GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 7, 2020

Sanjay Rattan
Dawns Res Care For Seniors Inc.
5701 Chicago Road
Warren, MI 48092

RE: License #: AL500007242
Investigation #: 2020A0986002
Dawns Center for Seniors
ADDENDUM REPORT
Original report date: December 12, 2019

Dear Mr. Rattan:

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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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,

Roeiah Epps, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(586) 256-1776

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL500007242
Investigation #:	2020A0986002
Complaint Receipt Date:	10/14/2019
Investigation Initiation Date:	10/15/2019
Report Due Date:	12/13/2019
Licensee Name:	Dawns Res Care For Seniors Inc
Licensee Address:	5701 Chicago Road Warren, MI 48092
Licensee Telephone #:	(586) 791-5800
Administrator:	Sanjay Rattan
Licensee Designee:	Sanjay Rattan
Name of Facility:	Dawns Center for Seniors
Facility Address:	22194 Thomson Clinton Township, MI 48035
Facility Telephone #:	(586) 791-5800
Original Issuance Date:	04/28/1992
License Status:	REGULAR
Effective Date:	10/23/2018
Expiration Date:	10/22/2020
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
• There are concerns regarding whether Resident A has been receiving his medications daily. Multiple days are not initialed on the hand-written medication record, although staff member Sonya Bhalla alleges Resident A received his medications. • Resident A is also not being bathed timely. • Staff members failed to report to Emergency Medical Technicians (EMT) about Resident A's abnormal mental status. • Staff members also did not assist Resident A with getting in bed in a timely manner, because they were short staffed.	Yes

III. METHODOLOGY

10/14/2019	Special Investigation Intake 2020A0986002
10/15/2019	Special Investigation Initiated – Telephone Troy Beaumont Hospital Social Work Department
10/16/2019	Contact - Document Sent Email to Troy Beaumont Hospital Social Work Department
10/23/2019	Contact - Document Sent Email to Troy Beaumont Hospital Social Work Department
10/23/2019	Inspection Completed On-site Interviewed Resident A and staff member Sonia Bhalla
12/09/2019	Contact - Telephone call made Voicemail message left for Troy Beaumont Hospital Social Work Department, Resident A's adult son, and case support management team at Troy Beaumont Hospital; and interviewed Resident A's adult daughter
12/12/2019	Exit Conference Licensee designee and administrator Sanjay Rattan

ALLEGATION:

- **There are concerns regarding whether Resident A has been receiving his medications daily. Multiple days are not initialed on the hand-written medication record, although staff member Sonya Bhalla alleges Resident A received his medications.**
- **Resident A is also not being bathed timely.**
- **Staff members failed to report to Emergency Medical Technicians (EMT) about Resident A's abnormal mental status.**
- **Staff members also did not assist Resident A with getting in bed in a timely manner, because they were short staffed.**

INVESTIGATION:

On 10/15/19, I contacted Troy Beaumont Hospital Social Work Department to leave a message for the complainant. The current hospital social work staff stated the complainant worked the afternoon shift, but they would ensure that my message was received.

On 10/16 and 10/23/19, I emailed the complainant and was told she worked the evening shift and that I would have to follow-up with her at that time. Consequently, I made two phone calls on the afternoon and evening shift on 10/23/19 and 10/24/19 for the complainant and still received no response from the complainant.

On 10/23/19, I conducted an unannounced onsite inspection and interviewed Resident A and staff member Sonya Bhalla. I noticed one staff member preparing dinner, and two staff members were left to care for more than 10 residents who require wheelchairs or walkers to ambulate. While Ms. Bhalla gathered documents (staff schedule and Resident A's records) for me, this left only one staff member to care for the remaining residents. According to the staff schedule, only two staff members were scheduled for the morning shift, afternoon shift, and midnight shift.

On 10/23/19, Resident A stated he is pleased with his care, and he believes that he takes his medications daily as required, but he is not for sure because sometimes he forgets. Resident A stated he was admitted to the facility a month ago and noticed quickly that staff members get extremely busy on a daily basis. Resident A also admitted he eats cookies and sweets that his family members and guests bring him, although he should not have them because he is diabetic. Resident A also stated that staff members assist him with bathing as required, so he disagrees that he is not bathed timely. Resident A also stated he accidentally urinated on himself on one occasion when staff members were changing his diaper as he was in a standing position. Consequently, his clothes and chair got wet, but staff cleaned him and his chair right away. Resident A admitted that he believes the facility has good staff, but they are extremely overworked because there is only one or two people to care for all of the residents. For example, Resident A stated he has to wait approximately 15 minutes to

get assistance with ambulating to his bed because he utilizes a wheelchair. On one occasion, during early October, Resident A stated he called for staff assistance to get out of his sofa chair and into bed at midnight; but no staff member came to assist him until the next morning. Resident A stated he believes they just honestly forgot or just got too busy with caring for the other residents. As a result, Resident A's diaper and pajama bottoms were extremely wet. Resident A also gave me his adult children's contact information, to obtain further information regarding his care.

On 10/23/19, I reviewed Resident A's file and his medication records. According to Resident A's medication records, from 10/1-10/23/19, staff initials are missing confirming administration of his medication for the following medications:

- Carvedilol 25 mg. every 12 hours – four days and the morning of 10/23;
- Docusate 100 mg. every 12 hours – 12 days;
- Inlyta 5 mg. by mouth twice daily – four days and the morning of 10/23;
- Ramolazine ER 1000 mg. every 12 hours – three days and the morning of 10/23;
- Rosuvastatin 20 mg. once daily at bedtime – three days;
- Magnesium Chloride 64 mg. once daily – six days;
- Mexiletine 150 mg. every 12 hours – four days and the morning of 10/23;
- Primidone 50 mg. three tablets every 12 hours – eight days and the morning of 10/23
- Tamulosin 0.4 mg. once daily at dinner – four days;
- Vitamin D3 1000 one tablet daily at dinner – 7 days;
- Insulin 100 unit once daily – two days.

On 10/23/19, staff member Sonya Bhalla stated she is the facility supervisor, and she has been employed at the facility for approximately four years. Ms. Bhalla admitted that initials were missing for Resident A's medication records for 10/4-10/7/19, due to her not completing his records right away, because she had to assist other residents. However, Ms. Bhalla assured he received his medications as required. Ms. Bhalla also corroborated Resident A's statement that he accidentally urinated on himself when staff members were changing him on one occasion and he accidentally wet himself and the chair. Ms. Bhalla stated that Resident A and all residents are given timely personal care and diaper changes as required. Despite the number of staff members scheduled to work, Ms. Bhalla stated that she believes she and the staff members could properly evacuate the facility properly in case of a fire or emergency. Ms. Bhalla stated although there have been staff shortages, staff members always ensure all the residents needs are met. Ms. Bhalla stated she was not working when Resident A was alleged to be left in his chair all night, so she could not provide an explanation as to what occurred. However, Ms. Bhalla stated that Resident A does like sleeping in his recliner chair at times. On 10/12/19, Ms. Bhalla stated an ambulance was dispatched due to Resident A complaining of shoulder pain and issues with his sugar levels. Resident A was discharged on 10/13 back to the facility. However, Ms. Bhalla admitted that no incident report was completed regarding his hospitalization. Ms. Bhalla also gave me a copy of the discharge instructions from Troy Beaumont Hospital for Resident A's hospitalization from 10/12-10/13/19, which corroborated he was treated for hypoglycemia and shoulder

pain among other non-emergent medical issues. Ms. Bhalla stated she has no information regarding the allegations of staff members not giving EMT's accurate information regarding Resident A's mental status.

On 12/09/19, I interviewed Resident A's adult daughter (AD) via telephone. AD stated the allegations were true and she was not pleased with the facility's care of her father, so he was discharged from the facility the first week of November. Since his discharge, Resident A has been doing much better in his current licensed facility. AD stated her brother who has power of attorney placed her father at Dawn's Center, based on a referral. However, she noticed quickly on her weekly visits that staff members did not provide timely personal care. For example, she came on one occasion and found her father in soiled diaper and clothing, due to staff members taking too long to assist him. On another occasion, Resident A was left overnight in his recliner chair, due to staff members not assisting him to his bed. As a result, Resident A was left in his chair until 6 am with a urine-soaked diaper. AD was extremely upset because had she known she would have come and assisted her father in bed herself. She stated Resident A has a cell phone but was not able to reach it because it was on his nightstand by his bed. AD stated she arrived at the facility the next morning and found her dad in a urine-soaked diaper and pajama bottoms. Resident A's blood sugar seemed to be out of control at the facility, which she believes was contributed to the facility not giving him his medications as required. AD also stated the hospital was upset because staff members did not tell EMT's that Resident A had took off his diaper and was flinging feces in his bedroom prior to EMT's arriving. Therefore, AD believes this is what the hospital meant about not providing information about Resident A's mental status. Furthermore, AD stated Resident A is very laid back and being nice about the staff members delay in providing assistance to him at the facility. AD stated she visited the facility weekly when her father was resided there and saw first had staff members take up to 30 minutes to assist her father and other residents on a regular basis. AD stated that she has complained to Sonya Bhalla, who admitted they have been short staffed. AD stated she felt sorry for Ms. Bhalla, because she is always at the facility, and never seems to get a break. AD emphasized, 15 minutes for staff to respond is a good day at the facility; as her father has been left for hours, even overnight before he was provided direct care.

On 12/12/19, I conducted the exit conference via email with the findings and recommendation for licensee designee and administrator Sanjay Rattan. I also left Mr. Rattan a voicemail message via his cell and at the facility with a staff member. Mr. Rattan was informed to contact me to discuss the findings of the investigation. I also emailed Mr. Rattan a copy of the investigation report and requested that he email his corrective action plan to me directly. Mr. Rattan was also informed to contact me if he had any issues or questions after reviewing the report and recommendation.

APPLICABLE RULE	
R 400.15305	**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:	In early October, Resident A was not treated with dignity or respect when staff members left him to sleep in his reclining chair overnight, due to no staff member assisting him with getting into bed. As a result, Resident A was found the next morning in a urine-soaked diaper, exposing him to skin breakdown and skin infection, due to staff members not ensuring his protection and safety.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: (b) Any accident or illness that requires hospitalization.
ANALYSIS:	On 10/12/19, Resident A was hospitalized at Troy Beaumont Hospital and the facility did not notify the department or complete an incident report.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: (b) Complete an individual medication log that contains all of the following information:

	(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.
ANALYSIS:	Staff initials or signatures are missing to confirm Resident A received his medications for approximately 12 days throughout the month of October from 10/1/19 - 10/23/19 for 11 medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	According to Resident A, he has to wait approximately 15 minutes for staff members to provide him personal care, and on one occasion he was left in his sofa chair overnight for hours. AD also confirmed during her weekly visits to the facility, it was not uncommon for staff members to take up to approximately 30 minutes to respond to residents, due to insufficient staff not on duty, and staff supervisor Sonya Bhalla also confirmed this. Moreover, the facility primarily staffs two staff members on each shift, to care for approximately 14 residents, when more than half of the residents require mobility assistance with either a walker or wheelchair.
CONCLUSION:	**VIOLATION ESTABLISHED**

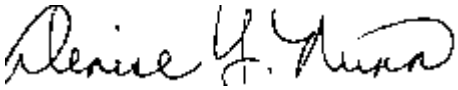
IV. RECOMMENDATION

Contingent upon the licensee submitting an acceptable corrective action plan, issuance of a provisional license is recommended.

12/12/19

Roeiah Epps Date
Licensing Consultant

Approved By:



12/12/2019

Denise Y. Nunn Date
Area Manager

ADDENDUM
SIR #2020A0986002

PURPOSE:

To include additional existing information for this investigation.

METHODOLOGY:

10/23/19 Inspection Completed On-site
Reviewed Resident A's file and relevant documents therein

DESCRIPTION OF FINDINGS AND CONCLUSION:

On 10/23/19, I reviewed Resident A's file which included his AFC admission paperwork, along with his medical and medication records. Both Resident A's care agreement and assessment plan were not signed by the licensee as verification of their completion.

APPLICABLE RULE	
R 400.15301	**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 resident is suitable pursuant to all of the following provisions: (a) The amount of personal care, supervision, and protection that is required by the resident is available in the home. (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. (c) The resident appears to be compatible with other residents and members of the household.
ANALYSIS:	Resident A's assessment plan was not signed or completed by licensee Sanjay Rattan.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following: (a) An agreement to provide care, supervision, and protection, and to assure transportation services to the resident as indicated in the resident's written assessment plan and health care appraisal. (b) A description of services to be provided and the fee for the service. (c) A description of additional costs in addition to the basic fee that is charged. (d) A description of the transportation services that are provided for the basic fee that is charged and the transportation services that are provided at an extra cost. (e) An agreement by the resident or the resident's designated representative or responsible agency to provide necessary intake information to the licensee, including health-related information at the time of admission.

	(f) An agreement by the resident or the resident's designated representative to provide a current health care appraisal as required by subrule (10) of this rule. (g) An agreement by the resident to follow the house rules that are provided to him or her. (h) An agreement by the licensee to respect and safeguard the resident's rights and to provide a written copy of these rights to the resident. (i) An agreement between the licensee and the resident or the resident's designated representative to follow the home's discharge policy and procedures. (j) A statement of the home's refund policy. The home's refund policy shall meet the requirements of R 400.15315. (k) A description of how a resident's funds and valuables will be handled and how the incidental needs of the resident will be met. (l) A statement by the licensee that the home is licensed by the department to provide foster care to adults.
ANALYSIS:	Resident A's care agreement was not signed or completed by licensee Sanjay Rattan.
CONCLUSION:	**VIOLATION ESTABLISHED**

RECOMMENDATION:

Contingent upon the licensee submitting an acceptable corrective action plan, issuance of a provisional license continues to be recommended.

Roeiah Epps 1/7/2020

Roeiah Epps Date
Licensing Consultant

Approved By:

Denise Y. Nunn 01/07/2020

Denise Y. Nunn Date
Area Manager