GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 24, 2019

Victoria Svet
AV Beverly Hills Inc.
20799 W. Kennoway Circle
Beverly Hills, MI 48025

RE: License #: AS630302438
Investigation #: 2019A0605039
Ambrosia Villa Beverly Hills

Dear Ms. Svet:

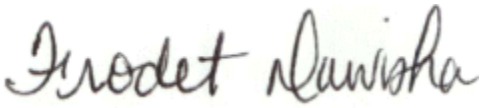
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 303-6348

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AS630302438 |
| | |
| **Investigation #:** | 2019A0605039 |
| | |
| **Complaint Receipt Date:** | 08/01/2019 |
| | |
| **Investigation Initiation Date:** | 08/01/2019 |
| | |
| **Report Due Date:** | 09/30/2019 |
| | |
| **Licensee Name:** | AV Beverly Hills Inc. |
| | |
| **Licensee Address:** | 20799 W. Kennoway Circle<br>Beverly Hills, MI 48025 |
| | |
| **Licensee Telephone #:** | (248) 207-6511 |
| | |
| **Administrator/Licensee Designee:** | Victoria Svet |
| | |
| **Name of Facility:** | Ambrosia Villa Beverly Hills |
| | |
| **Facility Address:** | 20799 Kennoway Circle<br>Beverly Hills, MI 48025 |
| | |
| **Facility Telephone #:** | (248) 207-6511 |
| | |
| **Original Issuance Date:** | 09/16/2009 |
| | |
| License **Status:** | REGULAR |
| | |
| **Effective Date:** | 05/15/2018 |
| | |
| **Expiration Date:** | 05/14/2020 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>ALZHEIMERS/AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A and Resident B are wheelchair bound and may not be getting proper care as staff member, Linda Rodriguez works 24/7 and is always tired. Ms. Rodriguez will sleep during her midnight shift leaving residents without any staff. | No |
| Additional Findings | Yes |

## II. METHODOLOGY

| | |
|---|---|
| 08/01/2019 | Special Investigation Intake<br>2019A0605039 |
| 08/01/2019 | Special Investigation Initiated - Telephone<br>Telephone call made with Reporting Source. |
| 08/01/2019 | APS Referral<br>Adult Protective Services (APS) referral denied. |
| 08/06/2019 | Inspection Completed On-site<br>I conducted an unannounced on-site investigation. I interviewed staff members Milagros Tan and MaLeonisa Delotindo and Residents A, B, C and D. I also interviewed via telephone licensee designee, Victoria Svet. |
| 08/07/2019 | Contact - Telephone call made<br>I interviewed via telephone Resident A's DPOA (A), Resident B's DPOA (B), and Resident C and D's DPOA (C)(D). |
| 08/27/2019 | Contact - Telephone call made<br>Left message for staff member, Linda Rodriguez. |
| 08/28/2019 | Contact - Telephone call made<br>I interviewed staff member Linda Rodriguez. |
| 08/29/2019 | Contact - Document Received<br>Ms. Svet emailed Resident's A, B, C, D and E's assessment plans. |
| 09/10/2019 | Contact - Telephone call made<br>Telephone call made with Ms. Svet regarding my findings. |
| 08/28/2019 | Exit conference-<br>Telephone call made with licensee designee, Victoria Svet. |

**ALLEGATION:**

**Residents A and B are wheelchair bound and may not be getting proper care as staff member, Linda Rodriguez works 24/7 and is always tired. Ms. Rodriguez will sleep during her midnight shift leaving residents without any staff.**

**INVESTIGATION:**

On 08/01/19, intake #166519 was received regarding Resident A and Resident B being wheelchair bound and residing at Ambrosia Villa. Resident B's health is declining since living at this home and is always lying in bed with no one attending to him. Resident B has lost 30 pounds within the last three months. When staff give Resident B food, they just leave it on his bed. Staff member Linda Rodriguez works 24/7 and sleeps on the floor of the home leaving no one to attend to the residents. I conducted an unannounced on-site investigation on 08/06/19 and interviewed staff members, Milagros Tan and MaLeonisa Delotindo as well as Resident's A, B, C and D. I also interviewed the licensee designee, Victoria Svet via telephone.

On 08/01/19, I left a voice mail message for the reporting person for additional information, but the reporting person never returned my call during this investigation.

On 08/06/19, I conducted an unannounced on-site investigation was conducted. Staff members Milagros Tan and MaLeonisa Delotindo were present with all the residents. Ms. Tan has been employed with this corporation since 2014 and Ms. Delotindo started on 06/01/19 and is currently in training. Both work the daytime shift from 8AM-7PM. Ms. Delotindo was unable to provide much information; therefore, my interview was directly with Ms. Tan. Ms. Tan stated that staff member Linda Rodriguez lives at this home but is currently on vacation for the next five days. There is only one midnight staff and that is Mrs. Rodriguez. Mrs. Rodriguez sleeps in the living room during her midnight shift but according to Ms. Tan, “Mrs. Rodriguez does not do nursing care at night.” Ms. Tan stated that Mrs. Rodriguez’s husband, Eddie Rodriguez is also staff here and works two to three times per week when Mrs. Rodriguez is off. Ms. Tan advised that Resident A is fully ambulatory and has never been wheelchair bound or uses any assistive device. However, Resident B does use a wheelchair and that occurred after being discharged from the hospital on 07/21/19. Resident B has hypertension and prostate cancer and gets chronic UTI’s. Resident B had an appetite before going into the hospital, but since hospitalization he’s had no appetite. I reviewed Resident B’s weight record and he weighed 131 pounds on 04/19/19 and only weighed 99 pounds on 07/29/19. Ms. Tan stated she and other staff try their best to get Resident B to eat, but they can’t force him to eat. She stated they bring him out at the dining room for his dinner and do not bring it to his bed even though he likes staying in his room. While I was there, lunch was being prepared for the residents by Ms. Delotindo. Ms. Tan stated she would like for me to speak with Resident B’s DPOA who would be able to provide additional information as to Resident B’s appetite. She stated that the family visits regularly and has also attempted to get Resident B to eat, but they’ve been unsuccessful as well. I requested to speak with the residents.

I interviewed Resident A in her bedroom. She was lying in bed and stated she was resting before lunch. Resident A stated she is fully ambulatory and has never been wheelchair bound nor does she use any assistive device to move around. He likes it here and gets enough food to eat. She stated she has no concerns and staff is attentive to her. She stated her son could provide additional information if I would like to call him.

I interviewed Resident B who was also lying in bed in his room. There was a wheelchair sitting near his hospital bed. Resident B stated, “compared to other places, I like it here.” He reported staff check on him regularly and are good in cleaning and bathing him. He gets enough food to eat, but his appetite hasn’t been that great. He is transferred to his wheelchair daily and sits in the living room, but since leaving the hospital, he has been wanting to stay in bed. I did not observe any pills lying on the floor of his bedroom or the home. Resident B stated he has no concerns to report.

I attempted to interview Resident C, but she was non-verbal and became very agitated. Both Ms. Tan and Ms. Delontindo had to attend to her to calm her down while the other residents were put at the dinner table to have lunch.

I briefly interviewed Resident C’s husband, Resident D who is also a resident. Resident D stated he has no concerns and did not want to talk. Ms. Tan reported that Resident C

becomes agitated often and needs to be redirected to calm her down. I also attempted to interview Resident E but was unsuccessful as Resident E did not want to talk.

While I was at this home, licensee designee Ms. Svet was contacted by Ms. Tan. I spoke with Ms. Svet on the telephone and advised her of the allegations. Ms. Svet confirmed that Ms. Rodriguez sleeps during her midnight shift and that she's always had her midnight shift sleep as that was "ok." I advised Ms. Svet that if she has a staff sleeping during the midnight shift, then she needed to have another staff awake as there should always be a staff that is awake 24/7. Ms. Svet believes these allegations came from Resident B's caregiver Robin Firlik who began working with Resident B when he was at the skilled nursing facility. Ms. Firlik continued as Resident B's caregiver at this home until she was fired by Resident B's family. Ms. Firlik was being disrespectful to staff and interfering with the care of the residents. Resident B's family is very happy with the care Resident B is currently receiving. Ms. Svet stated that Resident A has never been in a wheelchair and is fully ambulatory. Ms. Svet stated she has two staff during the morning and afternoon shift but that she only has one staff during the midnight shift; however, if a resident is "sick" then she supplements an additional staff to be awake during the midnight shift. She stated that the staff that is sleeping has a "baby monitor" and "motion detectors" to assist them in being alerted if there is an issue with a resident. I again advised Ms. Svet that staff must always be awake 24/7 as that is a licensing rule. I advised her that I have just begun my investigation and will contact her during my exit conference with my findings.

On 08/07/19, I interviewed Resident B's DPOA (B) via telephone. DPOA (B) stated that Resident B has been only recently in a wheelchair after being hospitalized. Resident B was in a wheelchair about 2-3 weeks ago and his blood pressure went down, so he was taken to the hospital. Resident B has been spending more time in bed then a year ago because he's getting weaker and his mental health is deteriorating. According to DPOA (B), Resident B stopped eating after his wife passed almost three years ago. This is the biggest concern they have with Resident B is that he will not eat. DPOA (B) visits Resident B three times a week and pesters him to eat, but Resident B won't, and therefore he's lost so much weight. DPOA (B) believes that Resident B is "just giving up," and is currently on palliative care because Resident B is not ready for hospice because he has "negative connotations" about hospice. The DPOA stated whenever he visits the home, there are about two to three staff members at the home and he has been very happy with the care they are providing to Resident B. He stated that staff are always awake when he visits the home. He too believes these allegations are coming from Robin Firlik because she was fired. Resident B's cares increased, and he required 24/7 care, and therefore he was moved into this home, but Ms. Firlik was being disrespectful towards staff, so he and his sisters decided to let Ms. Firlik go. DPOA (1) has no concerns to report regarding this home or the staff.

I interviewed Resident A's DPOA (A) via telephone. DPOA (A) reported that Resident A has never been in a wheelchair and stated, "the best thing we did is put her in this home." He stated, "this home is miles better than any other place and we couldn't be

happier.” DPOA (A) visits Resident A regularly and reported that staff is always awake and attentive. He has no concerns to report.

I interviewed Resident C and D’s DPOA (C)(D) via telephone. DPOA (C)(D) did not have much to report only that she did not have any concerns.

On 08/28/19, I interviewed staff member Linda Rodriguez via telephone. Mrs. Rodriguez’s primary language is not English; therefore, I was having difficulty understanding her and had to ask her to repeat several times. Mrs. Rodriguez is a live-in staff at this home and has worked for this corporation for nine years. She works all shifts but stated that there are two staff during the morning and afternoon shift but only one staff during the midnight shift. Mrs. Rodriguez is the staff that works the midnight shift and stated she always works it alone. She is responsible for six residents and has difficulty with Resident C who has significant behavioral issues as Resident C is agitated day and night. Mrs. Rodriguez stated that she tends to Resident C which leaves her unable to attend to the other residents however, she repositions Resident B when needed at night but is unable to attend to the other residents who are ambulatory. Mrs. Rodriguez stated she has been tired working because of Resident C whom usually needs her attention, so she sleeps during the night about 3-4 hours. She stated she utilizes a baby monitor and motion sensors when she’s sleeping that helps her know if the residents’ have needs to be met during the midnight shift. Mrs. Rodriguez was unable to state if one staff is adequate during the midnight shift to meet the needs of five residents.

| **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.** |

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| **ANALYSIS:** | Based on my investigation, I was unable to determine there is not enough staff during the midnight shift while staff member Linda Rodriguez is asleep. Ms. Rodriguez reported no incidents occurring during the midnight shift and has baby monitors and motion sensors in the home that are utilized during the midnight shift. The licensee designee, Ms. Svet confirmed that Ms. Rodriguez sleeps during the night, but that she supplements staff during the midnight shift if needed. I reviewed Residents A, B, C, D and E's assessment plans and was unable to determine if the midnight staff should always be awake as the assessment plans were incomplete. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

**ADDITIONAL FINDINGS**

**INVESTIGATION:**

On 08/28/19, I contacted Ms. Svet advising her that I will be citing her for staff not being awake during the midnight shift since Resident's B and C have needs that require a staff to be awake always. Ms. Svet stated she is not happy with being violated for that rule since she has always had the midnight staff sleep and the staff is able to attend to all the residents. I advised her that Ms. Rodriguez reported that Resident C's behavioral concerns are also present during the night, making it difficult for staff to attend to other residents, which imposes a safety risk especially if staff is sleeping when Resident C has an episode. Ms. Svet stated that Resident C does not have any behavioral issues because "she's on a lot of medications" during nighttime, even though I advised her that her staff reported that Resident C is still agitated at night. I advised Ms. Svet to send me all the residents' assessment plans for review to determine the residents' needs and how they are being met. She will email them to me.

On 08/29/19, licensee designee Ms. Svet emailed Residents A, B, C, D and E's assessment plans. I reviewed Residents A, B, C, D and E and found the following errors:

Resident A's assessment plan in section I: Social/Behavioral Assessment; "No" boxes are checked for "reads and writes, tells time, manages money" but under "describe needs and how they will be met" is blank. Also, "alert to surroundings" box was not checked, but "sometimes/confusion" was written in with no other explanation as to how the need will be met. In section II: Self Care Skill Assessment; "Yes" boxes are checked for "eating/feeding, toileting, bathing, grooming, dressing, and personal hygiene," but under "describe needs and how they will be met" is blank. Stair climbing boxes was not

checked at all and left blank. In section III: Health Care Assessment; taking medication box was checked “Yes,” but under “describe needs and how they will be met” was left blank. In section IV: Social and Program Activities; hobbies/special interest box was neither checked for “yes or no,” but in the explanation the word “pets,” was written. In section V: Medical Information was blank as to Resident A’s primary physician.

Resident B’s assessment plan in section I: Social/Behavioral Assessment; “No” boxes are checked for “manages money” but under “describe needs and how they will be met” is blank. Communicates needs box was checked “no,” and the explanation is “not always,” but no other information as to how this need will be met. In section II: Self Care Skill Assessment; “Yes” boxes are checked for “eating/feeding, toileting, bathing, grooming, dressing, personal hygiene and stair climbing,” but under “describe needs and how they will be met” is blank. In section III: Health Care Assessment; taking medication and susceptible to hypothermia or hyperthermia boxes were checked “Yes,” but under “describe needs and how they will be met” was left blank. In section IV: Social and Program Activities; recreation box was neither checked for “yes or no.”

Resident C’s assessment plan in section I: Social/Behavioral Assessment; communicates needs box was not checked “yes or no,” but explanation states, “sometimes” with no other information as to how this need will be met. Reads and writes box is not checked “yes or no” but explanation states, “reads-unable to write and tell time,” and tells time box was also left unchecked, but explanation states, “did previously- past two weeks, not so much,” but no other explanation was provided as to how these needs will be met. Manages money box was checked, “no,” but explanation was left blank. Participates in social activities and smokes boxes were left unchecked. In section II: Self Care Skill Assessment; “Yes” boxes are checked for “eating/feeding, toileting, bathing, grooming, dressing, personal hygiene, walking/mobility and stair climbing,” but under “describe needs and how they will be met” is blank except for eating/feeding that has the word “sometimes,” in the explanation with no other information. In section III: Health Care Assessment; taking medication, physical limitations and other difficulties (vision, weight, allergies etc.) boxes were checked “Yes,” but under “describe needs and how they will be met” was left blank. In section IV: Social and Program Activities; participates in religious practice, participates in household chores, adult activity program, physical exercise and family/friends’ boxes were checked “yes,” but there was no explanation provided as to how these activities will be provided or encouraged.

Resident D’s assessment plan in section I: Social/Behavioral Assessment; manages money box was checked “no,” and under “if no, describe needs and how they will be met” is blank. Exhibits self-injurious behavior and participates in social activities boxes were left unchecked. In section II: Self Care Skill Assessment; bathing and stair climbing were checked, “yes,” but under “describe needs and how they will be met” is blank. Also, grooming, dressing and personal hygiene boxes were checked, “no,” but the explanation for each of these items stated, “reminders.” The boxes should have been checked, “yes,” since there is a need for Resident D to be reminded. In section III: Health Care Assessment; taking medication, physical limitations boxes were checked

“Yes,” but under “describe needs and how they will be met” was left blank. In section IV: Social and Program Activities; participates in religious practice, participates in household chores and family/friends’ boxes were checked “yes,” but there was no explanation provided as to how these activities will be provided or encouraged.

Resident E’s assessment plan in section I: Social/Behavioral Assessment; alert to surroundings boxes are unchecked and manages money box is checked “no,” and under “if no, describe needs and how they will be met,” is left blank. In section II: Self Care Skill Assessment; bathing and stair climbing boxes are checked, “yes,” but explanation left blank under, “if yes, describe needs and how they will be met.” In section III: Health Care Assessment; taking medication is checked “Yes,” but under “if yes, describe needs and how they will be met” was left blank. In addition, susceptible to hypothermia or hyperthermia boxes were left unchecked. In section IV: Social and Program Activities; participates in household chores and family/friends’ boxes were checked “yes,” but there was no explanation provided as to how these activities will be provided or encouraged.

Based on my review of the residents’ assessment plans, I’m unable to determine if there is adequate staffing during the midnight shift as all the residents’ assessment plans have minimal information as to the needs of any of the residents and they’re incomplete.

On 09/10/19, I contacted Ms. Svet via telephone and conducted the exit conference. I advised her that I am unable to determine if staff must be awake during the midnight shift based on the assessments; therefore, I will not be substantiating the rule regarding staff requirements. However, I advised her that based on the lack of information and incomplete assessment plans for all the residents’, I will be citing rule: R400.14301 pertaining to assessment plans. Ms. Svet stated she and her staff provide excellent care to all the residents and does not follow the assessment plans although she has them completed at admission. I advised her that the assessment plans need to be detailed as to each residents’ needs and how staff will be meeting those needs. Ms. Svet advised she always makes sure there is enough staff during the midnight shift based on her residents’ needs. I advised her that I will close out this special investigation once an acceptable corrective action plan is received.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14301** | **Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.** |
| | **(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the** |

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|---|---|
| | **resident is suitable pursuant to all of the following provisions:**<br>**(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.**<br>**(b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.**<br>**(c) The resident appears to be compatible with other residents and members of the household.** |
| **ANALYSIS:** | Based on my review of Residents A, B, C, D and E's assessment plans, there was insufficient/incomplete information to determine the amount of personal care, supervision and protection that is required by the residents and if there is enough staffing during the midnight shift. The assessment plans lacked information regarding each of the residents' needs such as "self-care assessment" and how those needs were going to be met by staff. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## III. RECOMMENDATION

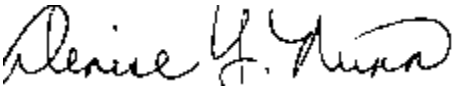
Contingent upon receipt of an acceptable corrective action plan, I recommend that this special investigation be closed and no changed to the status of the license.

Irodet Davisha 09/10/19

_____

Frodet Dawisha Date
Licensing Consultant

Approved By:



09/24/2019

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Denise Y. Nunn Date
Area Manager