GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

Dawn Foulke
Clinton Creek, Inc.
4438 Ramsgate Lane
Bloomfield Hills, MI 48302

March 12, 2024

RE: License #: AH500387884
Investigation #: 2023A1022054
Clinton Creek Assisted Living & Memory Care

Dear Dawn Foulke:

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 authorized representative and a date.

Please review the enclosed documentation for accuracy and contact me with any questions.

Sincerely,

Barbara P. Zabitz, R.D.N., M.Ed.
Health Care Surveyor
Health Facility Licensing, Permits, and Support Division
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Mobile Phone: 313-296-5731
Email: zabitzb@michigan.gov

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500387884
Investigation #:	2023A1022054
Complaint Receipt Date:	09/01/2023
Investigation Initiation Date:	09/01/2023
Report Due Date:	11/01/2023
Licensee Name:	Clinton Creek, Inc.
Licensee Address:	4438 Ramsgate Lane Bloomfield Hills, MI 48302
Licensee Telephone #:	(248) 701-5043
Administrator:	Geralyn Cummings
Authorized Representative:	Dawn Foulke
Name of Facility:	Clinton Creek Assisted Living & Memory Care
Facility Address:	40500 Garfield Road Clinton Township, MI 48038
Facility Telephone #:	(586) 354-2700
Original Issuance Date:	07/18/2019
License **Status:**	REGULAR
Effective Date:	01/18/2023
Expiration Date:	01/17/2024
Capacity:	62
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Residents in the facility do not get adequate incontinence care and are not provided baths or showers. Skin care is not adequate, and many residents have rashes and skin breakdown as a result.	No
Residents have fallen out of bed due to an inadequate number of caregivers to assist them.	No
Not enough food or water is available to residents in the facility.	No
Medication technicians are not adequately trained resulting in multiple medication errors and medications not administered.	No
Residents are subjected to verbal and physical abuse.	No
Additional Findings	Yes

The complainant identified concerns that are not related to or addressed in licensing rules and statutes for a home for the aged, including services of a licensed nurse, the way employees are treated by management and the cost charged to residents. Therefore, only specific items pertaining to homes for the aged provisions of care were considered for investigation. The items listed above were those that could be considered under the scope of licensing.

III. METHODOLOGY

09/01/2023	Special Investigation Intake 2023A1022054
09/01/2023	Special Investigation Initiated - Letter Request for information sent to facility.
09/21/2023	APS Referral
09/21/2023	Inspection Completed On-site
03/12/2024	Exit Conference

ALLEGATION:

Residents in the facility do not get adequate incontinence care and are not provided baths or showers. Skin care is not adequate, and many residents have rashes and skin breakdown as a result.

INVESTIGATION:

On 08/31/2023, the Bureau of Community and Health Systems (BCHS) received an anonymous complaint that in part read, “Many of the residents have been complaining due to the fact that they have gone many days weeks without getting a bath or shower. Many of the residents have bed sores rashes breakdown of skin also skin tears on arms legs back stomach. Many of the residents have worn the same brief for many days… [Name of Resident A] on memory care has multiple skin tears all over her body. [Name of Resident B] on memory care room 221 does not get adequate showers or brief changes. Many of the residents in the building are not checked and changed as they should be and this has caused multiple bed sores and skin breakdown on many of the residents.”

On 09/21/2023, a referral was sent to Adult Protective Services.

On 09/21/2023, at the time of the onsite visit, I interviewed the administrator and the nurse manager. When the administrator was asked about Resident A and Resident B, she stated that neither resident was living in the facility at that time. Resident A had passed away while receiving hospice benefits and Resident B had moved out of the facility with her family. When asked about Resident A having multiple skin tears on her body, the administrator acknowledged that prior to her death, Resident A had developed very fragile skin, that blistered all over her body. According to the administrator, the hospice nurse had been aware of the issue and had informed the facility that this was a condition associated with Resident A’s terminal state.

At the time of the onsite visit, I made observations of Resident F and Resident G for an evaluation of their incontinence care as well as the condition of their skin. Both Resident F and Resident G were described as being incontinent of both bowel and bladder, using adult incontinence briefs. Both residents lived in the memory care (MC) unit and both residents were confined to wheelchairs. When checked for incontinence, both Resident F and Resident G were found to be in clean, dry incontinence briefs. Resident F’s skin although appearing to be very thin and fragile, was without any major impairments. Resident G however, had skin impairments that appeared to be similar, on both of his lower legs, from right below the kneecap of both legs, down the shins, to just above his ankles. The two areas appeared to have lost their top layer of skin, as if it had been scaped-off and there was a small open area where there was a small amount of dried blood on his left shin. The nurse manager acknowledged that although Resident G had lived in the facility for several years, she had not previously been aware that he had this impairment. The nurse

manager went on to explain that Resident G was under hospice care and had long-standing treatment orders for staff to apply a moisturizing lotion and a topic steroidal ointment to be applied “to the affected area.” According to the administrator, the hospice nurse manager had described the areas of Resident G’s lower legs as eczema.

The facility provided skin assessments, for the month of July 2023, completed on the day that each resident was either given a bed bath or a shower. This documentation indicated that Resident C, Resident D, Resident E, Resident F and Resident G all received either a bath or a shower twice weekly.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	There was no evidence that residents did not receive appropriate care, either for incontinence or for personal hygiene.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents have fallen out of bed due to an inadequate number of caregivers to assist them.

INVESTIGATION:

According to the written complaint, “Many of the residents are hurt falling down falling out of bed due to short staff the girls are forced to work a unit by themselves… “

When the administrator and the nurse manager were asked if there were any incidents since July 2023 when a resident had fallen, especially out of bed, or during a transfer without enough assistance, they both denied that anything of that nature had occurred. The administrator described two falls during that time period; Resident C had experienced an episode of syncope during a shower. Resident C had been

seated in a shower chair at the time when she “passed out.” The second incident was when Resident H had experienced a seizure while seated on the toilet. Neither of these incidents were related to a lack of caregivers.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(2) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	There was no evidence that residents had fallen due to a lack of staff assistance.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Not enough food or water is available to residents in the facility.

INVESTIGATION:

According to the written complaint, “the residents’ food is terrible they do not get adequate water or food for that matter many of the residents are always hungry and looking for something to eat.” In the written complaint, the complainant referenced Resident C, Resident D and Resident E.

Resident C, Resident D and Resident E were all described as being able to reliably answer questions and could make decisions for themselves. At the time of the onsite visit, each of these residents were asked if they received an adequate amount of food and beverage. Each of these residents denied any issues with the quality or the quantity of food and beverage available in the facility.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(3) The owner, operator, and governing body of a home shall do all of the following:

	(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.
ANALYSIS:	There was no evidence that residents were not provided an adequate amount of food and beverage.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Medication technicians are not adequately trained resulting in multiple medication errors and medications not administered.

INVESTIGATION:

According to the written complaint, “The med tech is not properly trained to pass medication many of the residents do not get their medication some of them go days without medication, on multiple occasions residents has been given the wrong medications.”

The facility provided medication administration records (MAR) and medication exception reports for the month of July 2023. Review of the records and the reports revealed that the whenever residents did not receive their medications, the reason was documented. Resident C and Resident E, both who were able to make their own decisions frequently refused their medications. Medication technicians documented that Resident E often told them that she “didn’t like the way it (the medication) makes her feel.” Resident D was prescribed several medications to treat high blood pressure. The MAR and the exception report for Resident D indicated that on nine occasions, Resident D’s blood pressure was too low for the medication to be administered and that it was “held,” as ordered by the health care provider. Resident F, who was receiving hospice care was “physically unable to take” any of her medications on 07/31/2023, and they were held back. Resident F was administered all of his prescribed medications without exception.

Caregiver #1, caregiver #2 and caregiver #3, all administered medications during the month of July 2023, as their initials all appeared on July MARs. The facility provided written documentation that all 3 caregivers had been trained, passed an exam, and been deemed eligible to administer medications to residents.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.
R 325.1931	**Employees; general provisions.**
	(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following: **(g) Medication administration, if applicable.**
ANALYSIS:	There was no evidence that medications were not properly administered and no evidence that medication technicians were not properly trained.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents are subjected to verbal and physical abuse.

INVESTIGATION:

According to the written complaint, “There have been reports made to management about verbal and physical abuse on many of the residents [name of Resident C], [name of Resident D] and many residents on memory care… “

At the time of the onsite visit, Resident C, Resident D and Resident E were all asked if they had ever been verbally or physically abused, physically mistreated, or if staff or other residents used offensive language in their presence. Each of these residents denied of any verbal or physical abuse.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(l) A patient or resident is entitled to be free from mental and physical abuse**
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(4) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
For Reference: R325.1901	**Definitions.**
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	There was no evidence to substantiate the allegation that residents were subjected to verbal or physical abuse.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

At the time of the onsite visit, Resident G was observed with skin impairments on both of his lower legs, from right below the kneecap of both legs, down the shins, to just above his ankles. The two areas appeared to have lost their top layer of skin, as if it had been scaped-off and there was a small open area where there was a small amount of dried blood on his left shin. The nurse manager acknowledged that although Resident G had lived in the facility for several years, she had not previously been aware that he had this impairment.

When the nurse manager was asked to see skin assessments that had been completed for Resident G, there was no mention of these impairments on his lower legs. The nurse manager acknowledged that caregivers were instructed to only document "new" areas that had not been noted previously, but it was obvious that caregivers were not noting areas that had worsened or improved. When the nurse manager and the administrator were asked how a new employee assigned to provide care to Resident G, or any other resident for that matter, would know if an area was "new" or not, the administrator acknowledged that could be problematic. The nurse manager stated that most likely any new employee would ask a co-worker if the impairment had been previously noted but acknowledged that could also produce inaccurate results and documentation.

APPLICABLE RULE	
MCL 333.20175	**Maintaining record for each patient; wrongfully altering or destroying records; noncompliance; fine; licensing and certification records as public records; confidentiality; disclosure; report or notice of disciplinary action; information provided in report; nature and use of certain records, data, and knowledge.**
	(1) A health facility or agency shall keep and maintain a record for each patient, including a full and complete record of tests and examinations performed, observations made, treatments provided, and in the case of a hospital, the purpose of hospitalization.
ANALYSIS:	The facility was not keeping a record of their observations of changes in residents' skin impairments from week to week.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the administrator on 03/12/2024. When asked if there were any comments or concerns with the investigation, the administrator stated that there were none.

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend no change to the status of the license.

03/12/2024

Barbara Zabitz Date
Licensing Staff

Approved By:

03/11/2024

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section