GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 28, 2021

Sanjay Rattan
Marys Residential Care For Seniors Inc.
5701 Chicago Road
Warren, MI 48092

RE: License #: AL500007236
Investigation #: 2021A0986011
Marys Senior Center

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.
- 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,

Roeiah Epps-Ward, 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 #:	AL500007236
Investigation #:	2021A0986011
Complaint Receipt Date:	07/22/2021
Investigation Initiation Date:	07/22/2021
Report Due Date:	09/20/2021
Licensee Name:	Marys Residential Care For Seniors Inc
Licensee Address:	35225 Silvano Clinton Twp, MI 48035
Licensee Telephone #:	(248) 844-1407
Administrator:	Sanjay Rattan
Licensee Designee:	Sanjay Rattan
Name of Facility:	Marys Senior Center
Facility Address:	35225 Silvano Clinton Twp, MI 48035
Facility Telephone #:	(586) 790-0640
Original Issuance Date:	03/09/1979
License Status:	REGULAR
Effective Date:	09/09/2021
Expiration Date:	09/08/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
• Resident A has bilateral heal wounds that are supposed to be dressed daily and this is not being done, and she is not administered her medications. • Resident A was also observed with feces under her fingernails, and in soiled clothing and a soiled diaper.	No
Additional Findings	Yes

III. METHODOLOGY

07/22/2021	Special Investigation Intake 2021A0986011
07/22/2021	Special Investigation Initiated - On Site Interviewed licensee designee and administrator Sanjay Rattan and Resident A and staff members; Reviewed Resident A's file and medical documents
07/22/2021	APS Referral Debra Johns, Macomb County Adult Protective Services (APS)
07/28/2021	Contact - Telephone call made McLaren Homecare
07/28/2021	Contact - Document Received Resident A's medical records from McLaren Homecare
08/4/2021	Contact - Document Received Email from licensee designee and administrator Sanjay Rattan and telephone call to Resident A's adult niece (AN)
08/12/2021	Contact - Document Received Email from APS worker Debra Johns
08/23/2021	Contact - Face to Face Interviewed licensee designee and administrator Sanjay Rattan
08/23/2021	Contact - Telephone call made Interviewed former staff member (FS)

09/09/2021	APS Referral Karen Patyi APS worker Macomb County
09/09/2021	Contact - Face to Face Interviewed licensee designee and administrator Sanjay Rattan and interviewed Residents B and C
10/27/2021	Exit - Conference Email to licensee designee and administrator Sanjay Rattan
10/27/2021	Contact - Telephone call received Nadia Kent visiting nurse practitioner

ALLEGATION:

- **Resident A has bilateral heal wounds that are supposed to be dressed daily and this is not being done, and she is not administered her medications.**
- **Resident A was also observed with feces under her fingernails, and in soiled clothing and a soiled diaper.**

INVESTIGATION:

On 7/22/2021, I conducted an unannounced onsite inspection and interviewed licensee designee and administrator Sanjay Rattan and Resident A. I also reviewed Resident A's file, medical records, and her medical documents from McLaren Home Healthcare.

On 7/22/2021, Mr. Rattan stated the allegations are not true. Mr. Rattan stated that Resident A was admitted to McLaren Hospital on 7/9/2021, due to her physical condition declining from a fall she sustained at the facility on 6/9/2021. During Resident A's hospital stay the week of 7/9/2021, she developed pressure sores on her lower back and the heals of her feet. Due to the severity of the pressure sore on Resident A's back, a wound vac was administered by hospital medical staff. Mr. Rattan stated the discharge nurse told him that McLaren would be referring Resident A for in home healthcare for maintenance and assistance of the wound vac. However, Mr. Rattan learned on 7/19/2021, that McLaren never received a physician's approval via a medical script for the wound vac. As a result, he believes the McLaren Home Healthcare staff made this complaint to cover themselves. The weekend of 7/16/2021, Resident A's wound vac came out of her back. When staff members tried to call the nurse on call for McLaren Home Healthcare, she did not respond for two days. On 7/18/2021, Mr. Rattan stated the on-call nurse call and complained that it takes her two hours to drive to the facility, and that staff should be competent enough to re-apply the wound vacuum. Therefore, McLaren never provided the assistance they promised as a condition of Mr. Rattan admitting Resident A back to the facility. Mr. Rattan also stated that he and his staff provide all medications to Resident A as required. Mr. Rattan also showed me Resident A's medication records, to corroborate his account.

On 7/22/2021, I interviewed and observed Resident A. Resident A appeared to be appropriately dressed, and her wounds were properly bandaged on her tailbone, and the heels of both feet. No evidence of feces under her fingernails existed, nor was she observed in soiled linen or a soiled diaper. Resident A also appeared to be in good spirits and expressed being pleased with her care and with Mr. Rattan being her caretaker. Due to Resident A's clinical diagnosis of dementia, she could provide no information regarding her medical care and treatment with McLaren.

On 7/28/2021, I interviewed the home health care nurse (RN) with McLaren. RN stated the allegations are true, but admitted she did not photograph Resident A on the weekend of 7/16/2021 when she observed her. RN also stated staff did not display competence, evidence by their inability to reconnect Resident A's wound vac, or to ensure she received her medications. RN stated Resident A also had feces under her nails and her diaper was soiled. RN also observed used diapers in Resident A's medical supply box. RN stated staff expected her to drive two hours to reconnect the wound vac, when this can simply be done with minimal training as a direct care staff member. Further, RN stated staff members were not calling the correct phone number for her, which is why there was a delay in her responding. RN also confirmed that Resident A would be removed from McLaren Home Healthcare services, because the facility did not ensure that her wound vac was properly installed and no physician will authorize approval for its use.

On 8/4/2021, I received an email from Mr. Rattan from Resident A's adult niece (AN) who has power of attorney for Resident A's medical care. According to the email, Resident A was being formerly discharged from health care services, due to her not being seen by a physician for approval of the wound vac. Further, Mr. Rattan stated on 7/18/2021, when RN was at the facility, she and another McLaren medical staff person could not reattach Resident A's wound vac, which prompted an onsite visit from the McLaren Hospital social worker on 7/19/2021 to back date all orders and documents at the facility. As a result, Mr. Rattan is convinced McLaren attempted to cover themselves to prevent liability.

On 8/4/2021, I interviewed AN. AN stated she has been pleased with Resident A's care at the facility and has no issues or safety concerns. AN stated RN also complained to her about having to drive two hours to the facility, so she believes Mr. Rattan's account of the incidents that occurred regarding her aunt's care at the facility. Moreover, Resident A now has a new in-home health care agency (America's Choice Home Care, Inc.), and is being provided adequate personal care and medical treatment.

On 8/12/2021, APS worker Debra Johns stated that the allegations of the complaint would not be substantiated.

On 10/27/2021, visiting nurse practitioner Nadia Kent stated she saw Resident A at the facility on 10/26/2021, and her wounds were almost healed totally, and she had no issues or safety concerns regarding her care at the facility.

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:	According to RN, Resident A's protection and safety was not ensured the weekend of 7/16/2021, when staff did not properly reconnect her wound vac, after it came off. However, according to Mr. Rattan, the McLaren Hospital discharge nurse, maintenance, and care of Resident A's wound vac would be provided by the in-home nursing staff. Moreover, RN confirmed that McLaren was discharging Resident A from home health care services; specifically, because no physician authorized or approved the wound vac for Resident A's use. Therefore, sufficient evidence does not exist for violation of this rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING(S):

INVESTIGATION:

On 8/12/2021, APS worker Debra Johns stated that she would be substantiating a complaint for financial exploitation against a former staff member (FR) at the facility. According to Ms. Johns, between October 2020 and July 2021, FR used Resident B's debit card to remove $9,878.00, from the ATM machine. Resident B was afraid to say anything until FR was terminated, due to possible retaliation. The Clinton Township Police Department are also investigating the matter, with Detective Chirco as the lead officer of the investigation.

On 8/23/2021, I interviewed FR. FR stated that she stopped working at the facility in July. FR stated that initially Resident B was gifting her money, due to her knowledge of the staff shortage at the facility. Resident B would often offer FR money to conduct store runs and errands for her, so she didn't see an issue with borrowing money on a couple of occasions, because she always intended to pay her back. FR admitted that she knew it was wrong, but believed Resident B was comfortable with loaning her money since they developed a good friendship during her employment at the facility.

On 8/23/2021, Mr. Rattan stated that he terminated FR the last week of July when he learned of the allegations. Mr. Rattan stated that he reported the incident to APS and the police. Mr. Rattan stated when he confronted FR about the allegations, she admitted it was wrong and stated that she planned to pay Resident B back her money.

On 9/9/2021, I interviewed Resident B. Resident B stated the allegations are true and she feels stupid that FR took advantage of her financially. Resident B stated that FR was always giving her a sad story about not having enough money, so she loaned her money. Resident B stated FR started asking for more and more money each time, to the point it just became impossible to pay her all the money back that she owed, because she noticed FR was not working at the facility as much. Resident B stated that she and FR became close and spoke on the telephone often, so she does not understand why she would take advantage of her.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(1) A resident shall be assured privacy and protection from moral, social, and financial exploitation.
ANALYSIS:	From October 2020 until July 2021, a staff member took money out of Resident B's bank account, and has not reimbursed her nor noted the withdrawals on Resident B's funds transactions records.
CONCLUSION:	VIOLATION ESTABLISHED

INVESTIGATION:

On 9/9/2021, APS worker Karen Patyi stated she would be substantiating a complaint for improper supervision of Resident C at the facility. Ms. Patyi stated on 8/23/2021, Resident C was found lying in the grass in the neighborhood and with no staff supervision. Ms. Patyi stated she determined that Resident C was missing from the facility for approximately 15 minutes.

On 9/9/2021, I conducted an unannounced inspection and interviewed Resident C. Due to Resident C's clinical diagnosis of dementia, he could not properly follow the line of questioning regarding the allegations. Overall, Resident C appeared to be well cared for at the facility, and expressed being pleased with his care.

On 9/9/2021, Mr. Rattan stated the facility is currently undergoing outside construction, so he believes someone must have turned off the door alarm. Mr. Rattan stated it is also possible that a staff member may have accidentally turned off the alarm so that another resident could go out for a smoke break. As a result, Resident C was able to sneak outside. I also reviewed Resident C's file at the facility and observed his health care appraisal and assessment plan. Resident C has a clinical diagnosis of dementia, and although he can ambulate independently with assistive devices, he requires 24-hour supervision in the community.

On 10/27/2021, I conducted the exit conference via the licensee designee and administrator Sanjay Rattan's voicemail. The findings of the investigation were also given via email, and Mr. Rattan was instructed to contact me should he have any questions or concerns.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	According to Resident A's assessment plan, he requires 24-hour supervision, personal care, and protection at all times. However, this is did not occur on 8/23/2021, when he was observed outside the facility alone, for approximately 15 minutes.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the licensee submitting an acceptable corrective action plan, I recommend that the special investigation be closed with no change to the license.

10/27/2021

Roeiah Epps-Ward Date
Licensing Consultant

Approved By:

10/28/2021

Denise Y. Nunn Date
Area Manager