GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 2, 2022

Marcia Curtiss
MCAP East Paris Opco, LLC
Suite 115
21800 Haggerty Rd.
Northville, MI 48167

RE: License #:	AL410404573
Investigation #:	2022A0356023
	Addington Place of East Paris #8

Dear Mrs. Curtiss:

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 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410404573
Investigation #:	2022A0356023
Complaint Receipt Date:	04/19/2022
Investigation Initiation Date:	04/19/2022
Report Due Date:	06/18/2022
Licensee Name:	MCAP East Paris Opco, LLC
Licensee Address:	Suite 115 21800 Haggerty Rd. Northville, MI 48167
Licensee Telephone #:	(248) 773-4600
Administrator:	Marcia Curtiss
Licensee Designee:	Marcia Curtiss
Name of Facility:	Addington Place of East Paris #8
Facility Address:	3948 Whispering Way, SE Grand Rapids, MI 49546
Facility Telephone #:	(616) 949-9500
Original Issuance Date:	11/02/2020
License Status:	REGULAR
Effective Date:	05/02/2021
Expiration Date:	05/01/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A refuses to take medications with no follow-up by staff at the facility.	Yes
Resident A is aggressive towards other residents in the facility.	No
Additional Findings	Yes

III. METHODOLOGY

04/19/2022	Special Investigation Intake 2022A0356023
04/19/2022	APS Referral Lacey Lott, Kent County APS.
04/19/2022	Special Investigation Initiated - Telephone Lacey Lott.
04/22/2022	Inspection Completed On-site
04/22/2022	Contact - Face to Face Mechelle Genigeski, home manager, Resident A, staff Tonya Acklin.
04/28/2022	Contact - Document Sent Request for facility documents sent to Mechelle Genigeski and Jeannine Hayes, Regional nurse.
04/28/2022	Contact - Document Received Facility Documents received from J. Hayes.
05/04/2022	Contact - Telephone call made Legal Guardian, Tracy Booth.
05/17/2022	Contact - Telephone call made Lacey Lott, APS.
05/25/2022	Contact-Document Sent Ms. Hayes, Ms. Booth.
05/25/2022	Contact-Telephone call made Michelle Gingrich, nurse practitioner with Careline Health Partners.

05/26/2022	Contact-Telephone call received- Ms. Booth
06/02/2022	Exit Conference-Licensee Designee, Marcia Curtiss.

ALLEGATION: Resident A refuses to take medications with no follow-up by staff at the facility.

INVESTIGATION: On 04/19/2022, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaint. The complainant reported that Resident A refuses some of his medications such as high blood pressure, high cholesterol and a low dose medication prescribed for dementia without any follow-up by staff. Kent County Adult Protective Services (APS) worker, Lacey Lott is assigned to investigate for DHHS (Department of Health and Human Services).

On 04/19/2022, I interviewed APS worker, Ms. Lott via telephone. Ms. Lott confirmed the information reported in the complaint and that she is investigating this complaint.

On 04/22/2022, I completed an unannounced inspection at the facility and interviewed Mechelle Genigeski, Executive Director. Ms. Genigeski stated Resident A was admitted to the facility on 08/04/2020 and staff administer Resident A's medications as prescribed, and she is not aware of Resident A refusing any medications. Ms. Genigeski suggested I interview Jeannine Hayes, Regional Nurse for the facility.

On 04/22/2022, I interviewed Resident A in his room at the facility. Resident A stated he takes all of his medications including the high blood pressure pill and cholesterol pill but that he "quit taking the pink pill, it's an anti-anxiety pill" and that he does not like it because it causes him to sleep too much. Resident A stated the pill caused him to sleep 16 hours a day and so he "quit taking it weeks ago and it hasn't changed a thing."

On 04/22/2022, I interviewed Direct Care Worker (DCW) Tonya Acklin at the facility. Ms. Acklin stated she works 1st shift and Resident A takes his medications without any issues during her shift. Ms. Acklin reviewed the MAR (medication administration record) and stated Resident A's refusals to take prescribed medications are at bedtime, and it appears as though the Memantine 5 mg tablet for vascular dementia is the most frequent refusal. Ms. Acklin stated she is not aware if Resident A's refusals to take the Memantine tablet are reported to any health care professionals.

On 04/28/2022, I received and reviewed Resident A's MARs for February, March, and April 2022. Resident A is prescribed the following medications, AMLOD/BENAZP Cap 5-10 mg, take 1 capsule by mouth once daily at 8:00p.m., Atorvastatin Tab 20 mg, take 1 tablet by mouth daily at bedtime, Check vitals once per month on the 15th, Memantine Tab HCL 5 mg, take 1 tablet by mouth daily at bedtime for vascular dementia, Vitamin B-1, 100 mg, take 2 tablets by mouth once

daily (200 mg), temperature and O2 saturation, take temperature and O2 saturation daily, weight check once per month on the 15th and Nicotine TD DIS 7 mg/24HR, apply 1 patch topically once daily as needed for nicotine craving.

- The February 2022 MAR documents 12 dates during the month that Resident A refused to take Memantine 5 mg tablet. The rest of Resident A's medications and medical procedures are administered and documented as taken as prescribed with the exception of a few refusals of other medications throughout the month.
- The March 2022 MAR documents 22 dates during the month that Resident A refused to take Memantine 5 mg tablet. The rest of Resident A's medications and medical procedures are administered and documented as taken as prescribed with the exception of a few refusals of other medications throughout the month.
- The April 2022 MAR documents 18 dates during the month (to date, 04/27/2022) that Resident A refused to take Memantine 5 mg tablet. The rest of Resident A's medications and medical procedures are administered and documented as taken as prescribed with the exception of a few refusals of other medications throughout the month.

On 04/28/2022, I received and reviewed Resident A's Health Care Appraisal dated 02/21/2022 and signed by Ms. Gingrich, Nurse Practitioner. The HCA document states: '*He has been intermittently refusing to take his ordered Memantine because he thinks he does not need it and it makes him tired. He is in the memory care unit at the facility. He frequently speaks about not belonging there and that he is trying legally to find a way out. Patient instruction, continue Memantine 5 mg at bedtime, consult the care team for psych skilled nursing. Chronic Care Management, continue to take your medications as prescribed.'*

On 05/17/2022, I interviewed Ms. Lott and she reported she substantiated Resident A for self-neglect due to his refusal to take prescribed medications.

On 05/25/2022, I contacted Regional Nurse, Jeannine Hayes via email and she confirmed that Resident A's medication refusal, Memantine 5 mg tablet has been reported to Ms. Gingrich, nurse practitioner for Careline health group.

On 05/25/2022, I interviewed Ms. Gingrich via telephone. Ms. Gingrich stated she was unaware of Resident A's refusal to take Memantine 5 mg tablet for that many days in a row each month and stated she was at the facility today and asked staff how things were going, and no one informed her of his refusal to take Memantine the amount of time the MARs reflect. Ms. Gingrich stated she was aware that Resident A was resistant to taking his medications and did seek assistance from psychiatric nursing for some behaviors he has but because Resident A was resistive to taking his medications, psych nursing cannot help him if he will not take medications. Ms. Gingrich stated she will discontinue the Memantine medication since Resident A refuses on such a consistent basis.

On 05/26/2022, I interviewed Resident A's public guardian, Tracy Booth via telephone. Ms. Booth stated she was not notified by anyone at the facility that Resident A was refusing any medications including Memantine 5 mg. Ms. Booth stated she discovered Resident A was refusing medications "by chance" on different occasions while talking to staff at the facility.

On 06/02/2022, I conducted an Exit Conference with Licensee Designee, Marcia Curtiss via telephone. Ms. Curtiss stated she will review the information in this report, follow up with facility staff, nursing and submit a corrective action plan.

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: (f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.
ANALYSIS:	Based on investigative findings, there is a preponderance of evidence to show that Resident A refused the medication Memantine 5 mg tablet 12 times in February 2022, 22 times in March 2022 and 18 times in April 2022 and while Ms. Gingrich documented awareness that Resident A was resistive to taking medications, including Memantine, Ms. Gingrich reported she was not aware of the continuous refusals and number of times throughout those months that Resident A refused the Memantine medication. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A is aggressive towards other residents in the facility.

INVESTIGATION: On 04/19/2022, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaint. The complainant reported that Resident A is purchasing alcohol online and had the alcohol delivered to the facility. The facility staff allowed Resident A to consume alcohol and on one recent occasion, Resident A pushed an elderly resident out of his room and into a wall. This altercation resulted in a TV stand falling on top of the other resident.

On 04/19/2022, I interviewed APS worker, Ms. Lott via telephone. Ms. Lott confirmed the information reported in the complaint and that she is investigating this complaint.

On 04/22/2022, I completed an unannounced inspection at the facility and interviewed Mechelle Genigeski, Executive Director. Ms. Genigeski stated Resident A has a debit card that he used to purchase items with no restrictions at first. Ms. Genigeski stated it is possible that he purchased alcohol with the card in the past but his guardian, Ms. Booth has put restrictions on the card, and he is not currently able to purchase alcohol with the card. Ms. Genigeski stated staff have permission from Resident A's legal guardian, Ms. Booth, to look for alcohol in Resident A's room or deliveries he may receive at the facility. Ms. Genigeski stated if anything comes into the facility in Resident C's name that they suspect may be alcohol for Resident A, they will contact Resident C's legal guardian. Ms. Genigeski stated Ms. Booth told the facility nurse, Ms. Hayes, if Resident A continues to order under other resident's names, she will revoke his card and cancel his privileges. Ms. Genigeski stated she is not aware of an altercation between Resident A and another resident at this facility.

On 04/22/2022, I interviewed Resident A in his room at the facility. Resident A stated another resident in the facility was opening all the other residents' doors, including his (Resident A's). Resident A stated he told Resident B to get out of his room, Resident B "balled up his fists" like he wanted to "swing at me" so "I pushed him." Resident A stated Resident B fell into the TV stand in the common area and it fell over on Resident B's legs. Resident A stated he got staff and they got Resident B up and assisted him to his room. Resident A stated there was another time that he assisted staff in getting Resident B to go into his room, with no altercation, he helped staff and the time he (Resident A) pushed Resident B was the only time that ever happened and nothing like that has ever happened again. Resident A stated he has not had alcohol for the past 8-9 months and stated he has only been in this building for 2 months and prior to this building, he was in another building (building #7) on this campus. Resident A stated at that time, he "may have" ordered alcohol on his debit card but that was when he was in building #7 and it was over 8-9 months ago, Resident A stated it is not happening now.

On 04/22/2022, I interviewed Direct Care Worker (DCW) Tonya Acklin at the facility. Ms. Acklin stated Resident A orders a lot of things with his debit card and staff give him his purchases when they are delivered but as far as she knows, staff do not look in the bags. Ms. Acklin stated she keeps her eye on what comes in when Resident A orders items to be delivered. Ms. Acklin stated Resident A was in building #7 prior to coming to this building but that he has been under the influence of alcohol in this building (building #8) and can get mean verbally. Ms. Acklin stated Resident A has a friend, Resident C in this building, they watch TV together and there is suspicion that Resident A gets Resident C to order alcohol with her debit card for him. Ms. Acklin stated she has not seen Resident A under the influence of alcohol lately and has never seen Resident A get physically aggressive with any residents.

On 04/28/2022, I reviewed the Incident Report (IR) written on 03/17/2022 by DCW (direct care worker) Regis Fisher at 9:00 a.m. The IR documents the following:

‘(Resident A) proceeded to push (Resident B) because (Resident A) was agitated due to (Resident B) opening all doors. (Resident B) was pushed into the TV stand and has no bruises. Addressed/removed hazard from environment, escorted person to apartment, staff assisted, staff member requested additional assistance, staff remain with person, I removed (Resident B) from situation and escorted him to his room to calm down. Staff assisted with de-escalation. Assessed both residents for injuries. Escorted resident back to room. Educated resident on respect for peers and rules sent in place for personal safety and others.’

On 04/28/2022, I reviewed Resident A’s HCA dated 02/21/2022, signed by Ms. Gingrich. The HCA provided the following information: *‘Facility staff expressed concern that he has frequent “temper tantrums.” He is irritable, argumentative, angry, and rude. He has outbursts where he yells loudly and throws things. He sleeps well at night, His appetite is good, but he is very vocal about how much he dislikes the food. He continues to drink alcohol. Pertinent medical conditions include substance abuse, alcohol, and Vascular dementia. The frequency of episodes is daily.’*

On 04/28/2022, I received and reviewed Resident A’s Assessment Plan for AFC Residents dated 03/29/2022. The assessment plan documents that Resident A is able to control aggressive behavior and get along with others. However, the assessment plan documents Resident A’s inability to appropriately use alcohol/drugs and describes *‘resident has current, or history of frequent substance use which causes significant problems with others and severely impairs ability to function independently.’*

On 05/05/2022, I interviewed Resident A’s public guardian, Tracy Booth via telephone. Ms. Booth stated she was aware of the altercation between Resident A and Resident B and there was no indication that Resident A was under the influence of alcohol during this incident, and no one reported that Resident A was using alcohol. Ms. Booth stated this is the only time Resident A has had a physical altercation with another resident, yet the facility was going to issue a 30-day notice. Ms. Booth stated she has met with facility management to prevent the discharge and facilitate supports in an attempt to prevent further altercations. Ms. Booth stated she heard Resident A was accessing alcohol either by purchasing it with his own debit card or through a friend at the facility. In an attempt to curb this, Ms. Booth stated she provided Resident A with a prepaid Visa card and has put a block on ordering alcohol to be delivered. Ms. Booth stated Resident A could still go to the store and pick up alcohol, but she has requested facility management allow staff to conduct bag and room searches if they suspect Resident A has alcohol. Ms. Booth stated she is aware as are staff that Resident C may be ordering alcohol for Resident A using her own resources.

On 05/17/2022, I interviewed Ms. Lott via telephone. Ms. Lott stated she interviewed Dezirea Durden, facility supervisor prior to interviewing Resident A. Ms. Lott stated Ms. Durden told her Resident A did have an altercation with Resident B but there are

no more reports on Resident A having altercations with other residents in addition to Resident B. Ms. Lott stated Ms. Durden stated Resident A had door dash deliver alcohol to the facility, but Resident A's guardian has put limitations on his finances to prevent him from ordering alcohol. Ms. Lott stated Ms. Durden reported the same, Resident A may be getting Resident C to order for him, but they are watching out for that. Ms. Lott stated Ms. Durden also stated Resident A's guardian approved room and bag checks.

On 06/02/2022, I conducted an Exit Conference with Licensee Designee, Marcia Curtiss via telephone, Ms. Curtiss stated she agrees with the information, analysis, and conclusion of this applicable rule.

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:	Based on investigative findings, there is not a preponderance of evidence to show that staff at the facility are failing to protect residents from Resident A. Information indicates that Resident A has accessed alcohol while in the facility, but Resident A's legal guardian is placing restrictions on Resident A's ability to purchase alcohol. In addition, Resident A and Resident B had an altercation at the facility but there was no indication that Resident A was under the influence when the altercation occurred and no reports of any other physical altercations between Resident A and other residents. Therefore, a violation of this applicable rule is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

Additional Findings

Investigation: On 04/28/2022, I received and reviewed Resident A's Assessment Plan for AFC Residents dated 03/29/2022 and filled out by facility nurse, Jeannine Hayes. The assessment Plan for Resident A is void of any signatures. The assessment plan is not signed by the licensee, or the resident's legal guardian.

On 06/02/2022, I conducted an Exit Conference with Licensee Designee, Marcia Curtiss via telephone. Ms. Curtiss stated she will review resident documents and submit a corrective action plan.

APPLICABLE RULE	
R 400.15301	Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Resident A's assessment plan is dated 03/29/2022 and not signed by the licensee or the resident's legal guardian.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the current status of the license remains unchanged.

06/02/2022

Elizabeth Elliott — Date
Licensing Consultant

Approved By:

06/02/2022

Jerry Hendrick — Date
Area Manager