GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 22, 2024

Rayann Burge
RSR Creek LLC
5485 Smiths Creek
Kimball, MI 48074

RE: License #: AS740408305
Investigation #: 2024A0580044
Sandalwood Creek II

Dear Rayann Burge:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 do so can 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) 763-7960.

Sincerely,

Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 835-1019

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS740408305
Investigation #:	2024A0580044
Complaint Receipt Date:	07/09/2024
Investigation Initiation Date:	07/12/2024
Report Due Date:	09/07/2024
Licensee Name:	RSR Creek LLC
Licensee Address:	5485 Smiths Creek Kimball TWP, MI 48074
Licensee Telephone #:	(810) 204-0577
Administrator:	Rayann Burge
Licensee Designee:	Rayann Burge
Name of Facility:	Sandalwood Creek II
Facility Address:	5485 Smiths Creek Kimball TWP, MI 48074
Facility Telephone #:	(810) 367-7192
Original Issuance Date:	11/16/2021
License Status:	REGULAR
Effective Date:	05/16/2024
Expiration Date:	05/15/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED

	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A had live maggots in her scalp.	No
Additional Findings	Yes

III. METHODOLOGY

07/09/2024	Special Investigation Intake 2024A0580044
07/09/2024	APS Referral Denied by APS for investigation.
07/12/2024	Special Investigation Initiated - Telephone Call to Relative A.
07/15/2024	Inspection Completed On-site Unannounced onsite.
07/15/2024	Contact - Face to Face Interview with Resident A.
07/16/2024	Contact - Document Received Documents requested received via email.
08/16/2024	Contact - Telephone call received Call from Relative A.
08/20/2024	Contact - Telephone call made Call to Harmony Cares.
08/20/2024	Contact - Telephone call made Call to LD Burge.
08/20/2024	Exit Conference Exit conference with the Licensee Designee/Administrator, Rayann Burge.

ALLEGATION:

Resident A had live maggots in her scalp.

INVESTIGATION:

On 07/09/2024, I received a complaint via BCAL Online Complaints. This complaint was denied by Adult Protective Services (APS) for investigation.

On 07/12/2024, I placed a call to Relative A regarding the allegations. A voice mail message was left requesting a return call.

On 07/15/2024, I conducted an unannounced onsite inspection. Contact was made with the assistant manager on duty, Marie Carrier, who stated that Resident A does her own showering and grooming. Manager Carrier stated that Resident A has been released from the hospital and has since returned to the facility. There are currently 3 residents in the facility.

On 07/15/2024, while onsite I interviewed Resident A while in her room. Resident A stated that she showers and washes her hair on her own. Resident A adds that she does not wash her hair each time she showers, stating that she washes her hair twice a week. Resident A adds that her daughter in Texas is her guardian. Resident A expressed that although she wants to return to her own home, the staff at Sandalwood Creek II do a good job in meeting her needs. Resident A was observed adequately dressed and groomed. No concerns were noted.

Another resident was observed visiting with a family member, while another resident was observed watching television. Both were observed as being adequately dressed and groomed. They appeared to be receiving proper care.

On 07/16/2024, I received a copy of the IR (Incident Report), Medical Discharge Summary and AFC Assessment Plan for Resident A. The Incident Report indicates that on 07/06/2024 staff Carrier noticed that Resident A had a bloody napkin on her head and indicated that she scratched it with her comb. Staff Carrier observed a big bump with blood. Staff Carrier called EMS, the home manager, and Relative Guardian A. As a corrective measure, staff will follow instructions from hospital/physician upon discharge. Resident A was diagnosed as having a scalp abscess.

The McLaren Port Huron Discharge Summary indicates that Resident A presented on 07/06/2024 for a Scalp Abscess/Infestation with maggots. On 07/08/2024, Resident A received a Excision Scalp Mass Procedure. Resident A was discharged on 07/11/2024 with the following wound care instructions: daily hair wash with baby shampoo and application of bacitracin to the incision. Prescriptions include Ciprofloxacin HCl (Cipro) 500 mg, orally every 12 hours for 14 days and Acetaminophen, 1000mg, orally every 6 hours as needed for pain.

The assessment plan indicates that Resident A does not require assistance with bathing or personal hygiene. Resident A requires prompts for grooming and dressing (ensuring clothes are clean). Resident A does not require assistance with walking or mobility and has no identified physical limitations.

On 08/16/2024, I spoke with Relative A who stated that she is the assigned Power of Attorney (POA) for Resident A who is diagnosed with Dementia. Relative A adds that Resident A appears to be intellectual, until you talk to her for a while. Relative A stated that Resident A continues to be very independent and stubborn and does not always make good choices when it comes to her hygiene. Relative A added that Resident A could have very well indicated to the staff that she'd been washing her hair, when in fact, she probably was not. Relative A adds that the bump in Resident A's head was discovered sometime in October 2023. No medical treatment was required at the time. It was determined that the doctor would "keep an eye on it". Relative A shared that when she was contacted by the hospital staff, they indicated that it took 3 people to get her in the shower. Resident A has since been moved to the larger facility where staff can keep a closer eye on her. Relative A will also be speaking with the license administrator regarding updating Resident A's AFC Assessment Plan, allowing her to maintain her autonomy in as many areas as possible.

Relative A adds that due to living out of state, she typically visits unannounced, with the last visit having been at the end of May 2024. When visiting, Resident A did not appear unkept or dirty. Relative A stated that staff in the AFC home do well at meeting Resident A's needs.

On 08/20/2024, I spoke with Dianne Junior, Nurse Practitioner at Harmony Cares, located in Marysville, MI, who shared that Resident A received follow-up treatment from her primary physician, Dr. Galera on 07/17/2024 regarding an Abscess of the head. Nurse Junior explained that for the abscess to have become infected, the environment would have to been appropriate for a fly to lay an egg, i.e. a moist area, maybe after having sweated or having washed her hair, and not necessarily neglect.

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:	It was alleged that Resident A had live maggots in her scalp. Assistant Manager, Marie Carrier, who stated that Resident A does her own showering and grooming.

	Resident A stated that she showers and washes her hair on her own, however, she does not wash her hair each time she showers, stating that she washes her hair twice a week. The IR dated 07/06/2024 states that staff Marie Carrier noticed that Resident A had a bloody napkin on her head and indicated that she scratched it with her comb. Staff Carrier observed a big bump with blood. Staff Carrier called EMS, the home manager, and Relative Guardian A. The McLaren Port Huron Discharge Summary indicates that Resident A presented on 07/06/2024 for a Scalp Abscess/Infestation with maggots. On 07/08/2024, Resident A received an Excision Scalp Mass Procedure and was discharged on 07/11/2024. The assessment plan indicates that Resident A does not require assistance with bathing or personal hygiene. Relative A stated that Resident A continues to be very independent and stubborn and does not always make good choices when it comes to her hygiene. Relative A stated that staff in the AFC home do well at meeting Resident A's needs. Dianne Junior, Nurse Practitioner at Harmony Cares explained that for the abscess to have become infected, the environment would have to been appropriate for a fly to lay an egg, i.e. a moist area, maybe after having sweated or having washed her hair, and not necessarily neglect. Based on the interviews conducted and the documents reviewed, there is insufficient evidence to support the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 07/15/2024, while onsite I observed direct staff Kayla Stempowski on side I of the connected facilities. Staff Stempowski was identified as the only staff on duty at Sandalwood Creek II. Staff Stempowski left the residents alone while visiting at Sandalwood Creek Side I.

On 08/20/2024, during the exit conference, LD Burge was informed of the violation established and the importance of staff always maintaining supervision of the residents. LD Burge stated that Staff Stempowski no longer works at the facility. Other staff have been informed that if they leave their assigned side of the building during their shift, they will be terminated.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	On 7/15/2024, Staff on duty were observed outside of the facility, having left the residents alone.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 08/20/2024, I conducted an exit conference with the Licensee Designee Rayann Burge. LD Burge was informed of the findings in this report.

IV. RECOMMENDATION

Upon the receipt of an approved corrective action plan, no change to the status of the license is recommended.

Sabrina McGowan August 22, 2024

Sabrina McGowan Date
Licensing Consultant

Approved By:

Mary Holton August 22, 2024

Mary E. Holton Date
Area Manager