GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 21, 2025

Katie Edwards
Wood Care VIII, Inc.
910 S Washington Ave
Royal Oak, MI 48067

RE: License #: AL090281508
Investigation #: 2025A0572025
Monet House Inn

Dear Katie Edwards:

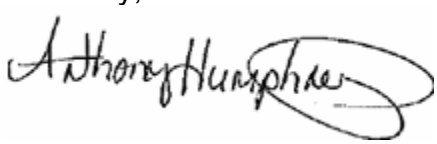
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 feel free to 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. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 643-7960.

Sincerely,



Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL090281508
Investigation #:	2025A0572025
Complaint Receipt Date:	02/27/2025
Investigation Initiation Date:	02/27/2025
Report Due Date:	04/28/2025
Licensee Name:	Wood Care VIII, Inc.
Licensee Address:	910 S Washington Ave Royal Oak, MI 48067
Licensee Telephone #:	(810) 299-1320
Administrator:	Katie Edwards
Licensee Designee:	Katie Edwards
Name of Facility:	Monet House Inn
Facility Address:	6700 Westside Saginaw Rd Bay City, MI 48706
Facility Telephone #:	(810) 299-1320
Original Issuance Date:	12/05/2007
License Status:	REGULAR
Effective Date:	12/15/2023
Expiration Date:	12/14/2025
Capacity:	20
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A fell on 02/23/2025 after lunch. Family Member #1 was not notified until 02/24/2025.	No
Resident A was screaming in pain on 02/24/2025 from a fall the day before. Resident A didn't complain, so staff thought Resident A was fine. Report of bedsore while Resident A was in the hospital.	Yes
Report of smelling marijuana in the home and staff sleeping while on duty.	No
Report of Resident A's shoes being missing for over a month and staff still cannot find them.	Yes
Resident A's toenails were trimmed on 12/02/2024. Family Member #1 inquired multiple times regarding toenails and provided pictures as of 02/24/2025.	No

III. METHODOLOGY

02/27/2025	Special Investigation Intake 2025A0572025
02/27/2025	Special Investigation Initiated - Letter Complainant.
03/04/2025	Inspection Completed On-site Manager, Kathy Campbell; Manager, Sara Schram; Staff, Kendra Thompkins and Staff, Quintoya Curry.
03/04/2025	Contact - Document Received Complainant.
03/17/2025	Contact - Document Received Licensing Consultant, Susan Hutchinson.
03/28/2025	Contact - Document Received Complainant.
04/09/2025	Inspection Completed-BCAL Sub. Compliance
04/14/2025	Contact – Telephone call made Manager, Sara Schram.
04/18/2025	Exit Conference

	Licensee Designee, Katie Edwards.
04/21/2025	Contact – Telephone call made Complainant.
04/21/2025	Contact - Document Received Complainant.
04/21/2025	APS Referral APS referral made.

ALLEGATION:

- **Resident A fell on 02/23/2025 after lunch. Family Member #1 was not notified until 02/24/2025.**
- **Resident A was screaming in pain on 02/24/2025 from a fall the day before. Resident A didn't complain, so staff thought Resident A was fine. Report of bedsore while Resident A was in the hospital.**

INVESTIGATION:

On 02/27/2025, the local licensing office received a complaint for investigation. Initial contact with the Complainant was made on 02/27/2025.

On 03/04/2025, I reviewed pics sent by the Complainant. The Complaint informed that the picture is a bedsore that Resident A suffered while at Monet House Inn. I did not notice a bedsore in the photo; however, it appeared to be some bruising in the area. I will contact staff and review service plan to see if Resident A is required to be rotated while in bed.

On 03/04/2025, I made an unannounced onsite at Monet House Inn, located in Bay County Michigan. Interviewed were Manager, Kathy Campbell; Manager, Sara Schram; Staff, Kendra Thompkins and Staff, Quintoya Curry.

On 03/04/2025, I interviewed Manager, Kathy Campbell regarding the allegation. Staff Quintoya was working when Resident A was found on the floor of another resident's bedroom. Resident A appeared to have fallen on 02/23/2025, sometime around lunch. Resident A appeared to be fine, so the family was not called until the next morning when Resident A was in pain. All staff, as well as Quintoya Curry received an in-service training informing them of the importance of notifying families immediately, regardless of time of day. Kathy Campbell denied that there was a line-of-sight procedure in place for Resident A. Kathy Campbell was not aware of any bedsores as Resident A is very mobile.

On 03/04/2025, I interviewed Manager, Sara Schram regarding the allegation. Sara Schram informed that Staff, Quintoya Curry was working with Resident A the day that Resident A was found on the floor and did not call the family immediately. Resident A is a 1-person assist who likes to get up by self, although Resident A is not supposed to. Line-of-sight is not required in Resident A's plan. Resident A was found in another resident's bedroom, possibly rummaging through their closet. Resident A was observed sitting on the floor with the resident's closet door open. Resident A was not screaming or yelling at this time. There were no signs of a fall, and it did not appear that Resident A was in any excruciating pain when staff got Resident A up off the floor. It wasn't until the next morning that Resident A exhibited any signs of pain. It's possible that Resident A has a high pain tolerance. Resident A appeared to be in pain when 3rd shift was getting Resident A up for the day. Sara Schram was not aware of any bedsores until Family Member #1 sent her the pics. It did not appear to be a bedsore to her, but she still asked staff if they had noticed any bedsores on Resident A and they did not. Resident A is very mobile and does not need to be rotated. Resident A does require assistance with toileting and getting onto Resident A's wheelchair. Resident A's wheelchair was in the bedroom where Resident A was found on the floor.

On 03/04/2025, I interviewed Staff, Kendra Thompkins regarding the allegation. Kendra Thompkins was working the day after the fall. Resident A's bottom was hurting, but at that time Resident A had mentioned being constipated and had been sitting on the toilet for quite a while. Due to Resident A being in pain, staff called the family and reported that Resident A was in a lot of pain, and it may be due to the fall from the day before. Kendra Thompkins informed that she remembers Resident A mentioning being constipated and had to wipe Resident A. At that time, she did not notice any bedsores. Resident A is mobile and does not require to be rotated in bed.

On 03/04/2025, I interviewed Staff, Quintoya Curry regarding the allegation. Quintoya Curry informed that on 02/23/2025, while changing a resident, Resident A was sitting in Resident A's wheelchair in the common area. When she came out of the resident's room, she could see Resident A from down the hall in another resident's bedroom, laying on the floor on Resident A's side. The closet door was open, but she was not sure if Resident A was trying to open the door or hold onto it. Staff Curry took Resident A's vitals, checked for marks and bruising, and staff assisted her in getting Resident A up. Quintoya Curry did not do any range of motion on Resident A. Resident A never yelled for help and informed staff that Resident A was okay, so they put Resident A in wheelchair, which was in the bedroom with Resident A and rolled Resident A into the dining room as it was almost lunch time. During lunchtime, Resident A complained of pain on buttocks, so Resident A was given 2 Tylenol and a drink of water, but Resident A spit the pills out. Quintoya Curry noticed that Resident A was in pain the next morning. A 3rd shift staff called the family. Staff Curry believes that Resident A must have been in pain when staff attempted to get Resident A up for the day. Quintoya Curry informed that she was not aware that she had to notify the family because the previous manager used to do it for them but was recently instructed by Sara Schram that staff are required to call

the family. Quintoya Curry denied that Resident A had any bedsores as Resident A is very mobile. Staff Curry became aware of a possible bedsore when Resident A went to the hospital, but informed that she always let Sara Schram know when she notices any unusual marks or bruises and she hadn't noticed any. She usually gives the showers and believe that she would have noticed if Resident A had a bedsore. Quintoya Curry denies that Resident A has to be rotated in bed as Resident A is very mobile.

On 03/04/2024, I reviewed the Incident Report and it indicated that on 02/23/2025 at 11:00am, after Staff, Quintoya Curry was changing a resident, they walked out to the hallway and observed Resident A was laying on the floor in another Resident's bedroom. Quintoya Curry got another staff member to assist with getting Resident A up and onto the wheelchair. After picking Resident A up and putting Resident A back into wheelchair, they checked to see if Resident A had any marks or bruises, which Resident A did not have any and the vitals were fine. Resident A stated that Resident A was hurting, so staff gave Resident A pain meds, but Resident A spit them out.

On 03/17/2025, the Complainant emailed Licensing Consultant, Susan Hutchinson to inform her that Resident A passed away on 03/13/2025. Susan Hutchinson forwarded the email to me. Resident A was transferred to the Toni &Trish Hospice House on 03/06/2025 until Resident A's passing.

On 04/09/2025, I spoke with Resident B to assess care and supervision. Resident B was sitting in wheelchair in tv room and was receiving appropriate care and supervision from staff. When asked how Resident B likes the home, Resident B laughed and stated, "It's nice here. I love it here. It's so fun living here."

On 04/09/2025, I spoke with Resident C to assess care and supervision. Resident C informed that the home is very good, and the staff are very helpful. Staff has been very good in helping them out.

On 04/09/2025, I stopped Resident D and Resident D's Family Member #2 to assess care and supervision. Resident D was being wheeled off in the hallway by Family Member #2. Family Member #2 informed that Resident D has been in the home for 7 years and this has been a very good home for Resident D. Family Member #2 has no issues or concerns regarding the care and supervision of Resident D. Resident D was asleep and is not very verbal.

On 04/09/2025, I reviewed Resident A's Service Plan. It indicates that Resident A is able to ambulate with limited assist of 1 and a walker for short distances and wheelchair for long distances to promote independence. When assisting Resident A, staff are to observe the skin for any redness, open areas, scratches, cuts, tears, bruises/discolorations and report any changes to the nurse. There is no mention that Resident A needs to be rotated while in bed.

On 04/18/2025, I conducted an exit conference with Licensee Designee, Katie Edwards regarding the allegation. Katie Edwards informed that she would ensure that the schedule some trainings with regards to what to do in case of a fall.

On 04/21/2025, I contacted the Complainant to ask for a copy of the Death Certificate. The Death Certificate will provide the cause of death of Resident A.

On 04/21/2025, I received Resident A's Death Certificate and Medical Report from the hospital. It indicates that Resident A's cause of death was due to Cerebral Atherosclerosis and Parkinson Disease.

On 04/21/2025, an Adult Protective Services (APS) referral was made for further investigation.

On 04/21/2025, I reviewed the hospital report for Resident A dated 02/24/2025 and signed by Dr. Emily McLaren. The report indicates that, (Resident A) an 85-year-old female who has a history of dementia, Parkinson's disease, who presents to the emergency department with complaints of right hip pain. (Family Member #1) provides most history as (Resident A) has minimal verbal responses at baseline due to dementia. Apparently (Resident A) fell out of her wheelchair yesterday and has been noting some pain in her right hip ever since. (Family Member #1) was told that (Resident A) did not hit head yet she is not sure whether or not the fall was witnessed. (Resident A's) baseline mental status has not changed acutely.

Resident A was diagnosed with a zone 1 sacral alla fracture, left subacute impacted femoral neck fracture. In the report, the Wound Ostomy & Continence C, Wound, Ostomy, & Continence Nurse made a report on 02/26/2025 which indicates that, Primary RN, Amanda was present at bedside at time of assessment and states there are no other areas of concern with the skin at this time. Pressure Injury: Present on admission. (Resident A) sustained a fall at outside facility with pelvic fracture. Coccyx with hypo and hyperpigmented skin in a linear fashion indicative of chronic intertrigo. In the sacral region to the left side is a Deep Tissue Pressure Injury, present on admission; [intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed]; Central areas that is deep maroon and does not blanch.

On 04/18/2025, I held an exit conference with Licensee Designee, Katie Edwards regarding the results of the special investigation. Katie Edwards understood the reasoning behind the rule violation and informed that she will be providing staff some additional trainings.

APPLICABLE RULE	
R 400.15311	**Incident notification, incident records.**
	(1) If a resident has a representative identified in writing on the resident's care agreement, a licensee shall report to the resident's representative within 48 hours after any of the following: **(a) Unexpected or unnatural death of a resident.** **(b) Unexpected and preventable inpatient hospital admission.** **(c) Physical hostility or self-inflicted harm or harm to others resulting in injury that requires outside medical attention or law enforcement involvement.** **(d) Natural disaster or fire that results in evacuation of residents or discontinuation of services greater than 24 hours.** **(e) Elopement from the home if the resident's whereabouts is unknown.**
ANALYSIS:	Based on the interviews of Staff, residents, family members, and review of Incident Report, there is not enough evidence to establish a rules violation. Resident A allegedly fell on 02/23/2025 at approximately 11am. Family Member #1 was contacted on 02/24/2025 at 5:37am and informed that Resident A was being transported to hospital due to a possible fall from the day before. Contact was made within 48-hour timeframe.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

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:	Based on the interviews of Staff, residents, family members, and review of Incident Report, there is enough evidence to establish a licensing rules violation. On 2/23/2025, Resident A was found on the floor of another resident’s bedroom. Staff checked vitals and skin for marks and bruises, but did not do any range of motion. Not doing range of motion appeared to have delayed emergency care. Medical treatment for Resident A was obtained on 2/24/2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:
Report of smelling marijuana in the home and staff sleeping while on duty.

INVESTIGATION:
On 03/04/2025, I interviewed Manager, Kathy Campbell regarding the allegation. Kathy Campbell informed that the family had mentioned smelling marijuana in the home, but she investigated it and could not determine where the smell could be coming from. Kathy Campbell suggested that it could have been on someone's clothing and somebody could have smelled it then. She informed that their fire detectors are too sensitive for anyone to try and smoke anything inside the building. She explained that they have gone off because of curling irons before, so she does not believe that anyone was smoking in the building. They also have a policy against being under the influence during working hours. If they suspect anyone is under the influence, they will conduct a random drug screen. In regard to staff sleeping, They had the Receptionist and a supervisor from the rehabilitation unit, walk around to see if anyone were sleeping. When they made their rounds, they did not notice anyone sleeping.

On 03/04/2025, I interviewed Manager, Sara Schram regarding the allegation. Sara Schram was made aware about the possible marijuana issue from Manager, Kathy Campbell. They never suspected anyone of smoking marijuana in the building and indicated that the smoke detectors would have gone off. The smoke detectors in their home are very sensitive. She was also made aware of staff possibly sleeping while on duty. They had their receptionist and a supervisor from their rehab facility on the other part of the building do a walkthrough and they did not see anyone sleeping.

On 03/04/2025, I interviewed Staff, Kendra Thompkins regarding the allegation. Staff, Kendra Thompkins denies ever smelling marijuana in the home and has never suspected anyone to be under the influence of marijuana. Kendra Thompkins also denied ever seeing anyone sleeping on the job as it is not allowed. She works 1st shift and stays very active.

On 03/04/2025, I interviewed Staff, Quintoya Curry regarding the allegation. Quintoya Curry informed that she never known for anyone to be under the influence at work. She has never smelled it while at work. Regarding staff sleeping, she informed that there have not been any recent incidents to her knowledge. It happened before, but that was in the past. Quintoya indicated that she would let the managers know if staff are sleeping on the job.

APPLICABLE RULE	
R 400.15206	**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:	Based on the interviews that I conducted, there was not enough evidence to establish a licensing rules violation. Staff and management all denied that seeing any staff sleeping and/or smoking marijuana on the job.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:
Report of Resident A's shoes being missing for over a month and staff still cannot find them.

INVESTIGATION:
On 03/04/2025, I interviewed Manager, Kathy Campbell regarding the allegation. Kathy Campbell informed that she was not aware of any missing shoes as the family never mentioned it to her directly. Kathy Campbell informed that if the family wants, they can purchase a pair of shoes, and they'll reimburse.

On 03/04/2025, I interviewed Manager, Sara Schram regarding the allegation. Sara Schram indicated that she was made aware of the missing shoes by the family. The shoes have been missing for a while, and they are not sure where they are. Staff has been looking throughout Resident A's bedroom as well as other resident's bedrooms.

On 03/04/2025, I interviewed Staff, Kendra Thompkins regarding the allegation. Kendra Thompkins was not aware that Resident A's shoes were missing. Most of the residents in the home have their feet covered with hard bottom slippers, so she's never seen Resident A barefooted.

On 03/04/2025, I interviewed Staff, Quintoya Curry regarding the allegation. Quintoya Curry informed that she was not aware of any missing shoes and that Resident A was wearing slippers prior to going to the hospital.

On 04/14/2025, I reinterviewed Manager, Sara Schram regarding the allegation. When asked if she had ever noticed the shoes in questioned, Sara Schram informed that she knows what shoes they are referring to because she has seen them, but to this day, they have not run across them.

On 04/18/2025, I held an exit conference with Licensee Designee, Katie Edwards regarding the results of the special investigation. Katie Edwards understood the reasoning behind the rule violation and informed that she will be providing staff some additional trainings.

APPLICABLE RULE	
R 400.15304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(j) The right of reasonable access to and use of his or her personal clothing and belongings.**
ANALYSIS:	Based on the interviews of staff in the home, there is enough evidence to establish rules violation. Resident A had a pair of shoes that has gone missing. At least one staff member is aware of the shoes and indicated that they cannot find them.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:
Resident A's toenails were trimmed on 12/02/2024. Family Member #1 inquired multiple times regarding toenails and provided pictures as of 02/24/2025.

INVESTIGATION:
On 03/04/2025, I reviewed pics sent by the Complainant. The Complaint informed that the pic is of Resident A's long toenails. The big toenail was a little long, but the other toenails were short. I informed the Complainant that I will contact staff at the home to see if there is a plan in place for Resident A's toenails to be trimmed.

On 03/04/2025, I interviewed Manager, Kathy Campbell regarding the allegation. Monet House Inn has 360 Podiatry come out and they provide services on a quarterly basis. They are going to start coming out on a monthly basis, so she is expecting them to come out this month. The Podiatrist makes the schedule as they have a generated list of residents to see, and they add to the list, as needed.

On 03/04/2025, I interviewed Manager, Sara Schram regarding the allegation. Monet House Inn has a mobile podiatrist come out to the home to see the residents. Sara Schram was not aware of an issue with long toenails as the family had not notified her of this concern. The Podiatrist was at the home a few weeks ago, but Resident A was not on the list. She will add Resident A on the list for this month to make sure that Resident A's nails get trimmed.

On 03/04/2025, I interviewed Staff, Kendra Thompkins regarding the allegation. Kendra Thompkins indicated that staff does not trim any of their residents' nails. A podiatrist comes out and trim the resident's fingernails and toenails.

On 03/04/2025, I interviewed Staff, Quintoya Curry regarding the allegation. Quintoya Curry indicated that staff does not trim residents' nails because most of their residents are either on hospice and they take care of them, or another agency comes out and do them.

On 03/28/2025, contact was made with Family Member #1 regarding any records of contacting the facility regarding Resident A's toenails and the facility's response. On 02/03/2025 at 7:04am, Family Member #1 emailed the facility and asked if they had seen the email that was sent because there was no response. Sara Schram responded at 7:53am and apologized for not seeing the email until now. Explained that she had a staff meeting on the subject of some of Family Member #1's specific concerns and working with staff to reset the expectations and improve the quality of care.

On 04/09/2025, I spoke with Resident C to assess care and supervision. Resident C informed that the podiatrist comes out to clip nails.

On 04/09/2025, I stopped Resident D and Resident D's Family Member #2 to assess care and supervision. Family Member #2 informed that comes out to trim Resident D's nails. The home usually schedules it and their insurance covers it.

On 04/14/2025, I contacted Manager, Sara Schram regarding an email that was sent to her from Family Member #1. Sara Schram informed that there had been several emails being sent and received and phone conversations and that they were actively addressing those needs. There was nothing in the email regarding toenails.

On 04/18/2025, I spoke with Licensee Designee, Katie Edwards regarding the allegation. She informed that if Resident A had toenails trimmed on 12/02/2024, then Resident A wouldn't be due until sometime in February because the Podiatrist comes out on a 9-week interval. Staff can trim fingernails but not toenails due to diabetics.

APPLICABLE RULE	
R 400.15314	**Resident hygiene.**
	(3) A licensee shall afford a resident opportunity, and instructions when necessary, to obtain haircuts, hair sets, or other grooming processes.
	Based on interviews of Staff, Residents and Family Member #2, there is not enough evidence to issue a licensing rules violation. A podiatrist comes out to the home to trim resident's fingernails and toenails. The podiatrist has a list of residents to see on each

ANALYSIS:	visit, but additional names can be added. I reviewed a picture of Resident A's toenails and aside from the big toe, they all appeared to be trimmed very low. The big toenail was long, but did not appear to be neglected.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 04/18/2025, I held an exit conference with Licensee Designee, Katie Edwards regarding the results of the special investigation. Katie Edwards understood the reasoning behind the rule violations and informed that she will be providing staff some additional trainings.

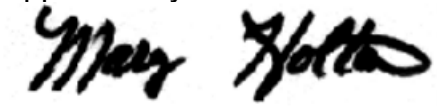
IV. RECOMMENDATION

I recommend that no changes be made to the licensing status of this large adult foster care group home (Capacity 13-20).

04/21/2025

Anthony Humphrey — Date
Licensing Consultant

Approved By:



04/21/2025

Mary E. Holton — Date
Area Manager