GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 25, 2019

Timothy Stoll
729 Ladyman Road
Sherwood, MI 49089

RE: License #: AS130380023
Investigation #: **2019A0579025**
Cosmopolitan AFC

Dear Mr. Stoll:

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 (616) 356-0183.

Sincerely,

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
322 E. Stockbridge Ave
Kalamazoo, MI 49001
(269) 615-5050

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS130380023
Investigation #:	2019A0579025
Complaint Receipt Date:	02/05/2019
Investigation Initiation Date:	02/05/2019
Report Due Date:	04/06/2019
Licensee Name:	Timothy and Julie Stoll
Licensee Address:	729 Ladyman Road Sherwood, MI 49089
Licensee Telephone #:	(269) 832-7894
Administrator:	Julie Stoll
Licensee Designee:	Timothy Stoll
Name of Facility:	Cosmopolitan AFC
Facility Address:	557 Cosmopolitan Marshall, MI 49068
Facility Telephone #:	(269) 789-2692
Original Issuance Date:	02/29/2016
License Status:	REGULAR
Effective Date:	08/31/2018
Expiration Date:	08/30/2020
Capacity:	6
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
On 02/02/2019, staff Ms. Melinda Juarez, left Resident A, Resident B, Resident C, Resident D, Resident E, and Resident F unattended for an unknown period of time.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/05/2019	Special Investigation Intake 2019A0579025
02/05/2019	Contact - Document Received Incident/Accident Report reviewed.
02/05/2019	Special Investigation Initiated - Telephone Telephone interview completed with Administrator, Ms. Julie Stoll.
02/05/2019	APS Referral
02/06/2019	Contact- Telephone call made Telephone interview with Relative A1.
02/19/2019	Contact- Face to face Unannounced onsite interview completed.
03/06/2019	Contact- Telephone call made Telephone interview with Ms. Julie Stoll.
03/06/2019	Exit Conference
03/08/2019	Contact- Documentation received Emails exchanged with Mr. Stoll.

ALLEGATION: On 02/02/2019, staff Ms. Melinda Juarez, left Resident A, Resident B, Resident C, Resident D, Resident E, and Resident F unattended for an unknown period of time.

INVESTIGATION: On 02/05/2019, I received this complaint through the BCHS on-line complaint system. The complaint alleged that on 02/02/2019, staff Ms. Melinda

Juarez, left Resident A, Resident B, Resident C, Resident D, Resident E, and Resident F unattended for an unknown period of time.

On 02/05/2019, I reviewed the *Incident/ Accident Report* form regarding the allegations. It stated Ms. Julie Stoll received a phone call from direct care staff member Liza, stating law enforcement called Liza and stated residents were abandoned by direct care staff member Ms. Melinda Juarez. One of the residents called 911 and law enforcement found Liza's phone number by looking through the home's call history. Once Liza call Ms. Stoll, Ms. Stoll called the Cosmopolitan home phone and spoke to law enforcement. She arrived at the home within 15 minutes of learning of the incident. In response to Ms. Juarez leaving the residents unattended, Ms. Stoll terminated Ms. Juarez's employment. Further, there is a warrant out for Ms. Juarez's arrest and Cosmopolitan AFC staff members are assisting law enforcement with all information they have in order to arrest Ms. Juarez.

On 02/05/2019, I completed a telephone interview with Ms. Stoll. She stated on 02/02/2019, she received a phone call from direct care staff member Liza who stated law enforcement contacted Liza after finding her phone number in the Cosmopolitan phone call history. She stated Liza told her the residents had been left alone by Ms. Juarez. Ms. Stoll stated she was already on her way to the home at that time. She stated she called law enforcement at the home and they confirmed the residents were unattended. She stated she arrived at the home within 15 minutes of learning of the incident. She stated she does not know exactly what happened, but Resident A stated she got into an argument with Ms. Juarez and Ms. Juarez just left the home. She stated Resident A was the person who called 911. She stated no residents were harmed and only one resident showed signs of distress from the incident and was monitored closely by staff until he was calm. Ms. Stoll stated she does not have a phone number for Ms. Juarez and that she used to contact a friend of Ms. Juarez to get in touch with her. She stated she is cooperating with law enforcement to assist with Ms. Juarez's arrest and Ms. Juarez's employment is terminated.

On 02/05/2019, I placed a return phone call to Relative A1 who requested to speak to me. Relative A1 stated she learned that Resident A began yelling at Ms. Juarez over Resident A's belief that Ms. Juarez did not give Resident A all her medication. Relative A1 stated due to Resident A's advanced age and memory loss, it is not uncommon for Resident A to falsely accuse staff of not giving her all her medication, and that it is a common behavior for Resident A. She stated Resident A stated Ms. Juarez told Resident A she was "done", she was leaving, and then left the home. She stated Resident A stated she immediately called 911.

On 02/05/2019, I forwarded the referral to Adult Protective Services.

On 02/19/2019, I completed an unannounced on-site investigation. Resident B was unable to be interviewed. Resident A was not interviewed due to her preparing to go

on an outing. Resident A was briefly spoken to but did not provide information regarding the allegations. Direct care staff member Alexis Swanger was interviewed but did not provide information regarding the allegations.

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:	The *Incident/Accident Report* form, Ms. Stoll's account, and Relative A1's account, confirmed there was an incident in the morning on 02/02/2019, where there was an argument with Resident A and direct care staff member Ms. Juarez, which resulted in Ms. Juarez leaving the home and not returning. Ms. Juarez's leaving resulted in six residents being left unsupervised, without care and protection for approximately 15 minutes. Ms. Stoll responded immediately and appropriately, but due to the incident occurring the violation is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING

On 02/05/2019, Relative A1 expressed numerous concerns including inadequate resident hygiene, the home smelling of urine and feces, Resident A's walker being taken to a different AFC home, staff not knowing how to use Resident A's oxygen, staff not ordering Resident A's medication on time, Resident A having items go missing, staff being outside in the evening, the driveway having an unlevel patch of gravel that makes it difficult for Resident A to enter a vehicle, and that the ramp to the home is not adequately shoveled and is icy.

On 02/14/2019, direct care staff member Ms. Swanger denied the allegations listed by Relative A1. She stated the home does not regularly smell of urine or feces. She stated residents typically shower once a week at minimum, but that there is a resident who attends school and on hot days will return with an odor but is bathed every day. She stated no residents run out of medication and direct care staff order medication when they notice the supply is low, unless a new prescription is needed and then the doctor's office is called to refill the prescription. She stated she is trained as a Certified Nursing Assistant, so she is extremely confident with all residents' medication, including Resident A's oxygen which Resident A typically only requests to wear in her room. She stated she has never heard Resident A or Resident A's family state that Resident A had items go missing, including Resident A's walker. She stated she remains in the home

supervising residents during her shift and is not aware of anyone going outside during their shift. She stated she does not know of any concerns with the driveway or the ramp being icy.

While at the home, I did not notice an odor of urine or feces in the home or in any resident rooms. The pads on the couch and chairs appeared clean and in good condition. Ms. Swanger was attentive to residents while I was present and was assisted by a traveling nurse who was engaging with Resident B. Resident A was seen using her walker. I did notice a triangular shaped patch that was approximately six inches wide that was filled with gravel in the driveway and was not perfectly level but did not pose a trip hazard. The patch was near the home but due to its size, it appeared it could be avoided, even by individuals using a walker, and did not imped resident access to getting into or out of a vehicle. I did observe the ramp of the home to be covered in thick ice in patches which would impede egress for residents using assistive devices.

On 03/06/2019, Ms. Stoll stated the home has never had an issue with ordering medication on time and there has been issues with the pharmacy returning refills for Resident A's topical cream on time, which was out of the home's control. She stated all staff are trained on medication administration, including Resident A's oxygen. She stated Resident A has made claims in the past that items were taken from her, but the items have always been located and it is typically that Resident A hides or misplaces them and then cannot recall where they are. She stated she never took Resident A's walker to another home. She stated Resident A had two walkers and there is no space for a second walker in Resident A's room. She stated she called to have the company come pick up the second walker as it was not needed, and it was returned. She stated the home does not have an odor of urine or feces regularly and the home is cleaned every day. She stated residents are bathed at least weekly and that there is a resident who is bathed daily due to her having increased hygiene needs. Ms. Stoll stated staff being outside or not supervising residents was not ever brought to her attention and is not something she believes occurs. Ms. Stoll acknowledged the build up of ice on the ramp of the home and reported the salt she purchased was insufficient to address the ice build up this winter and she would purchase a different type.

On 03/06/2019, I completed an exit conference with Ms. Stoll who did not dispute my findings or recommendations. It was noted Ms. Stoll responded immediately and appropriately to Ms. Juarez leaving the residents unattended but due to the incident occurring, the violation was substantiated. Ms. Stoll acknowledged the ice build up on the ramp and agreed to address it by purchasing a different type. It was noted there was insufficient evidence to support the additional concerns addressed by Relative A1 during the course of the investigation.

On 03/08/2019, I exchanged emails with Mr. Stoll who questioned the rule violation regarding the residents being left unattended, since he and Ms. Stoll could not control Ms. Juarez's actions. It was noted proactively, a second person could have been working to likely prevent the incident, reactively Ms. Stoll responded appropriately, and that since the incident did occur it was a substantiated rule violation.

APPLICABLE RULE	
R 400.14403	**Maintenance of premise.**
	(12) Sidewalks, fire escape routes, and entrances shall be kept reasonably free from all hazards, such as ice, snow, and debris.
ANALYSIS:	On 02/19/2019, I observed the ramp at the entrance of the home to have ice build up that would impede egress for resident using assistive devices.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Cassandra Duursma 03/12/2019

Cassandra Duursma Date
Licensing Consultant

Approved By:

Dawn Timm 03/25/2019

Dawn N. Timm Date
Area Manager