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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 11, 2022

Catherine Reese
New Friends Dementia Community, LLC
3700 W Michigan Ave
Kalamazoo, MI 49006

RE: License #: AL390299686
Investigation #: 2022A0462020
Vibrant Life Senior Living Kalamazoo 2

Dear Ms. Reese:

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,

Michele Streeter, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-9037

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL390299686
Investigation #:	2022A0462020
Complaint Receipt Date:	02/08/2022
Investigation Initiation Date:	02/08/2022
Report Due Date:	04/09/2022
Licensee Name:	New Friends Dementia Community, LLC
Licensee Address:	3700 W Michigan Ave Kalamazoo, MI 49006
Licensee Telephone #:	(734) 819-7790
Administrator:	Laurel Space
Licensee Designee:	Catherine Reese
Name of Facility:	Vibrant Life Senior Living Kalamazoo 2
Facility Address:	3712 W. Michigan Ave. Kalamazoo, MI 49006
Facility Telephone #:	(269) 372-6100
Original Issuance Date:	06/21/2011
License Status:	REGULAR
Effective Date:	07/26/2021
Expiration Date:	07/25/2023
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 01/18/2022 Resident A picked up a bottle of cleaning solution that was left in the facility's dining room and took a drink from the bottle.	Yes
Additional findings.	Yes

III. METHODOLOGY

01/18/2022	Contact- Received IR.
02/08/2022	Special Investigation Intake 2022A0462020. Special Investigation Initiated. Unannounced investigation on-site. Face-to-face interviews with administrator Laurel Space and direct care worker Destiny Lewis. Observation of Resident A.
02/09/2022	Contact- APS Referral.
02/10/2022	Contact- Email exchange with APS Specialist Amber Price.
02/14/2022	Contact- Email exchange with APS Specialist Amber Price.
02/24/2022	Contact- Document received via email.
03/07/2022	Exit conference with licensee designee Catherine Reese via telephone.

ALLEGATION: On 01/18/2022 Resident A picked up a bottle of cleaning solution that was left in the facility's dining room and took a drink from the bottle.

INVESTIGATION: On 01/18/2022 the facility submitted to the department an *AFC Licensing Division Incident/Accident Report* (IR) written by director of nursing Ruquiyah Alexander. According to documentation on the IR, at 3:32AM on 01/18, Resident A picked up a bottle of cleaning solution that was on the dining room table and drank some of the solution. Facility staff member "DL" took the cleaning solution away from Resident A. Subsequently, Resident A became angry, hit "staff" in the face and headbutted another "staff member."

On 02/08 I conducted an unannounced investigation at the facility and interviewed administrator Laurel Space who confirmed the incident occurred on 01/18, while she was working "off-site." According to Ms. Space, she was made aware of the incident

when she returned to working at the facility on 01/24. Ms. Space stated direct care worker (DCW) Destiny Lewis was the facility staff member identified as “DL” in the IR submitted to the department on 01/18. According to Ms. Space, Resident A was diagnosed with moderate dementia and occasionally displayed aggressive and combative behaviors. Due to Resident A’s dementia diagnosis, he would likely be unable to provide any details regarding the incident. Ms. Space stated she discussed the incident with director of nursing Ruquiyah Alexander but did not speak directly with Ms. Lewis regarding the incident. According to Ms. Space, it was her understanding Resident A did not experience any adverse reactions to drinking the cleaning solution.

Ms. Space showed me a bottle of cleaning solution called Array Ultimate Sanitizer. According to Ms. Space, this was the cleaning solution Resident A ingested on 01/18.

I requested and received a copy of Resident A’s written *Health Care Appraisal* (HCA) and the facility’s 01/18 electronic observation notes for Resident A. Documentation on Resident A’s HCA, dated 12/08/2021, confirmed Resident A was diagnosed with “high-severe dementia” and displayed behavioral disturbances.

An observation note entry by Ms. Lewis on 01/18 at 3:30AM read;

“while resident walked up and down hallway resident picked up a bottle of cleaner off of the dining room table and drunk some of it staff took it from [Resident A] became angry hit one staff all in the face and head butted another lead med tech was informed [sic].”

There were three additional observation note entries for Resident A on 01/18 following the incident: two entries by DCWs Chasity Gordon and Tikah Grace at 11:00AM, and another entry by facility staff member Shelley Simmons at 10:15PM. These observation entries did not indicated Resident A experienced any adverse reactions to drinking the cleaning solution.

I conducted a face-to-face interview with Ms. Lewis who stated that at approximately 2:00AM on 01/18, she and DCWs Jakaria Wallace and Claudia Nathan were cleaning the facility. Ms. Lewis admitted a bottle of Array Ultimate Sanitizer was left on a table in the facility’s dining room. Ms. Lewis confirmed she witnessed Resident A grab the bottle off the table and open it. According to Ms. Lewis, she witnessed Resident A bring the bottle of sanitizer up to his mouth as if he was going to drink it. Ms. Lewis stated, “I don’t even know if he actually drank any of it.” According to Ms. Lewis, she quickly grabbed the bottle from Resident A and proceeded to smell his mouth and hands to determine whether he drank the solution and/or was exposed to it. Ms. Lewis stated this startled Resident A and caused him to engage in physically aggressive behaviors with her and the other DCWs. According to Ms. Lewis, other than monitoring Resident A for the remainder of her shift, no further action was taken, as she did not believe Resident A actually ingested the cleaning solution. Ms.

Lewis' statements were inconsistent with Ms. Alexander's documentation on the IR submitted to the department, as well as inconsistent with Ms. Lewis' 01/18 entry in Resident A's electronic observation notes.

I attempted to conduct an interview with Resident A in his bedroom. However, Resident A was sleeping. Resident A was well groomed and appeared to be comfortable.

Using the internet search engine Google, I located the Safety Data Sheet (SDS) for Array Ultimate Sanitizer. Documentation on the SDS, under section 2. Hazard(s) Identification, read;

"IF SWALLOWED: Rinse mouth. Do NOT induce vomiting. If conscious, dilute by drinking up to a cupful of diagnosed milk or water as tolerated. IF INHALED: Remove person to fresh air and keep comfortable for breathing. START FIRST AID. IMMEDIATELY CALL A POISON CENTER OR PHYSICIAN. EMERGENCY TELEPHONE: 1-866-923-4913"

Documentation on the SDS, under section 4. First-Aid Measures, read;

"IF SWALLOWED: RINSE MOUTH. DO NOT INDUCE VOMITING. IF CONSCIOUS, DILUTE BY DRINKING UP TO A CUPFUL OF MILK OR WATER AS TOLERATED. IF INHALED: REMOVE PERSON TO FRESH AIR AND KEEP COMFORTABLE FOR BREATHING. START FIRST AID. IMMEDIATELY CALL A POISON CENTER OR PHYSICIAN. EMERGENCY TELEPHONE: 1-866-923-4913"

"MOST IMPORTANT SYMPTOMS / EFFECTS: *CAUSES SEVERE SKIN BURNS AND SERIOUS EYE DAMAGE. MAY CAUSE BLINDNESS WITHOUT IMMEDIATE FIRST AID. HARMFUL IF SWALLOWED. CAUSES BURNS AND SERIOUS DAMAGE TO MOUTH, THROAT AND STOMACH. CORROSIVE TO ALL BODY TISSUES."*

On 02/09 I referred the allegation to Kalamazoo County Adult Protective Services (APS) via an email to the Centralized Intake Unit for Abuse and Neglect.

On 02/10, via email, APS Specialist Amber Price informed me she was assigned to investigate the allegation.

On 02/14, via email, Ms. Price informed me she conducted separate interviews with Ms. Lewis, Ms. Wallace, Ms. Nathan, and Relative A1 regarding the allegation, and was provided with inconsistent statements. According to Ms. Price, Ms. Lewis' statements were consistent with the statements she provided to me on 02/08, except Ms. Lewis reported the cleaning solution was her own personal cleaning solution that she brought from home, and not Array Ultimate Sanitizer. According to Ms. Price, Ms. Wallace stated she witnessed Resident A drink cleaning solution left in the dining room, in the early morning hours of 01/18. Ms. Wallace reported that she

smelled Resident A's breath and his breath smelled like the cleaning disinfectant "Fabuloso." According to Ms. Wallace's statements, Resident A was given a glass of milk following the incident. Ms. Price informed me Ms. Nathan reported not witnessing the incident. Via her email, Ms. Price informed me that based upon her investigation, she established that on 01/18, facility staff members neglected Resident A by failing to provide him with a safe environment.

On 02/24 Ms. Space emailed me a copy of a letter she received from Ms. Price. According to documentation on this letter, Ms. Price closed her investigation on 02/16. Ms. Price's letter indicated that Resident A was considered to be safe in his current living environment at the facility. Subsequently, APS was no longer needed.

According to Special Investigation Report (SIR) 2021A0462010, dated 01/12/2021, the facility was in violation of AFC administrative licensing rule 400.15305(3) when it was established that at 11:07PM on 11/17, a resident (identified as Resident A in SIR 2021A0462010) with a diagnosis of vascular dementia and a history of "exit-seeking behavior", eloped from the facility without a coat, and was outside for 7 and ½ hours without facility staff members' knowledge. According to the website www.weather.com, it was 23 degrees Fahrenheit in the early morning hours of 11/18. SIR 2021A0462010 indicated that due to the quality of care violations cited in the report, a six-month provisional license was recommended. The facility's approved Corrective Action Plan (CAP), dated 01/26/2021, indicated the facility's Executive Director, Assistant Director of Nursing, Staffing Coordinator, and Human Resources Director would ensure that all facility staff members and newly hired facility staff members received training on the proper protocol for resident elopement. According to the facility's CAP, quarterly elopement drills, weekly door alarm checks, and Daily Assessment Sheets, as well as a process for checking door alarms, collecting pagers, walkie-talkies, and keys before each shift, would be implemented. One "card reader" and one "electronic magnetic lock", tied directly into the facility's fire alarm system, would be installed on the side door in the North Hall. Documentation on the facility's CAP indicated all facility employees, including those from outside staffing agencies, would be provided with a copy of the facility's policies and procedures and would receive required training prior to working in the facility on their own and/or assuming work responsibilities. The facility's CAP included a written statement from licensee designee Catherine Reese, accepting of the issuance of a six-month provisional license. Subsequently, on 01/26/2021 the facility's license was modified to a six-month provisional license. On 07/26/2021, following a licensing renewal inspection, the facility's license was modified back to regular statis.

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 provision of the act.

ANALYSIS:	Based upon my investigation, which consisted of multiple interviews, and a review of pertinent documentation relevant to this investigation, it has been established there is enough evidence to substantiate the allegation that on 01/18/2022, Resident A picked up a bottle of cleaning solution that was left unsecured in the facility's dining room and took a drink from the bottle.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE SIR #2021A0462010, DATED 01/12/2021, AND CAP, DATED 01/26/2021]**

APPLICABLE RULE	
R 400.15401	**Environmental health.**
	(6) Poisons, caustics, and other dangerous materials shall be stored and safeguarded in nonresident areas and in non-food preparation storage areas.
ANALYSIS:	Based upon my investigation, it has been established that on 01/18, cleaning solution was left unsecured in the facility dining room and was not stored and safeguarded in a nonresident area. Subsequently, Resident A picked up the cleaning solution and took a drink from the bottle.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: Ms. Alexander's documentation on the IR submitted to the department on 01/18, regarding Resident A taking a drink of unsecured cleaning solution in the early morning hours of 01/18, did not include actions taken by DCWs following the incident, treatment given to Resident A, or corrective measures taken to remedy and/or prevent the recurrence of the incident, nor did it indicate that DCWs attempted to make contact with Resident A's physician and/or designated representative, via telephone, to notify them of the incident.

During my face-to-face interview with Ms. Space on 02/08, she stated that upon learning of the 01/18 incident on 01/24, she discussed the incident with Ms. Alexander but did not speak directly with Ms. Lewis, or others involved with the incident. During my onsite investigation, Ms. Space checked the facility's electronic documentation for Resident A and confirmed that immediately following the incident on 01/18, it appeared nobody sought outside medical treatment for Resident A, and/or called poison control for direction on what to do. Ms. Space was unable to explain why this was.

During my onsite investigation on 02/08, I reviewed the facility's 01/18 electronic observation notes for Resident A. An observation note entry by Ms. Lewis on 01/18 at 3:30AM read;

"while resident walked up and down hallway resident picked up a bottle of cleaner off of the dining room table and drunk some of it staff took it from [Resident A] became angry hit one staff all in the face and head butted another lead med tech was informed [sic]."

There were three additional observation note entries for Resident A on 01/18 following the incident; two entries by Ms. Gordon and Ms. Grace at 11:00AM, and another entry by Ms. Simmons at 10:15PM. The observation entries did not indicate that following the incident, Resident A was given a glass of milk and monitored for the remainder of the evening. There were no observation entries indicating Resident A's physician and designated representative, Relative A1, were notified of the incident.

During my face-to-face interview with Ms. Lewis on 02/08, Ms. Lewis stated that following the incident on 01/18, other than monitoring Resident A for the remainder of her shift, no further action was taken, as she did not believe Resident A actually ingested the cleaning solution. Her statements were inconsistent with Ms. Alexander's documentation on the IR submitted to the department, as well as inconsistent with Ms. Lewis' 01/18 entry in Resident A's electronic observation notes. Ms. Lewis' statements were also inconsistent with Ms. Wallace's statements to Ms. Price.

According to an email Ms. Price sent to me on 02/14, Ms. Wallace reported witnessing Resident A drink cleaning solution on 01/18 and subsequently, Resident A was given a glass of milk. Via email, Ms. Price informed me that Ms. Lewis, Ms. Wallace, and Ms. Nathan all reported that following the 01/18 incident**,** they unsuccessfully attempted to make telephone contact with Relative A1. Subsequently, without Relative A1's prior approval, Resident A was not sent to the emergency room for further evaluation. According to Ms. Price, she interviewed Relative A1, who denied that anyone from the facility attempted to notify her of the incident. According to Relative A1, she found out about the incident on or around 02/07, after requesting and reading a copy of Resident A's "daily log sheets".

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: **(c) Incidents that involve any of the following:** ***(i) Displays of serious hostility.*** **(ii) Hospitalization.** ***(iii) Attempts at self-inflicted harm or harm to others.*** **(iv) Instances of destruction to property.** **(2) An immediate investigation of the cause of an accident or incident that involves a resident, employee, or visitor shall be initiated by a group home licensee or administrator and an appropriate accident record or incident report shall be completed and maintained.** **(6) An accident record or incident report shall be prepared for each accident or incident that involves a resident, staff member, or visitor. "Incident" means a seizure or a highly unusual behavior episode, including a period of absence without prior notice. An accident record or incident report shall include all of the following information:** **(c) The effect of the accident or incident on the person who was involved *and the care given*.** ***(d) The name of the individuals who were notified and the time of notification.*** ***(e) A statement regarding the extent of the injuries, the treatment ordered, and the disposition of the person who was involved.*** ***(f) The corrective measures that were taken to prevent the accident or incident from happening again.***
ANALYSIS:	Based upon my investigation, there is not enough evidence to verify that following an incident on 01/18 when Resident A took a drink of unsecured cleaning solution, that his designated representative, Relative A1, was notified by telephone, nor is there enough evidence to verify Relative A1 received a written report of the incident within 48 hours of the incident occurring. According to Relative A1, she found out about the incident on or around 02/07, after requesting and reading a copy of Resident A's "daily log sheets". Facility administrator Laurel Space stated that upon being made of the 01/18 incident on 01/24, she discussed the incident with director of nursing Ruquiyah Alexander but did not speak directly with Ms. Lewis or others involved in the incident. Subsequently, it has been established Ms. Space did not adequately conduct an investigation of the cause of the incident.

	The IR submitted to the department on 01/18 regarding this incident did not include the care/treatment given to Resident A following the incident, a statement regarding the extent of his injuries, or the corrective measures taken to prevent the incident from happening again.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15310	**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:	It has been established that in the early morning hours of 01/18, Resident A drank unsecured cleaning solution. Based upon my investigation, it has been established that neither DCWs Destiny Lewis, Jakaria Wallace, and Claudia Nathan called poison control for further direction, nor did they send Resident A to the emergency room for evaluation. According to Ms. Lewis', Ms. Wallace's, and Ms. Nathan's statements to APS Specialist Amber Price, Resident A was not sent to the emergency room following the incident on 01/18 because they were unable to reach Relative A1 to seek prior approval. Under no circumstance are facility staff members to delay or refrain from obtaining necessary care. Facility staff members should not be expected to contact facility management staff members and/or residents' family members prior to obtaining appropriate medical care for residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 03/07 I conducted an exit conference with licensee designee Catherine Reese via telephone and shared with her the findings of this investigation.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

03/07/2022

Michele Streeter — Date
Licensing Consultant

Approved By:

03/11/2022

Dawn N. Timm — Date
Area Manager