GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 18, 2024

Sharon Cuddington
Trinity Continuing Care Services
Suite 200
20555 Victor Parkway
Livonia, MI 48152

RE: License #:	AL610261127
Investigation #:	2024A0356032
	Sanctuary at the Oaks #1

Dear Ms. Cuddington:

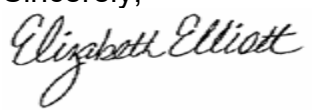
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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 (616) 356-0100.

Sincerely,



Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL610261127
Investigation #:	2024A0356032
Complaint Receipt Date:	04/23/2024
Investigation Initiation Date:	04/24/2024
Report Due Date:	06/22/2024
Licensee Name:	Trinity Continuing Care Services
Licensee Address:	Suite 200 20555 Victor Parkway Livonia, MI 48152
Licensee Telephone #:	(810) 989-7492
Administrator:	Jeanine Gomez
Licensee Designee:	Sharon Cuddington
Name of Facility:	Sanctuary at the Oaks #1
Facility Address:	1740 Village Drive 1st Floor Muskegon, MI 49442-4282
Facility Telephone #:	(231) 672-2700
Original Issuance Date:	04/21/2005
License Status:	REGULAR
Effective Date:	10/26/2023
Expiration Date:	10/25/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A's room is cluttered and unclean.	No
Resident A's medications were not administered as prescribed.	Yes
Resident A had a medical incident and care was not sought immediately.	No
Staff failed to protect Resident A when she sustained unexplained injuries.	No

III. METHODOLOGY

04/23/2024	Special Investigation Intake 2024A0356032
04/24/2024	Special Investigation Initiated - Telephone
05/07/2024	Contact - Telephone call made. Relative #1.
05/21/2024	Inspection Completed On-site.
05/21/2024	Contact - Face to Face Jeanine Gomez, administrator, DCW, Ashlyn Hilton, Ashley Sahagan.
05/21/2024	Contact - Document Received Facility documents.
05/21/2024	Contact - Face to Face Resident A. Room inspection, Resident A interviewed.
05/24/2024	Contact - Telephone call made. Lisa Edlund, RN, facility nurse.
05/29/2024	Contact-Telephone call made. DCW Aline Williams, no answer, could not leave a message. Latisha Gregory, voicemail message left.
05/31/2024	Contact-Telephone call made. Ms. Williams, no answer, could not leave a message. Ms. Gregory, voicemail message left.

06/03/2024	Contact - Telephone call made. Angela Hicks, RN, facility nurse. Ms. Williams and Ms. Gregory-not able to reach either DCW.
06/13/2024	Contact - Document Received Resident A MAR.
06/14/2024	APS Referral centralized intake.
06/14/2024	Contact - Telephone call made. Christa Dobrowski, RN and Michelle Nelson, social worker, Senior Resources, MA Waiver Program. Spoke to Ms. Nelson.
06/18/2024	Exit conference-Sharon Cuddington.

ALLEGATION: Resident A's room is cluttered and unclean.

INVESTIGATION: On 04/23/2024, I received a BCAL (Bureau of Children and Adult Licensing) online complaint. The complainant reported that Resident A's room is in complete disarray. The bathroom shelves have towels that are thrown onto the shelves. There is a shelf in the closet with clothes thrown on top of the shelf. The complainant reported the administrator said Resident A has "too much stuff" and that staff are very busy. The complainant reported that keeping Resident A's living area clean and neat is part of the duties of staff and that visitors and family should not have to do this.

On 05/07/2024, I interviewed Relative #1 via telephone. Relative #1 stated Resident A's bathroom and closet are "disaster." Relative #1 stated she often organizes and cleans the room, takes pictures of before and after and then shows the pictures to the administrator, Jeanine Gomez. Relative #1 stated Ms. Gomez said the staff are short in stature and they are busy. Relative #1 stated staff should keep Resident A's room organized and clean but the room is not always kept up.

On 05/21/2024, I conducted an unannounced inspection at the facility and interviewed Ms. Gomez. Ms. Gomez stated that Resident A has a lot of clothes in her closet and several bottles of lotions and products in her bathroom. When staff get clothes down for Resident A, sometimes the stack of clothes comes down from the shelf in the closet. Ms. Gomez stated at times, staff do not get the clothes folded and put away right then because they are busy, but it does get done. Ms. Gomez stated at times, Relative #1 does it before staff can get it accomplished. Ms. Gomez stated Resident A has several lotions in her small bathroom so the sink area can look cluttered, but the room is clean. Ms. Gomez stated in the past, the former facility nurse, Megan Woodin suggested that Relative #1 get Resident A one good lotion and it would save room on Resident A's sink since the area is small. Ms.

Gomez stated the facility has housekeeping that cleans once a week, cleans the floors, bathrooms, kitchen area, vacuums and straightens the room up, and the room is clean.

On 05/21/2024, I interviewed direct care workers (DCW) Ashlyn Hilton and Ashely Sahagan individually at the facility. Ms. Hilton stated she swept Resident A's room today and they try to keep the rooms clean, but they do not do the heavy cleaning housekeeping does. Ms. Hilton stated she has organized in Resident A's room, but she does have a lot of clothing and items in a small room. Ms. Hilton stated Relative #1 stocks Resident A up with a lot of lotions and shampoo and that is ok, but it does take up space that is small to begin with. Ms. Sahagan stated there is a lot of clothing in Resident A's closet. Ms. Sahagan stated there are clothes in totes and folded on the shelf and hung in Resident A's closet. Ms. Sahagan stated she has taken clothing out of the stacked clothes in the closet, and the stack has fallen but she has put it back. Ms. Sahagan stated she, and other DCWs try and put the clothing back but it can be hard to keep it up. Ms. Hilton and Ms. Sahagan stated housekeeping cleans resident rooms once a week keeping the residents' rooms clean including Resident A's.

On 05/21/2024, I inspected Resident A's room at the facility. I observed Resident A's closet and the clothes in the closet were folded and hung. Resident A's clothing was all housed in the closet. I observed Resident A's bathroom and noted the lotions next to the sink. The entire room and bathroom were clean, and the walkway was open and free from clutter.

On 05/21/2024, I attempted to interview Resident A in her room at the facility. Resident A is unable to provide pertinent information to this investigation due to cognitive deficits.

On 05/24/2024, I interviewed Lisa Edlund, facility RN (registered nurse) via telephone. Ms. Edlund stated she has not observed Resident A's room in disarray.

On 06/03/2024, I interviewed Angela Hicks, facility RN via telephone. Ms. Hicks stated she has not observed Resident A's room in disarray.

On 06/14/2024, I interviewed Michelle Nelson, Senior Resources social worker. Ms. Nelson stated she has not observed Resident A's room to be cluttered or in disarray.

On 06/18/2024, I conducted an exit conference with Licensee Designee, Sharon Cuddington. Ms. Cuddington stated she will review this report with the administrator, and she understands and agrees with the information, analysis, and conclusion of this applicable rule.

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:	The complainant reported that Resident A's room is in complete disarray. Relative #1 stated staff should keep Resident A's room organized and clean but the room is not always kept up. Ms. Gomez, Ms. Hilton, Ms. Sahagan acknowledged that Resident A's clothes fall in the closet, but staff try and keep up on the organization of the clothes. All stated Resident A's room is clean. Ms. Edlund, Ms. Hicks, and Ms. Nelson stated Resident A's room is clean and her clothes are folded and hung in the closet. I observed Resident A's room, and it was clean and the clothes in the closet were organized. Based on investigative findings, there is not a preponderance of evidence to show the maintenance of Resident A's room is poor and therefore, a violation of this applicable rule is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A's medications were not administered as prescribed.

INVESTIGATION: On 04/23/2024, I received a BCAL online complaint. The complainant reported that approximately 3 months ago, staff placed Resident A's medications in the microwave so she could go on break and another staff member could administer the medications at bedtime. The complainant reported concern that Resident A's medications are not administered as prescribed.

On 05/07/2024, I interviewed Relative #1 via telephone. Relative #1 stated she, her husband and Resident A were sitting in the dining room and former DCW Tiania Steele put a cup of Resident A's medications in the microwave to store them for later administration. Relative #1 stated she asked Ms. Gomez about this and Ms. Gomez

“blows me off” and said the incident was investigated and it did not happen. Relative #1 expressed concern regarding the administration of Resident A’s medications.

On 05/21/2024, I conducted an unannounced inspection at the facility and interviewed Ms. Gomez. Ms. Gomez stated she received information months ago that Ms. Steele placed a cup of Resident A’s medications in the microwave. Ms. Gomez reported that she and Ms. Woodin investigated this claim and interviewed Ms. Steele and she (Ms. Steele) stated she did not put Resident A’s medications in the microwave. Ms. Gomez stated Ms. Steele stated “maybe” she left Resident A’s medications “on the ledge” while she assisted another resident but that she never put the medications in the microwave. Ms. Gomez stated Ms. Steele stated she administered resident medications directly to the residents, that she never asked other staff to administer resident medications for her and recanted her statement that she left Resident A's medications “on a ledge.” Ms. Gomez stated from her investigation, she could not substantiate that Resident A did not get her medications due to this alleged incident. Ms. Gomez stated Resident A’s medications are administered as prescribed. Ms. Gomez stated Ms. Steele no longer works at the facility.

On 05/21/2024, I interviewed Ms. Hilton and Ms. Sahagan individually at the facility. Ms. Hilton stated she never heard of or saw staff place Resident A’s medications in the microwave or on a ledge at the facility. Ms. Sahagan stated she heard about staff placing Resident A’s medications in the microwave, but she did not witness it. Ms. Hilton and Ms. Sahagan stated they administer Resident A’s medications as prescribed.

On 05/21/2024, I attempted to interview Resident A in her room at the facility. Resident A is unable to provide pertinent information to this investigation due to cognitive deficits.

On 05/24/2024, I interviewed Lisa Edlund, facility RN via telephone. Ms. Edlund stated she acted as the facility nurse beginning in February 2024 after Ms. Woodin left. Ms. Edlund stated Relative #1 brought this issue up in a meeting, but Ms. Edlund stated the alleged incident did not occur when she was working at the facility. Ms. Edlund stated Ms. Gomez reported she investigated but did not substantiate this allegation. Ms. Edlund stated resident medications are administered as prescribed from what she has seen and Relative #1 has not brought up any current concerns or issues with the administration of Resident A’s medications.

On 06/13/2024, I received and reviewed Resident A’s medication administration records (MAR) for March, April, and May 2024.

Resident A’s March MAR documented Resident A’s medications administered as prescribed except for the following: Refresh Optive Drop 0.5/0.9%, instill 1 drop into both eyes six times daily. The medication was ordered to be administered at 3:00a.m., 7:00a.m.,11:00a.m.,3:00p.m.,7:00p.m., 11: 00p.m. The 11:00a.m. dose on

03/05/2024, 11:00a.m. dose on 03/11/2024, and 11:00a.m. on 03/23/2024 were not documented as administered. The pass notes documented on 03/07/2024, 7:21a.m., '*Refresh Optive drop 0.5/0.9%, 3rd shift forgot to doc* (document).

Resident A's April MAR documented Resident A's medications administered as prescribed except for the following medications: '*Special medical procedure, Blood pressure checks, check blood pressure once daily. Record in MAR for Dr. Klein to review.*' On 04/06/2024 there is no blood pressure reading recorded on the MAR. '*Refresh Optive Drop 0.5/0.9%, instill 1 drop into both eyes six time daily.*' The 11:00a.m. dose on 04/04/2024, 11:00a.m. dose on 04/13/2024, 11:00a.m. dose on 04/23/2024 and the 11:00A.M. dose on 04/25/2024 are not documented as administered. The pass notes documented on 04/03/2024, 08:28a.m., '*Refresh Optive drop 0.5/0.9%, 3rd shift* (forgot to doc).

Resident A's May MAR documented Resident A's medications administered as prescribed except for the following medication: '*Refresh Optive Drop 0.5/0.9%, instill 1 drop into both eyes six times daily*.' The 11:00a.m. dose on 05/01/2024, the 11:00a.m. dose on 05/17/2024, the 11:00a.m. dose on 05/19/2024, and the 11:00p.m. dose on 05/24/2024 are not documented as administered. The pass notes documented on 05/22/2024, 06:45a.m., '*Refresh Optive drop 0.5/0.9%, third shift* (forgot to document).'

On 06/18/2024, I conducted an exit conference with Licensee Designee, Sharon Cuddington. Ms. Cuddington stated she will review this report with the administrator, and she understands the information, analysis, and conclusion of this applicable rule. Ms. Cuddington stated they will write and enact an acceptable corrective action plan.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	It was alleged that Resident A's medications are not administered as prescribed.

	Relative #1 stated she saw Ms. Steele put a cup of Resident A's medications in the microwave to store them for later administration. Relative #1 expressed concern regarding the administration of Resident A's medications. Ms. Gomez, Ms. Hilton, Ms. Sahagan and Ms. Edlund stated Resident A's medications are administered as prescribed. A review of Resident A's medication administration record for March, April, and May 2024 indicated not all Resident A's medications are documented as being administered as prescribed and therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A had a medical incident and care was not sought immediately.

INVESTIGATION: On 04/23/2024, I received a BCAL online complaint. The complainant reported on 04/08/2024, staff notified the nurse there was a change in Resident A's condition, but no evaluation was done and there was no sense of urgency to assess Resident A. When Resident A was sent to the emergency room, she was hospitalized for a week and diagnosed with an ischemic stroke.

On 05/07/2024, I interviewed Relative #1 via telephone. Relative #1 stated she arrived at the facility at approximately 12:30p.m. and noted Resident A was having symptoms of a stroke, when she noticed Resident A was drooling. Relative #1 stated she told the facility nurse Resident A's symptoms, and was told, "ok, we'll be there in a minute." Relative #1 stated once Resident A was sent to the hospital, she was there for a week and had suffered from a stroke. Relative #1 stated there was a delay in medical attention for Resident A.

On 05/21/2024, I conducted an unannounced inspection at the facility and interviewed Ms. Gomez. Ms. Gomez stated Relative #1 was at the facility for over an hour, feeding her mom when she noticed that Resident A had a facial droop. Ms. Gomez stated residents including Resident A are normally checked on every two hours, but more frequent checks are conducted when necessary. Ms. Gomez stated Resident A was sent out by the facility nurse immediately upon evaluation and diagnosed as having had a stroke. Ms. Gomez stated there was not a delay before Resident A was evaluated by the facility nurse and 9-1-1 called. In addition, Ms. Gomez reported prior to this incident, there were no reports that Resident A's condition was different than it usually was.

On 05/21/2024, I attempted to interview Resident A in her room at the facility. Resident A is unable to provide pertinent information to this investigation due to cognitive deficits.

On 05/21/2024, I reviewed the Trinity Health Muskegon Hospital Medicine Daily Inpatient Progress Note dated 04/10/2024 written by Matthew Wagner, DO. The noted documented the following information, *'Subjective: Hospital Course to date: On the morning of presentation,* (Relative #1) *was reportedly feeding the patient and noticed acute (*as opposed to chronic*) onset of left facial asymmetry and drooling. Daughter called for help and patient presented to the ER for further evaluation. Last known well time at her facility was greater than 5 hours, Initial CT head negative for acute findings. She was admitted to general medical floor. Attending: Patient seen and examined. (Relative #1) was at the bedside. She is upset that nobody at the facility recognized that her mother was having a stroke and had she not been there she is not sure that they would have done anything about it. She does appear to be below her baseline, is almost completely flaccid on the left. She does have a very light handgrip. Will continue to monitor the patient for an additional day. Care timeline, 04/08 admitted from ED 1829.'*

On 05/21/2024, I reviewed an Incident/Accident report dated 04/08/2024, time of event, 12:45p.m., written by Angela Hicks, RN. The IR (incident report) documented the following information, *'(Relative #1) approached with concern that resident had a left side facility droop and noted drooling while eating. Assessment completed noted no independent movement in left arm. Slur noted with speech. Vital signs completed and stable, Physician notified and to be sent to ED for evaluation. (Relative #1) present and aware of transfer. EMS and fire department arrived. Symptoms continues. Transferred to ER at 1:10p.m. Physician or RN, Merideth Heinlein, NP (nurse practitioner) notified on 04/08/2024 at 12:50p.m.'*

On 06/03/2024, I interviewed Angela Hicks, facility RN via telephone. Ms. Hicks stated she was the nurse on duty on 04/08/2024 when Resident A was sent to the hospital due to a stroke. Ms. Hicks stated she was on the telephone with another resident's family member when Relative #1 alerted her that she thought there was something wrong with Resident A. Ms. Hicks stated she got off the phone, within 2 minutes and evaluated Resident A and once she assessed Resident A and noted slurred speech and a droop to her face, 9-1-1 was called immediately "literally within minutes." Ms. Hicks stated earlier on 04/08/2024, when Resident A was in her room, staff did not note any droop or drooling or any symptoms of a stroke with Resident A. Ms. Hicks stated Resident A was in the dining room for approximately ½ hour prior to Relative #1 getting to the facility and Resident A's condition was "normal".

On 06/18/2024, I conducted an exit conference with Licensee Designee, Sharon Cuddington. Ms. Cuddington stated she will review this report with the administrator and she understands and agrees with the information, analysis, and conclusion of this applicable rule.

APPLICABLE RULE:	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	The complainant reported that on 04/08/2024 Resident A's physical condition changed, and emergency assistance was not immediately called. Relative #1 stated Resident A had a stroke and staff at the facility did not obtain care immediately. Ms. Gomez and Ms. Hicks, RN stated Resident A was sent out immediately upon evaluation by Ms. Hicks and diagnosed as having had a stroke. The IR documented time of event as 12:45p.m. and Resident A was transferred to ER at 1:10p.m. Trinity Inpatient Progress Notes documented Relative #1 was feeding Resident A and noted acute (sudden) onset of facial drooping and drooling. Based on investigative findings, there is not a preponderance of evidence to show that upon the sudden adverse change in Resident A's physical condition, care was not sought immediately.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Staff failed to protect Resident A when she sustained unexplained injuries.

INVESTIGATION: On 04/23/2024, I received a BCAL online complaint. The complainant reported on 04/18/2024, Resident A had a large lump on her forehead and staff did not notice it.

On 05/07/2024, I interviewed Relative #1 via telephone. Relative #1 stated on 04/18/2024, at approximately 1:30p.m., she visited Resident A and noted a large lump on her forehead. Relative #1 stated staff said they had not noticed the lump while getting her dressed for the day and stated she could have fallen or hit her head on something and is concerned that staff do not know what happened. Relative #1 stated she requested that Resident A go to the hospital for an evaluation. In addition,

Relative #1 stated on 04/18/2024, while in the ER for evaluation of the lump to her forehead, hospital staff noted bruises to Resident A's left breast, a small bruise on the left forearm near the inner elbow and a bruise to the upper thigh. Relative #1 stated staff Ashlyn Hilton pointed out the bruise on Resident A's inner arm at the elbow to Relative #1. Relative #1 stated she requested staff at the ER document the bruises found on Resident A.

On 05/21/2024, I conducted an unannounced inspection at the facility and interviewed Ms. Gomez. Ms. Gomez stated an investigation was conducted and several staff were interviewed. Resident A had been seen by both nurses, Ms. Hicks and Ms. Edlund, the day prior to the lump being discovered and the day the lump was discovered, and the nurses did not see the lump on her forehead until Relative #1 saw it. Ms. Gomez stated they do not know how the lump occurred. Ms. Gomez stated Resident A uses a Hoyer lift for transferring and considered the possibility that she may have bumped it on the Hoyer, but staff do not support that. Ms. Gomez stated Resident A was sent to the ER for evaluation and returned to the facility.

On 05/21/2024, I interviewed DCW Ashlyn Hilton at the facility. Ms. Hilton stated she worked with Ms. Sahagan on the date the lump was discovered on Resident A's forehead. Ms. Hilton stated she did not notice the lump when she washed Resident A's face the morning of 04/18/2024 when Resident A woke up. Ms. Hilton stated Relative #1 did not notice the lump for 30-40 minutes when she was visiting Resident A on that date either. Ms. Hilton stated she and Ms. Sahagan did not bump Resident A's head while providing care to her or using the Hoyer lift. Ms. Hilton stated she always puts her hand on Resident A's forehead when transferring her and lifting her in the Hoyer. Ms. Hilton stated she and Ms. Sahagan rolled Resident A and used the Hoyer to lift her and she did not have a lump on her forehead nor did Resident A have a lump on her forehead the day prior because she and Ms. Sahagan cared for Resident A on 04/17/2024 and 04/18/2024. Ms. Hilton stated they used the Hoyer on 04/17/2024 also and Resident A did not have a fall or a bump on her head either date until reported by Relative #1 on 04/18/2024. Ms. Sahagan stated she noticed the bruise on Resident A's arm when she was on her way to the hospital on 04/18/2024 but she (Resident A) had just been in the hospital due to a stroke and it appeared as though the bruise could have been from an IV, so she assumed it occurred while in the hospital on 04/08/2024-04/12/2024. Ms. Hilton stated she did not see or know about any other bruising on Resident A.

On 05/21/2024, I interviewed DCW Ashely Sahagan at the facility. Ms. Sahagan stated she and Ms. Hilton got Resident A cleaned up and dressed on 04/18/2024 and did not notice a lump on Resident A's forehead until she looked at it from the angle Relative #1 was at. Ms. Sahagan stated Resident A "leans a lot," she falls asleep and leans over so Ms. Sahagan thought Resident A possibly bumped her head on the bedside table or the Hoyer. Ms. Sahagan stated 9-1-1 was called as soon as the lump was noticed, and she went right out to the ER. Ms. Sahagan stated Ms. Edlund was the nurse on duty on 04/18/2024. Ms. Sahagan stated she did not see or know about any other bruises on Resident A.

On 05/21/2024, I attempted to interview Resident A in her room at the facility. Resident A is unable to provide pertinent information to this investigation due to cognitive deficits.

On 05/21/2024, I reviewed the internal investigation conducted by facility RN, Lisa Edlund. Ms. Edlund interviewed 8 direct care workers on all shifts who reported no falls or bumps to Resident A's head. Ms. Edlund has a separate interview with Aline Williams (1st) on 04/19/2024 and Ms. Williams reported to Ms. Edlund that when using the Hoyer with Resident A, her "face gets close (to the Hoyer bar) since she is so long" and on 04/18/2024, at 7a.m. Ms. Williams saw DCW's cleaning Resident A up, at 7:35-7:45a.m. Resident A took medications, and she did not note any lumps on Resident A's head. Ms. Williams reported to Ms. Edlund, 3rd shift staff Leah Nummerdor noted Resident A slept through the night and there were zero incidents or concerns. Ms. Williams stated staff put cream on Resident A's face and at that time, Ms. Williams reported she did not see anything on Resident A's forehead. Ms. Williams explained that there are always 2 staff providing care to Resident A. They pull her bed out and stand on each side of the bed to provide care. This is how they always do it to ensure safety and no falls. Ms. Williams stated the only thing noted at that time was that Resident A's lips were a little puffy but that they had been that way since the stroke.

On 05/21/2024, I reviewed the IR dated 04/18/2024, written by Lisa Edlund, RN, time 13:45 (1:45p.m.). The IR documented the following information, *'Transfer to Emergency Department, Resident was noted to have contusion to left forehead. No known trauma.* (Relative #1) *requested transport to ER for evaluation. Dr. Jay Klein notified. Resident sent to ER for evaluation, investigation initiated for injury of unknown origin.'*

On 05/21/2024, I reviewed the Emergency Room report dated 04/18/2024 and written by Joel Visser, PA, Physician Assistant, Emergency Medicine. The ED report documented the following information, *'Chief complaint: Patient presents with bump on head*. *Patient was brought in for evaluation for a hematoma to her forehead. She currently resides at a nursing home facility and was recently discharged secondary in the hospital to a stroke and started on Plavix. Staff was unaware of any type of injury that they know of but (*Relative #1*) who saw her yesterday had not noticed the hematoma yesterday so wanted further evaluation. Patient has had no change in her mental status, she does have left facial asymmetry and weakness all the neurological findings are consistent with her previous stroke, no new symptoms, she has not had any new fevers, agitation, or changes in mental status, she does have known dementia as well. Family's only concern was this new hematoma that has developed.'* The report documented a physical exam and noted, '*head: hematoma to the left side of the forehead'* and '*skin: no rash or lesions.'*

On 05/24/2024, I interviewed Ms. Edlund via telephone. Ms. Edlund stated she assessed Resident A on 04/18/2024 when a lump was noticed on her forehead by

Relative #1. Ms. Edlund stated at that time she noted a small dime sized bruise on Resident A's left forearm. The bruise was "old, faded and yellowing." Ms. Edlund stated she initiated an investigation to see if Resident A could have possible suffered an unreported fall or possibly Resident A bumped her head on the Hoyer lift during a transfer. Ms. Edlund stated she interviewed 1st, 2nd, and 3rd shift staff and no one had any information that supported an unwitnessed fall or bump to the head that would have caused the lump on Resident A's forehead. Ms. Edlund stated when Resident A is tired, she will lay her head down on tables in the cafeteria and possibly sustained a bump to the forehead from that, it is unknown. Ms. Edlund stated Resident A was transported to the ER for evaluation and any necessary treatment and returned to the facility. Ms. Hicks evaluated Resident A the following day, 04/19/2024 and the lump was gone. Ms. Edlund stated she did not see any other bruises on Resident A.

On 06/03/2024, I interviewed Angela Hicks, facility RN via telephone. Ms. Hicks stated she was at the facility on 04/18/2024 and viewed the lump on Resident A's forehead. Ms. Hicks stated it was a small lump and the following day, 04/19/2024. She evaluated Resident A and did not see the lump at all and had it been a significant injury, there would have been some sign of the lump still on her forehead. Ms. Hicks stated she did not see or know about any other bruises other than the lump assessed on Resident A's forehead. Ms. Hicks stated the ER discharge information did not document any bruising on Resident A at all and there were no other reports from anyone regarding bruises other than the lump on Resident A's forehead.

On 06/14/2024, I interviewed Michelle Nelson, Senior Resources social worker. Ms. Nelson stated she has been involved with Resident A for approximately one year and was aware that Resident A suffered a stroke and then had a bump on her head that she was sent out to ER for evaluation and treatment both times. Ms. Nelson stated she has not noted neglectful care on the part of this facility but has offered Relative #1 a different placement for Resident A but at this time, this has been declined. Ms. Nelson will remain as the social worker for Resident A.

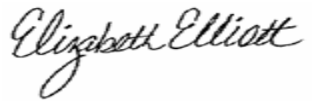
On 06/18/2024, I conducted an exit conference with Licensee Designee, Sharon Cuddington. Ms. Cuddington stated she will review this report with the administrator, and she understands and agrees with the information, analysis, and conclusion of this applicable rule.

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:	The complainant reported that 04/18/2024, Resident A had a large lump on her forehead and staff did not notice it. Based on my interview with Relative #1, the facility nurse, facility staff, a review of the ER report and facility incident report, there is not a preponderance of evidence to indicate staff failed to keep Resident A safe when a lump on the left side of her forehead appeared on 04/18/2024. A violation of this applicable rule is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

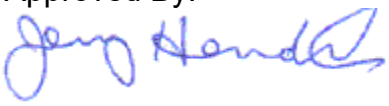
Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.



06/18/2024

Elizabeth Elliott Date
Licensing Consultant

Approved By:



06/18/2024

Jerry Hendrick Date
Area Manager