GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 19, 2022

Tamesha Porter
Safe Haven Assisted Living Of Haslett LLC
5917 Edson St
Haslett, MI 48840

RE: License #: AL330404984
Investigation #: 2022A1024039
Safe Haven Assisted Living Of Haslett

Dear Ms. Porter:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 (616) 356-0183.

Sincerely,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems
427 East Alcott
Kalamazoo, MI 49001

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL330404984
Investigation #:	2022A1024039
Complaint Receipt Date:	06/27/2022
Investigation Initiation Date:	06/27/2022
Report Due Date:	08/26/2022
Licensee Name:	Safe Haven Assisted Living Of Haslett LLC
Licensee Address:	5917 Edson St Haslett, MI 48840
Licensee Telephone #:	(517) 402-1802
Administrator:	Tamesha Porter
Licensee Designee:	Tamesha Porter
Name of Facility:	Safe Haven Assisted Living Of Haslett
Facility Address:	5917 Edson St Haslett, MI 48840
Facility Telephone #:	(517) 339-7278
Original Issuance Date:	09/29/2020
License Status:	REGULAR
Effective Date:	03/29/2021
Expiration Date:	03/28/2023
Capacity:	16
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was diagnosed with having a yeast infection and there is concern proper care has not been provided.	Yes - No

III. METHODOLOGY

06/27/2022	Special Investigation Intake 2022A1024039
06/27/2022	Special Investigation Initiated – Telephone with Relative A1
07/28/2022	Inspection Completed On-site with Shannon Bulock, Molly Jones, home manager Ashley Foreman, and Resident B
08/16/2022	Exit Conference with licensee designee Tamesha Porter

ALLEGATION:

Resident A was diagnosed with having a yeast infection and there is concern proper care has not been provided.

INVESTIGATION:

On 6/27/2022, I received this complaint through the Bureau of Community and Heath Systems (BCHS) online complaint system. This complaint alleged Resident A was diagnosed with having a yeast infection and there is concern proper care has not been provided.

On 6/27/2022, I conducted an interview with Relative A1 regarding this allegation. Relative A1 stated Resident A is diagnosed with Dementia and Diabetes. Relative A1 stated Resident A went to see her private physician because she was having pain in her ears and Resident A was diagnosed with having a yeast infection found under breast and in her genital area. Relative A1 stated that there is concern direct care staff members are not cleaning Resident A properly and keeping her dry since Resident A was found to have yeast infections.

On 7/28/2022, I conducted an onsite investigation at the facility and interviewed home manager Ashley Foreman, direct care staff members Shannon Bulock and Molly Jones, and Resident B. Ms. Foreman stated she worked regularly with Resident A who has resided in the home for about three years. Ms. Foreman stated Resident A's personal care needs were attended to daily. Ms. Foreman stated although Resident A occasionally refused to allow staff members to provide

assistance with her personal care needs such as bathing and dressing, staff members were able to redirect Resident A and provided personal care assistance routinely to Resident A. Ms. Foreman stated Resident A was diabetic and had issues with sweating therefore staff members applied a prescribed powder to specific areas on Resident A's body to assist with keeping Resident A dry. Ms. Foreman stated, recently Resident A went to see her primary care physician for ear pain, and she was diagnosed with having a yeast infection and a Urinary Tract Infection (UTI). Ms. Foremen stated, after this doctor visit, Relative A1 removed Resident A from the facility and relocated her out of the state without warning. Ms. Foreman stated Resident A received adequate care while she resided in the facility, and she never received any complaints from Relative A1 while she resided in the home.

Ms. Bulock stated direct care staff provided assistance for Resident A's personal care needs such as bathing, dressing, and grooming. Ms. Bulock stated she routinely gave Resident A showers twice a week as Resident A refused to be showered every day however Resident A allowed for staff members to "wipe her down" with soap and water every day in the morning Ms. Bulock stated staff tried to encourage Resident A to refrain from sleeping in a bra due to Resident A sweating often however Resident A insisted that she sleep with a bra, and this caused Resident A to have redness under her breast as Ms. Bulock often observed this area to be red. Ms. Bulock stated recently Resident A was seen by her primary care physician and was diagnosed with having a UTI and yeast infection. Ms. Bulock stated immediately shortly after this doctor's visit, Relative A1 relocated Resident A out of the facility. Ms. Bulock stated she has no knowledge of Resident A not getting adequate care while she resided in the facility and Resident A was always clean and well kept.

Ms. Jones stated she worked regularly with Resident A, and she believes Resident A was cared for properly. Ms. Jones stated although Resident A was combative sometimes, staff members assisted Resident A with bathing and grooming routinely at least two times a week. Ms. Jones stated Resident A had issues with perspiration therefore staff members applied a prescribed powder on specific areas of Resident A's body such as under her breast when Resident A allowed staff members to touch her. Ms. Jones stated Resident A would sometimes hit and swat at staff members to get away from her when she refused personal care assistance. Ms. Jones further stated staff members attempted to shower Resident A more than twice a week however Resident A was too combative for this frequency of showers. Ms. Jones stated Resident A was always clean and she has no knowledge of Resident A not getting cared for properly.

Resident B stated Resident A was her roommate while she resided at the facility. Resident B stated Resident A appeared to be clean when she resided in the facility, and she often observed staff members tend to Resident A's personal care needs such as dressing her or taking her to the bathroom for showers. Resident B stated Resident A never complained about not getting adequate care and Resident A appeared happy while living at the facility.

While at the facility I reviewed Resident A's *Assessment Plan for AFC Residents* dated 9/1/21. According to this plan, Resident A required assistance with dressing, grooming, personal hygiene and bathing. This plan stated Resident A has a walker however refuses to use walker.

I also reviewed Resident A's Medication Administration Record (MAR) for the month of April 2022. According to this MAR, Resident A was prescribed Nystatin Powder to apply as needed. This MAR stated Resident A refused the Nystatin powder on 4/17,2022, 4/18/2022, 4/20/2022, 4/24/2022, and 4/28/2022.

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:	Based on my investigation which included interviews with home manager Shannon Bulock, Molly Jones, home manager Ashley Foreman, and Resident B there is no evidence to support the allegation that proper care was not provided to Resident A. Relative A1 believed Resident A was not clean and kept dry due to Resident A being diagnosed with having a yeast infection. Ms. Bulock, Ms. Jones and Ms. Foreman all stated Resident A was provided with assistance with her personal care needs adequately and regularly although Resident A was occasionally resistant to care. Resident B stated she often observed staff members attend to Resident A's personal care needs such as dressing and taking her to the bathroom for showers. Resident B also stated Resident A never complained about not getting adequate care. According to Resident A's assessment plan Resident A was required to have assistance with grooming, dressing bathing and hygiene and according to staff members and Resident A's MAR, Resident A had issues with perspiration and was prescribed a powder that Resident A refused to take at times. Ms. Foreman stated she never heard of any complaints made from Relative A1 regarding the care Resident A received prior to Relative A1 relocating her from the facility. Despite Resident A's resistance to care, the home provided adequate personal care as specified in Resident A's written assessment plan.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 8/16/2022, I conducted an exit conference with licensee designee Tamesha Porter. I informed Ms. Porter of my findings and allowed her an opportunity to ask questions and make comments.

IV. RECOMMENDATION

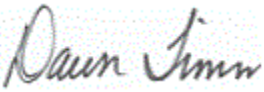
I recommend the current license status remain unchanged.

8/17/22

Ondrea Johnson
Licensing Consultant

Date

Approved By:



08/19/2022

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Dawn N. Timm
Area Manager

Date