GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 29, 2024

Robert Davis III
Olive Branch Senior Assisted Living LLC
P.O. Box 77
Perry, MI 48872

RE: License #: AL780065630
Investigation #: 2024A0584006
Olive Branch I

Dear Mr. Davis III:

Attached is the AMMENDED 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 (517) 284-9727.

Sincerely,

Candace Coburn, 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 #:	AL780065630
Investigation #:	2024A0584006
Complaint Receipt Date:	11/15/2023
Investigation Initiation Date:	11/16/2023
Report Due Date:	01/14/2024
Licensee Name:	Olive Branch Senior Assisted Living LLC
Licensee Address:	521 E. First St. Perry, MI 48872
Licensee Telephone #:	(517) 625-5650
Administrator:	Sandy Steele
Licensee Designee:	Robert Davis III
Name of Facility:	Olive Branch I
Facility Address:	521 E. First Street Perry, MI 48872
Facility Telephone #:	(517) 625-5650
Original Issuance Date:	06/03/1996
License Status:	REGULAR
Effective Date:	11/13/2023
Expiration Date:	11/12/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED

II. ALLEGATION(S)

	Violation Established?
On 11/14/2023, it was discovered facility staff members did not follow Resident A's physician's order when the condition of her wound had worsened.	Yes
Additional findings	Yes

III. METHODOLOGY

11/15/2023	Special Investigation Intake - 2024A0584006.
11/16/2023	APS Referral received from APS Central Intake.
11/16/2023	Special Investigation Initiated - Email to Rebecca Shalow, Shiawassee County Adult Protective Services Worker.
12/01/2023	Inspection Completed On-site.
12/01/2023	Contact - Email received from Rebecca Schalow, APS.
12/05/2023	Contact - Face to face interviews with direct care staff Anna Loomis, Lorraine Ochea, Melissa Knerr, Darlene O'Connor, Coral Shepard, administrator Sandy Steele, and Robert Davis licensee designee.
12/13/2023	Contact - Telephone call to Relative A. Left voicemail to call.
12/14/2023	Contact – Telephone interview with direct care staff Tiffany Little.
12/21/2023	Contact – Telephone interview with Relative A and B.
01/02/2024	Contact - Telephone to Jamie Koerner, Memorial Hospital hospice nurse.
01/04/2024	Contact - Telephone interview with Jamie Koerner.
01/05/2024	Exit conference-Telephone contact to Robert Davis, licensee designee. Voice message left.
01/08/2024	Exit conference – Telephone discussion of the findings with Robert Davis.

ALLEGATION:

On 11/14/2023, it was discovered facility staff members did not follow Resident A's physician's order when the condition of her wound had worsened.

INVESTIGATION:

On 11/15/2023 - the Bureau of Community and Health Systems (BCHS) received the above allegation via BCHS online complaint system.

On 11/16/2023, via email, I informed Shiawassee County Adult Protective Services Specialist Rebecca Shalow I was assigned to investigation this allegation.

On 12/01/2023, I conducted an onsite investigation at the facility and discovered Resident A moved out of the facility on 11/16/2023.

12/5/2023, I conducted a second onsite investigation and conducted face to face interviews with direct care staff members Anna Loomis, Lorraine Ochea, Melissa Knerr, Darlene O'Connor, and Coral Shepard, facility administrator Sandy Steele, and licensee designee Robert Davis.

Ms. Loomis stated she is the medication coordinator at the facility. Ms. Loomis stated she was familiar with Resident A's medical orders and provided repositioning, and wound care to Resident A, as well as administered Resident A her medication. Ms. Loomis stated that Resident A had a very bad wound on her back from an electrical stimulation device that was implanted in her spine. Ms. Loomis stated that Jamie Koerner, outside hospice care nurse, provided care to Resident A at the facility every Tuesday and Thursday. Ms. Loomis stated Resident A's wound was not improving, as Resident A's health continued to decline. Ms. Loomis stated she was working on 11/15/2023 when a substitute hospice nurse named Becky Rider visited Resident A at the facility and determined her wound had worsened. Ms. Loomis stated that Ms. Rider informed Resident A's family members, Relative A and Relative B, and Resident A was admitted to the Memorial Emergency Room for further assessment.

Ms. Ochea also stated she was familiar with Resident A's hospice care orders for wound care, including instructions to contact the hospice agency if Resident A's wound continued to get worse. Ms. Ochea stated she did not notice Resident A's wound getting worse. Subsequently, she had not made any calls to the hospice agency regarding the condition of the wound. Ms. Ochea stated that she diligently repositioned Resident A.

Ms. Shepard stated that on 11/14/2023, she observed Resident A's wound when Ms. Koerner changed the dressing, along with medication passer Tiffany Little. According to Ms. Shepard, she viewed a deep hole in the wound area with yellow discharge present. Ms. Shepard's statement regarding reporting to the hospice

agency if Resident A's wound worsened was consistent with the statements Ms. Ochea provided.

Ms. O'Connor stated she assists if the medication passer on duty requires help. However, her normal work duties involved cleaning, laundry, resident wellness checks and visits with residents' relatives if they needed any assistance. Ms. O'Connor stated she did not provide any wound care for Resident A. Subsequently, she was not aware of Resident A's wound care orders and had no information regarding the allegation.

Ms. Knerr's statements were consistent with Ms. O'Connor's statements.

Ms. Steele's statements were consistent with Ms. Loomis' statements.

Mr. Davis and I reviewed Resident A's *Assessment Plan for AFC Residents* (assessment plan), the facility's "staff notebook", Resident A's physician orders, Resident A's medication administration records (MAR) from 11/1/2023 through 11/15/2023 and an *AFC Accident/Incident Report* (IR), completed by Ms. Little on 11/15/2023.

Documentation on Resident A's assessment plan, dated 7/13/2023, under Section II, Box K read, "turn every couple of hours".

The entries by staff in the facility's "staff notebook" from 11/9/2023 to 11/15/2023 showed general notes regarding wellness checks on Resident A, feeding Resident A, and conducting wound dressings for Resident A. However, there were no entries documenting a call placed to the hospice agency regarding the worsening condition of Resident A's wound.

A written physician order, written on 10/19/2023, for Resident A read:

"Pressure injury to back: Cleanse with soap and water, pat dry, apply oil emulsion dressing to wound bed, cover with Lelfa, cover with 4x4 and secure with tape. Change every other day and as needed for soiled or dislodged dressing. Notify hospice with any signs and symptoms of infection. Jamie Koerner.

I read a copy of a prescription order for the medication Santyl, dated 10/30/2023, written for Resident A, by Dr. Patsy. According to the order, staff were to apply this medication to Resident A's wound bed, QD (once a day).

Documentation on an IR, dated 11/15/2023, and completed by staff member Tiffany Little regarding Resident A read:

"Patients Family and Hospice RN discussed and decided to send patient to the hospital due to an open wound from a stimulater [sic] in her back.
Called 911 (Hospice RN did) Patient transported to the hospital by ambulance."

On 12/14/2023, I conducted a telephone interview with Ms. Little. Ms. Little stated she was on duty on 11/15/2023 when a hospice nurse checked Resident A's wound. Ms. Little stated she also observed the wound, which was totally open and had a discharge that appeared infected. Ms. Little confirmed the hospice nurse and Resident A's family members discussed the severity of the open wound and made the decision for Resident A to go to the emergency room.

On 12/21/2023, I conducted telephone interviews with Relatives A and B.

Relative A stated they were very happy with the care Resident A received while at the facility until they had the discussion on 11/15/2023 with a hospice nurse, who informed them the condition of Resident A's wound had gotten much worse.

Relative B stated she observed Resident A receiving attentive care by staff in the beginning of her stay. However, they visited the facility the afternoon prior to 11/14/2023 when a hospice nurse visited Resident A at the facility. Relative B stated that during that visit, staff took Resident A's temperature, which was elevated, and provided Resident A Tylenol. Relative B stated that on 11/15/2023 she was told by a hospice nurse that Resident A had an open hole in her wound and it was not open like that the week before. Relative B stated they believed staff did not monitor Resident A's wound and alert the hospice agency when the wound was worsening. According to Relative B, they were not made aware of the wounds' condition until notified by a hospice nurse on 11/15/2023.

On 01/04/2024, I conducted a telephone interview with Ms. Koerner, who confirmed she is a registered Nurse with Memorial Hospice. Ms. Koerner stated that she had no concerns about the care Resident A received up until 11/14/2023. Ms. Koerner stated during her visit on 11/9/2023, the wound on Resident A's back was not an open skin wound. However, by 11/14/2023, the wound was totally opened with yellow discharge present, indicating an infection. Ms. Koerner stated facility staff members never notified her or the hospice agency that Resident A's wound was worsening, per the instructions on Resident A's written physician's order, dated 10/19/2023.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**

ANALYSIS:	Based upon my investigation, which included interviews with facility staff members, Relatives A and B, and hospice nurse Jamie Koerner, as well as a review of facility documentation relevant to this investigation, it has been established that there was a physician's order, dated 10/19/2023, instructing staff to notify the hospice agency if Resident A's wound was worsening. There is enough evidence to substantiate the allegation that staff did not follow this order.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

On 12/5/2023, Ms. Loomis stated that on 11/1/2023, a sample of Resident A's prescribed medication Santyl was provided to the facility. Ms. Loomis stated that when the sample ran out on 11/9/2023, a hospice nurse was to order a refill. However, the refill did not arrive with the 11/10/2023 delivery of medications to the facility from the pharmacy.

On 1/4/2024, Ms. Koerner stated she was aware that the facility ran out of Resident A's Santyl on 11/9/2023 and was told it was delivered on 11/13/2023. Ms. Koerner stated she also observed an unopened bottle of Resident A's Santyl during her visit to the facility on 11/14/2023.

Upon reviewing Resident A's MAR, I observed the initials of facility staff members, indicating they dispensed Santyl to Resident A from 11/09/2023 to 11/14/2023. Documentation on Resident A's MAR indicated only one date during that time frame when Resident A was not administered her Santyl, due to "*was physically unable to take*".

R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions. (4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: (b) Complete an individual medication log that contains all of the following information: (i) The medication. (ii) The dosage. (iii) Label instructions for use.

	(iv) Time to be administered. (v) The initials of the person who administers the medication, which shall be entered at the time the medication is given. (vi) A resident's refusal to accept prescribed medication or procedures.
ANALYSIS:	Based upon my investigation, which included interviews with facility staff members, Relatives A and B, and hospice nurse Jamie Koerner, as well as a review of facility documentation relevant to this investigation, it was established Resident A was not administered her prescribed medication Santyl from 11/9/2023, to 11/13/2023 because the facility was without the medication. Subsequently, documentation on Resident A's MAR indicated they administered Santyl to Resident A during this time frame.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 1/8/2024, I conducted an exit conference via telephone with licensee designee Robert Davis and informed him the findings of this investigation.

IV. RECOMMENDATION

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

1/9/2024

Candace Coburn Date
Licensing Consultant

Approved By:

1/12/2024

Michele Streeter Date
Area Manager

ADDENDUM to Special Investigation Report (SIR) # 2024A0584006.

I. Purpose of Addendum

On 01/25/2024, licensee designee Robert Davis provided me with additional information regarding this investigation, resulting in a change of the findings.

II. Methodology

01/25/2024	Contact- Document Received from licensee designee Robert Davis. Contact- Telephone Interview with licensee designee Rober Davis.
01/26/2024	Contact- Telephone interview with Memorial Hospice nurse Jamie Koerner.

III. Description of Findings and Conclusion

On 1/25/2024, Robert Davis, licensee designee submitted a written corrective action plan addressing the violations established in Special Investigation Report #2024A0584006 and disagreed with the additional findings.

I conducted a telephone interview with Mr. Davis, who stated after he received the Special Investigation Report, he conducted interviews with direct care staff members who provided wound care to Resident A. According to Mr. Davis, each staff member stated they administered samples of the medication Santyl to Resident A while waiting for the medication to be delivered, and were never without the medication. Mr. Davis stated Anna Loomis, whose title is health care manager, is responsible for ordering residents' prescription medication. Mr. Davis stated Ms. Loomis knew the prescription was not delivered on 11/10/2023, and assumed there was no Santyl available in the facility, as she did not know direct care staff were administering samples of the medication to Resident A.

IV. Recommendation

Based upon the additional information provided to me by Mr. Davis, there is not enough evidence to establish Resident A was not administered her prescribed medication Santyl from 11/9/2023 to 11/13/2023 because the facility was without the medication, or that direct care staff members inaccurately documented the administration of this medication to Resident A on her MAR during this time. Subsequently, the additional findings for a violation of administrative licensing rules 400.15312(2) and 400.15312(4) have been removed.

An acceptable corrective action plan has been received. I recommend no change in the status of the license.

1/29/2024

Candace Coburn — Date
Licensing Consultant

Approved By:

1/29/2024

Michele Streeter — Date
Area Manager