorney for Resident A, she followed this directive and stopped the 3pm dose of the Flexeril for Resident A. She reported she was not certain on which date this 3pm dose was stopped. Ms. Marshall reported that Resident A still appeared lethargic after this change had been made and she sought advice from Resident A's primary care provider, Ms. Butcher. She reported that Ms. Butcher communicated to Ms. Marshall on 7/14/23 that the Flexeril medication was going to be discontinued and Resident A would be ordered an alternate medication.

During the on-site investigation on 8/1/23 I reviewed the Medication Administration Records (MARs) for Resident A for the months of June 2023 and July 2023. On the June 2023 MAR next to the Flexeril medication was a notation that read, "Hold", next to the 3pm administration record. It was then indicated with an "H" on the MAR that the Flexeril was being held from administration to Resident A at 3pm for the dates 6/7/23 – 6/30/23. On the July 2023 MAR the Flexeril does not appear in the list of

3pm medications. It does appear on the MAR under the 8pm and “brkfst” medication administrations as well as the PRN medications. There were recorded dosages administered at “brkfst” and 8pm on the following dates, 7/1/23 – 7/14/23. I also reviewed the prescription bottle for Resident A’s ordered Flexeril. The label reads, Flexeril/Cyclobenzaprine HCL 10MG PO TAB, take one tablet by mouth three times daily muscle spasms. The medication was ordered by Susan Jurasek, MD.

On 8/2/23 I interviewed Citizen 1 via telephone. Citizen 1 reported she had requested licensee Ms. Marshall stop the administration of the Flexeril at the 3pm time slot but she could not recall what date she had requested this change. She reported that she had requested this change in medication administration as she felt the hospice provider was just trying to “sedate” Resident A and she was not happy with this. Citizen 1 did not have recollection of how this change in the administration of the Flexeril was conveyed to the medical provider.

On 8/7/23 I interviewed Ms. Butcher regarding Resident A’s Flexeril medication. Ms. Butcher reported that the Flexeril medication was ordered by the hospice physician and not by Ms. Butcher. She reported Ms. Marshall had reached out to her regarding the medication and wanted assistance getting the medication discontinued. Ms. Butcher reported that she spoke with Ms. Kobel and Ms. Marshall on 7/13/23 about changing the Flexeril from three times daily to an as needed medication and that this change was made.

On 8/9/23 I received an email correspondence from Ms. Kobel. Ms. Kobel reported that Citizen 1 had reached out to her, via text message, on 6/6/23 stating that she felt three times a day was too frequently for Resident A to receive the Flexeril medication. She reported that she had responded to Citizen 1 that they could try to reduce the medication to two times per day to see if this helped. She also reported that she had difficulty verifying, due to lack of communication with the responsible persons and the licensee, what dosage of the Flexeril Resident A was actually receiving per day. She reported that a former Responsible Person, Sky Kryska, had stated to her that Ms. Marshall was not allowing the Flexeril medication to be administered as ordered. Ms. Kobel stated she received telephone call from Ms. Butcher on 7/13/23, who stated that Ms. Marshall felt they “were drugging [Resident A].” Ms. Kobel reported that Ms. Marshall had never conveyed this message to her during her visits with Resident A or by telephone.

On 8/4/23 I received an email from Kelle Noxon, MSN, RN, CHPN, Hospice Branch Director for The Care Team Hospice. This email contained documentation from The Care Team Hospice staff pertaining to Resident A. These documents contained nursing visit notes. It was noted by Ms. Kobel, on the dates, 6/18/23, 6/21/23, & 6/25/23, that there were concerns Resident A may not be receiving his prescribed medications due to symptoms he was exhibiting on these dates.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(2) Medication shall be given pursuant to label instructions.
ANALYSIS:	Based upon interviews with Ms. Marshall, Citizen 1, Ms. Butcher, Ms. Kobel, as well as review of Resident A's MARs for June 2023 and July 2023, and nursing documentation from The Care Team Hospice, it can be determined that Ms. Marshall did not administer Resident A's Flexeril medication as prescribed, three times per day from 6/7/23 through 7/14/23. Although Citizen 1 had made a request to Ms. Kobel & Ms. Marshall to decrease the frequency of the Flexeril administration, there is a lack of evidence that Ms. Marshall carried this request further and verified with a physician or pharmacist regarding the modification of the dosage prior to 7/13/23 when she spoke with Ms. Butcher, who in turn spoke with Ms. Kobel and modified Resident A's Flexeril medication to as needed instead of routine medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(4) When a licensee or responsible person supervises the taking of medication by a resident, the licensee or responsible person shall comply with the following provisions: **(b) Not adjust or modify a resident's prescription medication without agreement and instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record in writing any adjustments or modifications of a resident's prescription medication.**

ANALYSIS:	Based upon interviews with Ms. Marshall, Citizen 1, Ms. Kobel, & Ms. Butcher, as well as review of Resident A's MARs for June 2023 and July 2023, it can be determined licensee Ms. Marshall modified the frequency of which Resident A was to receive his prescribed Flexeril medication without consulting and receiving agreement from the prescribing physician, Susan Jurasek, M.D., or a pharmacist who has knowledge of Resident A's medical needs. The conversation to modify Resident A's Flexeril prescription did not take place until 7/13/23, and the frequency of administration was modified, by Ms. Marshall on 6/7/23, as noted on the June 2023 MAR for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During on-site investigation on 8/10/23 I requested to review the employee file of former Responsible Person, Sky Kryska. Ms. Marshall reported that she did not have a file for this former employee and could not provide this individual's telephone number as she did not keep any records on this individual.

APPLICABLE RULE	
400.734b	**Employing or contracting with certain individuals providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; determination of existence of national criminal history; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.**
	(3) An individual who applies for employment either as an employee or as an independent contractor with an adult foster care facility or staffing agency and who has not been the subject of a criminal history check conducted in compliance with this section shall give written consent at the time of application for the department of state police to conduct a criminal history check under this section, along with identification acceptable to the department of state police. If the individual has been the subject of a criminal history check conducted in compliance with this section, the individual shall give written consent at the time of application for the adult foster care facility or staffing agency to obtain the criminal history record information as prescribed in subsection (4) or (5) from the relevant

	licensing or regulatory department and for the department of state police to conduct a criminal history check under this section if the requirements of subsection (11) are not met and a request to the Federal Bureau of Investigation to make a determination of the existence of any national criminal history pertaining to the individual is necessary, along with identification acceptable to the department of state police. Upon receipt of the written consent to obtain the criminal history record information and identification required under this subsection, the adult foster care facility or staffing agency that has made a good-faith offer of employment or an independent contract to the individual shall request the criminal history record information from the relevant licensing or regulatory department and shall make a request regarding that individual to the relevant licensing or regulatory department to conduct a check of all relevant registries in the manner required in subsection (4). If the requirements of subsection (11) are not met and a request to the Federal Bureau of Investigation to make a subsequent determination of the existence of any national criminal history pertaining to the individual is necessary, the adult foster care facility or staffing agency shall proceed in the manner required in subsection (5). A staffing agency that employs an individual who regularly has direct access to or provides direct services to residents under an independent contract with an adult foster care facility shall submit information regarding the criminal history check conducted by the staffing agency to the adult foster care facility that has made a good-faith offer of independent contract to that applicant.
ANALYSIS:	Background check information, including verification of fingerprinting, was not available to review for former Responsible Person, Sky Kryska as Ms. Marshall reported she did not have this information or any employee file information for this former responsible person.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan and due to the quality of care violations, a six-month provisional license is being recommended at this time.

09/13/23

_____

Jana Lipps Date
Licensing Consultant

Approved By:

09/14/2023

_____

Dawn N. Timm Date
Area Manager