GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 7, 2022

Brenda Ice
Loving Care Residential Assisted Living, LLC
27852 Starling Lane
Flat Rock, MI 48134

RE: License #: AS820292538
Investigation #: 2023A0116002
Loving Care Residential Assisted Living

Dear Ms. Ice:

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 (313) 456-0380.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820292538
Investigation #:	2023A0116002
Complaint Receipt Date:	10/06/2022
Investigation Initiation Date:	10/10/2022
Report Due Date:	12/05/2022
Licensee Name:	Loving Care Residential Assisted Living, LLC
Licensee Address:	31704 Marigold Dr. Brownstown, MI 48173
Licensee Telephone #:	(734) 348-6006
Administrator:	Brenda Ice
Licensee Designee:	Brenda Ice
Name of Facility:	Loving Care Residential Assisted Living
Facility Address:	31704 Marigold Dr. Brownstown, MI 48173
Facility Telephone #:	(734) 379-2601
Original Issuance Date:	02/07/2008
License Status:	REGULAR
Effective Date:	09/07/2022
Expiration Date:	09/06/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The residents have been given spoiled milk on multiple occasions and have become sick and experienced diarrhea.	No
The resident's medications are not being properly administered as prescribed.	No
Additional Findings	Yes

III. METHODOLOGY

10/06/2022	Special Investigation Intake 2023A0116002
10/06/2022	APS Referral Received.
10/06/2022	Inspection Completed-BCAL Sub. Compliance
10/10/2022	Special Investigation Initiated - On Site Interviewed staff, Sade Lindsay, Resident's A and B, reviewed, and took pictures of Medication Administration Records (MAR) and medications. Observed food supply.
11/07/2022	Contact - Telephone call made Interviewed Guardian (1).
11/07/2022	Exit Conference With licensee designee, Brenda Ice.

ALLEGATION:

The residents have been given spoiled milk on multiple occasions and have become sick and experienced diarrhea.

INVESTIGATION:

On 10/10/22, I conducted an unscheduled onsite inspection and interviewed staff, Sade Lindsay, and Resident A and B. Ms. Lindsay reported that the residents have not been given spoiled milk and denied that any of them have been sick or recently had diarrhea. Ms. Lindsay reported that this allegation is “a flat out lie.”

I interviewed Resident A, and she denied the allegations. Resident A reported that she has never been given spoiled milk, and stated if she had, she would have enough sense not to drink it. Resident A denied being sick or having any issues with diarrhea.

I interviewed Resident B, and she reported that the staff has never given her spoiled milk. Resident B reported that she would be able to smell and taste the difference if given spoiled milk. Resident B also denied that she has been ill or had any issues with diarrhea. Resident B added, “We’re old, not stupid.”

While onsite, I observed the food supply which was adequate. I also looked in the refrigerator and observed the two gallons of milk in there. The milk was not expired, and all of the other food was dated.

On 11/07/22, I interviewed Guardian (1) and she reported that Resident C had not been in the home since mid-September, and had passed away in a nursing home On 10/28/22. Guardian (1) reported that prior to her going into the nursing home, she had no concerns and reported Resident C would not have drunk spoiled milk. Guardian (1) reported for the most part the home provided pretty good meals and Resident C never complained to her about ever eating or drinking spoiled food or beverages. Guardian (1) denied Resident C having issues with diarrhea.

On 11/07/22, I conducted the exit conference with licensee designee, Brenda Ice and informed her of the findings of the investigation. Ms. Ice denied the allegations and agreed with the findings.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	Based on the findings of the investigation, which included interviews with Ms. Lindsay, Resident A and B, and Guardian (1) I am unable to corroborate the allegations. Ms. Lindsay denied that she or the staff serve spoiled milk to residents and denied that the residents have been ill or had issues with diarrhea as reported. Resident A and B both denied being served spoiled milk by the staff, and both reported that they would not drink it had they ever been given it. They both denied being ill or having diarrhea as reported. Guardian (1) reported that while Resident C was living in the home, she never complained of being served spoiled milk and reported that had staff tried to give her spoiled milk she would not have drunk it. Guardian (1) also denied that Resident C had any bouts with diarrhea prior to leaving the home.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The resident's medications are not being properly administered as prescribed.

INVESTIGATION:

On 10/10/22, I conducted an unscheduled onsite inspection and interviewed staff, Sade Lindsay and Residents A and B. Ms. Lindsay reported that all of the resident's medications are administered as prescribed. Ms. Lindsay reported that to her knowledge there have been no issues with medication.

I interviewed Resident A and she reported that she knows each and every medication she takes. Resident A reported that recently there have been no issues with her medication. She reported that in the past there were times when a new staff may have been passing medication and she noticed that a medication was missing. Resident A reported she had to bring it to the staff persons attention who in turn, rechecked the medication book, noticed that she had not passed the medication, and then administered it to her. Resident A reported currently she has been getting all of her medication as prescribed.

I interviewed Resident B and she reported that she is aware of all of the medications she takes and what they are for. Resident B reported that she will catch a

medication error and bring it to the staff persons attention. Resident B reported that the older staff are good and gives her medications as prescribed. She reported that it has been the newer staff that will miss a medication or give double of a medication. Resident B reported that she has caught an error a couple times and informed staff and it has been corrected. Resident B reported that there have not been issues with her medications in a while.

I reviewed the medications for Resident D and E and the medication counts were accurate and it appeared that their medication is being administered as prescribed.

On 11/07/22, I interviewed Guardian (1) and she reported that medication administration was something she never had any concerns about. Guardian (1) reported that at times while visiting, Resident C would say she hadn't received her medications. Guardian (1) reported she would request to see Resident C's medications and the medication log, and she would confirm that she had been receiving her medications. Guardian (1) reported that Resident C was in early-stage Dementia and so she knew that was the reason she would say she hadn't received her medications.

On 11/07/22, I conducted the exit conference with licensee designee, Brenda Ice. I informed Ms. Ice of the findings of the investigation, and she agreed with the findings.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.

ANALYSIS:	Based on the findings of the investigation, which included interviews of Ms. Lindsay, Resident A and B, and Guardian (1) I am unable to corroborate the allegations. Ms. Lindsay reported that the residents all receive their medication as prescribed and reported no concerns have been brought to her about any residents not getting their medication. Resident A and B both reported that they know all of their medications and reported that they get them as prescribed. Resident A and B reported in the past there have been times where they have prevented a medication error, when a new staff person either misses a medication or attempts to administer two doses of a particular medication instead of one dose. They reported that they brought it to the attention of the staff, and it was rectified. I reviewed the medication and medication administration records (MAR) of Resident D and E, and the counts were accurate. Guardian (1) reported while Resident C was residing in the home, she did not have any concerns about her not receiving her medication. Guardian (1) reported that the times she checked, she was able to confirm that Resident C was receiving all of her medications as prescribed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 10/10/22, I conducted an unscheduled onsite inspection and reviewed the medication administration logs for the months of September and October of 2022. I observed that on October 9, and 10, the MARs for Resident A, B, E and F did not contain the initials of the person who administered the medication.

I interviewed staff, Sade Lindsay and she admitted that she is the staff person who failed to initial the MARs. Ms. Lindsay reported that she administered all of the residents 8:00 a.m. medications on 10/09/22 and 10/10/22 and forgot to initial the MAR. I informed Ms. Lindsay that the licensing rules require the initials of the person who administers the medication, at the time of administration. Ms. Lindsay reported that she is aware of the rules and admitted that she knows better. Ms. Lindsay

reported moving forward she will initial the MAR at the time she administers the medication.

On 11/07/22, I conducted the exit conference with licensee designee, Brenda Ice, and informed her of the findings of the investigation. Ms. Ice reported that she knew the staff person responsible was Ms. Lindsay. Ms. Ice reported she has talked with her about this before and will do so again, as well the other staff. Ms. Ice reported all of the staff are fully trained and know the correct way to administer medication. Ms. Ice reported she would submit an acceptable corrective action plan to address the violation.

APPLICABLE RULE	
R 400.14312	**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: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	Based on the findings of the investigation, which included consultant observation and an interview of Ms. Lindsay, I am able to corroborate the allegations. I reviewed the MARs for Resident's A, B, E and F and observed that the MARs did not contain the initials of the person who administered the medication on 10/09/22 and 10/10/22 at 8:00 a.m. Ms. Lindsay also admitted that she was the day shift staff on both days and reported that she failed to initial the MARs as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

11/07/22

Pandrea Robinson
Licensing Consultant

Date

Approved By:

11/07/22

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Ardra Hunter
Area Manager

Date