GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 22, 2019

Daniela Cleminte
Daniela's Serenity Care LLC
1278 Leon
Walled Lake, MI 48390

RE: License #: AS630381180
Investigation #: 2019A0991013
Daniela Serenity Care II

Dear Ms. Cleminte:

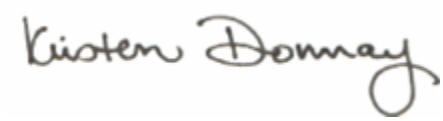
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.

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 (248) 975-5053.

Sincerely,



Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630381180
Investigation #:	2019A0991013
Complaint Receipt Date:	01/08/2019
Investigation Initiation Date:	01/09/2019
Report Due Date:	03/09/2019
Licensee Name:	Daniela's Serenity Care LLC
Licensee Address:	1278 Leon Walled Lake, MI 48390
Licensee Telephone #:	(248) 739-1964
Licensee Designee:	Daniela Cleminte
Name of Facility:	Daniela Serenity Care II
Facility Address:	1286 Leon Walled Lake, MI 48390
Facility Telephone #:	(248) 739-1964
Original Issuance Date:	05/12/2016
License **Status:**	REGULAR
Effective Date:	11/12/2018
Expiration Date:	11/11/2020
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
There are concerns that the home may not be staffed 24 hours a day.	No
Resident A eloped from the home and staff were unaware that she was gone due to the door alarms being turned off.	No
There are concerns that staff keep the residents heavily medicated at night, as visitors are not allowed after 4:00pm.	No
Resident A fell and hit her head on 01/04/19 and staff did not seek immediate medical care.	Yes

III. METHODOLOGY

01/08/2019	Special Investigation Intake 2019A0991013
01/09/2019	Special Investigation Initiated - Telephone To Resident A's family member
01/09/2019	APS Referral Received from Adult Protective Services (APS) - denied for investigation
01/10/2019	Contact - Telephone call made To Resident A's guardian
01/17/2019	Inspection Completed On-site Unannounced onsite inspection
01/17/2019	Contact- Document Received Hospital discharge paperwork
04/22/2019	Exit Conference Via telephone with licensee designee, Daniela Cleminte

ALLEGATION:

There are concerns that the home may not be staffed 24 hours a day.

INVESTIGATION:

On 01/08/19, I received a complaint alleging that Daniela Serenity Care II is supposed to be staffed 24 hours a day; however, there were concerns that this may not be the case. Adult Protective Services denied the complaint for investigation. On 01/09/19, I initiated my investigation by contacting Relative 1. Relative 1 stated that there is always a minimum of one staff person working in the home and there are six residents in the home. Relative 1 was not aware of a specific time when there was no staff person present in the home.

On 01/10/19, I interviewed Relative 2. Relative 2 stated that there is always at least one staff person on shift and the home is staffed around the clock. Relative 2 stated that the owner comes to the home at 6:00pm and the other staff leave. Relative 2 was not aware of a time when there was no staff person working in the home.

On 01/17/19 at approximately 9:30am, I conducted an unannounced onsite inspection at Daniela Serenity Care II. I observed one direct care worker, Samirra Sellers, working in the home, as well as the licensee designee, Daniela Cleminte. Ms. Cleminte stated that from 8:00am-6:00pm there are two staff working in the home and from 6:00pm-8:00am there is one staff person in the home. I reviewed a copy of the staff schedule, which also reflected two staff covering the day shift and one staff for the midnight shift. I interviewed direct care worker, Samirra Sellers, who stated that she works the 1st shift from approximately 7:30am-6:00pm. She stated that there are always two staff at the home during the day shift and one staff for the midnight shift. Ms. Sellers was not aware of a time when there were no staff in the home. She felt the home was adequately staffed to meet the needs of the residents.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.
ANALYSIS:	Based on the information gathered through my interviews, onsite inspection, and a review of the staff schedule, there is insufficient information to conclude that the home had less that one direct care staff on duty to supervise the six residents in the home. The schedule reflected two staff working during the day shift and one staff person working during the midnight shift. None of the relatives or staff interviewed had any knowledge of a time when there were no staff present in the home.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A eloped from the home and staff were unaware that she was gone due to the door alarms being turned off.

INVESTIGATION:

On 01/09/19, I interviewed Relative 1. Relative 1 indicated that Resident A was hospitalized last October after being found wandering on the side of the road. Relative 1 received a phone call from Huron Valley Hospital stating that Resident A was found and taken to the hospital. Relative 1 called the home and spoke to the licensee designee, Daniela Cleminte. Ms. Cleminte told Relative 1 that Resident A was eating breakfast even though she was at the hospital. Ms. Cleminte was not aware that Resident A had eloped from the home. Relative 1 believes that Resident A had been gone for 1-2 hours. She indicated that the home is equipped with door alarms, but they were not turned on when Resident A left the home.

On 01/10/19, I interviewed Relative 2 who stated that Resident A wandered away from the home on 10/06/18. The hospital contacted Relative 2, but was unable to reach him, so they contacted Relative 1. When Relative 1 called the home, staff did not know that Resident A was missing. Relative 2 stated that the door alarms were turned off when Resident A left the home, but Resident A had no prior history of eloping from the home before this incident.

On 01/17/19, I interviewed the licensee designee, Daniela Cleminte. Ms. Cleminte stated that on 10/06/18, Resident A had a urinary tract infection (UTI). She had been walking around and was agitated that night, so she did not sleep. Resident A went to rest in her bedroom at 7:00am. About an hour later, Ms. Cleminte received a phone call from Relative 1 asking about Resident A. Ms. Cleminte told Relative 1 that Resident A was sleeping, because she believed she was still in her bedroom. Relative 1 informed Ms. Cleminte that Resident A had wandered from the facility and was at the hospital. Ms. Cleminte was not aware that Resident A had left the facility. Resident A was located at the crossroads of Leon and Decker, about 0.2 miles from the facility or a five minute walk. Ms. Cleminte stated that Resident A had been gone for less than an hour, as she checks on her every hour. The door alarms were not activated at the time, because there had been no prior issues with any of the residents wandering away from the facility. Resident A has not had any wandering incidents since this occasion. The door alarms are always active now and a Nest camera was placed in Resident A's room for additional monitoring.

On 01/17/19, I interviewed direct care worker, Samirra Sellers. Ms. Sellers indicated that she was not working in the home at the time Resident A wandered away from the facility. She had no knowledge of any incidents of Resident A wandering away from the facility since that time. Ms. Sellers indicated that since she has been working in the

home, the door alarms are always activated. She could not recall a time when the door alarms were not working.

On 01/17/19, I reviewed Resident A's assessment plan. The assessment plan did not specify how often staff should check on Resident A. It did not note any history of elopement or indicate that door alarms were required.

APPLICABLE RULE	
R 400.14305	**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:	Based on the information gathered through my investigation, there is insufficient information to conclude that Resident A's protection and safety were not attended to at all times. Resident A was resting in her room when she then wandered away from the home. Less than an hour had passed since staff checked on Resident A. Resident A had no prior history of wandering and her assessment plan did not specify how often staff should check on her or state that door alarms should be used. Additional precautions including door alarms and cameras have been implemented to ensure Resident A's safety since the incident occurred.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

There are concerns that staff keep the residents heavily medicated at night, as visitors are not allowed after 4:00pm.

INVESTIGATION:

On 01/09/19, I interviewed Relative 1. Relative 1 stated that she believes staff at the facility are overmedicating the residents in order to keep them calm. She did not have any knowledge of staff giving the residents medications that were not prescribed by a physician; however, the owner has requested that Relative 2 take Resident A to the doctor to increase her medications because they cannot handle her behaviors. Relative 1 stated that family members are only allowed to visit the home before 4:00pm, as the residents are "knocked out" after that time.

On 01/10/19, I interviewed Relative 2. Relative 2 stated that he does not have any concerns that the facility is overmedicating the residents. He stated that they have

requested that he speak to the doctor to increase Resident A's medications, because she can be aggressive and she moves around a lot, frequently pacing around the facility. Resident A was previously prescribed Risperidone, but he felt Resident A was too out of it when she was on this medication, so it was changed. Relative 2 is responsible for taking Resident A to medical appointments and providing Resident A's medications from the pharmacy.

On 01/17/19, I interviewed the licensee designee, Daniela Cleminte. Ms. Cleminte stated that they do not give the residents any medications that are not prescribed by a physician and they are not sedating the residents. She stated that visiting hours are generally until 5:30 or 6:00pm. After that time, the residents begin to go to their rooms to get ready for bed and retire for the evening. Most of the residents go to sleep early. Ms. Cleminte is willing to accommodate visitors later than that if necessary. She noted that Relative 2 frequently visits the home after work at 7:00 or 8:00pm. Ms. Cleminte stated that Resident A receives a small dose of Seroquel to help her sleep, but she is not knocked out. She noted that on the day of my onsite inspection Resident A had been awake since 5:00am, pacing around the house. Ms. Cleminte did recommend that Relative 2 speak to Resident A's doctor about possibly changing her medications, due to an increase in aggressive behaviors, pacing, and changes to her sleep patterns.

On 01/17/19, I interviewed direct care worker, Samirra Sellers. Ms. Sellers stated that the residents only receive medications as prescribed by a physician. She had no concerns that any of the residents were being overly medicated.

On 01/17/19, I reviewed Resident A's medications and medication administration record. There was no indication that Resident A was receiving any medications that were not prescribed by a physician. I observed Resident A pacing and wandering around the home.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the information gathered through my interviews and onsite inspection, there is insufficient information to conclude that the facility is overmedicating the residents. None of the relatives or staff who were interviewed had any direct knowledge of the residents receiving medication in a manner that was not pursuant to the label instructions as prescribed by a physician. Resident A's medications and medication administration record did not give any indication that Resident A was being overly medicated. Ms. Cleminte indicated that visiting hours are generally until 6:00pm, because the residents begin

	getting ready for bed at that point, not because the residents are being sedated.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A fell and hit her head on 01/04/19 and staff did not seek immediate medical care.

INVESTIGATION:

On 01/09/19, I interviewed Relative 1 who indicated that Resident A fell and hit her head on a wheelchair which was sitting next to her bed. Relative 2 took Resident A to the hospital and she needed seven staples in her head to close the wound. Relative 1 expressed concern that staff did not seek medical care immediately following Resident A's fall. She was unsure exactly how long it was before Resident A was taken to the hospital for medical care.

On 01/10/19, I interviewed Relative 2. Relative 2 stated that he received a phone call from Ms. Cleminte at approximately 8:00am stating that Resident A had a UTI again. Ms. Cleminte stated that Resident A also fell earlier that morning around 5:30am and had a cut on her head. Relative 2 arrived at the facility at approximately 9:00am and observed a two-inch gash on Resident A's head. The wound was still open. Relative 2 took Resident A to the hospital where she received 7 staples in her head and was treated for a severe UTI. Relative 2 noted that Resident A is on blood thinners and he felt that she should have been transported to the hospital immediately after experiencing a fall and injuring her head.

On 01/17/19, I interviewed Ms. Cleminte. Ms. Cleminte stated that on 01/04/19, she suspected that Resident A might have a UTI again, as she was pacing all night and did not sleep at all. She was standing right next to Resident A in the living room at 5:00am when Resident A stumbled, fell, and hit her head on a wheelchair that was in the living room. Ms. Cleminte observed a cut on Resident A's head that was approximately 1 inch long. She stated that there were six or seven drops of blood on the floor, but the injury stopped bleeding right away. She did not call 911 because she did not feel it was an emergency. The staff at the home do not transport residents to the doctor or hospital. The family is responsible for providing transportation or an ambulance is called if needed. Ms. Cleminte called Relative 2 at approximately 7:00am to inform him that Resident A might have a UTI and that she experienced a fall. Relative 2 contacted Resident A's doctor who advised that Resident A should be taken to the hospital. Resident A was admitted to the hospital from 01/04/19-01/09/19, where she received staples for the cut on her head and was treated for a UTI. Resident A was discharged back to the home with home care nursing services in place.

On 04/22/19, I conducted an exit conference with the licensee designee, Daniela Cleminte. Ms. Cleminte indicated that she did not feel it was necessary for Resident A to be sent out by ambulance based on the injury she sustained, but she would use this as a learning experience in the future. She also noted that Resident A is no longer residing in the home.

APPLICABLE RULE	
R 400.14310	**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 information gathered through my interviews and onsite inspection, there is sufficient information to conclude that the facility did not seek needed care immediately when Resident A fell and hit her head. Resident A fell between 5:00-5:30am and Ms. Cleminte did not contact Relative 2 until two hours later, between 7:00-8:00am. Relative 2 arrived at the facility around 9:00am and observed an open wound on Resident A's head. Resident A is prescribed blood thinners, which raises additional concerns regarding the delay in seeking medical treatment. Relative 2 took Resident A to the hospital where she needed staples to close the wound on her head.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.

Kristen Donnay 04/22/2019

Kristen Donnay Date
Licensing Consultant

Approved By:

Denise Y. Nunn 04/22/2019

Denise Y. Nunn Date
Area Manager