Pamela Workman
Flushing AL Operations LLC
Suite 210
777 E Main St
Westfield, IN 46074

June 24, 2024

RE: License #: AH250408318
Investigation #: 2024A1022045
Majestic Care of Flushing AL

Dear Pamela Workman:

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 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 #:	AH250408318
Investigation #:	2024A1022045
Complaint Receipt Date:	05/13/2024
Investigation Initiation Date:	05/13/2024
Report Due Date:	07/12/2024
Licensee Name:	Flushing AL Operations LLC
Licensee Address:	Suite 210 777 E Main St Westfield, IN 46074
Licensee Telephone #:	(317) 288-4029
Administrator/Authorized Rep	Pamela Workman
Name of Facility:	Majestic Care of Flushing AL
Facility Address:	640 Sunnyside Dr Flushing, MI 48433
Facility Telephone #:	(810) 487-0045
Original Issuance Date:	09/01/2021
License **Status:**	REGULAR
Effective Date:	03/01/2024
Expiration Date:	07/31/2024
Capacity:	40
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
The Resident of Concern (ROC) did not receive appropriate care.	No
Additional Findings	Yes

III. METHODOLOGY

05/13/2024	Special Investigation Intake 2024A1022045
05/13/2024	Special Investigation Initiated - Letter Request sent to Valley Area Agency on Aging worker for additional information.
05/13/2024	Contact - Telephone call made Interview conducted with daughter
06/04/2024	APS Referral
06/04/2024	Inspection Completed On-site
06/13/2024	Contact - Document Received Email exchange with clinical director.
06/24/2024	Exit Conference

ALLEGATION:

The Resident of Concern (ROC) did not receive appropriate care.

INVESTIGATION:

On 05/13/2024, the Bureau of Community and Health Systems (BCHS) received a referral from the Valley Area Agency on Aging (Genesee County) that read, "[Name of the Resident of Concern (ROC)] stayed (at the facility) for out of home respite from 4/23/24 to 5/2/24. Upon discharge (from the facility), [name of the ROC] had altered mental status and weakness. He went to the hospital and his daughter was informed he was dehydrated. He also now has a 50-cent sized wound on his scrotum and can no longer assist with transferring. Prior to admission he did not have any wounds or issues assisting with transferring. He used to use assistive

devices and would complete locomotion with the devices, but now he is unable and is bedbound at this time."

The Agency Senior Supports Coordinator provided me the contact information for the ROC's daughter, who was interviewed by phone on 05/13/2024. The ROC's daughter clarified that while the ROC had some short-term memory issues, generally, he was able to reliably answer questions. While he was not able to bear weight and was confined to a wheelchair, he had been able to transfer himself in and out of bed with the use of a transfer board. The ROC's daughter stated that while at home, the ROC was able to ask for assistance in using the toilet and was not incontinent. He wore boxer shorts and did not use incontinence briefs. The daughter went on to say that she needed to be out-of-state for a brief period of time and could not leave the ROC by himself. She chose respite care at the facility. She stated that she was quite alarmed when the ROC arrived back at her home because he was weak, had bruises and had excoriation in his groin area from the use of incontinence briefs that had not been changed frequently enough. When asked what had happened to him, the ROC told his daughter that "they were rough" with him and that he never wanted to see them again.

On 06/04/2024, a referral was sent to Adult Protective Services.

On 06/04/2024, at the time of the onsite visit, I interviewed the administrator and the clinical director. When they were asked about the ROC, neither the administrator nor the clinical director had in-depth knowledge of the resident, but remembered he had an electric wheelchair, transferred into the chair with a sit-to-stand mechanical lift, generally was continent but wore incontinence briefs because of occasional "accidents," and was able to vocalize his needs. According to the administrator, the ROC admitted through the Michigan Medicaid Waiver program for respite care, would have gone through the same assessment process for establishing a service plan as all other residents living in the facility. The administrator then stated that there had been an issue on the day the ROC left the facility regarding his transportation back to his daughter's residence. It was the family's obligation to arrange for the transportation in advance and this had not been done timely. The administrator described how the ROC sat in the lobby waiting for "hours." According to the administrator's written recollection of the events of 05/02/2024, the ROC's "… daughter called me (the administrator) around 10am on May 2nd. She said that she forgot to set up his transportation. She said that his insurance will pay for his transportation if she sets it up 3 days in advance. She said the only way he would be able to get transportation at this point is that I would need to call to set it up. She emailed a copy of his insurance card. I called right away to set up the transportation. Humana said it would be around 12:30pm. We got him ready and brought him to the front door. He ate his lunch while he was waiting. When they did not come, I called to ask when they will be here. I did this several more times during the afternoon. The driver finally came to get him at 5:10pm. He looked very uncomfortable while he was waiting for four and a half hours. I put the overbed table near him so he could have a

water and snacks. I felt so bad for him. I even tried to give him the dinner tray, but the ride showed up, so he didn't get to finish."

At the time of the onsite visit, I made observations of 3 residents who had care needs similar to the ROC.

I observed Resident A in her room. Resident A was able to reliably answer questions and make her own decisions. She was unable to transfer herself from bed to wheelchair without assistance. Caregiver #1 was in the room to provide Resident A with morning care. Caregiver #1 assisted Resident A to a seated position at the side of her bed and provided physical support to help Resident A to her feet. Resident A was then able to pivot into her wheelchair and into the bathroom. Using the assist bar adjacent to the toilet, caregiver #1 assisted Resident A onto the toilet. When asked if caregivers were "rough" when transferring her, Resident A said no. Resident A's incontinence brief was noted to be moist and Resident A acknowledged that while transferring, she had voided a small amount into the brief. As caregiver #1 was providing Resident A with incontinence care, I was able to observe that the skin on both sides of her buttock was impaired. There were two small slits, about an inch to an inch and a half, but less than a quarter inch wide, that appeared as though the top layer of skin had been scraped off. Caregiver #1 applied a thick layer of calmospetine to Resident A's buttocks. According to caregiver #1, these impairments had started out as "bumps," with white heads, but had then broken open. Resident A stated that she had seen her physician the day before and he had advised continued use of calmoseptine moisture barrier ointment. When the clinical director was asked about Resident A's skin, she acknowledged that prevention of skin breakdown for Resident A was challenging because Resident A was unable to shift her weight on her own and tended to sit or lie in the same position. The clinical director stated that a pressure relieving wheelchair cushion had been ordered and the next step might be a low air loss mattress.

I observed Resident B in her room, as caregiver #2 was providing morning care. Resident B appeared to be hard of hearing but was able to reliably answer questions. Caregiver #2 assisted Resident B to a seated position on the side of her bed and using Resident B's walker, assisted her to a standing position. Resident B was able to walk on her own into the toilet room and sit on the toilet. Resident B's incontinence brief was moist but not saturated. Resident B was not observed to have any skin impairments or bruising.

I observed Resident C in his room. Resident C was a hospice patient and used a sit-to-stand mechanical lift to transfer from bed to chair. Caregiver #3 provided incontinence care to Resident C before assisting him with his clothing for the day. Resident C's incontinence brief was mildly wet. After cleaning his genital area and buttocks, caregiver #3 applied a thick coating of calmoseptine. Resident C did not have any observable skin impairments on his genitals or buttocks, but the skin was darkened, as if it was healed skin. After assisting him with his clothing, caregiver #3, assisted by the clinical director assisted Resident C into a seated position and used

the sit-to-stand mechanical lift to assist Resident C to his wheelchair. According to his service plan, Resident C had limited mobility, with a contracture of his left leg.

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: **(e) A patient or resident is entitled to receive adequate and appropriate care**
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.**
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:	The investigation was not able to establish that the ROC was provided inadequate care. Residents who were living in the facility at the time of the onsite visit received adequate and appropriate care.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

At the time of the onsite visit, Resident A was observed for incontinence care. Observation revealed that Resident A had two areas of skin impairment on her buttocks that appeared as though the top layer of skin had been scraped off. Review of Resident A's service plan revealed that there were two interventions to prevent skin breakdown dated 05/19/2023, to assist with routine toileting and to routinely inspect her skin weekly. Ten additional interventions were added on 06/07/2024, after the onsite visit, including the use of moisture barrier ointment, assisting with repositioning, the use of a pressure reducing cushion in her wheelchair and increased attention to incontinence care.

At the time of the onsite visit, Resident B was observed for incontinence care. Resident B used incontinence briefs, but with assistance, was able to use the toilet. Although Resident B needed a 1-person assist for transferring, review of her service plan revealed that there were no entries for assistance with toilet use/toileting, other than "encourage resident to sit on toilet to evacuate bowels" for prevention of constipation.

At the time of the onsite visit, Resident C was observed for incontinence care. Resident C was provided incontinence care while lying in bed and needed the assistance of a caregiver using a sit-to-stand mechanical lift to get out of bed. According to Resident C's service plan, caregivers were to "assist with routine toileting as needed."

On 06/13/2024, via an email exchange with the administrator and the clinical director, the facility was asked to explain why the service plans for these residents did not accurately reflect the care that these residents required. According to the clinical director, the service plans had not been updated.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.

For Reference: R325.1901	**Definitions.**
	(t) "Service plan" means a written statement prepared by the home in cooperation with a resident, the resident's authorized representative, or the agency responsible for a resident's placement, if any, that identifies the specific care and maintenance, services, and resident activities appropriate for the individual resident's physical, social, and behavioral needs and well-being, and the methods of providing the care and services while taking into account the preferences and competency of the resident.
ANALYSIS:	The service plans were not updated to reflect the care needed by the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the authorized representative (AR) on 06/24/2024. When asked if there were any comments or concerns with the investigation, the AR stated that there were none.

IV. RECOMMENDATION

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

06/24/2024

Barbara Zabitz Date
Licensing Staff

Approved By:

06/20/2024

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