GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

Ronisha Robinson
Symphony Network
910 S. Washington Av
Royal Oak, MI 48067

November 17, 2023

RE: License #: AL110270687
Investigation #: 2024A0579006
Caretel Inns of Royalton-Eaton

Dear Ronisha Robinson:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

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

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Cassandra Duursma

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(269) 615-5050
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL110270687
Investigation #:	2024A0579006
Complaint Receipt Date:	10/02/2023
Investigation Initiation Date:	10/03/2023
Report Due Date:	12/01/2023
Licensee Name:	Cliffside Company
Licensee Address:	910 S. Washington Ave Royal Oak, MI 48067
Licensee Telephone #:	(947) 282-7555
Administrator:	Ronisha Robinson
Licensee Designee:	Ronisha Robinson
Name of Facility:	Caretel Inns of Royalton Eaton
Facility Address:	3905 Lorrain Path St. Joseph, MI 49085
Facility Telephone #:	(269) 428-1111
Original Issuance Date:	10/04/2006
License Status:	REGULAR
Effective Date:	12/11/2021
Expiration Date:	12/10/2023
Capacity:	20
Program Type:	ALZHEIMERS/ AGED

ALLEGATION(S)

	Violation Established?
Resident A did not receive adequate care.	Yes
Resident A's hearing aid was lost or taken by direct care workers.	No
Resident A's room was unclean.	No

II. METHODOLOGY

10/02/2023	Special Investigation Intake 2024A0579006
10/03/2023	Special Investigation Initiated - Face to Face Resident A Tracey Bromagin, Direct Care Worker
10/03/2023	Contact- Documentation Sent Ronisha Robinson, Licensee Designee
11/15/2023	Contact- Documentation Sent Ronisha Robinson, Licensee Designee
11/16/2023	Contact- Telephone Call Made Daniella Alvarado, Direct Care Worker
11/16/2023	Contact- Telephone Call Made Shawnee Warfield, Direct Care Worker
11/16/2023	Contact- Telephone Call Made Employee #1, Direct Care Worker
11/20/2023	Exit Conference Ronisha Robinson, Licensee Designee

ALLEGATION:

Resident A did not receive adequate care.

INVESTIGATION:

On 10/2/23, I received this referral through the Bureau of Information Tracking System on-line complaint system. The referral alleged on 9/28/23, Resident A was sliding out of her wheelchair, and no one helped her. She also needed to be toileted. The three direct care workers (DCWs) working were on their cellphones instead of assisting residents.

On 10/3/23, I completed an unannounced on-site investigation at the home. Contact was made with Resident A and DCW Tracey Bromagin. I attempted to speak to Resident A, but she was napping and would not wake for interviewing.

Ms. Bromagin stated she had heard rumors of the allegations but was not present so she cannot say for certain what happened. She stated Resident A does have a behavior for sliding down while in a sitting position, but she does not believe Resident A has ever fallen and DCWs just adjust her to a more comfortable position when they check on her. She stated when she is working, she is certain Resident A is checked and/or toileted every two hours. She stated she has never had concerns that other DCWs are not toileting Resident A appropriately or witnessed skin breakdown or excessive wetness to Resident A's clothing or bedding that suggested Resident A was not toileted correctly. She denied believing that DCWs were neglecting Resident A or all on their cellphones instead of assisting residents. Although, she stated she was not there, so she cannot say for certain.

On 10/3/23, I exchanged emails with licensee designee Ronisha Robinson. She stated she learned that on 9/28/23, a Hospice Nurse found Resident A leaning in her wheelchair and asked DCWs to assist her with adjusting Resident A and they dismissively replied, "We'll get to it." Ms. Robinson provided the names of the DCWs working that day and reported it was Employee #1 who was reported to have been dismissive of Resident A needing care.

I also received and reviewed Resident A's assessment plan from 8/11/23 which noted she was dependent on DCWs for transferring, positioning, and toileting.

On 11/15/23, I exchanged emails with Ms. Robinson to obtain the contact information for the DCWs working on 9/28/23.

On 11/16/23, I completed a telephone interview with DCW Daniella Alvarado who reported she no longer works at the home and does not specifically recall working on 9/28/23. She stated third shift workers primarily stay on their phones and do not check on or toilet residents appropriately. She stated there have been times when she has arrived in the morning and found Resident A "wet up to her head" with urine

and regularly with her brief fully saturated. She stated Resident A does not urinate excessively, so she knew that Resident A had not been toileted overnight as she should have been. She stated this has happened with other residents as well. She stated some DCWs during the day would complain about having to care for residents and might be slow to respond to them, but they did eventually assist the resident and did not remain on their phones ignoring residents. She denied anyone refusing to assist Resident A.

On 11/16/23, I completed a telephone interview with DCW Shawnee Warfield who reported she no longer works at the home and does not specifically recall working on 9/28/23. She stated she had concern that Resident A was regularly not toileted appropriately by third shift staff. She stated she would often arrive for her shift at 7:00 a.m. and would find Resident A in a completely saturated brief. She stated Resident A did not urinate excessively so she knew that Resident A was not toileted overnight as she should have been. She stated some DCWs she worked with during the day "did have an attitude" and would state they did not want to care for certain residents and would be slow to respond to them if they did not like them. She stated some workers did not like caring for Resident A and would state they were not going to respond to her. She stated if that happened, she or Ms. Bromagin would either remind them it was their job to care for the residents, regardless of their feelings, or they would just toilet Resident A themselves. She denied that Employee #1 was a worker who refused to help and stated it was primarily Ms. Alvarado who did not want to assist residents during the day, although she would eventually care for them.

On 11/16/23, I attempted a telephone interview with Employee #1. An automated message played stating the voicemail box was not set up yet. I sent Employee #1 a text message requesting a return phone call. She responded via text message. I placed a return phone call on 11/17/23. It was not answered. I sent a text message to Employee #1. A response was not received at the time of report disposition.

APPLICABLE RULE	
R 400.15305	**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:	Resident A's assessment plan noted she was dependent upon direct care workers (DCWs) for toileting, transferring, and positioning. The allegations reported Resident A needed positioning and toileting, but staff did not respond. Ms. Robinson confirmed it was reported to her that a Hospice Nurse requested assistance from Employee #1 with positioning Resident A and she was dismissive and not responsive. DCWs Ms. Alvarado and Ms. Warfield stated they witnessed third shift DCWs were not toileting residents, including Resident A, overnight. They stated they could tell because Resident A's brief and/or bedding and clothing would be saturated with urine indicating she was not toileted appropriately. Ms. Warfield and Ms. Alvarado stated some DCWs would be slow to respond to residents they did not want to care for. Employee #1 did not respond to interviewing at the time of report disposition. Based on the interviews completed and documentation reviewed, there is sufficient evidence that Resident A, who is dependent upon DCWs for positioning and toileting, was not treated with dignity and her needs attended to at all times, when it was reported DCWs would not assist with her positioning and DCWs reported regularly finding her in excessively saturated briefs. DCWs also reported other residents were not toileted and left in saturated briefs and that DCWs are slow to respond to residents they "do not like."
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A's hearing aid was lost or taken by direct care workers.

INVESTIGATION:

On 10/2/23, I reviewed the referral which alleged DCWs lost one of Resident A's hearing aids.

On 10/3/23, Ms. Bromagin stated she was the DCW accused of stealing Resident A's hearing aid over a year ago. She stated she did not take Resident A's hearing

aid as it has no purpose to her. She stated she was the DCW who reported the hearing aid missing because she could not find it when she arrived for her shift and woke Resident A up. She stated the previous day, Resident A had an appointment at the hair salon on this home's campus. She stated the hair salon regularly forgets to return resident belongings, such as glasses or hearing aids, when they return from the appointment. She stated they will often return the belongings later in the day. She stated she believes that Resident A's hearing aid was lost at her hair appointment by the staff there and no one noticed or reported it until she did. She stated, unfortunately, she was blamed for it.

On 10/3/23, Ms. Robinson stated there was an incident where Resident A's hearing aid was lost in 2022 and a replacement pair was immediately ordered, they were replaced, and have not gone missing again since.

I reviewed an *Incident/Accident Report* dated 7/21/22 completed by Ms. Bromagin which noted Resident A's hearing aid was missing and believed to have been accidentally thrown away outside of the home. Ms. Bromagin reported on 7/20/22, a DCW working first shift reported they saw Resident A leave with her hearing aids to go to the hair salon that day and when she returned, she was missing a hearing aid. The DCW working that day did not report the missing hearing aid because she believed it was at the hair salon and would be returned. Ms. Bromagin noted that Resident A's hearing aids did regularly fall out of her ears. It was noted second and third shift staff denied seeing Resident A's hearing aid and suggested maybe it was in her bedding or washed in her laundry. It was not found in the laundry or in her bedding. All common areas and Resident A's room was searched on 7/23/22 and the hearing aid was not located. On 7/25/22, the salon beautician denied seeing Resident A's hearing aid and reported it was not present for the appointment. Law enforcement was contacted but a report was not completed since it was not believed the device was stolen. The hearing aids were replaced by Symphony Network at the request of Resident A's family on 7/27/22.

APPLICABLE RULE	
R 400.15315	**Handling of resident funds and valuables.**
	(10) A licensee, administrator, direct care staff, other employees, volunteers under the direction of the licensee, and members of their families shall not accept, take, or borrow money or valuables from a resident, even with the consent of the resident.

ANALYSIS:	Ms. Robinson confirmed Resident A's hearing aid was lost in 2022 but was immediately ordered and replaced. An *Incident/Accident Report* confirmed this. Ms. Bromagin stated she reported Resident A's hearing aid missing in 2022, after Resident A had an appointment at the hair salon on this campus. She stated it was common that the salon staff would forget to return resident items with the resident but typically would return them later. She stated she was blamed for losing or taking the hearing aid, but she strongly believes it was lost at the hair salon. Based on the interviews completed, there is insufficient evidence that DCWs took Resident A's hearing aid.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A's room was unclean.

INVESTIGATION:

On 10/2/23, I reviewed the referral which alleged Resident A's room "was a mess."

On 10/3/23, I found Resident A's room to be neat, clean, and orderly. I did not witness any concern for the condition of the room.

Ms. Bromagin stated the condition of Resident A's room today is how it typically is. She stated immediately after toileting Resident A, her soiled briefs are taken out of her room so there is no odor. She stated DCWs clean during their shift to keep the resident rooms clean and there is housekeeping that regularly deep cleans resident rooms. She denied concern for the condition of Resident A's room.

On 10/3/23, Ms. Robinson stated she has been made aware of the two previous concerns addressed in this report, but no one has ever brought concerns or complaints to her attention regarding the cleanliness of Resident A's room.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.

ANALYSIS:	Ms. Bromagin and Ms. Robinson denied concerns or complaints regarding Resident A's room conditions. I observed Resident A's room to be neat, clean, and free of concerns. Based on the interviews completed and observation made, there is insufficient evidence to support allegations that Resident A's room is not arranged or maintained to provide adequately for the health, safety, and well-being of Resident A.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On 11/20/23, I completed an exit conference with Ms. Robinson who did not dispute my findings or recommendations and reported the concern regarding overnight care of residents was addressed in a training on 11/20/23.

III. RECOMMENDATION

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

Cassandra Duursma 11/17/23

Cassandra Duursma Date
Licensing Consultant

Approved By:

Russell Misiak 11/20/23

Russell B. Misiak Date
Area Manager