GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 17, 2022

Tamesha Porter
Safe Haven Assisted Living, LLC
981 Jolly Road
Okemos, MI 48864

RE: License #: AM330349436
Investigation #: 2022A0466058
Safe Haven Assisted Living

Dear Ms. Porter:

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 #:	AM330349436
Investigation #:	2022A0466058
Complaint Receipt Date:	08/19/2022
Investigation Initiation Date:	08/22/2022
Report Due Date:	10/18/2022
Licensee Name:	Safe Haven Assisted Living, LLC
Licensee Address:	981 Jolly Road Okemos, MI 48864
Licensee Telephone #:	(517) 402-1802
Administrator:	Tamesha Porter
Licensee Designee:	Tamesha Porter
Name of Facility:	Safe Haven Assisted Living
Facility Address:	981 Jolly Road Okemos, MI 48864
Facility Telephone #:	(517) 574-4579
Original Issuance Date:	02/07/2014
License Status:	REGULAR
Effective Date:	07/29/2020
Expiration Date:	07/28/2022
Capacity:	12
Program Type:	AGED ALZHEIMERS

II. ALLEGATIONS:

	Violation Established?
Resident A required two-person assistance and the facility only had one direct care worker (DCW) on duty at night.	No
Resident A was administered Resident B's medications. ***NOTE- Previously investigated. Please see SIR#2022A0783030.**	No
Resident A's designated representative was given Resident C's medications.	Yes
Resident A was not administered medications as prescribed.	Yes
Resident A's room has a loose electrical outlet and a hole in the ceiling.	No
Resident A was not provided a low sodium diet nor was she weighted daily as required.	No

III. METHODOLOGY

08/19/2022	Special Investigation Intake-2022A0466058.
08/22/2022	Special Investigation Initiated – Telephone call to Complainant, interviewed.
08/22/2022	Contact - Document Sent, email sent to Complainant.
08/31/2022	Inspection Completed On-site.
10/12/2022	Contact- telephone call to house manager Ashley Foreman, interviewed.
10/12/2022	Exit Conference with licensee designee Tamesha Porter.

ALLEGATION: Resident A required two-person assistance and the facility only had one direct care worker (DCW) on duty at night.

INVESTIGATION:
On 08/19/2022, Complainant reported licensee designee Tamesha Porter reported facility direct care staff members were capable and staffed to care for Resident A's medical needs including through end-of-life care on hospice. Complainant reported the facility was not properly staffed while Resident A was actively dying as there was only one overnight direct care staff. Complainant reported she and Relative A1 were there overnight to assist and Resident A would not have received proper care otherwise as Resident A required two people to assist / lift/ rotate / turn her.

On 08/22/2022, Complainant reported Resident A was a large woman and required the assistance of two people to move her. Complainant reported she was not aware of a written assessment plan being completed upon admission. Complainant reported Resident A lived at the facility from 02/06/2022 through 03/03/2022 which totaled 26 days. Complainant reported Resident A died on 03/03/2022 and that she and Relative A1 had to assist the funeral home in transferring Resident A out of the facility as there were no DCWs available to assist.

On 08/31/2022, I conducted an unannounced investigation and I interviewed direct care worker (DCW) Corrynn Eberly and licensee designee Tamesha Porter who reported the facility currently has 10 residents. DCW Eberly and licensee designee Porter reported they both had worked with Resident A and that Resident A only required assistance from one person. DCW Eberly reported Resident A walked well and was able to lift herself up and out of a chair/bed so even though Resident A was a heavier person, one DCW could assist her as needed. DCW Eberly reported that while Resident A was dying, which was only for a couple of days, Resident A was bedbound and that one DCW was able to move and reposition her every few hours. DCW Eberly reported first and second shifts have two DCWs per shift and third shift typically has only one DCW assigned.

I reviewed Resident A's record which contained a written *Assessment Plan for Adult Foster Care (AFC) Residents* which was dated 02/06/2022 and signed by Resident A. Resident A's written *Assessment Plan for AFC Residents* did not document that Resident A required two-person assistance. Resident A's written *Assessment Plan for AFC Residents* documented Resident A required assistance with bathing, dressing and stair climbing. Resident A's written *Assessment Plan for AFC Residents* documented Resident A was independent with eating, toileting, grooming, personal hygiene, and mobility.

I reviewed Resident A's record which contained a *Level of Care* document dated 2/18/2022 completed by Sparrow Hospice which documented that Resident A was on Hospice for chronic obstructive pulmonary disease (COPD) and she required "routine" care. I reviewed Resident A's Sparrow Hospice documents that were in the record and I did not find any evidence that Resident A required two-person assistance.

I reviewed Resident A's *Health Care Appraisal* dated 02/03/2022 which documented that Resident A is 77 years old and uses a "walker and wheelchair for mobility." There was nothing noted Resident A required two-person assistance on this *Health Care Appraisal*.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the

	responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years. **(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.**
ANALYSIS:	Complainant reported Resident A required two direct care staff members to assist with routine personal care and mobility. Resident A's written *Assessment Plan for Adult Foster Care (AFC) Residents* dated 02/06/2022 did not document Resident A required two-person assistance. I reviewed Resident A's record which contained both medical and hospice documents and I did not find any documentation Resident A required two-person assistance therefore there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A was administered Resident B's medications.

INVESTIGATION:
On 08/18/2022 Complainant reported that in February 2022, Resident A ingested Resident B's medication because it was placed on table next to Resident A's plate so Resident A took the medication assuming it was hers. Complainant reported that Resident A was sent to the Sparrow Hospital Emergency Room by ambulance in Lansing as a precaution due to Resident A ingesting a long-acting medication-Metformin. Complainant reported Resident A's sugar dropped into the 50's after taking the medication.

On 08/31/2022, licensee designee Porter reported that this allegation was already investigated, and a report was issued with the findings in May 2022.

I conducted a file review and found SI # 2022A0783030 which contained the allegation that direct care staff member Marshadiki Wheeler gave Resident a Resident B's medications and Resident A had to be hospitalized as a result. Please see that report for the findings of this allegation. This allegation will not be reinvestigated here.

ALLEGATION: Resident A's designated representative was given Resident C's medications.

INVESTIGATION:
On 08/18/2022, Complainant reported that on 3/23/22 she and Relative A1 went to the facility to pick up Resident A's medications that had not been returned on 03/03/2022 at the time of Resident A's death. Complainant reported the medications being picked up were the medications provided to the facility at the time of her admission on 02/06/22. Complainant reported she was given two bags of medication from manager Foreman including a full white kitchen trash bag and another full Aldi shopping bag. Complainant reported both bags were full of medication and were not itemized. Complainant reported the facility did not provide her with any written documentation of the medications that they were returning to her. Complainant reported when she returned home later that evening and went through the medications, she discovered that one of the bags was full of Resident C's prescription medications. Complainant reported she phoned the adult protective services (APS) investigator who had an open investigation at the time. Complainant reported that APS advised that she contact the facility. Complainant reported she called DCW Foreman and made arrangements for her to come pick up the medications. Complainant reported DCW Foreman kept rescheduling the pickup date and then ultimately after the last no show on 04/04/2022, DCW Foreman stopped responding to text messages. Complainant reported the medication she was provided for Resident C contained Resident C's identifying information, her full name, date of birth and home address. Complainant reported she still had the medications.

On 08/22/2022, I interviewed Relative A2 who provided a list and pictures of the medications she received that were prescribed and in pharmacy containers labeled for Resident C. Relative A2 reported she received 29 prescriptions that were labeled and prescribed to Resident C. Relative A2 reported none of the medications provided to her for Resident A and some of Resident C's medications were controlled substances.

On 08/22/2022, I reviewed Relative A2's documentation of the medications that she was provided for Resident C. All medications are listed below:

- "Potassium Chloride, 10% oral solution, 3 bottles.
- Iron Supplement Ferrous Sulfate 220 mg/5ML liquid- 3 bottles.
- Metoprolol Tartrate 25mg, 4 bottles."

In the bubble packs from Central Pharmacy, there was a nine-day supply with the below 10 medications per package and labeled as "morning."

- "1-24-hour oxybutynin cl 15 mg xr.
- 2-creon 24 dr-10 pills.
- 1-Furosemide 20 mg.
- 1-Lactase 3000 unt.
- 1-Levothryoxine sodium 0.05.

- 1-Loratadine 10mg
- 1-MI acid gas relief 80-mg chewable.
- 1-Omeprazole 20 mg.
- 1-Vitamin B12-1mg."

In the bubble packs from Central Pharmacy, there was a 13-day supply with the below five medications per package and labeled as "noon."

- "2-Creon 24 dr.
- 1-Lactase 3000 unt.
- 1-Levetiracetam.
- 1-MI Acid gas relief 80 mg chewable."

In the bubble packs from Central Pharmacy, there was a 11-day supply with the below seven medications per package and labeled as "evening."

- "3-Cholecalciferol 2000 unt.
- 2-Creon 24 dr.
- 1- Lactase 3000 unt.
- 1-MI-Acid gas relief 80 mg chewable."

In the bubble packs from Central Pharmacy, there was a 10-day supply with the below three medications per package and labeled as "bedtime."

- "1-Levetiracetam
- 1-MI Acid relief 80 mg chewable.
- 1-Sertraline 100 mg."

On 08/31/2022, licensee designee Porter reported Resident C had not been without any of her prescribed medications. Licensee designee Porter reported Ashley Foreman did give Relative A2 Resident C's medications that had been discontinued. Licensee designee Porter was not aware of what medications were given to Relative A2 in error nor how many prescriptions Relative A2 had. Licensee designee Porter reported Ashley Foreman has tried to call Relative A2 to get the medications back and Relative A2 is not responding. Licensee designee Porter reported DCW Foreman was handling the situation and that she has not reached out to Relative A2 nor has she intervened to obtain the medications in any way.

On 10/12/2022, I interviewed DCW Foreman who reported that on 03/23/2022, Relative A2 came to the facility to pick up medications that belonged to Resident A. DCW Foreman reported she drafted a letter to have Relative A2 sign acknowledging Relative A2 picked up Resident A's medications but reported that the medications that she provided Relative A2 were not documented or itemized on the form Relative A2 signed. DCW Foreman reported that she quickly glanced though the bag that she gave Relative A2 as she was the one that conducted the admission, so she knew what bag of medication Relative A2 provided upon admission. DCW Foreman reported that either later that same day or the next day, Relative A2 did contact her by phone to report that she had received also another resident's medications but DCW Foreman reported Relative A2 did not tell her which resident's medications

she had nor did she tell her how many prescriptions she had. DCW Foreman reported the facility disposes of all narcotics, so she knew Relative A2 was not given any controlled substances for any resident. DCW Foreman reported Relative A2 reported that she worked in Charlotte, MI and wanted DCW Foreman to pick up the medication from her work. DCW Foreman reported that due to some staffing shortages at the facility and Relative A2's work schedule they could not agree on a day/time to meet for DCW Foreman to get the medications. DCW Foreman reported she assumed that Relative A2 only had one or two prescriptions. DCW Foreman reported none of the residents at the faiclity have gone without their prescribed medications as the only medications that are stored in the medication closet that had Resident A's medications are overflow medications were those that have been provided by family members or were discontinued medications. DCW Foreman reported the facility requires the residents to order bubble wrapped medications through their pharmacy upon admission so once those medications are recevied any medications that have been provided by family members are stores in the locked hallway medication closet. DCW Foreman reported that she assumed that one or two of other residents' medications had to have fallen from a shelf for into Resident A's bag for them to have been given to Relative A2 by accident. DCW Foreman reported that she has still not obtained the medication Relative A2 has for another resident.

On 10/12/2022, Relative A2 reported that she continues to have all of the above medications for Resident C in her possession as the facility did not return her calls/texts nor did they come to pick them up.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.

ANALYSIS:	Complainant, Relative A2, licensee designee Porter and DCW Foreman all reported Relative A2 is in possession of Resident C's medications. The facility was made aware in a timely fashion Relative A2 was inadvertently provided with Resident C's medications, however licensee designee Porter did not make arrangements to pick-up Resident C's discontinued medications that were given to Relative A2. Although over six months have passed, licensee designee Porter still had not made reasonable precautions to ensure that Resident C's prescription medications were not used by a person other than for whom the medication was prescribed as Relative A2 remains in possession of Resident C's medications. As of 10/12/2022, licensee designee Porter has not obtained Resident C's medications on behalf of Resident C, therefore a violation has been established.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: **Resident A was not administered medications as prescribed.**

INVESTIGATION:
Complainant reported on 08/18/2022 that Resident A's Orencia injection was scheduled weekly on Thursdays and this was missed from admission on 02/06/2022 through 2/18/22. Complainant reported Resident A was not given Tylenol when requested for pain because the facility did not have any. Complainant reported that on 02/06/22 the facility told her to take home all the over-the-counter medications (Tylenol, MiraLAX, Tums) because they had all such medication on site, yet when Resident A needed some, they did not have any. Complainant reported that on 2/28/22 when Resident A was having chest pain, the facility though perhaps it was indigestion or that Resident A was constipated. Complainant reported that they had not given Resident A MiraLAX that was prescribed by the Sparrow Hospice Doctor as Resident A was started on morphine to control pain. Complainant reported that Morphine was started but despite the MiraLAX script having been filled days prior to 2/28/22, Complainant was told that they did not have it on site, so she had been taking Morphine for days without any MiraLAX. Complainant reported the facility did not have any over the counter MiraLAX to provide to Resident A as they had previously indicated nor did they have any tums on hand to give her to help with what they thought was indigestion.

On 08/31/2022, I conducted an unannounced investigation and I reviewed Resident A's *Physician's Orders* and medication administration records (MARs) which were dated February 2022. Resident A was prescribed "Orencia, inject 1ml sub-q every Thursday." This injectable medication is used to address adult Rheumatoid Arthritis according to the Orencia website. This medication was ordered on 02/04/2022 and discontinued on 02/28/2022. Resident A's MAR indicated that this medication was never administered by the facility as there are no initials documenting administration.

At the time of the investigation, Resident A's medications were not available to compare to the MAR as she had passed away on 03/03/2022 and all of her medications were given to Relative A2 on 03/23/2022.

Resident A was prescribed "Acetaminophen tab 325 mg, take 2 tablets (650mg) by mouth every 6 hours for pain (not to exceed 3GM Acetaminophen/24hrs)." This medication was discontinued on 02/17/2022. This medication was administered starting on 02/06/2022 at 12pm and administered as prescribed with the following exception: On 02/12/2022 at 6pm there is a note in the MAR that states, "given to family to give later."

Resident A was also prescribed pro re nata (PRN) "Acetaminophen tab 325 mg take 2 tablets (650 mg total) by mouth every 8 hours as needed for pain." This was ordered on 02/17/2022 and discontinued on 02/24/2022. This medication was administered to Resident A on 02/22/2022, 02/23/2022 and 02/24/2022 according to the MAR. In the "Pass Notes" of the MAR it stated this medication was administered on 02/22/2022 for "pain in body", on 02/23/2022, "body/back hurts," and 02/24/2022, "back hurting."

I reviewed Resident A's *Physician's Orders* and MARs which were dated February 2022, and found MiraLAX and Tums were not prescribed to Resident A.

On 10/12/2022, I interviewed DCW Foreman who reported she is trained to administer resident medication and her role is as the house manager and direct care staff member. DCW Foreman could not recall Resident A's prescribed medications nor if she administered them. DCW Foreman reported she only administered medications when she had to cover shifts on the floor. DCW Foreman reported that if a DCW administers a medication, they sign for the medication and their initials are saved on the MAR. DCW Foreman reported that if there are no initials on the MAR, it is safe to assume the medication was not administered.

I conducted a file review and found SI # 2022A0783030 which contained the allegation Resident A's morphine was not administered according to her physician's written order. Please see that report for the findings of this allegation.

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

ANALYSIS:	Resident A's *Physician's Orders* and medication administration records (MARs) which were dated February 2022 documented that Resident A was prescribed "Orencia, inject 1ml sub-q every Thursday." This medication was "ordered on 02/04/2022 and discontinued on 02/28/2022." Resident A's MAR documented that this medication was never administered by the facility as there are no initials documenting administration. There is no other explanation provided if the injectable was given at a different location such as a physician's office. A violation has been established as Resident A's Orencia was not administered as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A's room has a loose electrical outlet and a hole in the ceiling.

INVESTIGATION:
On 08/18/2022, Complainant reported there were two loose electrical outlets in Resident A's bedroom as well as a hole in the ceiling. Complainant reported the outlets were never repaired. Complainant reported Resident A was in bedroom #3.

On 08/31/2022, I conducted an unannounced investigation and I inspected Resident A's former resident bedroom #3 which did not contain any loose electrical outlets or a hole in the celling.

I interviewed DCW Eberly and licensee designee Porter who both reported Resident A's bedroom never had a loose electrical outlet and/or a hole in the celling.

On 10/12/2022, I interviewed DCW Foreman who reported that Resident A's bedroom never had a loose electrical outlet and/or a hole in the celling.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.

ANALYSIS:	I conducted an unannounced investigation on 08/31/2022 and found Resident A's bedroom did not contain exposed or loose electrical outlets and there was no hole in the celling. I observed Resident A's bedroom to be arranged and maintained to provide adequately for the health, safety, and well-being of residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A was not provided a low sodium diet nor was she weighted daily as required.

INVESTIGATION:
On 08/19/2022, Complainant reported that on 03/03/22, a resident asked the DCW if dinner was a low sodium meal and the DCW responded "I don't know." Complainant reported that this is a concern as Resident A was admitted to the facility requiring a low sodium diet due to congestive heart failure, kidney issues and COPD. Complainant reported she was assured numerous times that there were other residents with dietary restrictions and that the facility adhered to a low sodium diet for residents. Complainant reported Resident A was served several dishes that were not compliant with a low sodium diet. Complainant reported Resident A was also supposed to be weighed daily as part of the monitoring of fluid buildup and the need to adjust medications to manage it but this was not done. Complainant reported that on 2/11/22 she brought this to licensee designee Porter's attention that Resident A was not being weighed and she was assured that it would be added to the medication chart so that it would not be missed. Complainant reported this did not occur.

On 08/31/2022, I conducted an unannounced investigation and I interviewed licensee designee Porter who reported the meals provided to all residents are low sodium. Licensee designee Porter reported the facility uses low sodium seasonings and they do not add any salt.

I reviewed Resident A's record which contained a written *Assessment Plan for AFC Residents* which was dated 02/06/2022 and signed by Resident A. Resident A's written *Assessment Plan for AFC Residents* documented in the "Special Diets" section of the report, "She is pre-diabetic. She can eat what she wants in moderation." Resident A's written *Assessment Plan for AFC Residents* did not document any special instructions about weighing Resident A nor that she required a low sodium diet.

I reviewed Resident A's *Health Care Appraisal* dated 02/03/2022 and in the "Special Dietary Instructions and Recommended Caloric Intake" section of the report was left blank. Resident A's *Health Care Appraisal* did not document any special instructions for how often Resident A was to be weighed or that she required a low sodium diet.

I reviewed the facilities menu for 01/06/2022-03/05/2022.

On 10/12/2022, I interviewed DCW Foreman who reported that she believed that Resident A was on a low sodium diet but DCW Foreman reported that the facilities menu prepares all of the meals with low sodium. DCW Foreman reported that Resident A was good about following a low sodium diet and that she did not add any extra seasoning or salt to any of her food. DCW Foreman who reported she does not believe Resident A's record documented she was prescribed a low sodium diet but reported that was Resident A's preference. DCW Foreman reported Resident A's record did not contain any physician order to be weighted daily nor did Resident A ask to weigh daily.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(b) Special diets.** **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	Complainant reported that Resident A was not provided a low sodium diet nor was she weighted daily as required. I reviewed Resident A's written *Assessment Plan for AFC Residents* and Resident A's *Health Care Appraisal* and neither documented that Resident A was prescribed a low sodium diet or needed to be weighed daily.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, no change in license is recommended.

10/12/2022

Julie Elkins Date
Licensing Consultant

Approved By:

10/17/2022

Dawn N. Timm Date
Area Manager