GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 31, 2023

Nancy Posey and Theresa Posey
8470 Parshallville
Fenton, MI 48430

RE: License #: AM470078613
Investigation #: 2023A0790054
Fenton Assisted Living

Dear Nancy Posey and Theresa Posey:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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. If I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Rodney Gill, 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 #:	AM470078613
Investigation #:	2023A0790054
Complaint Receipt Date:	07/27/2023
Investigation Initiation Date:	07/31/2023
Report Due Date:	09/25/2023
Licensee Name:	Nancy Posey and Theresa Posey
Licensee Address:	8470 Parshallville Fenton, MI 48430
Licensee Telephone #:	(810) 632-7760
Administrator:	Nancy Posey
Licensee Designee:	N/A
Name of Facility:	Fenton Assisted Living
Facility Address:	6077 Linden Fenton, MI 48430
Facility Telephone #:	(810) 629-1131
Original Issuance Date:	11/22/1997
License **Status:**	REGULAR
Effective Date:	01/03/2023
Expiration Date:	01/02/2025
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was found to have maggots in his heel wound due to poor care by direct care staff members.	No
The facility received a Bureau of Fire Services Disapproval rating during their annual inspection.	No

III. METHODOLOGY

07/27/2023	Special Investigation Intake 2023A0790054
07/31/2023	Special Investigation Initiated – Telephone call made- An attempt was made to interview the Complainant via phone on 07/31/2023. A voicemail message was left requesting a return call. Interviewed a colleague of the Complainant.
08/07/2023	Contact – Telephone call made. Interviewed the Complainant.
08/08/2023	Inspection Completed On-site- Interviewed Resident A, direct care staff members (DCSMs) Sueanne Talmadge, Stephanie Schwind, and Terrany Gilkerson.
08/08/2023	Contact – Telephone call made to speak with licensee designee Nancy Posey
08/08/2023	Contact - Face to Face- Interviewed licensee designee Nancy Posey.
08/08/2023	Contact - Telephone call made. Interviewed DCSM Chelsey Fox.
08/08/2023	Contact - Telephone call made. Interviewed DCSM Linda Calpitts.
08/21/2023	Contact - Document Sent- Emailed licensee designee Nancy Posey and state fire marshal inspector Donald Collick to ask if the facility is in full compliance with fire safety rules.
08/21/2023	Contact - Document Received- Mr. Collick emailed indicating he has not been out for a reinspection. Mr. Collick said he is booked with school inspections until after Labor Day 09/04/2023.
08/21/2023	Contact - Telephone call made. Interviewed Relative A1.

08/22/2023	Inspection Completed-BCAL Sub. Compliance
08/22/2023	Exit Conference with licensee designee Nancy Posey.
08/22/2023	Corrective Action Plan (CAP) Received.
08/22/2023	Corrective Action Plan Approved.
08/22/2023	Contact – Document Sent. I sent Ms. Posey a copy of the CAP Approval Letter.
08/23/2023	APS Referral called into Centralized Intake.
08/24/2023	Contact – Telephone call made to licensee designee Nancy Posey requesting additional information.
08/24/2023	Contact – Telephone call received from registered nurse Jennifer Young.

ALLEGATION: Resident A was found to have maggots in his heel wound due to poor care by direct care staff members.

INVESTIGATION:

I reviewed a BCAL Online Complaint dated 07/27/2023 which indicated Resident A was evaluated in the Trinity Livingston Emergency Department and found to have maggots in his heel wound.

I interviewed a colleague of Complaint via phone on 07/31/2023. The colleague indicated she does not have any direct knowledge regarding the allegation but according to documentation she reviewed the allegation is accurate and comprehensive.

I interviewed Complainant via phone on 08/07/2023. Complainant stated there were maggots found in Resident A's wound at the time of hospitalization on 07/23/2023. Complainant said Resident A spent nine days in the hospital from 07/23/2023 to 08/01/2023. Complainant said Residential Home Care was working with Resident A providing home health care services prior to his hospitalization. She said the registered nurse was responsible for wound care when at the facility visiting Resident A. Complainant said Resident A's family members were consulted after it was found Resident A had maggots in his wound, gangrene, and Osteomyelitis (a bone infection) in his left foot. Complainant said Resident A also suffers from cerebral palsy**.** Complainant said the family decided against aggressive measures and declined surgery

to remove the foot. Complainant stated Resident A's family spoke to palliative care and requested Resident A return to the facility and receive hospice services. Complainant stated Resident A returned to the facility on 08/01/2023 on hospice through Residential Home Care.

Complainant stated being unaware what direct care staff members (DCSMs) were responsible for regarding Resident A's wound care. Complainant said she was not sure if the registered nurse from Residential Home Care was completely responsible for cleaning the wound or if DCSMs were to share the responsibility. Complainant said she believes the registered nurse was the one who discovered the maggots in Resident A's wound and immediately sent him to the emergency room.

I conducted an unannounced onsite investigation on 08/08/2023. I interviewed Resident A who stated he recently spent time at the hospital. He said he was hospitalized for approximately a week. Resident A said he was transported to the hospital after direct care staff member (DCSM) Linda Calpitts discovered he had maggots in his wound located on his left heel wound and great toe. He said Ms. Calpitts immediately contacted resident nurse Jen Young upon discovering the maggots and Ms. Young told Ms. Calpitts to have Resident A transported to the hospital. Resident A stated he was never informed of having gangrene in his heel wound or great toe.

Resident A stated he receives "excellent care" at the facility. He said he has never had maggots in a wound before. Resident A stated it surprised him. Resident A said he loves living at the facility and wants to continue residing there. Resident A said his bandages were changed every other day without fail. He stated when resident nurse Jen Young visited him, Ms. Young changed his bandages. He stated when Ms. Young did not visit on a day when his bandages were scheduled to be changed, a DCSM was responsible for changing his bandages. Resident A stated his bandages were always changed when required. He said his bandages are changed every other day and Ms. Calbitts changes them much of the time. Resident A said he is well cared for which is why it was a shock to discover the maggots.

I reviewed Resident A's *Medication Administration Record (MAR)* and it indicated Foot Bandage Change - Monday, Wednesday, and Friday. I reviewed the 07/2023 *MAR* and found initials indicating the bandages were changed by a DCSM on Monday 07/03/2023 and Friday 07/07/2023 the first week, Friday 07/14/2023 the second week, and Monday 07/17/2023, Wednesday 07/19/2023, and Friday 07/21/2023 the third week. Registered nurse Jennifer Young was interviewed and indicated she or her coworker visited Resident A and changed his foot bandages and cleaned his wounds the days not indicated in Resident A's MAR. Ms. Young confirmed Resident A was hospitalized on 07/23/2023 and remained hospitalized until 08/01/2023.

Resident A said he feels like he is improving daily both physically and medically since being released from the hospital. He stated he will never be able to "jump" again. Resident A said he also suffers from cerebral palsy and when able to ambulate walks

with his legs bent. Resident A stated he experiences a lot of pain and is currently taking 11 different medications.

I interviewed DCSMs Sueanne Talmadge, Stephanie Schwind, and Terrany Gilkerson. Ms. Talmadge, Ms. Schwind, and Ms. Gilkerson who all stated Resident A receives good care at the facility and all his needs and wants are met. They had no knowledge of Resident A's wound care ever being neglected.

I spoke with licensee designee Nancy Posey via phone on 08/08/2023, and she requested I come to her office to speak with her. Ms. Posey stated she was unaware of Resident A failing to receive wound care as ordered. She said she always ensures either the registered nurse or treating physician provide a detailed outline in writing explaining step-by-step how to change a resident's bandages and clean their wound(s). Ms. Posey stated the written outline is placed in the resident's *Resident Records.*

I reviewed Resident A's *Resident Records* and found the written outline from the treating physician Dr. Plaldini dated 05/31/2023 explaining step-by-step how to change Resident A's bandages and clean his left heel wound and great toe every Monday, Wednesday, and Friday. Dr. Plaldini listed the following diagnoses: osteomyelitis of the heel, type two diabetes (DMII), diabetic foot ulcer, and chronic kidney disease (CKD).

I reviewed Resident A's *Assessment Plan for AFC Residents* and found Resident A requires assistance with all activities of daily living (ADLs).

I reviewed a text message sent from registered nurse Jen Young to Resident A's family on 07/11/2023 informing them of Resident A's current medical condition and both positive and negative changes taking place. The message indicated Resident A's weight went down two pounds, he still had edema to both legs, his heel looked good still seeing new growth, toe is unchanged. Ms. Young asked if it would be possible to get Resident A to and from a wound clinic if necessary. She indicated Resident A's toe may heal a little faster if they debride it (scrape off the top layer to promote tissue growth). Ms. Fox said she was going to check with Resident A's primary care physician (PCP) Doctor Kopel.

Ms. Posey stated Residential Health Care has been providing in-home services to Resident A since 03/21/2023. She said when registered nurse Jen Young visited Resident A she was responsible for changing his bandages and cleaning his wounds. Ms. Posey stated DCSMs were responsible for doing so when Ms. Young did not visit Resident A every Monday, Wednesday, and Friday. Ms. Posey said DCSM Linda Calpitts changed Resident A's bandages and cleaned his wounds most often.

Ms. Posey said on 07/22/2023 Resident A left the facility and spent the day with family for an overnight visit at their home. Ms. Posey stated she thinks Resident A may have contracted the maggots during the visit because when she asked a family member about it, the family member indicated they were outside most of the day on 07/22/2023

and recalled there being an unusually large number of flies landing on and irritating them throughout the day.

I interviewed DCSM Ms. Calpitts via phone on 08/08/2023. Ms. Calpitts stated Ms. Young normally visited Resident A on Wednesdays and occasionally Fridays and would change his bandages and clean his wounds. She said she would normally change his bandages and clean Resident A's wounds on Mondays and Fridays when Ms. Young did not visit.

Ms. Calpitts said she checked Resident A's wound on 07/23/2023 and it visually looked black and was saturated with discharge. Ms. Calpitts stated she immediately removed the bandages and could see maggots in the wound eating the flesh. She said she sprayed the wound with wound care and called registered nurse Jen Young who requested they send Resident A to the hospital. Ms. Calpitts stated Resident A was hospitalized from 07/23/2023 to 08/01/2023.

Ms. Posey said she contacted Resident A's PCP Doctor Kopel on 07/23/2023 and asked if maggots were being used to treat Resident A's wound. Doctor Kopel stated to defer the question to the physician overseeing the wound care through Residential Home Care. Ms. Posey said treating physicians at the hospital gave Resident A and his family the option of emergency medical procedures. She said they suggested amputation of the foot from the ankle down or potentially the knee down to ensure no infection remained. Ms. Posey said Resident A and his family opted to bring Resident A back to the facility on hospice and declined surgery at this time.

I interviewed Relative A1 via phone on 08/21/2023. Relative A1 said Resident A has had ongoing medical issues and conditions exacerbated by poor medical and physical care received at previous facilities which led up to his current medical condition. Relative A1 said she and other family members visit Resident A often and play an active role in supporting him, making decisions, and assisting with his medical and physical care.

Relative A1 stated she was not aware of Resident A not receiving required dressing changes or wound care as ordered. She said Resident A has a registered nurse Jen Young who visits Resident A once or twice a week, assesses his overall medical, emotional, and physical condition, changes his bandages, and cleans his wounds. Relative A1 said DCSMs change Resident A's bandages and clean his wounds on Monday, Wednesday, and Friday when Ms. Young does not visit. She said Ms. Young is vigilant about providing the family updates regarding Resident A's overall medical, emotional, and physical condition.

Relative A1 said she and family visit Resident A on a regular basis at the facility and believe Resident A is receiving excellent care. She stated Resident A loves where he lives and has nothing but positive things to say about the DCSMs and the care he receives. Relative A1 stated she does not know how Resident A contacted maggots in his heal wound. She said she did look up information and found maggots can develop

within eight to 20 hours after exposure. Relative A1 stated Resident A did spend the day before the maggots were noticed at her home and they noticed there were an extraordinary number of flies which were landing on Resident A and other family members while sitting and lounging outside.

Relative A1 said Resident A was given the option to undergo emergency medical procedures while he was hospitalized. She said they suggested amputation of the foot from the ankle down or potentially the knee down to ensure no infection remained. Relative A1 said Resident A and family decided to bring Resident A back to the facility on hospice and declined surgery.

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:	Based on the information gathered during this special investigation through review of documentation and interviews with Resident A, DCSMs Ms. Talmadge, Ms. Schwind, Ms. Gilkerson, Ms. Fox, Ms. Calpitts, licensee designee Ms. Posey, and Relative A1 there was no evidence found indicating supervision, protection, and personal care were not provided as defined in the act, as specified in Resident A's *Assessment Plan for AFC Residents,* as well as additional documentation found in Resident A's *Resident Records.* Upon noticing the maggots in Resident A's wounds, he was immediately sent to the emergency room for additional care and evaluation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The facility was found to be in substantial non-compliance with applicable fire safety rules.

INVESTIGATION:

I reviewed an Inspection Report from the Department of Licensing and Regulatory Affairs (LARA) Bureau of Fire Services (BFS) dated 07/28/2023. The report indicated the facility was found to be in substantial non-compliance with applicable fire safety rules because the inspecting official Don Collick observed two extension cords with non-surge and non-circuit protected multiplug adapters in use in the kitchen.

Mr. Collick's BFS report indicated there was no logbook onsite for review to ensure operational integrity. Mr. Collick's BFS report specified he was unable to ensure all automatic sprinkler and standpipe systems were properly inspected, tested, and

maintained; emergency egress and relocation drills had been conducted not less than once per quarter per scheduled shift; daytime, 7 a.m. to 3 p.m., evening 3 p.m. to 11 p.m., and night, 11p.m. to 7 a.m.; and/or testing of required emergency lighting systems had been tested. Mr. Collick's BFS report documented logbooks and maintenance records shall be onsite and readily available upon request by an inspector.

I inspected the entire facility. I found one extension cord in use located on the right side of the entrance to the kitchen which was used to power the microwave. I found no other extension cords in the kitchen. This is the only extension cord I witnessed during my unannounced onsite investigation.

The *House Book* was at the facility at the time of my unannounced onsite investigation. I reviewed the *House Book* and found all the required documentation mentioned in the LARA BFS Inspection Report dated 07/28/2023. I found the facility's fire alarm system had been tested quarterly and fire drills completed monthly and on all shifts. I found the automatic sprinkler system had been tested by Beck Fire Protection, Inc. annually and by DCSMs quarterly and fire extinguishers had been tested monthly the past five years. The fire alarm system had been professionally tested by Allstar Alarm LLC on 02/27/2023, as well as tested by DCSMs monthly.

Ms. Posey stated BFS makes unannounced visits when they conduct onsite inspections. She said she was in a class when Mr. Collick conducted an unannounced onsite inspection on 07/28/2023. Ms. Posey said Mr. Collick had conducted a re-check of the facility on 02/28/2023 and their certification was approved so she was surprised Mr. Collick was visiting the facility again.

Ms. Posey explained once a month she requests the House Book from each of her facilities be brought to her office for review to ensure all fire safety requirements are being completed. She said she had requested the House Books be brought to her office on 07/28/2023 which is why the House Book was not at the facility when Mr. Collick arrived unannounced to complete an onsite inspection.

Ms. Posey said she did not receive the Inspection Report I showed her from the inspection Mr. Collick conducted on 07/28/2023 and Mr. Collick has not attempted to contact her regarding the deficiencies he found. She stated this is the first she is hearing of this. Ms. Posey stated she will forthwith create a written Corrective Action Plan (CAP) and email it to Mr. Collick.

I received a copy of a CAP written by Ms. Posey via email dated 08/10/2023 which was also sent to Mr. Collick. The CAP indicated the House Book (see index provided) is at the facility. The book is picked up monthly and taken to the office for quality control. We will perform the quality control report "in house" in the future. The extension cord to the microwave has been replaced with an accepted extension cord with a surge and GFCI protector multiplug adaptor.

I conducted an exit conference with licensee designee Nancy Posey via phone on 08/22/2023. I informed Ms. Posey of the rule violation established because of the special investigation and requested a Corrective Action Plan (CAP) be provided by 09/06/2023. An acceptable CAP was provided by Ms. Posey on 08/22/2023.

APPLICABLE RULE	
R 400.14403	**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:	Based on the information gathered during this special investigation through review of documentation and interviews with Resident A, DCSMs Ms. Talmadge, Ms. Schwind, Ms. Gilkerson, Ms. Fox, Ms. Calpitts, licensee designee Ms. Posey, and Relative A1 there was evidence found indicating at the time of state fire marshal inspector Donald Collick's unannounced onsite inspection on 07/28/2023 there was two extension cords with non-surge and non-circuit protected multiplug adapters in use in the kitchen. There was also no logbook onsite for review to ensure operational integrity leading to substantial non-compliance.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, it is recommended that the status of the license remains unchanged.

08/28/2023

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Rodney Gill Date
Licensing Consultant

Approved By:

08/31/2023

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Dawn N. Timm Date
Area Manager