



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 15, 2023

Tracy Rucker
Peace of Mind Caregiving Facility LLC
19076 England Drive
Macomb, MI 48042

RE: License #: AS500395475
Investigation #: 2023A0617026
Peace of Mind Caregiving Facility
AMENDED REPORT
Original Report dated June 21, 2023

Dear Ms. Rucker:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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 (248) 975-5053.

Sincerely,

A handwritten signature in blue ink, appearing to read "EJ".

Eric Johnson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
3026 W Grand Blvd.
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500395475
Investigation #:	2023A0617026
Complaint Receipt Date:	05/04/2023
Investigation Initiation Date:	05/05/2023
Report Due Date:	07/03/2023
Licensee Name:	Peace of Mind Caregiving Facility LLC
Licensee Address:	19076 England Drive Macomb, MI 48042
Licensee Telephone #:	(586) 693-5693
Administrator:	Tracy Rucker
Licensee Designee:	Tracy Rucker
Name of Facility:	Peace of Mind Caregiving Facility
Facility Address:	3580 Denson Drive Sterling Heights, MI 48310
Facility Telephone #:	(586) 693-5693
Original Issuance Date:	04/11/2019
License Status:	REGULAR
Effective Date:	01/22/2023
Expiration Date:	01/21/2025
Capacity:	6
Program Type:	AGED; ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
There are concerns that Resident A was not being moved while placed at the facility. Resident A currently has Stage 2 and Stage 3 bed sores. Resident A also appears to have poor dental hygiene and her vaginal area was not very clean.	Yes

III. METHODOLOGY

05/04/2023	Special Investigation Intake 2023A0617026
05/04/2023	APS Referral Adult Protective Services (APS) referral received – APS worker is Shelley Anders
05/05/2023	Special Investigation Initiated - Face to Face Email sent to LD Ms. Rucker
05/05/2023	Contact - Document Sent Email sent to Ms. Rucker
05/05/2023	Contact - Document Received Email received from Ms. Rucker
05/07/2023	Contact - Document Received I received the following documents from licensee designee Tracy Rucker for Resident A: Assessment plan, AFC care agreement, Funds Part 1 and 2, Resident ID form, inventory of valuables, driver's license, daily progress notes, weight record, health care appraisal, resident registry and a skin assessment completed by Ms. Rucker on 3/19/23.
05/08/2023	Contact - Document Received Fax received from Ms. Rucker
05/10/2023	Inspection Completed On-site I conducted an unannounced onsite investigation of the facility. During the onsite investigation I interviewed licensee designee Mrs. Rucker. Resident A was discharged from the facility on 04/17/23.

05/13/2023	Contact - Document Received Email received from Ms. Rucker
05/25/2023	Contact - Telephone call made I conducted an interview with Resident A's daughter.
05/26/2023	Contact - Document Received Email received from Resident A daughter
06/01/2023	Contact - Document Received Email rec from Resident A daughter- I received the following documents from Resident A s daughter: Hospital records from Troy Beaumont; Social worker notes/ charts from Troy Beaumont; pictures of Resident A's injuries
06/02/2023	Contact - Document Sent Email sent to Resident A daughter.
06/05/2023	Contact - Document Received Email received from APS worker Ms. Heather Horan
06/05/2023	Contact - Document Sent Email sent to Ms. Horan
06/06/2023	Contact - Document Received Email received from Ms. Horan
06/08/2023	Contact - Telephone call made TC to Divinity Home Care - Ms. Carol Robinson
06/08/2023	Contact - Document Sent Email request of Records to Ms. Carol Robinson - Divinity Home Care
06/08/2023	Contact - Telephone call made TC with Beaumont Troy Social Work department
06/08/2023	Contact - Telephone call made I interviewed Ms. Amy Canup, social worker for St. Anthony Health Care.
06/09/2023	Contact - Document Received Email received from Ms. Carol Robinson
06/12/2023	Contact - Document Received Email received from Ms. Robinson

06/12/2023	Contact - Telephone call made TC with Ms. Amy Canup
06/12/2023	Contact - Document Received Received Resident A's medical documentation - skin assessment
06/12/2023	Contact - Document Received Fax rec from Ms. Robinson - Resident A medical records
06/12/2023	Exit Conference I contacted licensee designee Tracey Rucker for the exit conference to inform her of the findings of the investigation.
06/21/2023	Exit Conference I contacted licensee designee Tracey Rucker for the exit conference to inform her of the additional rule violations.

ALLEGATION:

There are concerns that Resident A was not being moved while placed at the facility. Resident A currently has Stage 2 and Stage 3 bed sores. Resident A also appears to have poor dental hygiene and her vaginal area was not very clean.

INVESTIGATION:

On 05/04/23, I received a complaint on the Peace of Mind Caregiving facility. The complaint stated, Resident A needs assistance with being moved, managing her dental care, and managing her hygiene so it would have been the group home's responsibility to manage these things. There are concerns that Resident A was not being moved while in their care and it was prescribed that she be moved up to three times a day. Resident A currently has Stage 2 and Stage 3 bed sores. She also appears to have poor dental hygiene and her vaginal area was not very clean.

It should be noted that the facility was previously placed on a provisional license from 07/22/22 to 01/22/23 per Special Investigation Report #2022A0617016.

On 05/07/23, I received the following documents from licensee designee Tracy Rucker for Resident A: Assessment plan, AFC care agreement, Funds part 1 and 2, Resident ID form, inventory of valuables, Driver's License, Daily progress notes, weight record, Health care appraisal, resident Registry and a skin assessment completed by Ms. Rucker on 3/19/23. According to the Resident registry, Resident A was admitted to the facility on 03/19/23. According to the skin assessment of Resident A that was completed on 03/19/23, by Ms. Tracy Rucker states that, "Resident A's crack of the buttocks area has skin tear, skin very dry, skin white and red in color. Resident A's private area had very dry skin." According to Resident A's Health care appraisal completed on 03/18/23

by Dr. Addulilah Obeid, Resident A had no abnormalities to her skin, buttock, or private area. According to Resident A's assessment plan, she requires assistance toileting, managing hygiene. Resident A uses a wheelchair, has dementia, is unable to understand verbal communication, and wears dentures.

The daily progress notes are listed below:

- Daily Progress Note-3/19- Used barrier cream due to dry skin. Wound size of a dime. 2 hourly rotations.
- Daily Progress Note-3/20- 3/27/23 states that -2 hourly rotation and wound care were completed.
- Daily Progress Note-3/28-2 hourly rotation and wound care completed. Resident A Refused to get out of bed on this date.
- Daily Progress Note-3/29- 3/30/23 states that -2 hourly rotation and wound care were completed.
- Daily Progress Note-4/1- 2 hourly rotation and wound care completed. Resident A Refused to get out of bed on this date.
- Daily Progress Note-4/2-2 hourly rotation and wound care were completed.
- Daily Progress Note-4/3-2 hourly rotation and wound care completed. Note reflects wound on butt area is size of a dime.
- Daily Progress Note-4/4-2 hourly rotation and wound care completed. Refused to get out of bed on this date.
- Daily Progress Note-4/5-2 hourly rotation and wound care completed.
- Daily Progress Note-4/6-2 hourly rotation and wound care completed. Refused to get out of bed on this date.
- Daily Progress Note-4/7-2 hourly rotation and wound care completed. Note reflects wound on butt area is size of a dime.
- Daily Progress Note-4/8-2 hourly rotation and wound care completed. Note reflects applied protective skin barrier to buttocks.
- Daily Progress Note-4/9-2 hourly rotation (resident must sit up), afraid to get out of bed.
- Daily Progress Note-4/10-2 hourly rotation - No wound care completed.
- Daily Progress Note-4/11-2 hourly rotation, Refused to get out of bed.
- Daily Progress Note-4/12-2 hourly rotation, Refused to get out of bed.
- Daily Progress Note-4/13-2 hourly rotation, Refused to get out of bed.

On 05/10/23, I conducted an unannounced onsite investigation of the facility. During the onsite investigation I interviewed licensee designee Mrs. Rucker. Resident A was discharged from the facility on 04/17/23.

According to Ms. Rucker, Resident A arrived at the facility on 03/19/23 with bedsores. Ms. Rucker stated that she completed her own skin assessment on Resident A and she found a bedsore around the crack of Resident A's buttock. I reviewed Resident A's Health Care appraisal with Ms. Rucker. According to Resident A's Health care appraisal completed on 03/18/23 by Dr. Addulilah Obeid, Resident A had no abnormalities to her

skin, buttock or private area. Ms. Rucker stated that Resident A was a large woman, and she could have developed the bedsore while being transported to the facility. Ms. Rucker stated that it was possible that the bedsore could develop in the 24 hours between the assessment completed by Dr. Obeid and the assessment completed by herself. Ms. Rucker stated that staff got Resident A was out of bed every day unless she refused, until Resident A was be evaluated by the physical therapist. Once Resident A started physical therapy, the facility got Resident A out of bed every other day according to Ms. Rucker. On 04/07/23, Resident A was evaluated by a nurse Jeannie Mikulski from Divinity Home Care. Ms. Rucker stated that the nurse did not find any bedsores or had any concerns. Ms. Rucker could not produce any documentation from the medical evaluation on 04/07/23. According to Ms. Rucker, Resident A's daughter picked up Resident A on 04/13/23, and took her to a doctor's appointment with Resident A's personal doctor. Resident A's daughter brought Resident A back to the facility with a doctor's order stating that Resident A needs to be moved three times a day. Ms. Rucker provided me with the doctor's order to review. According to the order from Dr. Justin E. Trivax, Resident A needs the following:

- continue physical therapy/ occupational therapy
- increased ambulant/ activity
- reduced bedtime, should be up in a chair at least 3 times per day
- Resident A's leg should be elevated while in bed or chair

According to Ms. Rucker, she immediately implemented the doctor's orders. On 04/16/23, Resident A was sent to the emergency via EMS. Ms. Rucker stated that the morning of 04/16/23, when staff woke Resident A up for her morning diaper change and med pass at 7 am, Resident A had blood in her urine. Resident A seemed confused, but she was alert and talking but not herself at all. Ms. Rucker called and spoke with Resident A's daughter and reported it to her and the facility called EMS. Ms. Rucker stated that Resident A's family visited her at the facility every other day and there were happy with her care.

On 05/13/23, I received an email from Ms. Rucker. The email stated, "Hello, this letter is in regard to the investigation of the complaint made against Peace of Mind caregiving facility. I ask that you be mindful of the reason Resident A's diaper was wet and unchanged when she arrived at the Troy hospital. The reason was because she was a heavy wetter meaning she drinks a lot of fluids and urinates heavy. The morning that she was sent to the hospital was 7 am in the morning and we felt it was urgent to send her to the hospital. It could have appeared that she was in a wet diaper. Because of that, the hospital nurse said Resident A was not taken care of well. The morning when we woke her up for her morning diaper change and med pass at 7 am Resident A had blood in her urine, and she seemed confused, but she was alert and talking but not herself at all. I called and spoke with her daughter and reported it to her. Also, Peace of Mind facility called EMS and the EMS arrived so quickly there was not time to change her nightly diaper it was an urgent matter. So, we thought it was more important to get her to the hospital to be evaluated. That is the reason the hospital nurse is saying that Resident A arrived in a wet diaper seeming to look like she was uncared for properly but that is totally not the case. Resident A's family visited her at the facility every other day

and they were happy with her care. Also, Resident A drinks a lot of fluids all day; she drinks several 8 oz cups of water all through the day and she eats well. Most of all the pictures I have of Resident A, was her up and out of the bed and in her wheelchair just the day before we sent Resident A to the hospital. She was laughing and joking and happy, just 13 hours before.”

On 05/25/23, I conducted an interview with Resident A’s daughter. According to Resident A’s daughter, Resident A was admitted into the Peace of Mind facility on March 19, 2023, when she was transferred from St. Anthony’s rehab facility. Resident A was placed at this facility because she has vascular dementia. Before arriving at Peace of Mind, she had a healthy skin check-up which didn’t reveal any issues. Upon arrival, at Peace of Mind, they noticed that there was only one staff member on duty, Tracy Rucker. Ms. Rucker informed Resident A’s daughter that her mother wouldn’t be getting out of the bed until physical therapy arrived from Divinity Home Care. Ms. Rucker told Resident A’s daughter that there were no bed sores and that everything was fine. Resident A’s daughter had to go back and forth with the doctor and Divinity Home Care to arrange for her mother to have the care she needed. According to Resident A’s daughter, the doctor and a nurse from Divinity Home Care came to see Resident A on April 7th to do an assessment. The nurse reported concern about Resident A not being moved. The first time that she ever used a wheelchair was on 4/13 when she was taken to the doctor’s office. At that time, the provider wrote a script indicating the need to get Resident A up at least three times daily, but the facility didn’t comply. On 4/16, the ambulance transported Resident A to the hospital. The nurses at the hospital were so upset with her physical condition that they notified Macomb Adult Protective Services about their findings. Resident A presented with blood in her urine, a UTI, her genitalia hadn’t been cleaned, she was dehydrated to the point where the nurse could tell by the odor from her body, she had a Stage 2 and a Stage 3 bedsore, and her mouth had “thrush like” symptoms. According to Resident A’s daughter, Ms. Rucker told her that she could only visit Resident A twice a week for two hours each visit because Resident A had a roommate and that would not be courteous to Resident A’s roommate. Resident A’s daughter stated that Ms. Rucker never notified her that Resident A had bedsores.

On 06/01/23, I received the following documents from Resident A’s daughter:

- Hospital records from Troy Beaumont
- Social worker notes/ charts from Troy Beaumont
- Pictures of Resident A’s injuries

According to the hospital records from Troy Beaumont completed by nurse Christina G (full last name not available) on 04/16/23 at 09:20am, Resident A is confused. She is able to state her name. She appears pleasantly confused. Daughter is at bedside and reports Resident A has dementia and is normally confused. However, Resident A is normally more talkative and can answer more questions than what she is today. Resident A does not follow any commands due to confusion. Resident A has poor oral care. Mouth is coated in white film. Resident A’s vaginal area was extremely dirty. Resident A cleaned with bath wipes prior to straight cath. Resident A’s urine is brown in

color with pus, thick and foul smelling. Resident A does have a Stage 1 bedsore on sacral area.

According to the hospital records from Troy Beaumont completed by nurse Heather L (full last name not available) on 04/16/23 at 5:50pm, Resident A was admitted to the emergency room on 04/16/23. Resident A was diagnosed with Stage 2 on sacrum, dry flaky skin on feet.

According to the Beaumont Troy social worker notes from Sean M (full last name not available), Resident A has a couple shallow full thickness wounds located to inter gluteal cleft area, r/o intertrigo vs stage III pressure injury. Wound care regimen established.

I observed pictures of Resident A which display gruesome bedsores to her buttock area. Pictures also show Resident A with a dry mouth and lips, that included white film.

On 06/05/23, I conducted an interview with Adult Protective Services worker Heather Horan. According to Ms. Horan, the progress notes that she obtained from the Peace of Mind facility do not reflect wound care for Resident A was completed as of 4/9/23. Ms. Horan stated that she is not substantiating the allegations of neglect. However, that may change following supervision review.

On 06/08/23, I received an email from Ms. Horan that stated, Resident A passed away earlier this week and Ms. Horan will be submitting the investigation for closure. Ms. Horan is not substantiating the allegations of neglect. However, that may change following supervision review.

On 06/08/23, I interview Ms. Carol Robinson of Divinity Home Care. According to Ms. Robinson, nurse Jeannie Mikulski completed an assessment of Resident A on 04/07/23. Nurse Jeannie Mikulski found Stage 2 pressure ulcer on sacrum. Ulcer is 1 cm width, 1 sq cm, 0.1 depth. I gave both a verbal and written request of records to Ms. Robinson.

On 06/08/23, I interviewed Ms. Amy Canup, social worker for St. Anthony Health Care. Ms. Canup stated that the doctor completed a full body skin assessment of Resident A on 03/17/23 and no abnormalities were found. Also, an examination of Resident A on 03/18/23 and no bedsore or any issues were noted. I gave an oral request of records to Ms. Canup.

On 06/12/23, I received and reviewed medical documents from St. Anthony Health Care regarding Resident A. LPN Dianne Fuderanan completed a full body skin assessment of Resident A on 03/17/23 and no abnormalities were found. LPN Dianne Fuderanan also completed an examination of Resident A on 03/18/23 and no bedsore or any issues were noted.

On 06/12/23, I received and reviewed medical documents from Divinity Home Care regarding Resident A. According to the medical documentation, nurse Jeannie Mikulski

completed an assessment of Resident A on 04/07/23. Nurse Jeannie Mikulski found stage 2 pressure ulcer on sacrum. Ulcer is 1 cm width, 1 sq cm, 0.1 depth.

On 6/12/23, I contacted licensee designee Tracey Rucker for the exit conference to inform her of the findings of the investigation. Ms. Rucker was in disagreement with the recommendation of this report. Ms. Rucker stated that Resident A arrived at the facility with the bedsore which was the size of a nickel. Ms. Rucker stated that Resident A was a large woman and the tear in her skin could have occurred during the transportation to her facility.

On 06/21/23, I held a second exit conference, with Ms. Rucker to discuss the updated recommendations and rule violations. Ms. Rucker again denied the allegations, as well as inquired of the rules and regulations to operate an unlicensed facility in the event that her license is revoked.

APPLICABLE RULE	
R 400.14301	Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physicians instructions; health care appraisal.
	<p>(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions:</p> <p>(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.</p> <p>(b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.</p>
ANALYSIS:	<p>Ms. Rucker denied all allegations and stated that Resident A arrived at the facility with a small bed sore. Resident A was admitted into the Peace of Mind facility on 03/19/23. Ms. Rucker's explanation to the cause of Resident A's bedsore was that Resident A was a large woman, and she could have developed the bedsore while being transported to the facility. Ms. Rucker stated that it was possible that the bedsore could develop in the 24 hours between the assessment completed by Dr. Obeid and the assessment completed by herself upon Resident A's arrival to the facility.</p> <p>Resident A was admitted to Troy Beaumont Hospital on 04/16/23. According to the hospital records from Troy Beaumont completed by nurse Christina G on 04/16/23 at 09:20am,</p>

	<p>Resident A has poor oral care. Mouth is coated in white film. Resident A's vaginal area was extremely dirty. Resident A's urine is Brown in color with pus, thick and foul smelling. Resident A does have Stage 1 bedsore on sacral area. According to the hospital records from Troy Beaumont completed by nurse Heather L on 04/16/23 at 5:50pm, Resident A was admitted to the emergency room on 04/16/23. Resident A was diagnosed with Stage 2 on sacrum, dry flaky skin on feet.</p>
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.14303	Resident care; licensee responsibilities.
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	<p>Based on the information gathered through my interviews and documentation reviews, the facility did not provide personal care as defined in the act and as specified in Resident A's written assessment plan. According to Resident A's assessment plan, the facility was supposed to provide assistance with the following: toileting, bathing, grooming, personal hygiene and mobility.</p> <p>On 04/07/23, Nurse Jeannie Mikulski completed an assessment of Resident A. Nurse Mikulski found Stage 2 pressure ulcer on sacrum. Ulcer is 1 cm width, 1 sq cm, 0.1 depth. Resident A was admitted to Troy Beaumont Hospital on 04/16/23. According to the hospital records from Troy Beaumont completed by nurse Christina G on 04/16/23 at 09:20am, Resident A has poor oral care. Mouth is coated in white film. Resident A's vaginal area was extremely dirty. Resident A's urine is brown in color with pus, thick and foul smelling. Resident A does have Stage 1 bedsore on sacral area. According to the hospital records from Troy Beaumont completed by nurse Heather L on 04/16/23 at 5:50pm, Resident A was admitted to the emergency room on 04/16/23. Resident A was diagnosed with Stage 2 bedsores on sacrum and dry flaky skin on feet.</p>
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.14305	Resident protection.
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	<p>Based on the information gathered through my interviews and documentation reviews, the facility did not treat and care for Resident A with dignity and her personal needs, including protection and safety, have not been attended to at all times in accordance with the provisions of the act. Ms. Rucker denied all allegations and stated that Resident A arrived at the facility with a small bed sore. Resident A was admitted into the Peace of Mind facility on 03/19/23. Ms. Rucker's explanation to the cause of Resident A's bedsore was that Resident A was a large woman, and she could have developed the bedsore while being transported to the facility. Ms. Rucker stated that it was possible that the bedsore could develop in the 24 hours between the assessment completed by Dr. Obeid and the assessment completed by herself upon Resident A's arrival to the facility.</p> <p>However, according to Resident A's Health care appraisal completed on 03/18/23 by Dr. Addulilah Obeid, Resident A had no abnormalities to her skin, buttock or private area. According to Resident A's daughter, before Resident A arrived at Peace of Mind, she had a healthy skin check-up which didn't reveal any issues. Ms. Canup stated that the doctor completed a full body skin assessment of Resident A on 03/17/23 and no abnormalities were found. Also, an examination of Resident A on 03/18/23 and no bedsore or any issues were noted.</p> <p>According to medical documentation, LPN Dianne Fuderanan completed a full body skin assessment of Resident A on 03/17/23 and no abnormalities were found. LPN Dianne Fuderanan also completed an examination of Resident A on 03/18/23 and no bedsore or any issues were noted.</p> <p>Nurse Jeannie Mikulski completed an assessment of Resident A on 04/07/23. Nurse Mikulski found stage 2 pressure ulcer on sacrum. Ulcer is 1 cm width, 1 sq cm, 0.1 depth.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

I recommend revocation of the license.

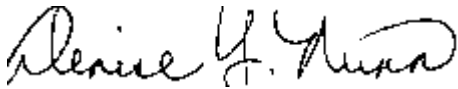


06/21/23

Eric Johnson
Licensing Consultant

Date

Approved By:



06/21/2023

Denise Y. Nunn
Area Manager

Date

**AMENDED REPORT
SPECIAL INVESTIGATION #2023A0617026**

PURPOSE

The purpose of this addendum is to change the recommendation of special investigation #2023A0617026, based upon further review by the department.

METHODOLOGY

06/29/2023	Special Investigation Report sent to Lansing for review with a recommendation for revocation. Recommendation not supported.
10/26/2023	Exit Conference I contacted licensee designee Tracey Rucker for the exit conference to inform her of the change of recommendation.

DESCRIPTION OF FINDINGS AND CONCLUSION:

Upon further review by the department, the recommendation is being changed from revocation due to lack of information and documentation to support disciplinary action. Therefore, the recommendation has been amended to contingent upon receipt of an acceptable corrective action plan (CAP) with no changes to the license status.

On 10/26/23, I held an exit conference, with Ms. Rucker to discuss the updated recommendations to the special investigation. Ms. Rucker was very pleased with the decision and recommendation.

RECOMMENDATION

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

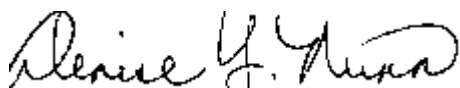


10/26/2023

Eric Johnson
Licensing Consultant

Date

Approved By:



11/09/2023

Denise Y. Nunn
Area Manager

Date