GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 25, 2022

Lijo Antony
Meadows Assisted Living, Inc.
71 North Avenue
Mt. Clemens, MI 48043

RE: License #: AL500388667
Investigation #: 2022A0990025
Meadows Assisted Living I

Dear Mr. Antony:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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 (248) 975-5053.

Sincerely,

LaShonda Reed, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(586) 676-2877

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL500388667
Investigation #:	2022A0990025
Complaint Receipt Date:	06/28/2022
Investigation Initiation Date:	06/30/2022
Report Due Date:	08/27/2022
Licensee Name:	Meadows Assisted Living, Inc.
Licensee Address:	71 North Avenue Mt. Clemens, MI 48043
Licensee Telephone #:	(586) 461-2882
Administrator:	Lijo Antony
Licensee Designee:	Lijo Antony
Name of Facility:	Meadows Assisted Living I
Facility Address:	71 North Avenue Mt. Clemens, MI 48043
Facility Telephone #:	(586) 461-2882
Original Issuance Date:	12/06/2018
License Status:	REGULAR
Effective Date:	02/23/2022
Expiration Date:	02/22/2024
Capacity:	18
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL ALZHEIMERS AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident are having frequent urinary tract infections.	Yes
A metal wire brush was used on Resident A's scalp which took off skin.	Yes
There are residents with bedsores.	Yes
One night, one of the med techs refused to give Resident A Xanax that she was prescribed as needed.	No
Resident A had a bowel movement. Resident A is not able to physically clean herself up. Resident A asked staff named Michelle to wipe her. Michelle did so and then shove the wipe in Resident A's face.	No
Staff are not bathing residents on a regular basis. A resident went six days without a bath resulting in raw skin and infections.	Yes
The Reporting Person was left alone to work both facilities nine separate times from 3PM to 7:30AM shift.	Yes
The Reporting Person has pictures on his phone of patients that have been neglected, laying in soiled sheets.	No
Residents would sometimes have meals in their bed and would be left with mashed food and old food all over their beds.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/28/2022	Special Investigation Intake 2022A0990025
06/28/2022	APS Referral Adult Protective Services (APS) complaint denied at intake for special investigation #2022A0990025.
06/30/2022	Special Investigation Initiated - On Site I conducted an unannounced onsite. I interviewed Lijo Antony, licensee designee (LD), Rita Kanan (Assistant to Mr. Antony), and

	Jennifer Hiller, manager. I requested several documents that will be emailed no later than 07/05/2022.
07/01/2022	Contact - Document Sent I requested and received several documents from Mr. Antony pertaining to the allegations.
07/08/2022	Contact - Telephone call made I conducted a phone interview with Relative A.
07/18/2022	Contact - Telephone call made I conducted a phone interview with Resident A.
08/11/2022	Inspection Completed On-site On 08/11/2022, I interviewed staff Jennifer Hiller and Yolanda Smith-Cook and Resident C. I observed Resident D, Resident F and Resident G. Resident B passed away two days prior to onsite visit. I briefly interviewed Mr. Antony and his assistant Ms. Kanan.
08/18/2022	Contact - Telephone call made I reviewed Resident A's documents.
08/18/2022	Contact - Document Received I reviewed documents for Resident B, Resident C and Resident D.
08/18/2022	Contact - Document Sent I texted five former direct care staff (all terminated) requesting a phone interview. Two former staff replied, and one requested to remain anonymous.
08/18/2022	Contact - Document Sent I emailed the five current staff. Only Brittny Taylor replied.
08/19/2022	Contact - Telephone call made I called Staff 1. I left a detailed message.
08/19/2022	Contact – Telephone call made I conducted a phone interview with Relative C.
08/23/2022	Contact - Document Received I received an email reply from Brittny Taylor and former staff Diondra Johnson.
09/08/2022	Contact – Telephone call made I conducted a phone interview with direct care staff Michelle Chisnell.

09/08/2022	Contact – Telephone call made I left a detailed message with Relative D.
09/09/2022	Contact – Telephone call received I conducted a phone interview with Relative D.
09/13/2022	Exit conference I attempted to conduct an exit conference with Mr. Antony.
10/24/2022	Exit conference I conducted an exit conference with Mr. Antony.

ALLEGATION:

- **Residents are having frequent urinary tract infections.**
- **A metal wire brush was used on Resident A's scalp which took off skin.**
- **There are residents with bedsores.**

INVESTIGATION:

On 06/28/2022, this special investigation was re-assigned from Kristine Cilluffo. In addition to the above allegations, it was reported that Meadows Assisted Living provides, hospice, rehab, a locked memory unit and long-term care. A new owner and staff, Lijo Antony, took over the facility about a month and a half ago. Since the change in ownership and staff, there has been a significant decline in the residents' care. The concerns have been brought to the new owner's attention. The new owner will not address any problems.

On 06/30/2022, I conducted an unannounced onsite. I interviewed Lijo Antony, licensee designee (LD) and Rita Kanan (Assistant to Mr. Antony). Mr. Antony said that urinary tract infections (UTIs) are very common with this population. Mr. Antony said that he would compile a list of names of residents that had recent UTIs. Mr. Antony denied that there are any residents currently diagnosed with an UTI. Mr. Antony is unaware of any resident with scalp infections or metal brushes used on residents. Ms. Kanan denied that they use metal brushes in the facility. Ms. Kanan said that the residents' scalps are too sensitive for metal brushes.

Mr. Antony said that there are two residents that had bedsores which are Resident B and a different resident in the other building. Mr. Antony said that Resident B was admitted to the facility with bedsores and is currently on hospice. Mr. Antony said that Resident B is receiving wound care from hospice and would provide the information later.

On 07/05/2022, Mr. Antony provided some documents requested via email. Mr. Antony also reported that there were two residents with UTIs and prescribed antibiotics in June 2022 which are Resident C and Resident D.

On 07/08/2022, I conducted a phone interview with Relative A. Relative A said that the new owner Mr. Antony took over two months ago. Relative A said that one of the staff at the facility, name unknown brushed Resident A's hair with a metal brush causing scalp lacerations. Relative A said that Resident A had a UTI a few months ago and because of it being untreated, she had a fall in which, she shattered her right shoulder. Relative A described that Resident A's scalp had lacerations and was extremely irritated.

On 07/18/2022, I conducted a phone interview with Resident A. Resident A said that she is prescribed a medicated shampoo for "cradle cap" (which may occur as a result of excessive oil production by skin glands surrounding hair follicles, i.e. excessive dandruff). Resident A said that the staff never used the medicated shampoo and the cradle cap worsened. Resident A said that when she went to the beauty salon in the facility, the hairdresser scraped her scalp and then added coconut oil to it. Resident A said that staff person (name unknown) used a metal brush and as result her scalp was raw.

Resident A said that she had a UTI that was left untreated because they did not give her all the medications prescribed to treat it. Resident A said that the staff took her off the medication before it was done. Because of this, she fell going to the bathroom. Resident A said that when she fell, she broke her shoulder and had to be in a rehabilitation facility for six weeks. Resident A said that when she was hospitalized for the fall, they told her that she still had the UTI.

On 08/11/2022, I interviewed Resident C, I observed Resident D, Resident F and Resident G. Resident B passed away two days prior to onsite visit. The residents not observed could not be interviewed due to cognitive deficits. I interviewed Ms. Hiller. Ms. Hiller said that they do not currently have a hairdresser but is looking to hire one soon.

Resident C said that she was receiving "good care" until about two weeks ago. Resident C said that the staff took her belongings such as her clothing. Resident C said that she does not have bedsores.

On 08/18/2022, I reviewed Resident A's documents. Resident A's physician orders as of June 17, 2022. The order documented that Resident A is prescribed baby oil which is to be applied to scalp two times per day, Ketoconazole shampoo to be used twice a week on Sundays and Wednesdays. I reviewed Resident A's medication administration record (MAR). According to the MAR provided for the month of May 2022, the baby oil and Ketoconazole shampoo was administered as prescribed and was to stop per the MAR on 06/18/2022. I observed that Resident A was prescribed Methenamine medication for reoccurring UTI. The Methenamine was prescribed on 10/13/2021 and

Resident A was admitted to the facility on 06/07/2021. I observed on the physician orders and *Health Care Appraisal* that Resident A's diagnosis are as follows: Unspecified mood disorder, unspecified asthma, hypotension, anemia, unspecified rheumatoid arthritis, unspecified osteoarthritis, hyperlipidemia, hypertension, gastro-esophageal reflux disease, nonrheumatic mitral valve prolapse and bipolar disorder.

I reviewed Resident A's an incident report regarding a fall. Resident A was found on the floor bleeding from forehead and transported to the emergency room for evaluation on 09/21/2021. I reviewed Resident A's *Assessment Plan*. The following needs were checked marked: toileting, bathing, grooming and personal hygiene.

On 08/18/2022, I reviewed documents for Resident B, Resident C and Resident D. Per the *Assessment Plan*, Resident B is bedridden, nonverbal, does not leave room. Resident B was admitted to the facility with an unchangeable coccyx (tail bone) wound (which is a bedsore). Resident B was admitted on hospice the same day.

Per the *Assessment Plan*, Resident C needs assistance with mobility and refuses medications. Per the *Assessment Plan*, Resident D uses a wheelchair.

On 08/19/2022, I conducted a phone interview with Relative C. Relative C said that Resident C has lived in the facility for one year and has had two falls. Relative C said that when Resident C first moved into the facility there were good staff. Relative C said that within the last couple of months, things have changed for the worse. Relative C said that Resident C has bedsores in which, she did not have prior to moving into the facility. Relative C said that Resident C had an UTI about six months ago for which she was hospitalized.

On 08/22/2022, I received an email reply from Staff #1. Staff #1 said that as a med tech she has observed a head injury regarding one of the residents (name not provided) caused by a Metal brush. Staff #1 said that the resident had very too little hair and it not sure why a metal brush would be used on her. Staff #1 said that as a med tech she has observed a head injury regarding one of the residents caused by a metal brush. Staff #1 said that there were a couple of residents (names not provided) with bed sores. Staff #1 said that one resident had a bed sore so bad that she did not want to be touched and we could see her bones. Staff #1 described the bedsore as "it looked as if something was eating away at her bottom". Staff #1 said that the bedsore was so bad that it had an unpleasant smell. Staff #1 said that the wound care they provided was not enough to keep it from decaying. Staff #1 said that there was a lack of checks and changes provided to this resident.

On 08/23/2022. I received an email response from current direct care staff Brittny Taylor. Ms. Taylor denied observing staff brush residents' hair with a metal brush or scalp infections. Ms. Taylor denied observing residents fall or remain on the floor for extended periods of time. Former staff Diondra Johnson did not answer to the allegations although, asked.

On 09/08/2022, I conducted a phone interview with direct care staff Michelle Chisnell. Ms. Chisnell denied observing scalp laceration on Resident A. Ms. Chisnell denied observing residents' hair being groomed with a metal brush. Ms. Chisnell said that she recalled that Resident A had frequent UTI's but unsure about other residents as she works as fill in staff on midnight shift.

On 09/09/2022, I conducted a phone interview with Relative D. Relative D said that Resident D passed away two weeks ago. Relative D said that Relative D developed bed sores while living at the facility. Relative D said that Resident D developed a bedsore two months ago. Relative D said the bedsore began as a red mark. Relative D said that Resident D started hospice services and they hospice company began treating the wound. Relative D had no knowledge about staff using metal brushes on resident's head.

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:	There is sufficient evidence that Resident A acquired a scalp laceration while living at the facility as evidenced by the MAR and physician orders for Ketoconazole shampoo and baby oil for her scalp prescribed in May and June of 2022. Furthermore, Resident A's diagnosis at admission did not list cradle cap. According to Relative A, Resident A's scalp had lacerations and was extremely irritated. Resident A said that she got cradles cap and was prescribed a medicated shampoo. Resident A said that one of the staff used a metal brush and scraped her scalp causing lacerations. Staff #1 observed a head injury regarding one of the residents caused by a metal brush. Lastly, there is no documentation in the Assessment Plan regarding interventions needed for grooming and scalp treatment.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15310	**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: (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:	There is sufficient evidence to support that the Resident A and Resident C had other health care needs that were not being provided for. Resident A was admitted to the home on 06/07/2021 and was not diagnosed with frequent UTI's. Resident A was prescribed Methenamine medication four months after admission for reoccurring UTI's. Resident A said that she had a UTI that was not treated properly that resulted in a fall in which she sustained a shoulder fracture. There is sufficient evidence to support that Resident C had bedsores in which, she did not have prior to moving into the facility. Relative C said that Resident C had a UTI about six months ago in which, she was hospitalized as a result. Resident B was admitted to the facility with an unchangeable coccyx and passed away during this investigation. Relative D said that Resident D would go unchanged with dirty diapers for six hours. Relative D said that Resident D developed a bedsore two months ago. Furthermore, Staff #1 said that there were a couple of residents (names not provided) with bed sores. Staff #1 said that one resident's bedsore was so bad that it had an unpleasant smell and was down to the bone. Staff #1 said that the wound care they provided was not enough to keep it from decaying.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

One night, one of the med techs refused to give Resident A Xanax that she was prescribed as needed.

INVESTIGATION:

On 06/30/2022, I conducted an unannounced onsite. I interviewed Lijo Antony, Licensee designee (LD), Rita Kanan (Assistant to Mr. Antony and Jennifer Hiller, manager. Ms. Kanan said that there was an incident with Resident A who was discharged two weeks ago. Ms. Kanan said that she received phone call from a relative for Resident A asking why the med tech Brittney was refusing to give her PRN for Xanax one evening. Ms. Kanan said that she looked at the cameras to see what occurred and can only see the med tech passing the meds. Mr. Antony said he investigated this as well and found that the relative called back and said that the medication was given.

Ms. Hiller said that she received a call from Relative A reporting that the med tech refused to give Resident A her PRN Xanax. Ms. Hiller called the facility and spoke to direct care staff Brittney who said that the Xanax was not a nighttime medication but a PRN. Ms. Hiller told Brittney that she could give Resident A the medication.

On 07/18/2022, I conducted a phone interview with Resident A. Resident A said that she asked a nurse (name not provided) one night for Xanax. Resident A said that the nurse told her that in the computer there was not an order for Xanax at night. Resident A explained that the Xanax is as needed. Resident A said the nurse called the manager Ms. Hiller who told the nurse that she could administer the Xanax.

On 08/18/2022, I reviewed Resident A's documents. I reviewed Resident A’s physician orders for Xanax to be taken as a PRN one tablet by mouth every 12 hours as needed. I observed the medication logs that the Xanax was given 27 times in May of 2022. I observed that the Xanax was given 15 times at bedtime.

On 08/22/2022, I received an email reply from Staff #1. Staff #1 said that the manager Jennifer Hiller would pop medicine and have the staff pass it out to residents. Staff #2 said that they would put any staff person on the medication therefore, meds were passed out wrongfully or not given at all. Staff #1 said that there were a lot of mistakes on the Med cart. No further information was provided.

On 08/23/2022, I received an email response from current direct care staff Brittny Taylor. Ms. Taylor denied observing staff not passing medications properly to residents. Former staff Diondra Johnson did not answer to the allegations although, asked.

On 09/09/2022, I conducted a phone interview with Relative D. Relative D said that she did not observe any medication errors. Relative D said that Resident D was returned nurse and at times she would ask the staff what they were giving her, and one would say “vitamins”. Relative D said that she thought that was condescending because Resident D was aware of her medications and what they were prescribed for.

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: (e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.
ANALYSIS:	There is insufficient evidence to support that Resident A was not given her prescribed Xanax medication as needed. The Xanax is prescribed a PRN to be taken by mouth every 12 hours. I observed on Resident A's MAR that the Xanax was given to her at 15 times at bedtime in May of 2022 and a total of 27 times. Ms. Hiller, the manager admitted there was a discrepancy one night with the med tech Brittny Taylor who thought that Resident A was not to receive the Xanax because it was not listed as prescribed nighttime medication. Ms. Hiller staid that she explained to Ms. Taylor that the Xanax was a PRN and could be administered. Ms. Hiller said that she informed Ms. Taylor that she could give Resident A the medication in which, she did.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A had a bowel movement. Resident A is not able to physically clean herself up. Resident A asked staff named Michelle to wipe her. Michelle did so and then shove the wipe in Resident A's face.

INVESTIGATION:

On 07/08/2022, I conducted a phone interview with Relative A. Relative A said that Resident A has severe arthritis in her hands. Relative A said that Resident A asked a staff person to help clean her bottom because she had a bowel movement and Resident A told her that staff person Michelle (possible last name Chisnell per staff schedule) threw a diaper wipe at her telling her to clean it herself.

On 07/18/2022, I conducted a phone interview with Resident A. Resident A said that one night she had a bowel movement and asked direct care staff Michelle to help her wipe clean. Resident A said Michelle initially put the wipes in front of her. Resident A said that she is not able to clean herself well and asked Michelle to assist and she did.

Resident A said that once she wiped her, she placed the wipe towards her face angrily showing her that she was clean. Resident A said that she reported this to Mr. Antony who told her that he would talk to Michelle about the incident but will not terminate her because she is a good employee.

On 08/22/2022, Staff #1 said at times the residents would become combative and she has heard a couple times staff (names not provided) say mean things to the residents because they were upset. Staff #1 said that this occurred mostly on the memory care side.

On 09/08/2022, I reviewed Resident A's *Assessment Plan*. The following needs were marked: toileting, bathing, grooming and personal hygiene.

On 09/08/2022, I conducted a phone interview with direct care staff Michelle Chisnell said that she changed Resident A quite often. Ms. Chisnell said that Resident A had many accidents with bowel and bladder retention. Ms. Chisnell denied that she never "angrily" placed a dirty diaper wipe into Resident A's face after cleaning her bottom. Ms. Chisnell said that one time she recalled that Resident A said that she did not feel wiped properly and she wiped her showed her the that the diaper wipe was clean. Ms. Chisnell said that would never place a dirty diaper wipe in Resident A's face or any other resident.

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:	Resident A said that once Ms. Chisnell wiped her, she placed the wipe up to her face angrily. Resident A told her that staff person Michelle threw a diaper wipe at her telling her to it herself. Ms. Chisnell said that changed Resident A frequently. L Ms. Chisnell said that she recalled one time that Resident A did not feel clean after she wiped her. Ms. Chisnell displayed the diaper wipe showing Resident A that she was clean. She denied not treating Resident A with dignity and respect. There is insufficient evidence to support that Resident A personal needs were not met or that she was not treated with dignity and respect.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Staff are not bathing residents on a regular basis. A resident went six days without a bath resulting in raw skin and infections.

INVESTIGATION:

On 06/28/2022, in addition to the above allegation it was reported in a separate intake that photos were taken of Resident A's sores and can be provided if needed. Additionally, it was reported that Resident A was supposed to be in the secure memory care unit but was instead put in the assisted living unit. There have been multiple occasions, staff have not changed Resident A within a 12-hour span. Several residents are not being changed when they soil their briefs. The Reporting Person walked into a room at 3pm shift and the residents would still be wearing the same clothing and briefs from his previous afternoon shift.

On 07/08/2022, I conducted a phone interview with Relative A. Relative A said that Resident A has skin an infection that is cottage cheese like due to not being cleaned properly.

On 07/18/2022, I conducted a phone interview with Resident A. Resident A said that she went six days without getting a bath.

On 08/11/2022, I interviewed staff Jennifer Hiller and Yolanda Smith-Cook during the onsite. I interviewed Resident C. Resident C said that she can shower, toilet and clean herself.

On 08/18/2022, I reviewed Resident A's documents. I observed on Resident A's physician orders that she was prescribed A&D Ointment to be applied to dry skin. The A&D ointment was ordered at Resident A's bedside and to be applied as needed. I observed on Resident A's physician order that she was prescribed Nystatin on 10/21/2021 which is, an antifungal cream that is to be applied to the hands.

On 08/19/2022, I conducted a phone interview with Relative C. Relative C said that there are several issues with lack of hygiene. Relative C said that due to Resident C's dementia she has bowel and bladder accidents. Relative C said that two weeks ago while visiting Resident D she was full of hard stool. He said that he called for assistance from staff, but no one came. Relative C said that he cleaned Resident C himself and found that the feces was old as to how it was hard and back-up into the rectum. Relative C said that Resident C has sat in dirty diapers for extended periods of time. Relative C believes that she had not been cleaned for three days at least.

On 08/22/2022, I received an email reply from Staff #1. Staff #1 said that the managers started making staff write times and dates on briefs which sometimes made the residents feel uncomfortable. Staff #1 said that sometime the residents were not changed until the next day or over 12+ hours. Staff #1 said that each resident had a

scheduled shower day. Some of the showers on afternoons were not done because they were not enforced, or the staff just did not get around to them because there was so much to do or slack to pick up from the previous shift.

On 08/23/2022. I received an email response from current direct care staff Brittny Taylor. Ms. Taylor said that the residents are showered two times a week and as needed. Ms. Taylor said that the residents get checked and changed every 2 hours. Former staff Diondra Johnson did not answer to the allegations although, asked.

On 09/09/2022, I conducted a phone interview with direct care staff Michelle Chisnell. Ms. Chisnell described that she works as a fill-in staff and at one point did not work there for six months. Ms. Chisnell said that she worked midnights and did not observe the allegations. Ms. Chisnell said that the residents are showered twice a week or more if needed.

On 09/09/2022, I conducted a phone interview with Relative D. Relative D said that Resident D had a stroke and required to be checked every two hours. Relative D said that the staff would check Resident A's diaper every 4-6 hours by only touching the top of the diaper to see if it is wet/dry. Relative D said that Resident D would go six hours without a diaper change. Relative D said that she complained to the manager Ms. Hiller and many staff persons with no change. Relative D said that hospice services gave Resident D bed baths 2-3 times per week. Relative D said that the facility was to bath Resident D at least one a week and did not. Relative D said that when she would ask about the staff bathing Resident D staff would respond that hospice it supposed to do it. Relative D said that Resident D was given bed baths and the staff would fully expose her while they bathed her and there was a roommate at one point. Relative D said that there was no privacy or decency provided for Resident D and her prior roommate who has also passed away.

APPLICABLE RULE	
R 400.15314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions, when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	There is sufficient evidence to support that Resident A's hygiene was not properly cared for by staff. Relative A said that Resident A had skin an infection that is cottage cheese like due to not being cleaned properly. Resident A said that she went six days without getting a bath. Staff #1 said that sometimes the residents were not changed over 12+ hours. Staff #1 that some of the showers on afternoons were not done because they were not enforced, or

	the staff just didn't get around to them because there was so much to do or slack to pick up from the previous shift. Relative C has observed Resident C full of old feces in which, he cleaned himself. Relative C said that Resident C sits in dirty diapers for extended periods of time. Relative D said that Resident D would go unchanged for six hours. Relative D said that the staff refused to bath Resident D unless asked and assumed that Resident D was to only be cleaned by hospice.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The Reporting Person was left alone to work both facilities, nine separate times from 3PM to 7:30AM shift.

INVESTIGATION:

On 07/07/2022, in addition to the above allegations, the Reporting Person (RP) was told that he should be able to handle working both buildings alone because there are not that many residents. It was reported that the afternoon and midnight shift only schedule one staff and a med tech to cover both shifts. The med techs stay until after dinner and then leave the single staff working by themselves. Management will not come in to help when staff do not show up to work. An incident happened in May 2022, where the owner Lijo Antony was at the facility. When the RP arrived at 3pm to work his shift he was scrambling to help multiple residents. When the RP had the dinner carts and was pushing it to serve the residents in their rooms Mr. Antony said, "Busy tonight huh," and then walked out the door. The RP said that Mr. Antony left before making sure another staff was coming to help or stopping to help himself. Mr. Antony left the RP alone and the other staff never came to help work the afternoon shift. The RP has 8-10 pictures on his phone of residents experiencing neglect from staff on prior shifts when he would arrive to work. It was reported that due to the lack of staffing dinner times are later than they are supposed to due to lack of staff.

On 07/08/2022, I conducted a phone interview with Relative A. Relative A said that the new owner fired all the "good staff". Relative A said that during the night shift, there are not bed checks done on the residents.

On 07/08/2022, I conducted a phone interview with the Reporting Person (RP) for intake number 188444. The RP worked both buildings at least nine times alone on the afternoon and midnight shift. The RP said that the med tech would begin the night shift with him but leaves after dinner.

On 07/18/2022, I conducted a phone interview with Resident A. Resident A said that there is not enough staff because there are always residents sitting in the hallways asking for help and not receiving it.

On 08/11/2022, I interviewed Ms. Hiller, Ms. Smith-cook and Resident C. Ms. Hiller said that dinner is served between 5PM-5:30PM. Ms. Hiller said that dinner trays are sent to the rooms in which residents are bed bound or prefer to eat in their room are delivered to the memory care side around 4:45PM. Ms. Smith said that dinner is always served to all residents by 5:30PM. Ms. Smith said the latest food is given is around 6PM. Resident C said that staffing is ok. Resident C said that the meals are decent, and dinner is served around 5:30PM.

On 08/18/2022, I reviewed staff schedules from March 5, 2022, through July 2, 2022. I observed that the schedules did not specify which building that staff were working. I observed that there is only one staff person on the schedule for the 11PM to 7AM shift for both buildings.

On 08/19/2022, I conducted a phone interview with Relative C. Relative C said that they need more staffing and staff that know what they are doing. Relative C said that one time he looked for help to clean Resident C and there was no one available. Relative C said that Resident C is a fall risk and has alarms on her bed and chair. Relative C said that Resident C fell and used the call alarm for help and not one came to assist her.

On 08/22/2022, I received an email reply from Staff #1. Staff #1 said that the afternoon shift was always low staffed. Staff #1 said that there would be a Med tech and a caregiver when there's supposed to be two caregivers and a Med tech. Staff #1 said at times she was overwhelmed because there was only one caregiver on the other side and she would need help. If she were on the other side of the building, she would have to leave her med cart to assist. Staff #1 said that some days you could call for help over the walkie talkie and no one would answer or assist with help because they were either with a resident or they did not have a walkie talkie. Staff #1 said that she has been left on shift a couple of hours as a Med tech to take care of both sides because at times midnights would not show up for their shift. Staff #1 said that she was left there alone from 11pm till 5am and had a resident fall that night. Staff #1 said that she had to ask one of the sitters who watched one of the residents to help her get the resident off the floor.

Staff #1 said dinner for everyone is supposed to be served at 4:30-5pm. Staff #1 said that room trays would go out about 4:00pm for anyone who could not get out of their bed and memory care would not get their food until about 5:15pm.

On 08/23/2022. I received an email response from current direct care staff Brittny Taylor and former direct care staff Diondra Johnson. Ms. Taylor denied observing residents in the hallway asking for help and not being helped. Ms. Taylor said that she has not observed staff working alone on a shift, Ms. Taylor said that there are always

two or three people on each shift. Ms. Taylor said that dinner is served between 5PM-5:30PM.

Ms. Johnson said there was not enough staff to take care of the residents her first two days of working there. Ms. Johnson said that the person that trained him were the only two staff working in both buildings. Ms. Johnson was able to help because she had already been trained to be a caregiver.

On 09/08/2022, I conducted a phone interview with direct care staff Michelle Chisnell. Ms. Chisnell said that she is a fill-in staff and works full-time as a caregiver at a different facility. Ms. Chisnell has never worked alone on the midnight shift. Ms. Chisnell said that there was always another person on staff with her. Ms. Chisnell said that she did not work in the home for six months.

On 09/09/2022, I conducted a phone interview with Relative D. Relative D said that the facility was always short staffed. Relative D said that on most shifts, there would be one staff person for both sides and one med tech. Relative D said management told her initially the staffing shortage was due to the pandemic however, alas time went on the management fired most of the competent staff.

APPLICABLE RULE	
R 400.15206	Staffing requirements.
	(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:	Based on this investigation, I determined that there is sufficient information that there are not enough staff on the afternoon midnight shift. According to the staff schedules, I observed only one staff person for the 11PM to 7AM shift for both buildings. I observed that the schedules do not specify which building staff are working. There is only one caregiver on schedule for the 11PM to 7AM shift for both buildings. The Reporting Person (RP) said that the afternoon and midnight shift only schedule one staff and a med tech to cover both shifts. The RP said that the med techs stay until after dinner and then leave the single staff working alone. Staff #1 worked alone from 11pm until 5AM. Former direct care staff person Diondra Johnson said that on her second day of employment, she worked with the person training her for both buildings. Ms. Johnson said that there was inadequate staffing.

	Resident A said that there is not enough staff because there are always residents sitting in the hallways asking for help and not receiving it. Relative C looked for help to clean Resident C and there was no one available. Relative C said that Resident C fell and used the call alarm for help and no one came to assist her. Relative D said that there was only one staff person covering both buildings and one med tech.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

- **The Reporting Person has pictures on his phone of patients that have been neglected, laying in soiled sheets.**
- **Residents would sometimes have meals in their bed and left with mashed and old food all over their beds.**

INVESTIGATION:

On 07/08/2022, I conducted a phone interview with the Reporting Person (RP). The RP said that he has photos of another resident in the adjacent building. The RP said that he had several photos of dirty linen and agreed to send them to me. However, to date no photos were received. The RP said residents that ate inside of their bedrooms were left with mashed food and old food in their beds.

On 08/11/2022, I conducted an onsite investigation and interviewed staff Jennifer Hiller. I interviewed Resident C and observed (due to their limited cognitive abilities) Resident D, Resident F, Resident G were unable to be interviewed. Resident B passed away two days prior to onsite investigation. I did not observe any dirty rooms or sheets. Resident C did not provide any information regarding the soiled and dirty sheets. Resident C said that the meals are decent. Ms. Hiller said that residents are allowed to eat in their bedrooms if they desire.

On 08/22/2022, I received an email reply from Staff #1. Staff #1 said that some residents were not changed until the next day and over 12+ hours. Staff #1 said that some residents would stay in their room to eat and whenever they would get ready for bed there would be ants crawling on or around their beds. Some rooms had ants worse than others.

On 08/23/2022. I received an email response from current direct care staff Brittny Taylor. Ms. Taylor denied seeing residents on dirty or soiled sheets. Ms. Taylor said that the residents get checked and changed every two hours

On 08/19/2022, I conducted a phone interview with Relative C. Relative C said that Resident C prefers to eat in her bedroom. Relative C said that the staff have been inconsistent with picking up her food tray. Relative C has observed dirty cups inside of

Resident C's bedroom that have been left there for days. Relative C stated that Resident C was hospitalized for a UTI. Resident C was hospitalized from a Tuesday through Thursday. When Relative C returned Resident C back to the facility, the room was left the way they had left it. Relative C said that two months ago, there was old and molded food and dirty dishes in the resident's bedroom.

On 08/22/2022, I received an email reply from Staff #1. Staff # 1 said that there were bugs such as worms and ants in the home. Staff #1 said that there was blood and coffee stains on the carpets and the residents' bathrooms were disgusting. Staff #1 said that there were a lot of bugs in the facility. Every other day there was bags of trash or left-over room trays in the rooms. Some residents would stay in their room to eat and whenever they would get ready for bed there would be ants crawling on or around their beds. Some rooms had ants worse than others.

On 08/23/2022. I received an email response from current direct care staff Brittny Taylor. Ms. Taylor denied observing old food in residents' bedrooms. Ms. Taylor said that facility is clean but there is always room for improvement. Former staff Diondra Johnson did not answer to the allegations although, asked.

On 09/09/2022, I conducted a phone interview with direct care staff Michelle Chisnell. Ms. Chisnell denied observing old food and dirty linen. Ms. Chisnell said that the resident's linen is laundered one time a week and their clothing/personal items are laundered on their shower day.

On 09/09/2022, I conducted a phone interview with Relative D. Relative D said that she did not observe dirty or oiled linen. Relative D said that Resident D ate meals in bed. At times food would drop on the floors and no one would sweep the floors after meals. Relative D said that food was always dropped off in the bedroom, but it would be some time before staff could return to feed Resident D. Relative D fed most meals to Resident D as well as her roommate because the food would get cold. Relative D said that there were ants in the room and an odor due to Resident D's roommate catheter bag not being changed frequently as it was full.

APPLICABLE RULE	
R 400.15411	**Linens.**
	(1) A licensee shall provide clean bedding that is in good condition. The bedding shall include 2 sheets, a pillowcase, a minimum of 1 blanket, and a bedspread for each bed. Bed linens shall be changed and laundered at least once a week or more often if soiled.

ANALYSIS:	There is not enough information to support that there was dirty linen. On 08/11/2022 during an unannounced onsite, I did not observe any dirty rooms or sheets. Direct care staff, Ms. Taylor said that facility is cleaned but there is always room for improvement. Direct care staff Michelle Chisnell said that the residents' linens are laundered once a week. Relative D denied observing soiled or dirty linen.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.15403	**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:	The RP said residents that ate inside of their bedrooms were left with mashed food and old food in their beds. Staff #1 said that every other day there were bags of trash or left-over room trays in the resident bedrooms. Some residents would stay in their bedroom to eat and whenever they would get ready for bed there would be ants crawling on or around their beds. Staff #1 said that there was blood and coffee stains on the carpets. Staff #1 said that the residents' bathrooms were disgusting. Relative C said that he has observed dirty cups inside of Resident C's bedroom that have been left there for days. On 08/11/2022 during an unannounced onsite, I did not observe any dirty rooms or sheets. However, there is sufficient information to support that there has been left over food trays in resident's bedrooms per two former staff and Relative C. Relative D said that food particles would be on the floor after meals in the bedrooms. Relative D said that there were ants and a foul odor in Resident D's room.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 06/30/2022, Mr. Antony said that there are two residents that had bedsores, Resident B and a different resident in the other building. Mr. Antony said that Resident B was admitted to the facility with bedsores and is currently on hospice. Resident B is receiving wound care from hospice.

On 08/18/2022, I reviewed documents for Resident B, Resident C and Resident D. Per the *Assessment Plan*, Resident B is bedridden, nonverbal, does not leave room. Resident B was admitted to the facility with an unchangeable coccyx (tail bone) wound. Resident B was admitted on hospice. I reviewed the hospice order, dated 12/07/2021. Resident B was admitted to the facility on 12/10/2022. Resident B is diagnosed with dementia and was referred to hospice by McClaren Macomb Hospital. Resident B passed away on 08/07/2022.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(1) A licensee shall not accept, retain, or care for a resident who requires continuous nursing care. This does not preclude the accommodation of a resident who becomes temporarily ill while in the home, but who does not require continuous nursing care.
ANALYSIS:	There is sufficient information that Resident B required continuous nursing care at admission as evidenced by being enrolled in hospice. Resident B was bedridden, nonverbal and did not leave her room. Resident B was admitted to the facility with an unchangeable coccyx (tail bone) wound. Resident B passed away on 08/07/2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 09/08/2022, I reviewed Resident A's *Assessment Plan*. The following needs were marked: toileting, bathing, grooming and personal hygiene. I observed that there was no description of the needs.

On 09/09/2022, I conducted a phone interview with Relative D. Relative D said that Resident D was bed ridden, a two person assist, has paralysis on one side of her body,

weakness, used diapers and suffered stroke. I reviewed Resident D's *Assessment Plan* and there was no description of her needs and she is a full assist.

On 08/13/2022, I attempted to conduct an exit conference with Mr. Antony. Mr. Antony responded that he is out of the country. I sent an email with the allegations and findings as the tentative exit conference until he returns.

On 10/24/2022, I conducted an exit conference with Mr. Antony.

APPLICABLE RULE	
	R 400.15301 Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: (a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.
ANALYSIS:	I reviewed Resident A'a *Assessment Plan*. Resident A requires assistance with toileting, bathing, grooming and personal hygiene. There was no description of how the needs were going to be met. Resident D was a full assist with activities of daily living. I observed that there were no details provided for the care she required.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

L. Reed

10/24/2022

LaShonda Reed — Date
Licensing Consultant

Approved By:

Denise Y. Nunn

10/25/2022

Denise Y. Nunn — Date
Area Manager