GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 9, 2022

Achal Patel
Divine Life Assisted Living Center 1, LLC
2045 Birch Bluff Drive
OKEMOS, MI 48864

RE: License #: AM190404916
Investigation #: 2022A0466037
Divine Life Assisted Living Center 1 LLC

Dear Mr. Patel:

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) 284-9727.

Sincerely,

Julie Elkins, 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 #:	AM190404916
Investigation #:	2022A0466037
Complaint Receipt Date:	04/19/2022
Investigation Initiation Date:	04/19/2022
Report Due Date:	06/18/2022
Licensee Name:	Divine Life Assisted Living Center 1, LLC
Licensee Address:	607 Turner Street DeWitt, MI 48820
Licensee Telephone #:	(517) 277-0544
Administrator:	Achal Patel
Licensee Designee:	Achal Patel
Name of Facility:	Divine Life Assisted Living Center 1 LLC
Facility Address:	607 Turner Street DeWitt, MI 48820
Facility Telephone #:	(517) 277-0544
Original Issuance Date:	11/18/2020
License Status:	REGULAR
Effective Date:	05/18/2021
Expiration Date:	05/17/2023
Capacity:	11
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION:

	Violation Established?
Direct care workers (DCW)s at the facility are rough while changing Resident A's brief.	No
Resident A is not receiving her pain medications as prescribed.	No
Additional Findings	Yes

III. METHODOLOGY

04/19/2022	Special Investigation Intake- 2022A0466037.
04/19/2022	Special Investigation Initiated – Telephone call to APS Thomas Hilla, interviewed.
04/19/2022	Contact - Telephone call made to Elizabeth Prudhomme, social worker at Care Line Heath Group, Resident A's Hospice.
04/19/2022	Contact - Telephone call made to Relative A1 interviewed.
04/28/2022	Contact - Telephone call made; Complainant interviewed.
04/29/2022	Contact - Telephone call made to Relative A1 interviewed.
05/05/2022	Inspection Completed On-site.
06/02/2022	Contact - Telephone call made to DCW Neya Jones Jackson, interviewed.
06/02/2022	Contact - Telephone call made to DCW Janaya McKinney, interviewed.
06/03/2022	Contact- Document sent to Achal Patel.
06/03/2022	Contact- Document received from Vivek Thakore.
06/09/2022	Exit Conference with licensee designee Achal Patel.

ALLEGATION: Direct care workers (DCW)s at the facility are rough while changing Resident A's brief.

INVESTIGATION:
On 04/19/2022, Complainant reported direct care workers (DCWs) were violent with Resident A and threatening violence to the family. Complainant reported while DCWs check Resident A's brief they "kind of throw [her] around the bed." Complainant reported Resident A only weighs about 80 pounds, so there is no need to be so rough. Complainant reported DCWs have thrown Resident A around to the point she has almost fallen off the bed. Complainant reported it is unknown if Resident A has had any marks, bruises, or injuries due to the caretaker's aggressive handling of her.

On 04/19/2022, adult protective service (APS) worker Thomas Hilla reported that he went to the facility that day (04/19/2022). APS Hilla reported Relative A1 told him that the facility is no longer caring for Resident A rather Relative A1 and Relative A2 have taken over her care. APS Hilla reported he did not observe any marks and/or bruises on Resident A and reported Relative A1 and Relative A2 had no concern for Resident A's well-being anymore as the DCWs at the facility are no longer changing Resident A's brief. APS Hilla reported Relative A1 and Relative A2 are changing Resident A's brief and providing all of her care.

On 04/19/2022, I contacted Relative A1 to discuss the allegation. Relative A1 reported Resident A was in the process of dying and that she and Relative A2 would be caring for her around the clock until she passes. Relative A1 reported she and Relative A2 would be changing Resident A's brief therefore there was no longer any concern for Resident A's well-being. Relative A1 requested she be allowed to spend time with Resident A and asked if I could come to the facility after Resident A passes as she does not want to cause and trouble and be asked to leave. Relative A1 could not provide the names of the DCWs that were rough with Resident A.

On 04/19/2022, I interviewed Elizabeth Prudhomme, social worker with Careline Health Group, who reported she had spoken to Relative A1 about her concerns at the facility. Social worker Prudhomme reported Relative A1 stated she had observed DCWs on duty being "rough" with Resident A but did not provide any dates or names of any DCWs that were allegedly involved. Social worker Prudhomme reported none of the nurses or aids that check in on Resident A reported this behavior nor did anyone report any marks or bruises on Resident A. Social worker Prudhomme confirmed Resident A was in the process of dying and she was trying to support Resident A, Relative A1 and Relative A2 thought this process. Social worker Prudhomme reported Relative A1 and Relative A2 were staying at the facility around the clock to take care of Resident A. Social worker Prudhomme reported Relative A1 and Relative A2 were exclusively changing Resident A's brief instead of DCWs at the facility. Social worker Prudhomme reported since Relative A1 and Relative A2 have taken over the care of Resident A they both reported that their concerns have subsided.

On 04/28/2022, Relative A1 called and reported that Resident A had passed away. Relative A1 reported she and Relative A2 stated at the facility for twelve days prior to her passing to care for Resident A while she was dying. Relative A1 reported she and Relative A2 did not intend to take care of Resident A but after they observed the way DCWs talked and interacted with the residents, including Resident A, they did not trust them to care for Resident A. Relative A1 reported she and Relative A2 observed a DCW being rough with Resident A when they changed Resident A's brief. Relative A1 could not remember the date this occurred nor which DCW it was she had observed being "rough" with Resident A. Relative A1 reported that was when they talked with Careline Health Group about taking over the care of Resident A. Relative A1 reported initially, she wanted to take Resident A home with her to care for her in her final days however Careline Health Group advised against that. Relative A1 reported she agreed to allow Resident A to stay at the facility if she and Relative A2 took over all of her care. Relative A1 reported the facility provided meals if Resident A wanted them. Relative A1 reported she knew if she and/or Relative A2 was with Resident A that she would be safe and well cared for.

On 04/29/2022, I interviewed Relative A2 who reported she and Relative A1 stayed at the facility for twelve days prior to her passing to care for Resident A while she was dying. Relative A2 reported she and Relative A1 did not intend to take care of Resident A but after they observed the way DCWs talked and interacted with the residents including Resident A they did not trust them to care for Resident A. Relative A2 reported she and Relative A1 observed a DCW being rough with Resident A when they changed Resident A's brief. Relative A2 reported the DCW changing Resident A did not roll her correctly, moved her roughly and the DCW was not talking to her/telling Resident A what she was doing. Relative A2 could not remember the date this occurred nor the name of the DCW involved. Relative A2 reported she knew if she and/or Relative A1 were with Resident A that she would be safe and well cared for.

On 05/05/2022, I conducted an unannounced investigation and I interviewed DCW Debra McKinney who reported she was the manager and direct care staff member of the home. DCW McKinney reported Resident A passed away on 04/21/2022 and she was at the facility when she died. DCW Debra McKinney reported Resident A had been on hospice care for about three months before she passed. DCW McKinney reported Relative A1 and Relative A2 provided care to Resident A for two weeks prior to her passing. DCW Debra McKinney reported Relative A1 and Relative A2 made it clear that they wanted to spend time with Resident A and they wanted to care for her. DCW Debra McKinney reported Resident A was not eating or drinking much and she had little urine output. DCW Debra McKinney reported DCWs on duty would always check in with Relative A1 and Relative A2 to see if Resident A needed anything during each shift. DCW Debra McKinney reported Relative A1 and Relative A2 sat in Resident A's room all day and all night with the door closed. DCW Debra McKinney reported Relative A1 and Relative A2 did not report any concerns to her about Resident A's care. DCW Debra McKinney reported

Relative A1 and Relative A2 reported they just wanted to have the end of life time alone with Resident A. DCW Debra McKinney denied that she was ever rough with Resident A while changing her brief and she had never witnessed any other DCW being rough with Resident A either. DCW Debra McKinney denied that any other DCW or resident ever reported to her that any DCW was rough with Resident A. DCW Debra McKinney reported that she and three other DCWs are the only staff at the facility.

On 05/05/2021, I reviewed Resident A's record which contained an *Assessment Plan for Adult Foster Care (AFC) Residents* dated 05/06/2021 and which documented that Resident A requires "1 person assist" for toileting.

Resident A was not at the facility at the time of the unannounced investigation because she had passed on 04/21/2022 therefore Resident A was not able to be interviewed nor observed.

On 06/03/2022, I interviewed DCW Neya Jones Jackson and DCW Janaya McKinney who both reported Relative A1 and Relative A2 provided care to Resident A for two weeks prior to her passing. DCW Jones Jackson and DCW Janaya McKinney reported Relative A1 and Relative A2 made it clear that they wanted to spend time with Resident A and wanted to care for her and spend time with her at the end of her life. DCW Jones Jackson and DCW Janaya McKinney reported Relative A1 and Relative A2 did not report any concerns to either of them about Resident A's care. DCW Jones Jackson and DCW Janaya McKinney denied that they were ever rough with Resident A while changing her brief nor did they ever witness any other DCW being rough with Resident A. DCW Jones Jackson and DCW Janaya McKinney both denied that any other DCW or resident ever reported to them that any DCW was rough with Resident A. DCW Janaya McKinney reported Resident A was one of the residents in the facility that everyone liked and that no one would have done anything to hurt her.

APPLICABLE RULE	
R 400.14305	**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:	Although Complainant, Relative A1 and Relative A2 reported a DCW was rough while changing Resident A, the name of a DCW and when this occurred could not be provided. DCW Debra McKinney, DCW Jones Jackson and DCW Janaya McKinney denied ever being rough with Resident A while they were changing her brief and they all reported that they had never witnessed any other DCW being rough with Resident A either, therefore there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A is not receiving pain medications as prescribed.

INVESTIGATION:
On 04/19/2022, Complainant reported Resident A has Lewy body dementia. Complainant reported Relative A1, is Resident A's power of attorney (POA). Complainant reported Resident A is actively dying and receives hospice care. Complainant reported DCWs at the facility are refusing to give Resident A pain medication as prescribed/ordered by the hospice doctor. Complainant reported DCWs refuse to give Resident A additional prescribed pain medication prescribed "as-needed" and they give the scheduled medication one to two hours late. Complainant reported it is unknown why the facility is not complying. Complainant reported Resident A is in a coma, but it is obvious she is in pain as she will move her brow or moan in pain. Complainant reported Resident A's family has taken over administering Resident A her medication. Complainant reported the facility is threatening to remove Resident A from the facility.

On 04/19/2022, APS worker Hilla reported he went to the facility today (04/19/2022). APS Hilla reported Relative A1 told him DCWs were no longer administering Resident A her medication. APS Hilla reported Relative A1 and DCW Debra McKinney confirmed Relative A1 and Relative A2 are administering Resident A her medications as they are staying at the facility to care for her while she is in the active stages of dying.

On 04/19/2022, I interviewed social worker Prudhomme who reported she had spoken to Relative A1 about her concerns regarding Resident A's medications. Social worker Prudhomme reported she believed that there may have been some confusion at the facility initially as Resident A was prescribed pain medication every two hours and also prescribed the same pain medication as-needed for break though pain. Social worker Prudhomme reported Relative A1 and Relative A2 have taken over medication administration for Resident A as relatives believed Resident A was not getting her medications timely and DCWs did not want to administer the pro re nata (PRN) pain medications. Social worker Prudhomme did not know the name of any DCW who had administered Resident A's pain medication late nor the date.

Social worker Prudhomme did not know the name of the DCW or the date any DCW did not/would not administer Resident A a PRN medication.

On 04/19/2022, I contacted Relative A1 who reported she and Relative A2 were administering Resident A all of her medications including PRN medications. Relative A1 reported Resident A was not getting her PRN pain medication however Relative A1 could not provide the date nor the DCW names who refused to administer Resident A pain medication. Relative A1 did not know the name of the alleged DCW who had administered Resident A's pain medication late or the date. Relative A1 reported Resident A is non-responsive but that when she does exhibit signs of pain, they want her to have pain medication to keep her pain free.

On 04/28/2022, Relative A1 called and reported that Resident A had passed away on 04/21/2022. Relative A1 reported she and Relative A2 stayed at the facility for twelve days prior to her passing to care for Resident A while she was dying. Relative A1 reported Resident A was not getting pain medication timely and the DCWs did not wanting to administer Resident A's additional PRN pain medication as prescribed, so she did not want to leave Resident A alone. Relative A1 reported she and Relative A2 talked with the hospice provider about taking over Resident A's medication administration since the hospice provider did not recommend Resident A being transferred to Relative A's home until her death. Relative A1 reported since she and/or Relative A2 had been administering Resident A's medications they have been timely and they have been administering the PRN. Relative A1 could not report which DCW refused to administer Resident A's PRN, nor could she report which DCW administered Resident A's medication late. Relative A1 could not recall the dates of these incidents.

On 04/29/2022, I interviewed Relative A2 who reported that she and Relative A1 stayed at the facility for twelve days prior to her passing to care for Resident A while she was dying. Relative A2 could not provide the date nor the names of the DCW who refused to administer Resident A pain medication. Relative A2 did not know the name of any DCW who administered Resident A's pain medication late nor the date.

On 05/05/2022, I conducted an unannounced investigation and I interviewed DCW Debra McKinney who reported that when hospice notified Relative A1 that Resident A was declining, she and Relative A2 came to the facility and they did not leave until she died which was on 04/21/2022, twelve days later. DCW Debra McKinney reported Resident A received her scheduled pain medication timely and PRN medication was administered as needed and in accordance with the prescription. DCW Debra McKinney reported Resident A's hospice physician authorized in writing for Resident A's family members to administer her medications. DCW Debra McKinney reported DCWs followed the written direction of the physician and Resident A's family members administered her medications. DCW Debra McKinney reported Resident A was not discharged from the facility until she died.

On 05/05/2022, I reviewed Resident A's record which contained a physician order dated 04/16/2022 at 3:30am which stated "PT is in the active dying phase and requires comfort meds to meet comfort needs. Per Jayne Boyle, NP, OK for patient's family to administer medication at bedside per hospice orders including all prescribed controlled medications. PT's family to be educated by [hospice] staff on safe use, dose, and frequency of meds and when to call [hospice]."

On 05/05/2022, I reviewed the facility's *Resident Register* which documented that Resident A was admitted on 11/19/2020 and the discharge date was blank.

On 05/05/2022, Resident A's record did not contain medication administration records (MAR). DCW Debra McKinney reported since Resident A is no longer active in the electronic system, she cannot pull up Resident A's MAR. DCW Debra McKinney reported copies of the MARs were not printed for resident records.

Resident A was not at the facility at the time of the unannounced investigation because she had passed on 04/21/2022. At the time of the unannounced investigation, Resident A's room was empty and all of her belongings were gone including her medications. Resident A was not able to be interviewed nor were her medications able to be reviewed.

On 06/03/2022, I interviewed DCW Jones Jackson and DCW Janaya McKinney who reported that Resident A received her scheduled pain medication timely and PRN medication was administered as needed.

On 06/03/2022, Vivek Thakore provided me with Resident A's MARs for April 2022. I reviewed Resident A's MAR which documented all Resident A's medications were administered as prescribed including PRN medications.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	Complainant, Relative A1 and Relative A2 reported that DCWs at the facility were refusing to give Resident A pain medication as prescribed/ordered by the hospice doctor. Complainant, Relative A1 and Relative A2 could not provide the date nor the name/names of any DCW that refused to administer Resident A pain medication. DCW Debra McKinney, DCW Jones Jackson and DCW Janaya McKinney all denied that Resident A received medications late and all reported that PRNs were administered as prescribed. I reviewed Resident A's MAR which documented all prescribed medications were administered to Resident A including PRN medications.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(3) Unless a resident's physician specifically states otherwise in writing, the giving, taking, or applying of prescription medications shall be supervised by the licensee, administrator, or direct care staff.
ANALYSIS:	Resident A's record contained a physician order dated 04/16/2022 at 3:30am allowing Resident A's family members to administer Resident A's medications including all controlled medication. Therefore, a violation has not been established.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS

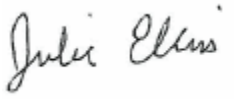
INVESTIGATION:
On 05/05/2022, I conducted an unannounced investigation and I reviewed Resident A's record. Resident A's record did not contain any MARs at the time of the investigation.

On 05/05/2022, I interviewed DCW Debra McKinney who reported resident MARs are kept electronically and because Resident A passed, she was no longer active in the electronic MAR system and therefore Resident A's MARs were not available for review. DCW Debra McKinney reported I contact licensee designee Achal Patel to see if he can locate Resident A's MARs.

APPLICABLE RULE	
R 400.14316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: **(a) Identifying information, including, at a minimum, all of the following:** **(ii) Medication logs.** **(2) Resident records shall be kept on file in the home for 2 years after the date of a resident's discharge from a home.**
ANALYSIS:	On 05/05/2022, at the time of the unannounced investigation, Resident A's record did not contain any medication logs nor were direct care staff able to access those medication logs. Therefore, a violation has been established as the facility is required to keep the medication logs in the resident record in its entirety at the facility for two years after the resident discharges.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of correction, I recommend no change in the current license status.



06/09/2022

_____

Julie Elkins Date
Licensing Consultant

Approved By:

06/09/2022

_____

Dawn N. Timm Date
Area Manager