GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 15, 2022

Rose Ogolla
Precious Care Assisted Living, LLC
720 W. Walnut Street
Kalamazoo, MI 49007

RE: License #: AS390406091
Investigation #: 2022A0581052
Academy Assisted Living

Dear Ms. Ogolla:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390406091
Investigation #:	2022A0581052
Complaint Receipt Date:	09/21/2022
Investigation Initiation Date:	09/21/2022
Report Due Date:	11/20/2022
Licensee Name:	Precious Care Assisted Living, LLC
Licensee Address:	720 W. Walnut Street Kalamazoo, MI 49007
Licensee Telephone #:	(269) 414-8013
Administrator:	Rose Ogolla
Licensee Designee:	Rose Ogolla
Name of Facility:	Academy Assisted Living
Facility Address:	735 Academy St. Kalamazoo, MI 49007
Facility Telephone #:	(269) 414-8013
Original Issuance Date:	11/15/2021
License Status:	REGULAR
Effective Date:	05/15/2022
Expiration Date:	05/14/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A is deaf, and facility direct care staff are unable to communicate with him.	No
Direct care staff are rude to Resident A.	No
Resident A didn't receive multiple prescriptions for several months while at the facility.	Yes

III. METHODOLOGY

09/21/2022	Special Investigation Intake 2022A0581052
09/21/2022	APS Referral APS received the allegations and is investigating.
09/21/2022	Special Investigation Initiated - Letter Email with APS specialist, Lauren Crock
09/23/2022	Inspection Completed On-site Interview with residents and staff
09/23/2022	Contact - Telephone call made Interview with licensee designee, Rose Ogolla.
09/23/2022	Referral – Recipient Rights Via telephone made referral to Integrated Services of Kalamazoo (ISK)
09/23/2022	Contact - Telephone call made Left voicemail with ISK RRO, Lisa Smith.
09/27/2022	Contact - Document Received Email from ISK, RRO
09/27/2022	Contact - Telephone call received Interview with ISK RRO, Lisa Smith
09/29/2022	Contact - Face to Face Interview with licensee designee and staff. Observed Resident A.
10/13/2022	Contact - Face to Face

	Interview with Resident A via interpreter, in conjunction with RRO, at facility.
10/18/2022	Contact - Document Received Received documentation from RRO
10/25/2022	Inspection Completed-BCAL Sub. Compliance
11/14/2022	Exit conference with licensee designee, Rose Ogolla, via telephone.

ALLEGATION:

- **Resident A is deaf and facility direct care staff are unable to communicate with him.**

- **Direct care staff are rude to Resident A.**

INVESTIGATION:

On 09/21/2022, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged Resident A was born deaf and uses American Sign Language to communicate; however, the facility wasn't utilizing anything to translate for Resident A, like an interpreter, and no one could sign with him. The complaint alleged when Resident A writes things out staff will tell him they can't read his writing and don't understand him. Additionally, the complaint alleged direct care staff are rude to Resident A and try not to communicate with him.

On 09/21/2022, I confirmed with Adult Protective Services specialist, Lauren Crock, she had also received the allegations and was investigating. She indicated she attempted to interview Resident A on 09/21/2022 while he was in the hospital. She stated in her email to me she was able to communicate with Resident A by writing out questions with Resident A answering, by shaking his head in a yes or no fashion and using hand gestures. Ms. Crock stated Resident A indicated to her there was no translator in the facility and staff were rude to him; however, no additional information was provided by Resident A.

Ms. Crock stated in her email she had spoken to Resident A's Integrated Services of Kalamazoo (ISK) case manager, TJ Hurley, who confirmed with her there were no translators in the facility and Resident A was placed in the home "last minute" due to his previous placement closing.

On 09/23/2022, I conducted an unannounced onsite investigation at the facility. I interviewed the only direct care staff at the facility, Philomina Omolaja. Ms. Omolaja indicated she uses some American Sign Language (ASL) to communicate with Resident A; otherwise, she stated she and Resident A communicate by writing back and forth on a pad of paper. Ms. Omolaja stated this form of communication worked effectively. She showed me the pads of paper she and Resident A use to communicate with one another. On these pads of papers, I observed questions and answers, which Ms. Omalaja indicated were written in her and Resident A's handwriting. Ms. Omolaja denied being rude to Resident A. She stated she had not observed any other staff being rude to him either. She stated he would get angry if he did not have money to spend or if staff did not drop what they were doing to take him places.

During my investigation, I observed various pictures throughout the facility's kitchen indicating what various ASL signs meant. Ms. Omolaja indicated these signs were placed around the facility when Resident A was admitted assisting staff in communicating with him. She also indicated Resident A communicates through gestures and will point to items or things he needs or wants.

I did not interview Resident A during the onsite as he was still hospitalized. I interviewed Resident B and Resident C. Resident B and Resident C both indicated facility staff and Resident A communicate with one another; however, they did not recall seeing staff or Resident A communicating by writing on a pad of paper. Neither Resident B nor Resident C stated they ever saw staff be rude or inappropriate with Resident A. They both indicated Resident A would throw "temper tantrums" because he would not get what he wanted or when he did not have money.

I reviewed Resident A's *Assessment Plan for AFC Residents* (assessment plan), dated 05/11/2022, which stated Resident A is deaf and utilizes ASL; however, there was no indication in the assessment plan what was expected of staff in order to communicate with him. In the section of "reads and writes" it was indicated Resident A can read and write but he has "broken English."

I also reviewed the only ISK assessment in the facility, dated 07/21/2021, which stated Resident A gets frustrated because he's unable to communicate with everyone and that "life would be easier if everyone knew ASL or he had an interpreter with him at all times." The assessment also stated "[Resident A] has done fairly well with communicating with others being it through text message, written communication, gesturing, etc.…".

I also reveiwed his ISK Treatment Plan Addendum, dated 05/11/2022, but this did not provide any additional information on how staff are expected to communicate with Resident A. It was indicated in the treatment plan addendum that ASL services are coordinated for Resident A's medical and psychiatric appointments.

On 09/23/2022, I interviewed the facility's licensee designee, Rose Ogolla, via telephone. Her statement to me was consistent with Ms. Omolaja's statement to me. Ms. Ogolla stated Resident A was previously residing in an independent living placement, but the facility closed, and Resident A needed placement. She stated there had been no discussion with his case manager about providing continual ASL services in the facility. Additionally, Ms. Ogolla stated she was not aware of any direct care staff being rude to him.

On 09/29/2022, ISK Recipient Rights Officer, Lisa Smith, and I conducted an announced onsite investigation at the facility. Ms. Ogolla, Ms. Omolaja, and Resident A were all present for the onsite. During the onsite, I observed Resident A writing and answering questions on a pad of paper with both Ms. Ogolla and Ms. Omolaja. I also observed him gesturing and using ASL. Based on my observations of Resident A and with staff he appeared to relay his needs and had his questions answered appropriately.

On 10/05/2022, Ms. Smith and I interviewed direct care staff and facility transporter, Keith Sowers, and direct care staff, Connie Barnes, via MiTeams.

Mr. Sowers stated he communicates with Resident A by using some sign language otherwise, he stated he writes his questions and comments on a notepad. He stated he purchased an ASL book to increase his knowledge of ASL signs. Mr. Sowers stated most of Resident A's questions are about getting in touch with his case manager. Mr. Sowers stated an ASL interpreter is present for Resident A's medical and psychiatric appointments.

Mr. Sowers also indicated when Resident A "demands" things like money or pop and staff cannot provide it to him (e.g., money or pop) or they do not know how to answer him (e.g., when he's getting spending money) then he gets frustrated. Mr. Sowers stated he believes Resident A then thinks staff are not paying attention to him.

Ms. Barnes stated she's worked for the licensee since June 2022 and while she primarily works at another facility of the licensee's, she does occasionally work at Academy Assisted Living if staff need to be relieved or take time off. Ms. Barnes stated she was familiar with Resident A and his needs. Her statement to me regarding how staff communicates with him and vice versa was consistent with other staff's statements to me. She indicated that long statements may "confuse" Resident so when she communicates with him, she uses shorter sentences or rephrases sentences, so he understands. She also denied staff being rude to him but indicated staff may "get frustrated" due to Resident A's expressed frustration with more restrictions and/or lack of funds compared to his previous independent living placement.

On 10/13/2022, Ms. Smith and I interviewed Resident A at the facility using an ASL translator service through ISK. Resident A stated "not really" when asked if staff are

able to communicate with him at the facility. He stated they “always write”, but he does not believe this is the best way for him to communicate. He stated he would like to have an interpreter brought in to communicate because when he cannot communicate, he gets frustrated. He was not able to explain how staff talk to him (e.g., if they’re rude, say things inappropriate, etc.).

Ms. Smith confirmed ASL translators are coordinated for Resident A when he has medical and psychiatric appointments.

APPLICABLE RULE	
R 400.14301	**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: **(b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.**
ANALYSIS:	I observed facility direct care staff and Resident A communicating with one another using gestures and handwritten notes. Additionally, I observed ASL pictures throughout the facility kitchen indicating direct care staff have obtained limited ASL information in order to communicate with Resident A. Additionally, I confirmed with recipient rights Resident A has an interpreter available to translate during medical or psychiatric appointments. Despite Resident A being deaf, facility staff can communicate with him, so his basic needs are met.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights:

	(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy. **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	There was no evidence found indicating any direct care staff are rude to Resident A, as alleged.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A had not been receiving multiple prescriptions for several months while at the facility.

INVESTIGATION:

On 09/23/2022, APS specialist, Ms. Crock, sent email correspondence indicating she received additional allegations alleging Resident A had not received at least 21 days worth of his psychiatric medications while he was residing at the facility. Ms. Crock did not know the specific medications that were supposed to be administered; however, she provided me with the contact information for the Physician's Assistant at WMed that could provide the information to me.

I attempted to contact WMed to obtain the names of the medications that were not being administered while at the facility; however, no one returned my voicemails.

The facility's licensee designee, Ms. Ogolla, stated when Resident A was admitted to the hospital, he wasn't taking any psychiatric medications. She indicated he only recently was put on psychiatric medication; however, she was unable to state when these medications started or what the names of the medications were called.

During my onsite investigation, direct care staff, Ms. Omolaja, stated all the medications that were being administered to Resident A were indicated on his Medication Administration Record (MAR). She indicated all the medications he was prescribed were accounted for in the medication cabinet. Ms. Omolaja provided me with Resident A's August and September 2022 MARs, which indicated the facility was providing the following scheduled medications with their respective instructions:

- Amlodipine Besylate, one tablet, once daily
- Azathioprine, 50 mg, one tablet once daily
- Ferrous Sulf, 325 mg, one tablet once daily
- Fluticasone, 50 mg, one spray in each nostril once daily
- Furosemide, 20 mg, one tablet once daily

- Guanfacine ER, 2 mg, one tablet once daily
- Lokelma, 10 mg powder, one packet once daily
- Melatonin, 10 mg, one capsule at bedtime
- Pantoprazole Sod Dr, one tablet once daily
- Prednisone, 5 mg, one tablet once daily with food at the same time each day
- Cyclosporine, 25 mg, three capsules by mouth twice daily
- Sodium Bicarb, 650 mg, four tablets by mouth twice daily

I also reviewed Resident A's medication while onsite to confirm that what was listed on the MAR was actually in the medication cabinet. All the medications listed on the MAR were in the facility and there were no additional medications being kept by the facility that were not accounted for on Resident A's MAR.

Resident B and Resident C both recalled facility staff administering medication to Resident A.

On 09/27/2022, ISK RRO, Ms. Smith indicated the following medications were prescribed by ISK, but were not accounted for on Resident A's September MAR:

- Risperdal (generic name: Risperidone), 1mg, twice a day
- Amantadine, 100 mg, at bedtime
- Topamax, 25mg, twice a day
- Topamax, 50mg at bedtime
- Melatonin, 3mg

Ms. Smith stated that according to the facility MARs, these medications weren't being administered; despite all the prescriptions being current and active. Ms. Smith stated she contacted and interviewed Resident A's ISK case manager, TJ Hurley, who stated to her Resident A's psychiatric medications were sent to a different pharmacy rather than to the one where all of Resident A's other medications are filled.

Ms. Ogolla indicated during the 09/29/2022 onsite investigation that Mr. Hurley informed her while Resident A was in the hospital that Resident A's psychiatric medications were sent to a different pharmacy. During the investigation, I reviewed Resident A's May 2022 MAR, which indicated he was admitted to the facility on 05/11/2022. In addition to the prescriptions identified on his September MAR, Resident A was also prescribed, Risperidone 1 mg Po Tab, with the instruction of "take 1 tablet by mouth twice daily". According to this MAR, Resident A received the medication as required from 05/11/2022 until the am on 05/28/2022; however, there was no indication he received this medication the following dates and times:

- 05/28/2022 at 8 pm
- 05/29/2022 at 8 am and 8 pm
- 05/30/2022 at 8 am and 8 pm
- 05/31/2022 at 8 am and 8 pm

Based on this review, Resident A missed 7 does of his Risperidone medication in May.

In my review of Resident A's June and July MARs, the Risperidone, 1 mg, medication was listed on the MARs; however, there was no indication the medication was administered at all during June or July. Ms. Ogolla was unable to explain why the Risperidone medication wasn't administered to Resident A after 05/28/2022. Additionally, there was no explanation for why the Topamax or Amantadine medications were never administered to Resident A or why the Melatonin dosage wasn't updated to reflect the change from 10 mg to 3 mg.

Available for review in Resident A's record was a "DOCTOR'S MEDICAL REPORT AND VISIT SHEET", dated 08/30/2022, which indicated Resident A had an appointment with ISK's psychiatric doctor. Attached to the visit sheet was a list of Resident A's current medications, which included the following six medications starting on 08/30/2022:

- Amantadine HCl, 100 mg, cap, oral 1 each bedtime
- Intuniv ER, 2 mg, Tb24, oral 1 each morning
- Melatonin, 3 mg, tab, oral 1 each bedtime
- Risperdal, 1 mg, tab, oral 1 each twice a day
- Topamax, 25 mg, tab, oral 1 each twice a day
- Topamax, 50 mg, tab, oral 1 each bedtime

Additionally, in Resident A's resident record, I reviewed a pharmacy physician's order and medication administration record for August, which had the following medications listed as being prescribed to Resident A:

- Amantadine HCl, 100 mg, cap, oral 1 each bedtime
- Risperdal, 1 mg, tab, oral 1 each twice a day
- Topamax, 25 mg, tab, oral 1 each twice a day
- Topamax, 50 mg, tab, oral 1 each bedtime

When Ms. Smith and I interviewed Resident A using the ASL translator, he indicated he uses a lot of medications and direct care staff administer them to him. Resident A could not recall the names of his medications or if he was receiving the correct medications since residing at the facility.

Mr. Sowers stated he transported Resident A to three medical appointments since he's resided at the facility, which included an appointment for his health care appraisal, a scan at the hospital, and lab work. He stated he provides the medical professionals with a doctor visit form, which they complete. He stated the form indicates what the appointment is for, if there are any instructions or changes and if follow-up is needed. He stated, in addition, he also obtains the after-visit summary for the appointment. He stated he takes the doctor visit form and the after-visit

summary back to the facility and goes over it with direct care staff and then files the document in the resident's record.

Mr. Sowers stated that as part of his job, he also calls the pharmacies to ensure resident medications have been sent out. Mr. Sowers was aware of Resident A receiving medications from two separate pharmacies. He indicated he was recently made aware of Resident A missing at least one medication that he should have been provided. Mr. Sowers was unable to provide any explanation for why Resident A's psychiatric medications weren't delivered to the facility, followed up on, or administered to Resident A. He stated it was staff's responsibility to review medications that are delivered to the facility and cross check them with the resident MAR.

Ms. Barnes' statement to me regarding Resident A's medications, the process for taking Resident A to appointments, and relaying information to direct care staff was consistent with Mr. Sowers' statement to me.

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

ANALYSIS:	Based on my investigation, Resident A did not receive several medications, as prescribed, for at least one month. Upon Resident A's admission to the facility, he was administered Risperidone, 1 mg, twice a day; however, facility staff stopped administering this medication to him on 05/28/2022 with no explanation. This medication was not administered to Resident A from 05/28/2022 until September 2022 when the error was discovered by hospital staff. It was also learned that in addition to this medication, there were also several other medications that had not been administered to Resident A, as well. Resident A's resident record confirms Resident A had a psychiatry appointment on 08/30/2022, which indicated Resident A was prescribed Amantadine HCl, 100 mg, cap, oral 1 each bedtime, Intuniv ER, 2 mg, Tb24, oral 1 each morning, Melatonin, 3 mg, tab, oral 1 each bedtime, Risperdal, 1 mg, tab, oral 1 each twice a day, Topamax, 25 mg, tab, oral 1 each twice a day, and Topamax, 50 mg, tab, oral 1 each bedtime; however, upon my review of Resident A's September MAR there was no indication Resident A received any of these medications. Additionally, in my review of Resident A's September MAR, he continued receiving Melatonin, 10 mg, rather than decreased amount of 3 mg, which was ordered on 08/30/2022. In my interviews with direct care staff and the facility's licensee designee, Ms. Ogolla, there was no explanation for Resident A's medications not being present in the facility or not being administered to him other than the medications were sent to a different pharmacy.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/14/2022, I attempted to conduct the exit conference with the licensee designee, Rose Ogolla, informing her of my findings; however, I was unable to reach her via telephone. Subsequently, I sent her an email informing her of my findings.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

11/14/2022

Cathy Cushman — Date
Licensing Consultant

Approved By:

11/15/2022

Dawn N. Timm — Date
Area Manager