GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 6, 2024

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

| | |
|---|---|
| RE: License #: | AL610261127 |
| Investigation #: | 2025A0356005 |
| | Sanctuary at the Oaks #1 |

Dear Ms. Cuddington:

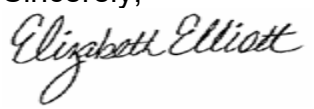
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:** | 2025A0356005 |
| | |
| **Complaint Receipt Date:** | 10/09/2024 |
| | |
| **Investigation Initiation Date:** | 10/09/2024 |
| | |
| **Report Due Date:** | 12/08/2024 |
| | |
| **Licensee Name:** | Trinity Continuing Care Services |
| | |
| **Licensee Address:** | 20555 Victor Parkway, Suite 200<br>Livonia, MI 48152 |
| | |
| **Licensee Telephone #:** | (810) 989-7492 |
| | |
| **Administrator:** | Julie Treakle |
| | |
| **Licensee Designee:** | Sharon Cuddington |
| | |
| **Name of Facility:** | Sanctuary at the Oaks #1 |
| | |
| **Facility Address:** | 1st Floor<br>1740 Village Drive<br>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 assessed needs are not being met by staff at the facility. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 10/09/2024 | Special Investigation Intake<br>2025A0356005 |
| 10/09/2024 | Special Investigation Initiated.<br>Relative #1. |
| 10/09/2024 | Contact-Face to face.<br>Interviewed Administer, Julie Treakle and Christy Votjke, RN. |
| 10/09/2024 | Contact - Document Received<br>Facility documents reviewed. |
| 10/22/2024 | Contact - Face to Face<br>Administrator, Julie Treakle, RN Angela Hicks, reviewed facility documents. |
| 11/22/2024 | Contact - Face to Face<br>Julie Treakle, Administrator, Angela Hicks, RN and Jennifer Dunn, RN. Residents A-E, Relative #2, DCW's Jamila Griffen and Myeisha Anderson. |
| 12/06/2024 | Exit conference-Licensee Designee, Sharon Cuddington. |

**ALLEGATION: Resident A's assessed needs are not being met by staff at the facility.**

**INVESTIGATION:** On 10/09/2024, I received a LARA-BCHS complaint. The complainant reported on 10/07/2024, Resident A's call button was not around her neck and was on a chair out of arm's reach. Her clothes were wet and soiled with food that was served to her and left for her to eat on her own. The complainant stated it is unknown how long Resident A was left alone. The complainant stated Resident A was discovered alone in her room and halfway out of her bed. The complainant reported when staff were questioned, they did not see a problem with how Resident A was left.

On 10/09/2024, I interviewed Relative #1 who reported on 10/07/2024, she walked in Resident A's room at the facility and found Resident A slumped over in bed with a plate of food, unsupervised and unassisted when she requires staff assistance while eating. Relative #1 stated she took photos of the way she found Relative #1.

On 10/09/2024, I received and reviewed five photos from Relative #1 showing Resident A slumped over in bed, in her room with her head leaning on the bed rail, a large neck pillow around her neck with a tray across her bed. On the tray, there is a Styrofoam container with some food left in it, and a Styrofoam cup in the food tray. Resident A's pants were wet from spilled liquid and chunks of food are spilled in the bed. Relative #1 stated dinner is served at 4:00p.m. and she found Resident A in this condition at 6:30p.m on 10/07/2024. Relative #1 stated Resident A had a stroke and is supposed to be supervised while eating meals. Relative #1 stated, there were no staff with her and there was still food in the bed and on the tray and it did not appear as though she had been supervised when she ate given the condition she was found in.

On 10/09/2024, I conducted an unannounced inspection at the facility and interviewed July Treakle, administrator and Christy Votjke, RN. Ms. Treakle and Ms. Votjke stated Resident A requires a 1-person assist with meals and she is encouraged to go to the dining room but if she chooses to remain in her room, staff should be with her while she eats. Ms. Treakle acknowledged the pictures taken by Relative #1 and stated she has taken steps to make sure Resident A is taken to the dining room for meals and if she does not want to go, staff are with her as she eats as she requires a 1-person assist with meals.

On 10/15/2024, Relative #1 reported that on 10/14/2024, during the afternoon meal, Resident A did not get fed.

On 10/22/2024, I met with Ms. Treakle and Angela Hicks at the facility and reviewed Resident A's assisted living assessment. The assessment documented Resident A *'needs escorts to every meal, requires direction to order meals and/or altered consistency (cutting up of food, mechanical soft, puree) of food.'* Ms. Treakle stated that she is aware of Relative #1's concern that Resident A did not get fed on 10/14/2024. Ms. Treakle stated the staff member who was working on the date Relative #1 found Relative A with food in her bed is the same DCW that worked on 10/14/2024 and that staff no longer works at the facility.

On 10/22/2024, I reviewed the ADL (activities of daily living) log for October 2024. The log documented a mealtime routine originated 05/07/2024 and documented, *'mechanical soft, thin liquids, upright 90 degrees for meals. It is preferred that resident is out of bed for all meals as she will allow. Line of sight supervision required.'* This ADL was on the log as a PRN (as needed) and DC'd (discharged) on 10/08/2024. Ms. Hicks stated Resident A's mealtime instructions were documented PRN, which means the mealtime instructions should be followed as needed. Ms. Hicks stated that was not correct and the PRN instructions were discharged and

changed as of 10/08/2024 to document that Resident A's mealtime instructions are to be carried out daily for each meal and documented on the ADL log by staff.

On 10/22/2024, I reviewed the updated ADL log for October 2024 that began on 10/08/2024 to date. The instructions on this ADL documented, *'one assist with meals. Mechanical soft, think liquids, upright 90 degrees for meals. Encourage dining room for meals.'* The ADL log is documented with staff initials beginning on 10/08/2024 to date (10/22/2024), except for three dates where there are no staff initials showing Resident A received staff assistance or a one person assist with meals on those dates, 10/11/2024, 10/14/2024, & 10/18/2024 in the afternoon.

On 11/22/2024, I interviewed Ms. Treakle and she stated she is meeting on a regular basis with Relative #1, and two new RN's have been hired so issues such as these are being addressed and remedied.

On 11/22/2024, I reviewed Resident A's assessment plan for AFC residents. The assessment plan documented Resident A required a one-person assist from staff for all meals, mechanical, soft, thin liquids, upright 90 degrees for meals.

On 11/22/2024, I observed Resident A and Resident B in the dining room of the facility. Resident A & B are not able to provide information pertinent to this investigation due to cognitive deficiencies.

On 11/22/2024, I interviewed Relative #2 in Resident C's room. Resident C is not able to be interviewed due to cognitive deficiency. Relative #2 stated overall Resident C's care from the staff in the facility is good.

On 11/22/2024, I interviewed Resident D & E. Both stated the care they receive from staff is good.

On 11/22/2024, I interviewed DCW Myiesha Anderson. Ms. Anderson stated when she works, she brings Resident A to the dining room. If she does not want to go to the dining room, staff sit with her, but she is pretty good about coming out to the dining room. Ms. Anderson stated staff were not aware that they were supposed to sit with Resident A in her room while she was eating until "a few months ago." Ms. Anderson stated she was unaware that staff were supposed to watch Resident A, but the issue has been fixed since Relative #1 brought the issue to the attention of the administrator.

On 11/22/2024, I interviewed DCW Jamila Griffen. Ms. Griffen stated she usually works on the second and third floors at this building and was not aware of Resident A's special dietary requirements until recently and now they make sure she is in the dining room or staff are with her.

On 12/06/2024, I conducted an exit conference with Licensee Designee, Sharon Cuddington via telephone. Ms. Cuddington stated she understands the information,

analysis, and conclusion of this applicable rule and will submit an acceptable corrective action plan.

| APPLICABLE RULE | |
|---|---|
| **R 400.15303** | **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:** | The complainant reported on 10/07/2024 Resident A was left to eat on her own and was found in wet, soiled clothes. Resident A was not supervised by staff while she was eating.<br><br>Based on investigative findings there is a preponderance of evidence to show that once the PRN (as needed) instructions were changed to a daily requirement, staff still did not provide care according to Resident A's assessed needs on at least three occasions. Therefore, a violation of this applicable rule is established. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

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

12/06/2024

Elizabeth Elliott — Date
Licensing Consultant

Approved By:

12/06/2024

Jerry Hendrick — Date
Area Manager