GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 27, 2022

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

RE: License #: AL500388683
Investigation #: 2022A0990026
Meadows Assisted Living II

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 #:	AL500388683
Investigation #:	2022A0990026
Complaint Receipt Date:	07/01/2022
Investigation Initiation Date:	07/01/2022
Report Due Date:	08/30/2022
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 II
Facility Address:	75 North Avenue Mt. Clemens, MI 48043
Facility Telephone #:	(586) 461-2882
Original Issuance Date:	12/06/2018
License Status:	REGULAR
Effective Date:	06/06/2021
Expiration Date:	06/05/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident are having frequent urinary tract infections.	No
There are residents with bedsores.	No
Resident B is 93 years old and is a wheelchair assist and bathroom assist, was left sitting on the toilet by himself when staff arrived.	No
There are resident falls.	No
Staff are not bathing residents on a regular basis. A resident went six days without a bath resulting in raw skin and infections.	No
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.	No

III. METHODOLOGY

07/01/2022	Special Investigation Intake 2022A0990026
07/01/2022	APS Referral Adult Protective Services (APS) referral made on 06/28/2022.
07/01/2022	Special Investigation Initiated - On Site I conducted an onsite investigation on 06/28/2022 with the initiation of the companion facility as this one Meadows Assisted Living I. I interviewed Lijo Antony, licensee designee (LD), Rita Kanan (Assistant to Mr. Antony), and Jennifer Hiller, manager.
07/05/2022	Contact - Document Received Mr. Antony provided some documents requested via email. Mr. Antony also reported that there were two residents with urinary tract infections (UTI) and prescribed antibiotics.

07/08/2022	Contact - Telephone call made I conducted a phone interview with the Reporting Person (RP) for new intake. The intake will be dismissed, and the allegations will be addressed in this investigation as the allegations are the same.
08/11/2022	Inspection Completed On-site On 08/11/2022, I interviewed staff Jennifer Hiller and Yolanda Smith-cook. I interviewed Resident B and Resident C. I observed Resident A and she was not interviewed due to her limited cognitive abilities.
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 one staff replied, Brittny Taylor.
08/18/2022	Contact - Telephone call made I conducted a phone interview with Relative B.
08/18/2022	Contact - Document Received I reviewed documents for Resident A, Resident B and Resident C.
08/19/2022	Contact - Telephone call made I called Relative A. Relative A said that she was visiting Resident A and would call back. No phone call received to date.
08/19/2022	Contact - Telephone call received I conducted a phone interview with Debra Johns, Adult Protective Services Specialist (APS).
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.
09/13/2022	Exit Conference I attempted to conduct an exit conference with Mr. Antony.

10/24/2022	Exit Conference LaShonda Reed completed exit conference with Licensee Designee, Lijo Antony, by phone.

ALLEGATION:

- **Residents are having frequent urinary tract infections.**
- **There are residents with bedsores.**
- **Resident B is 93 years old and is a wheelchair assist and bathroom assist, was left sitting on the toilet by himself when staff arrived.**
- **There are resident falls.**

INVESTIGATION:

On 06/28/2022, the special investigation was re-assigned to me from Kristine Cilluffo via email. In addition to the 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. There are resident falls.

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 (UTI's) are very common with this population. Mr. Antony said that he would compile a list of names of residents that had recent UTI's. Mr. Antony denied that there are any residents currently diagnosed with an UTI. Mr. Antony said that bed alarms were added to the resident beds that are fall risks and are added to all new residents' beds for their first 72 hours residing in the home. Mr. Antony said that the residents that are a fall risk are provided with bed alarms, motion sensors, wheelchair alarms and floor mats. Mr. Antony denied frequent falls and said that the communal area of the facility is monitored by cameras.

On 07/05/2022, Mr. Antony provided some documents requested via email. Mr. Antony said Resident A has a bedsore. Mr. Antony said that there are no residents with UTI's.

On 07/08/2022, I conducted a phone interview with the Reporting Person (RP). The RP said that when he arrived on his shift in March 2022, he found Resident B sitting on his toilet in his bedroom around 3:15PM. The RP said that he asked Resident B how long he had been there, and he said, "a long time" and that no one was there to help him get up.

On 08/11/2022, I interviewed Resident B, Resident C and observed Resident A due to limited cognitive abilities. Resident D passed away March 2022. I interviewed and observed residents that resided in Meadows Assisted Living I (AL500388667).

Resident B said that he has become more independent since living in the home. Resident B said that he has slipped out of his chair in the past, but staff assisted home with getting up Resident B said that he does not have any bedsores or UTI's. Resident C said that she had a fall but does not recall much about it. Resident C was not able to answer most questions related to the allegations.

On 08/18/2022, I reviewed documents for Resident A, Resident B and Resident C. Per Resident A's *Assessment Plan* she uses a wheelchair and is full assist with ADL's. Resident A was admitted to hospice one month after her admission to the home 06/2022. Per Resident B's *Assessment Plan*, he feeds independent however, needs assistance with setting up, he is independent with ADLs with some staff assistance and uses a wheelchair.

On 08/18/2022, I conducted a phone interview with Relative B. Relative B said that she does not have any concerns with the facility or care Resident B is receiving. Relative B said that Resident B used to be bedridden and has made much improvement since living in the facility. Relative B said that Resident B is ambulatory and has not had any falls recently. Relative B said that the falls were when Resident B first came to the facility.

On 08/19/2022, I conducted a phone interview with Debra Johns, Adult Protective Services Specialist (APS). Ms. Johns said that her investigation is regarding Resident B only. Ms. Johns said that she did not observe bedsores or neglect of Resident B. Ms. Johns is not substantiating the APS investigation.

On 08/22/2022, I received an email reply from Staff #1. 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 said that the residents that have bedsores or bedbound are turned every two hours and bedsore are to be cleaned with every change. 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 said that she recalled that a resident at the other building had frequent UTI's but unsure about other residents as she works as fill in staff on midnight shift.

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:	Per Resident B's *Assessment Plan*, he feeds independently however, needs assistance with setting up, he is independent with ADLs with some staff assistance and uses a wheelchair. Resident B said that he has slipped out of his chair in the past, but staff assisted him with getting up. Resident B does not have any bedsores or UTI's. Relative B said that Resident B is ambulatory and has not had any falls recently. The falls were when Resident B first came to the facility. Resident C admitted to having a fall but did not elaborate. Mr. Antony said that bed alarms were added to the resident beds that are fall risks and are added to all new residents' beds for their first 72 hours residing in the home. Staff #1 said that there were residents with decaying bedsores but did not specify the name of the resident. The residents could be a resident at the adjacent facility. Ms. Taylor denied observing residents fall or remain on the floor for extended periods of time.
CONCLUSION:	VIOLATION NOT 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 the Reporting Person (RP). 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 08/11/2022, I interviewed Resident B, Resident C and observed Resident A due to limited cognitive abilities I was unable to interview Resident A. Resident B said that there is not enough staff there to help him or the other residents. Resident C did not provide any information about the lack of staffing.

On 08/18/2022, I conducted a phone interview with Relative B. Relative B said that she does not have any concerns with the facility or care Resident B is receiving. Relative B said that there have many new owners.

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.

On 08/18/2022, I reviewed staff schedules from 03/05/2022, through 07/02/2022. I observed that the schedules did not specify which building that staff were working. I observed that there is only one staff person in the schedule for the 11PM to 7AM shift for both buildings.

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 would need help and 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 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 me were the only two staff working in both buildings. Ms. Johnson said that she 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 s caregiver at a different facility. Ms. Chisnell said that she 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.

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:	There is sufficient information to support that there is not enough staff on the afternoon and midnight shift. I observed only one staff person on the schedule for the 11PM to 7AM shift for both buildings. I observed that the schedules do not specify which building staff are working. I observed that there is only one caregiver on schedule for the 11PM to 7AM shift for both buildings. According to the Reporting Person (RP), 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 till 5AM. On her second day of employment, former direct care staff Diondra Johnson worked with the person training her for both buildings. Ms. Johnson said that there was inadequate staffing. Resident B said that there is not enough staff there to help him or the other residents.
CONCLUSION:	**VIOLATION 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 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 08/11/2022, I conducted an onsite and interviewed Resident B, Resident C and observed Resident A due to limited cognitive abilities, she was not interviewed. Resident B said that he can shower himself without assistance. Resident B said that he has been left with a dirty diaper on "But it's no big deal" because he can clean himself. Resident C said that she had a shower today and has showers on a regular basis. Resident C said that when her bottom was irritated, the staff applied salve and it had healed.

On 08/19/2022, I conducted a phone interview with Debra Johns, Adult Protective Services Specialist (APS). Ms. Johns said that she interviewed some family members and Resident B. She does not have any evidence to support the allegations.

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. Staff #1 that 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 two 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 08/18/2022, I conducted a phone interview with Relative B. Relative B said that she does not have any concerns with the facility or care Resident B is receiving.

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 insufficient evidence to support that Resident A, Resident B and Resident C hygiene was neglected by staff. Resident A was unable to be interviewed due to limited cognitive abilities. Resident B said that he showers himself. Resident C said that she was showered on the day interviewed and is showered regularly. Staff #1 that 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. It is presumed that Staff #1 was speaking to the residents at the adjacent facility.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

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

INVESTIGATION:

On 07/08/2022, I conducted a phone interview with the Reporting Person (RP). The RP said that residents that ate inside of their bedrooms were left with mashed food and old food in their beds.

On 08/11/2022, during the onsite investigation, I did not observe any dirty rooms or sheets. I interviewed Resident B and Resident C. I observed Resident A and due to limited cognitive abilities, was not interviewed. Resident B said that he eats in the dining room and not in his bedroom. Resident C said that she goes to the dining room for all meals and at times she eats in her room. I observed each room in the facility and resident bedrooms.

Resident B denied laying on soiled sheets and bedding. Resident C said that the staff does her laundry regularly and nicely. Resident D stated that the staff hang her clothes neatly in her closet.

On 08/18/2022, I conducted a phone interview with Relative B. Relative B said that she does not have any concerns with the facility or care Resident B is receiving.

On 08/19/2022, I conducted a phone interview with Debra Johns, Adult Protective Services Specialist (APS). Ms. Johns said that she did not observe any urine/feces on the floor or dirty sheets and each room was clean.

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. Mr. Taylor denied seeing residents on dirty or soiled sheets. Ms. Taylor said that the residents get checked and changed every two hours.

On 08/22/2022, I received an email reply from Staff #1. Staff # 1 said that there were bugs such as worms and ants. Staff #1 said that there was blood and coffee stains on the carpets. Staff #1 said that the residents' bathrooms were disgusting. Staff #1 said that there were a lot of bugs in the facility. Staff #1 said that 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 resident's 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 08/18/2022, I conducted a phone interview with Relative B. Relative B said that she has not observed the facility dirty or soiled linens.

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

On 10/24/2022, LaShonda Reed completed an exit conference with Licensee Designee, Lijo Antony by phone.

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:	I conducted an unannounced onsite investigation on 08/11/2022. I observed each bedroom in the facility. I did not observe any dirty bedrooms or any other areas of the facility not clean. Resident B eats in the dining room and not in his bedroom. Resident C goes to the dining room for all meals and at times she eats in her room. There is insufficient information to support that the premises are not maintained.
CONCLUSION:	VIOLATION NOT ESTABLISHED

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:	I conducted an unannounced onsite investigation on 08/11/2022. I observed each bedroom in the facility. I did not observe any dirty or soiled sheets. Ms. Johns, APS investigator did not observe any urine/feces on the floor or dirty sheets and each room was clean. Resident B denied laying on soiled sheets and bedding. Resident C said that the staff does her laundry regularly and nicely. There is insufficient information to support that there is dirty linen.
CONCLUSION:	VIOLATION NOT ESTABLISHED

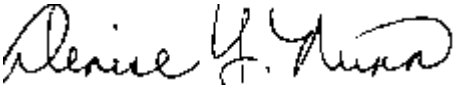
IV. RECOMMENDATION

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

10/24/2022

LaShonda Reed Date
Licensing Consultant

Approved By:



10/27/2022

Denise Y. Nunn Date
Area Manager