STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

October 8, 2021

Karen Laseck
Pathway Home of Elsie, LLC
133 W. Main Street
Elsie, MI 48831

RE: License #: AM190394424
Investigation #: 2021A1030030
Pathway Home Of Elsie

Dear Ms. Laseck:

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) 284-9730.

Sincerely,

Nile Khabeiry, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM190394424
Investigation #:	2021A1030030
Complaint Receipt Date:	08/13/2021
Investigation Initiation Date:	08/17/2021
Report Due Date:	10/12/2021
Licensee Name:	Pathway Home of Elsie, LLC
Licensee Address:	133 W. Main Street Elsie, MI 48831
Licensee Telephone #:	(517) 281-2729
Administrator:	Karen Laseck
Licensee Designee:	Karen Laseck
Name of Facility:	Pathway Home Of Elsie
Facility Address:	133 W Main Street Elsie, MI 48831
Facility Telephone #:	(517) 281-2729
Original Issuance Date:	10/31/2018
License Status:	REGULAR
Effective Date:	04/30/2021
Expiration Date:	04/29/2023
Capacity:	11
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Direct care staff member Autumn McGovern did not know how to use Resident A's Glucadon Kit.	Yes
Licensee designee Karen Laseck attempted to financially exploit Resident B by taking money out of her account after she moved.	No
Additional Findings	Yes

III. METHODOLOGY

08/13/2021	Special Investigation Intake 2021A1030030
08/14/2021	Contact - Telephone call made- Interview with complainant
08/17/2021	Special Investigation Initiated - Telephone call to complainant
08/19/2021	Contact - Face to Face- Interview with licensee designee
08/19/2021	Contact - Face to Face- Interview with Resident B
08/19/2021	Contact - Face to Face- Interview with Annette Shetterly-Seamon
08/19/2021	Contact - Face to Face- Interview with Resident C
08/19/2021	Contact - Document Received- Received and reviewed documents
08/24/2021	Contact - Telephone call made- Interview with Autumn McGovern
09/27/2021	Exit Conference with licensee designee Karen Laseck by phone

ALLEGATION:

Direct care staff member Autumn McGovern did not know how to use Resident A's Glucadon Kit.

INVESTIGATION:

On 08/14/2021, I spoke with Complainant regarding the allegations. Complainant reported he is concerned about the staff being able to manage the residents at the Pathway Home of Elsie AFC. Complainant reported he responded to a medical

emergency and the direct care staff member who was working did not provide very clear information and did not know some important facts about the resident. Complainant reported the direct care staff member indicated she did not use the emergency Glucadon Kit because she "does not know how to use it."

On 08/19/2021, I made an unannounced on-site investigation at Pathway Home of Elsie at 133 W. Main Street Elsie, MI. Upon arrival I noted Licensee Designee Karen Laseck and direct care staff member Annette Shetterly-Seamon were outside of the facility. I toured the facility and noted it was neat and clean. In addition, the residents appeared to be clean and well groomed. I informed Ms. Laseck that I was assigned two separate investigations that need to be discussed. Ms. Laseck reported Resident A is a "brittle diabetic" and they are having trouble controlling her diabetes. Ms. Laseck reported Resident A is receiving hospice services. Ms. Laseck reported direct care staff member Autumn McGovern was working alone and will have more information regarding the allegation. Ms. Laseck reported an incident report was not completed regarding the incident and admitted she knows that is a violation of AFC rules.

On 08/19/2021, I received and reviewed Resident A's *Medication Administration Record* (MAR) for August 2021 and the *Interdisciplinary Team Note* (ITN) dated 8/12/2021. Both documents indicated Resident A blood sugar was tested at 3:30pm and measured 337 so Resident A was given 6 units of Insulin per instructions on the MAR.

On 08/19/2021, I interviewed Resident A who was in bed but awake. Resident A reported she does not remember going to the hospital but did confirm that she is diabetic. Resident A reported she checks her blood sugar herself every day and injects herself with insulin, however it is unclear if Resident A is fully capable of checking her own blood sugar or injecting herself. Resident A reported she likes living in this facility and especially likes the food. Resident A reported the direct care staff members "take good care of me."

On 08/19/2021, I interviewed direct care staff member, Annette Shetterly-Seamon regarding the allegations. Ms. Shetterly-Seamon reported she does not have any knowledge of the situation with Resident A as she was not working during that shift.

On 08/24/2021, I interviewed direct care staff member Autumn McGovern regarding the allegations. Ms. McGovern reported she was working during the incident when Resident A had to be taken to the hospital. Ms. McGovern reported it was a "traumatic event for me." Ms. McGovern reported she checked Resident A's blood sugar at 3:30pm and it was high so she administered 6 units of insulin. Ms. McGovern reported she then assisted Resident A get into bed. Ms. McGovern reported she gave Resident A a snack at 4:05pm and went to finish making dinner. Ms. McGovern reported she went into Resident A's bedroom at 5:10pm to inform Resident A that dinner was ready and notice she was "twitching and unresponsive." Ms. McGovern reported she called 911 at 5:12pm and assisted the EMT's when they arrived. Ms. McGovern reported she did get Resident A's Glucadon kit but did not know how to use it. Ms. McGovern reported EMTs used their own kit and took Resident A to the hospital. Ms. McGovern

reported she did not complete an incident report but is aware that she should have completed an incident report based on the situation.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(a) Medications.**
ANALYSIS:	Based on my investigation which included review of Resident A's *Medication Administration Record* (MAR), Interdisciplinary *Team Note* (ITN), and interviews with complainant, Resident A, licensee designee Karen Laseck and direct care staff member Autumn McGovern this violation will be established. On 08/12/2021, Resident A had a medical emergency due to diabetes. Direct care staff member, Autumn McGovern did not know how to use the emergency Glucadon kit which she reported to me and the EMT who responded to the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Licensee Designee Karen Laseck attempted to financially exploit Resident B by taking money out of her account after she moved.

INVESTAGATION:

On 08/18/2021, I spoke with Complainant regarding the allegations. Complainant reported she is concerned about Karen Laseck as she believes Ms. Laseck tried to steal money from Resident B. Complainant reported she moved Resident B of the facility on June 17, 2021, and Ms. Laseck took rent for the month of July 2021. Complainant reported they set up an automatic withdrawal system with the credit union so the monthly rent would be taken out of Resident B's account at the beginning of every month. Complainant reported she spoke with Ms. Laseck and they agreed that Resident B would pay from July 1, 2021 to July 17, 2021 as the rent in June was already paid and there was not a 30-day notice given which was what was agreed upon when she moved in. Complainant reported she thinks Ms. Laseck purposely took the money hoping that she would not notice and thinks that Ms. Laseck "manually" takes the money and it's not automatic. Complainant reported she was fully reimbursed ($3,000.00) by Ms. Laseck.

On 08/19/2021, I made an unannounced on-site investigation at Pathway Home of Elsie at 133 W. Main Street Elsie, MI. I interviewed Ms. Laseck who reported Resident B's family agreed to auto-pay out of convenience for them as she does not require her residents to use auto-pay. Ms. Laseck reported Resident B moved from the AFC facility without any notice after the family picked her up stating they were taking Resident A to a medical appointment but instead moved her to another facility. Ms. Laseck reported she assumed the family would go to the credit union and stop the auto-pay because they are "so focused on money." Ms. Laseck reported after she was informed by the family that the $3,000.00 dollars was taken out of the account in July 2021, she stated she apologized, and wrote them a check that day. Ms. Laseck reported the auto-pay program is called "Auto-Books" and she was not trying to be dishonest.

On 08/19/2021, I interviewed direct care staff member, Annette Shetterly-Seamon regarding the allegations. Ms. Shetterly-Seamon reported she did not have any information regarding Resident B's rent payments as she does not deal with any of the administrative duties.

On 08/19/2021, I received and reviewed Resident B's *Resident Funds Part II* and an authorization agreement for automatic withdrawal in the amount of $3,000.00 for rent from Resident B's bank account dated 12/22/2020. The authorization indicated that "this authorization is to remain in full force and effect until Pathway Home of Elsie, LLC, has received written notification for the Payee of its termination in such time and in such manner as to afford Pathway Home of Elsie, LLC. And Depository a reasonable opportunity to act on it", *Resident Care Agreement* (RCA) dated 12/28/2020 indicating monthly rent in the amount of $3,000.00, copy of check written to Janet Kosht for $3,000.00 to reimburse her for July 2021 rent.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(1) A resident shall be assured privacy and protection from moral, social, and financial exploitation.

ANALYSIS:	Based on my investigation which included review of Resident B's *Resident Care Agreement, Resident Funds Part II,* authorization agreement for automatic withdrawal, copy of a check written to Janet Kosht and interviews with the complainant and Karen Laseck this violation will not be established. Resident B and her family signed an agreement to have her monthly rent automatically withdrawn from her account on 12/22/2020. Resident B was moved without prior notice on 6/17/2021 and the auto-pay remained in effect. Resident B's rent was automatically withdrawn in July 2021 however once the problem was identified Ms. Laseck reimbursed Resident B and the auto-pay was discontinued.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During my interviews with licensee designee, Karen Laseck and direct care staff member, Autumn McGovern it was reported that an incident report was not competed when Resident A had a medical emergency and taken to the hospital on 08/12/2021.

APPLICABLE RULE	
R 400.14311	**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: **(c) Incidents that involve any of the following:** **(ii) Hospitalization.**
ANALYSIS:	Based on my investigation which included review of Resident A's *Medication Administration Record* (MAR), Interdisciplinary *Team Note* (ITN), and interviews with complainant, Resident A, licensee designee Karen Laseck and direct care staff member Autumn McGovern this violation will be established. On 08/12/2021, Resident A had a medical emergency due to diabetes requiring hospitalization. A written incident report was not received within the required time frame reporting Resident A's hospitalization.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Based on the acceptance of an approved corrective action plan, I recommend no change to the current license status.

Nile Khabeiry, LMSW 10/07/2021

Nile Khabeiry Date
Licensing Consultant

Approved By:

Dawn Timm 10/08/2021

Dawn N. Timm Date
Area Manager