GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 21, 2022

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

RE: License #: AL500388667
Investigation #: 2022A0604028
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.
- 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 (248) 975-5053.

Sincerely,

Kristine Cilluffo, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 285-1703

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL500388667
Investigation #:	2022A0604028
Complaint Receipt Date:	07/21/2022
Investigation Initiation Date:	07/21/2022
Report Due Date:	09/19/2022
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?
Background checks are not completed for staff.	No
Resident A was slapped in face by caregiver.	Yes
Resident B's skin is breaking down and is not cleaned properly.	Yes
Resident C fell and was found on floor. Resident C did not have any guardrails on her bed despite being a fall risk.	No

III. METHODOLOGY

07/21/2022	Special Investigation Intake 2022A0604028
07/21/2022	APS Referral Referral received from Adult Protective Services (APS)
07/21/2022	Contact - Document Sent Email to and from APS Worker, Debra Johns. Received two incident reports by email from Ms. Johns.
07/21/2022	Special Investigation Initiated - Letter Email to APS Worker, Debra Johns.
07/22/2022	Contact - Document Sent Email to and from Lijo Antony regarding incident reports
07/22/2022	Contact - Document Sent Email to APS Worker, Debra Johns. Sent copy of incident report.
07/22/2022	Inspection Completed On-site Completed unannounced onsite investigation. Interviewed Staff Jennifer Hiller, Tina Shaw, Lalittle Kinnard, Elise Rogan and observed Resident A and Resident B. Interviewed Relative 1, Relative 2 and Relative 3.
07/22/2022	Contact - Document Sent Email to and from APS Worker, Debra Johns.
07/25/2022	Contact - Telephone call made TC to Relative 4
07/25/2022	Contact - Document Sent Email to Lijo Antony

08/03/2022	Contact- Document Received Email from Debra Johns
08/04/2022	Contact- Document Sent Email to Debra Johns
08/16/2022	Contact - Document Received Email to Lijo Antony regarding requested documents. Received documents by email from Lijo Antony
08/18/2022	Contact - Telephone call made TC to Lijo Antony
09/06/2022	Contact- Document Received Email from Debra Johns
09/07/2022	Contact- Document Sent Email to and from Debra Johns. APS does not believe they will substantiate allegations.
09/14/2022	Contact- Telephone call made TC to McLaren Hospice Nurse, Ann Meerschaert. Left message.
09/14/2022	Exit Conference TC to Licensee Designee, Lijo Antony. Left message

ALLEGATION:

Background checks are not completed for staff.

INVESTIGATION:

I received a complaint regarding Meadows Assisted Living I on 07/21/2022. It was alleged that the owner, Lijo Antony, hires people without doing background checks. Residents at Meadows get mistreated, like slapped or left on the floor for two or three hours at a time. For example, one resident (Resident A) was slapped on the face by a caregiver. Mr. Antony reported that (Resident A) was slapped and the alleged perp was terminated. There are concerns of Resident B having skin breakdowns (not being cleaned properly) she is under hospice care. Resident C resides at Meadows Assisted Living. Resident C has dementia. A couple of weeks ago, Resident C fell out of the chair in her room and was found on the floor. It is unknown how long Resident C was on the floor before being found.

On 07/21/2022, I received an email from APS Worker, Debra Johns. Ms. Johns indicated that she received another complaint regarding Resident C. The complaint

alleged a couple of weeks ago, Resident C fell out of the chair in her room and was found on the floor. It is unknown how long Resident C was on the floor before being found. Family requested the chair be removed from her room. Resident C did not have any guardrails on her bed despite being a fall risk. It is unknown if Resident C has fallen from bed but on 07/16/2022 it was reported that Resident C had fallen "a couple times" at the assisted living facility. Resident C was transported to the hospital and was found to have a fractured hip. Resident C required surgery to repair her hip at McLaren Macomb and is going to be discharged to Church of Christ Rehab Facility. There is concern that Resident C was neglected and not properly monitored being a known fall risk, which led to significant injury. Other residents have also fallen and not gotten immediate assistance. On 07/21/2022, I also received copies of two incident reports from Ms. Johns. The incident reports were regarding Resident A being slapped by staff on 07/10/2022 and Resident C's fall on 07/12/2022.

On 07/22/2022, I completed an unannounced onsite investigation at Meadows Assisted Living. I interviewed Manager, Jennifer Hiller. She stated that there has been a lot of recent terminations. She stated that there is never one person on shift for both buildings. All staff are trained and fingerprinted before they are on shift alone. On 07/25/2022, I sent Licensee Designee, Lijo Antony an email requesting clearances for staff working during onsite investigation. On 08/16/2022, Mr. Antony emailed requested fingerprinting clearances for Staff, Tina Shaw, Lalitte Kinnard, Jennifer Hiller and Elise Rogan.

APPLICABLE RULE	
MCL 400.713	**License required; application; forms; investigation; on-site evaluation; issuance or renewal of license; disclosures; maximum number of persons; stating type of specialized program; issuance of license to specific person at specific location; transferability of license; sale of facility; notice; items of noncompliance; refusal by department to issue or renew license; conditions; unlicensed facility; violation as misdemeanor; penalty; receipt of completed application; issuance of license within certain time period; inspections; report; criminal history and records check; storage of fingerprints in automated fingerprint identification system database; convictions; "completed application" defined.**
	(3) Before issuing or renewing a license, the department shall investigate the activities and standards of care of the applicant and shall make an on-site evaluation of the facility. On-site inspections conducted in response to the application may be conducted without prior notice to the applicant. On-site inspections conducted for renewing a license may be conducted within 12 months before the expiration date of the current license without impact on the license renewal date or the license fee. Subject to

	subsections (9), (10), and (11), the department shall issue or renew a license if satisfied as to all of the following: **(e) The good moral character of the licensee or licensee designee, owner, partner, director, and person responsible for the daily operation of the facility. The applicant is responsible for assessing the good moral character of the employees of the facility. The person responsible for the daily operation of the facility shall be not less than 18 years of age.**
ANALYSIS:	There is not enough information to determine that clearances are not being completed for staff. Licensee Designee, Lijo Antony, provided clearances for Staff, Tina Shaw, Lalitte Kinnard, Jennifer Hiller and Elise Rogan.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

- **Resident A was slapped in the face by a caregiver.**
- **Resident B's skin is breaking down and is not cleaned properly.**
- **Resident C fell and was found on the floor. Resident C did not have any guardrails on her bed despite being a fall risk.**

INVESTIGATION:

On 07/21/2022, I received an incident report by email regarding Resident A being slapped by staff. The incident report indicates that on 07/10/2022, the administrator was contacted and told that staff, Zaire, slapped Resident A's hand while she was combative and hitting both staff. The Sheriff was contacted and the employee was terminated.

On 07/22/2022, I completed an unannounced onsite investigation at Meadows Assisted Living. I interviewed Manager, Jennifer Hiller. She stated that it was reported that a new staff, Zaire Webb, hit Resident A. Mr. Webb was in the process of being trained and working with another staff, Tiffany. She stated that Resident A was being combative, and Mr. Webb hit her. Owner, Lijo Antony, Staff, Rita and Ms. Hiller were contacted, and the Macomb County Sheriff was called. Mr. Webb was escorted off the property. Resident A has no recollection of the incident. Jennifer Hiller stated that Resident B has bed sores. She is on McLaren hospice. She came to Meadows with the wounds. Jennifer Hiller stated that Resident C did fall at Meadows Assisted Living I. She slid and fell down the footrest of her recliner. She also got out of her wheelchair and tried to walk and fell. She went to the hospital and needed a hip replacement. She is currently at a rehab program. She uses a walker/wheelchair.

During the onsite investigation, I observed Resident A. She was visiting with family, Relative 1 and Relative 2. Relative 1 stated that the incident regarding Resident A being

hit was already addressed. They were notified of the incident and interviewed by APS at McLaren Hospital. Resident A does not remember the incident. Resident A's family felt that the incident was addressed properly and did not have any additional concerns to report regarding Meadows Assisted Living.

During the onsite investigation, I observed Resident B. Resident B was sleeping in her room. She was being visited by Relative 3 who stated that Resident B's guardian, Relative 4, would have additional information regarding Resident B. Relative 3 stated that Resident B is on hospice and sees a nurse. She is repositioned every two hours. Resident B does have bedsores on her backside. Relative 3 is not sure if proper care is provided for wounds because he is not a medical professional.

On 07/22/2022, I interviewed Staff, Tina Shaw. Ms. Shaw stated that she was not present when Resident A was allegedly slapped by a staff. She stated that Resident B does have bed sores. The med tech does wound care and Resident B is also on hospice. Resident B must be turned every two hours or as needed. Ms. Shaw was not sure if Resident B had wounds when she arrived at Meadows Assisted Living.

Ms. Shaw stated that she was not working when Resident C fell. Ms. Shaw stated that she had no concerns to report regarding the care residents receive at Meadows Assisted Living. She believed that complaints may have been received because a lot of staff have been fired. She stated that the owner is quick to terminate people if there is an issue.

On 07/22/2022, I interviewed Staff, Lalittle Kinnard. She stated that residents are very well taken care of, changed fed and showered. She was not at Meadows when Resident A was allegedly slapped, however, she was told about incident. Ms. Kinnard stated that Resident B does have skin breakdown. Her wounds are very bad and can see bone. The med tech provides wound care and packs and sprays wounds. Resident B is repositioned every two hours. Hospice also comes out to provide care for Resident B. Ms. Kinnard believes that Resident B is getting proper care for wounds. Ms. Kinnard stated that she was not present at Meadows for any of Resident C's alleged falls. Ms. Kinnard stated that she had no concerns to report regarding the care provided at Meadows Assisted Living. She believed complaints may have been received due to new employees being fired.

On 07/22/2022, I interviewed Staff, Elise Rogan. Ms. Rogan stated that she was not present when Resident A was allegedly slapped. Ms. Rogan stated that Resident B had wounds when she got to Meadows in March 2022. She stated that she broke down in tears when she first saw them and talked to her manager. She stated that are really bad and Resident B is seen by a nurse and has her bandages changed. She stated that some staff do not like changing Resident B because of the severity of her wounds. She stated that she has not seen any residents on the floor. She stated that memory care residents do get up and not use their walkers. They try to catch falls with two staff on shift. Ms. Rogan stated that she was aware that Resident C fell and was taken to hospital. She believes that Resident C could use bed rails. Ms. Rogan stated that there

has been occasions where she has found residents wet in the morning. She also has found soaked pillow from resident not being changed at all during the night. She stated that there is a high turnover rate with staff and there have been times where there is only one staff available for building.

On 07/25/2022, I interviewed Relative 4 by phone. She stated she has spoken to staff at Meadows, hospice and wound care nurse regarding Resident B. Relative 4 stated that Resident B is 94 years old and surgery is not an option to treat her wounds. A surgeon would probably not take it on. Relative 4 stated that hospice is aware of Resident B's wounds. Resident B had the wounds when she arrived at Meadows. She developed them at the hospital and another home she was at. Relative 4 stated that she has no concerns regarding Meadows and she has been there when they changed and dressed the wounds. She stated that Resident B's wounds are bad, however, staff seem to be caring and gentle. They shower Resident B and Resident B seems to enjoy the showers.

On 08/16/2022, I received a copy of Resident B's assessment plan and health care appraisal. Resident B's health care appraisal dated 12/10/2021 indicates that she has several wounds. Resident B's assessment plan dated 12/10/2021 indicates that Resident A was admitted with wounds. The plan also indicates that Resident B is on hospice care and wounds are at risk to worsen due to poor prognosis.

On 08/16/2022, I received a copy of Resident C's assessment plan, health care appraisal and assistive device authorization form. Resident C's only authorized assistive devices are use of walker and wheelchair. Plan does not include the use of bedrails. An incident report was provided dated 07/12/2022 which states that Resident C fell getting out of her wheelchair.

On 08/18/2022, I spoke to Licensee Designee, Lijo Antony by phone. He believes the complaints are anonymous and baseless. He stated that he has not done anything wrong. He stated that people are upset that he is now the owner of Meadows Assisted Living.

On 09/07/2022, I received an email from APS Worker, Debra Johns. Ms. Johns stated that she does not believe APS will be substantiating allegations.

On 09/14/2022, I interviewed McLaren Hospice Nurse, Ann Meerschaert, by phone. She confirmed that Resident B has passed away. She stated that she had no concerns regarding the care Meadows Assisted Living provided for Resident B. They provided care as directed and communicated with her. Resident B came from another facility and already had bedsores when she arrived at Meadows. Resident B had been seen by a wound care nurse. She stated that she did have to educate staff who were concerned regarding wounds as to why Resident B was not being sent to the hospital for further wound care. She did not have any concerns regarding Meadows beyond possibly seeing a resident in same clothes for a couple days. She believes they are providing decent care for residents.

On 09/14/2022, I contacted licensee dsignee, Lijo Antony, by phone to complete an exit conference. I left a message for Mr. Antony with my findings and asked him to contact me for any additional information.

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 not enough information to determine that Resident B's skin was breaking down because she was not cleaned properly. Resident B's assessment plan and Relative 4 indicated that Resident B arrived to Meadows Assisted Living with wounds and was on hospice. McLaren Hospice Nurse, Ann Meerschaert, also stated that the facility provided care as directed. Also, there is not enough information to determine that Resident C fell and was left on the floor. An incident report dated 07/12/2022 indicates that Resident C fell out of her wheelchair and was sent to McLaren Hospital for treatment. Resident C has not returned to Meadows Assisted Living. None of the staff interviewed stated that they have found residents who have fell left on the floor. According to staff, Elise Rogan, there have been occasions where she has found residents wet in the morning. She also has found a soaked pillow from resident not being changed at all during the night.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15306	**Use of assistive devices.**
	(2) An assistive device shall be specified in a resident's written assessment plan and agreed upon by the resident or the resident's designated representative and the licensee.
ANALYSIS:	There is not enough information to determine that Resident C fell because guardrails were not being used. Resident C's health

	care appraisal and assistive device authorization form only allow the use of walker and wheelchair for Resident C.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(a) Use any form of punishment** **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	The manager, Jennifer Hiller, reported that Resident A was hit by staff, Zaire Webb. On 07/10/2022, an incident report was completed that indicated the administrator was contacted and told that staff, Zaire Webb, slapped Resident A's hand while she was combative and hitting both staff. The Sheriff's office was contacted, and the employee was terminated.
CONCLUSION:	**VIOLATION ESTABLISHED**

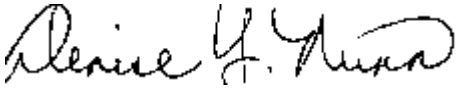
IV. RECOMMENDATION

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

09/14/2022

Kristine Cilluffo Date
Licensing Consultant

Approved By:



09/21/20221

Denise Y. Nunn Date
Area Manager