GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 22, 2022

Brooke Bosman
Rhema-Armada Village Operating, LLC
22600 W. Main Street
Armada, MI 48005

RE: License #: AL500382677
Investigation #: 2023A0617011
Meadow Ridge Assisted Living

Dear Ms. Bosman:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. A recommendation for revocation is also being made in Special Investigation Report #2023A0617007. You will be notified in writing of the department's action and your options for resolution of this matter.

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,

Eric Johnson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
3026 W Grand Blvd.
Detroit, MI 48202

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL500382677
Investigation #:	2023A0617011
Complaint Receipt Date:	11/21/2022
Investigation Initiation Date:	11/22/2022
Report Due Date:	01/20/2023
Licensee Name:	Rhema-Armada Village Operating, LLC
Licensee Address:	22600 W. Main Street Armada, MI 48005
Licensee Telephone #:	(586) 473-3227
Administrator:	Brooke Bosman
Licensee Designee:	Brooke Bosman
Name of Facility:	Meadow Ridge Assisted Living
Facility Address:	22590 W. Main Street Armada, MI 48005
Facility Telephone #:	(586) 473-3227
Original Issuance Date:	08/02/2016
License Status:	REGULAR
Effective Date:	01/01/2021
Expiration Date:	12/31/2022
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident C eloped out of his bedroom window. There is not enough staff for the residents.	Yes
Manager Sherry Skivba. is forcing the Med Techs to pass resident evening medications as early as 2 or 3 pm due to being short staffed.	Yes

III. METHODOLOGY

11/21/2022	Special Investigation Intake 2023A0617011
11/21/2022	Contact - Telephone call received I conducted a phone interview with the complainant.
11/22/2022	Special Investigation Initiated - Face to Face I conducted an unannounced onsite investigation at the facility During the onsite investigation, I interviewed staff members Delaney Verschure, Karlie Friedmann, managers Keri Sikora, Sherry Skivba, Diane Thomas and Ruby Buckner.
11/22/2022	Contact - Telephone call received I conducted a phone interview with facility's staff scheduler Megan Frazier.
11/22/2022	Inspection Completed On-site I conducted an unannounced onsite investigation at the facility During the onsite investigation, I interviewed Resident C, staff members Delaney Verschure, Karlie Friedmann, managers Keri Sikora, Sherry Skivba, Diane Thomas, Jewel Maluchnik, and Ruby Buckner.
11/30/2022	APS Referral I completed an Adult Protective Services (APS) referral
12/01/2022	Contact - Face to Face I conducted an unannounced onsite investigation of the facility. During the onsite investigation, I interviewed unofficial licensee designee David Duffy, Resident B's Daughter.

12/02/2022	Contact - Telephone call made I conducted a phone interview with Ms. Jennie Wesley.
12/02/2022	Contact - Telephone call received Resident B's daughter
12/06/2022	Exit Conference I attempted to hold an exit conference with Ms. Boseman via telephone, but she did not answer. A follow email was sent as well.

ALLEGATION:

- **Resident C eloped out of his bedroom window. There is not enough staff for the residents.**
- **Manager Sherry Skivba is forcing the Med Techs to pass resident evening medications as early as 2 or 3 pm due to being short staffed.**

INVESTIGATION:

On 11/21/22, I received a complaint on Meadow Ridge Assisted Living facility. The complaint indicated that Resident C busted out his screen window and successfully left the facility without any of the care staff/managers noticing. It wasn't until a housekeeper from the facility was driving into work who noticed an elderly man walking towards True Rd in Armada MI and happened to tell one of the care staff working that unit. The facility is supposed to have working alarms on the windows, but the window alarms are not checked frequently to make sure they are working for our resident's safety. One of the aides were filling out her statement about the incident that happened, and the mangers made her word her statement a certain way to make it seem like it was her fault as to why the resident escaped, taking the blame off of the facility! The resident is mainly independent and happened to barricade his door, and then escaped out the window. Thankfully the resident was not harmed but did have to seek medical attention due to a mental status change. Care staff has repeatedly told the managers and corporate about the negligence that is happening in this building, and nothing has been done to improve the quality of care the residents receive.

On 11/21/22, I conducted a phone interview with the complainant. The complainant stated that a week or so ago, Resident C busted out his screen window and successfully left the facility without any of the care staff/managers noticing. It wasn't until a housekeeper from the facility was driving into work noticed an elderly man walking towards True Rd in Armada MI and happened to tell one of the care staff that was working that unit.

On 11/22/22, I conducted an unannounced onsite investigation at the facility During the onsite investigation, I interviewed Resident C, staff members Delaney Verschure, Karlie

Friedmann, managers Keri Sikora, Sherry Skivba, Diane Thomas, Jewel Maluchnik, and Ruby Buckner.

Resident C was unable to accurately answer any questions and was very confused as he kept repeating himself and his statements did not make sense. Resident C appeared to be healthy, clean and well groomed.

According to manager Ruby Buckner, she was not in the building as she primarily works at the skilled nursing facility on the premises. Ms. Buckner stated that Resident C eloped and staff found him on the premises and brought him back to the facility. Resident C wanted to go home and wouldn't come back into the facility. Resident C's son was contacted to speak with Resident C and hopefully calm him down. This was ineffective so the police and EMS were called. Resident C was transported to the hospital and admitted.

According to Sherry Skivba, she was not in the building as she primarily works at the skilled nursing facility on the premises. When she arrived outside of the facility, staff already located Resident C and were in the process of returning to the facility. The police were contacted, and they took him to the hospital to be evaluated. Ms. Skivba stated that the facility completed an incident report (IR), but it was not sent to the department. I was presented with an incident report dated 11/9/22. The IR indicated that Resident C barricaded himself in his room, went out window and was retrieved by a staff member in front of the building. Resident C proceeded to walk into town and unable to be redirected by staff to come back in, police were able to bring him back to the facility. The IR is signed by Ms. Skivba, however she admitted that she was not present for the elopement. Ms. Skivba stated that she wrote the IR based on the information she was provided to her by Jewel Maluchnik.

During the onsite investigation, I interviewed manager Jewel Maluchnik. According to Ms. Maluchnik, she was not in the building as she primarily works at the skilled nursing facility on the premises. There was a code green called which means resident elopement and she immediately ran outside to assist. She saw staff talking with Resident C and he did not want to come back into the facility. Resident C's son was called as well as the police. The police came and got Resident C into the building, but Resident C was still very agitated. EMS was called and Resident C was sent to the hospital. According to Ms. Maluchnik this happened around 7 am on 11/9/22 and Jennie Wesley was the staff on shift.

During the onsite investigation, I interviewed staff Karlie Friedmann. According to Ms. Friedmann, On 11/9/22 around 7 am, Resident C took out his screen window and successfully left the facility without any of the care staff/managers noticing. A housekeeper from the facility was driving into work noticed Resident C walking towards True Rd in Armada MI and happened to tell one of the care staff that was working that unit.

During the onsite investigation, I interviewed staff Delaney Verschure. According to Ms. Verschure, Resident C took out the screen to the window in his room and went eloped without staff noticing. A housekeeper found him walking down the street and reported it to staff at the facility.

On 12/02/22, I conducted a phone interview with Ms. Jennie Wesley. Ms. Wesley stated that on 11/9/22, staff Rhonda Milton was the only care staff member on shift and Ms. Wesley was the Med Tech on shift. Ms. Wesley gave Resident C his medication at 6:37am and he took his medication without issue. Ms. Wesley went back to her med cart to get the medications ready for the next resident when she heard a resident's wheelchair alarm go off. She immediately locked up the cart and went to check on the resident. Ms. Milton was already there assisting the resident but asked Ms. Wesley for assistance getting the resident up and dressed. This took approximately 10 minutes. Once Ms. Wesley was done, she went back to her med cart but she seen the house keeper Ellen franticly walking through the facility towards Resident C's room. Ms. Wesley asked Ellen what was wrong, and she believed she had just saw Resident C walking down the road. Ms. Wesley attempted to open Resident C's door, but it was stuck. She had to forcefully push the door open; the door was barricaded shut with Resident C's laundry basket and a very heavy rocking chair. When Ms. Wesley went into the room it was extremely cold. Ms. Wesley stated that this happened at 7:11 am. Resident C could not be found in his room and his window was found open. Ellen left the facility to go retrieve Resident C. Ms. Wesley ran and called for a code green which means resident elopement. Ellen brought Resident C back to the facility, but he would not enter the building. Resident C was then taken to the hospital by emergency services. Ms. Wesley called and notified Resident C's son about the incident. Managers Jewel and Ruby told Ms. Wesley to document what happened and put it in the computer system.

Ms. Wesley typed a report in the system detailing what happened but was told by Jewel, Ruby and Sherry Skivba to rewrite the statement because they did not like the way she worded her report. The management staff forced Ms. Wesley to complete another statement and they told her what to say. Ms. Wesley stated that the manager's version indicates that Resident C was found in the parking lot, but that was not true. The manager's version also indicates that staff was inside doing a head count of residents and Ms. Wesley stated that was not true. Ms. Wesley took a picture of both statements and kept them in her phone to prove the difference. Ms. Wesley provided me with copies of both statements via email.

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:	On 11/9/22 around 7 am, Resident C took out his screen window and successfully left the facility without any of the care staff/managers noticing. A housekeeper from the facility was driving into work noticed Resident C walking towards True Rd in Armada MI and happened to tell one of the care staff working that unit. According to Ms. Wesley, on 11/9/22, she assisted Ms. Milton with getting a resident up and dressed. While Ms. Milton and Ms. Wesley were assisting a resident, Resident C barricaded his room door with a chair and laundry basket and eloped. Staff was unaware that Resident C had eloped.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Manager Sherry Skivba is forcing the Med Techs to pass resident evening medications as early as 2 or 3 pm due to being short staffed.

INVESTIGATION:

On 11/21/22, I conducted a phone interview with the complainant. The complaint stated that manager Sherry Skivba. is forcing the Med Techs to pass resident evening medications as early as 2 or 3 pm due to being short staffed. Sherry Skivba forces staff to pass out the medication and fill out a paper MAR (Medication Administration Record) and after 6pm Sherry Skivba will enter the information into the computer system to make it seem like the medications were given at the appropriate time.

During the onsite investigation on 11/22/22, I interviewed staff Karlie Friedmann. Ms. Friedmann stated that caring for the residents at the three facilities is too much work for one person to do alone. She has often had to pass medications and care for the residents at the same time. According to Ms. Friedmann, she was scheduled to work yesterday 11/21/22, from 6 am to 2pm. There was no other med tech schedule to work after 2pm. She texted Ms. Frazier and asked her what to do and Ms. Frazier stated that manager Sherry Skivba said to pass the evening medications early and leave at 3pm. Ms. Friedmann stated that she felt that was wrong and she did not feel comfortable doing that to the residents so she stayed until 7 pm to ensure that the residents would receive their medication at the appropriate time. Ms. Friedmann showed me a text message from Ms. Frazier that stated, “if you go to Diane, she will print you the paper MAR (Medication Administration Record) and you could do the meds and be done by 3 if you don’t mind staying an extra 30 minutes”.

During the investigation I interviewed staff Delaney Verschure. Ms. Verschure stated the facility is still extremely short staffed and there is a growing concern for the wellbeing of the residents. When the facility is short staffed and does not have anyone to pass medications, manager Sherry Skivba tells her to pass the evening medications early and chart it on a paper copy of the Medication Administration Record and Ms. Skivba

will put it in the system at 6pm to make it look like it was given at the appropriate time. Ms. Verschure stated that she has given evening medications to residents as early as 2 or 3pm that were not to be given prior to 6pm.

During the onsite investigation, I tried to conduct a medication review of the resident's medication. As I was reviewing the medications in the computer system with staff Delaney Verschure, I was interrupted by Keri Sikora, Sherry Skivba, and Ruby Buckner. Sherry Skivba and Ruby Buckner stated that they did not work at the actual facility; but at the affiliated Skill Nursing facility that is on the same campus as this facility. Keri Sikora, Sherry Skivba, and Ruby Buckner told me to stop reviewing the medication records that were in the computer system because they would print and email me copies of the records. I informed them that was not necessary, and I could continue reviewing the documents in the system, as well as continuing to take photo records with my State of Michigan issued cell phone. I was told by the above-mentioned individuals that I was not allowed to take pictures of the medication records. I specifically stated that I needed to review the medication administration records onsite and I needed to see the times that the medications were given (which is shown in the computer system). The management team still denied me the opportunity to continue reviewing the records in detail, as well as take pictures of the records. I informed the managers that if I cannot review the records in the system then they would have to print and provide me with copies of the medication records as well as the administration details that show the actual time given, while I was onsite.

After waiting for approximately 30 minutes, I was finally able to briefly continue reviewing the records in the system but still was not allowed to document the records by taking photos. When I was able to resume reviewing the medication records in the system I was assisted by Ruby Buckner and Sherry Skivba. I found several medication errors; as there were medications given at the incorrect time and Ruby Buckner and Sherry Skivba could not provide a reason for the errors. Both Sherry Skivba and Ruby Buckner stated that they do not pass medications and were unfamiliar the resident's medications. However, Sherry Skivba's initials were observed as the staff that administered several resident's medications on several occasions.

Sherry Skivba's initials were observed as the staff person that administered the following medications:

- Resident C - Donepezll HCl tablet 10 MG, Quetiapine Fumarate tab 25mg,Carvedilol tab 12.5mg, and Hyralazine HCl tab 25mg on 11/09/22.
- Resident G - Docusate Sodium Tab 100mg, Omeprazole 20mg, Zoloft Tab 100mg, and Acetaminophen 325mg on 11/09/22 and 11/10/22.
- Resident J's - Ativan Tab 1mg, Artificial Tears Solution 1.4%, on 11/10/22 and 11/09/22.
- Resident H's - Mematine HCl Tab 10mg, Colace Capsule 100MG, Trazodone HCl tab 50MG, Lamotrigine tab 100MG, and Tylenol tab 325mg on 11/09/22 and 11/10/22.

Prior to leaving I was provided with printed copies of the medication records but not the actual documentation (details) of when the medications were given as I asked for previously. I was then told by Keri Sikora, Sherry Skivba, Diane Thomas and Ruby Buckner that they do not have the capability to print that requested information. By denying me the opportunity to take pictures of the required information and forcing me to stop my investigation for approximately 30 minutes, caused an interference in my investigation process.

The following errors were observed during the medication review:

- Resident J:
  Received Lorazepam 1mg at 14:50 on 11/20/22
- Resident B:
  Tylenol tab 325mg is to be given 4x a day, on 11/17/22 she received a dose at 14:08 and 14:07. On 11/18/22, she received the 21:00 dose at 17:23. On 11/20/22, she received her 21:00 dose at 15:15.
  Omeprazole 20 MG was given at 14:08 on 11/17 and at 15:15 on 11/20/22
- Resident F:
  Escitalopram tab 10mg was given at 14:20 on 11/20/22 and 14:15 on 11/17/22
  Quetiapine tab 25mg was given at 14:20 on 11/20/22 and 14:15 on 11/17/22
  Acetaminophen tab 325 mg was given at 14:21 on 11/20/22 and 14:15 on 11/17/22

On 11/22/22, I conducted a phone interview with facility's staff scheduler Megan Frazier. According to Ms. Frazier, she was unable to meet with me during my onsite investigation at the facility today because she was instructed by the facility's unapproved acting licensee designee David Duffey that when I come to the facility, she is to leave and take a lunch until I am gone to avoid being interviewed by me. Ms. Frazier stated that Sherry Skivba has forced staff to pass the residents evening medications earlier than prescribed due to the lack of staffing at the facility. According to Ms. Frazier, Sherry Skivba instructed staff to get a paper copy of the MAR (Medication Administration Record) for the residents and administer the medications early and Ms. Skivba will enter the information into the electronic record keeping system at the appropriate time to make it appear like the meds were administered properly. According to Ms. Frazier, Ms. Skivba does not work on the floor with the residents nor does she pass medications.

On 12/02/22, I conducted a phone interview with Ms. Jennie Wesley. According to Ms. Wesley, Sherry Skivba would tell the med techs that they could fill out a paper MAR and pass the residents medications early. Ms. Skivba would enter the information into the system later so that it would appear they were administered on time. Ms. Wesley stated that Diane Thomas would print the paper MARS and give them to the med techs to use. Ms. Wesley stated that she refused to administer the medications early as it was wrong and neglectful to the residents. Ms. Wesley stated that she would instead work additional hours to ensure that the residents received the medications as prescribed.

On 12/06/22, I attempted to hold an exit conference with Ms. Boseman but she did not answer. A follow-up email was sent as well.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Manager Sherry Skivba forces staff to pass out the medication and fill out a paper MAR (Medication Administration Record). Then after 6pm, Sherry Skivba will enter the information into the computer system to make it seem like the medications were given at the appropriate time. The following errors were observed during the medication review: Resident J - Received Lorazepam 1mg at 14:50 on 11/20/22 Resident B - Tylenol tab 325mg is to be given 4x a day, on 11/17/22 she received a dose at 14:08 and 14:07. On 11/18/22, she got the 21:00 dose at 17:23. On 11/20/22, she received her 21:00 dose at 15:15. Omeprazole 20 MG was given at 14:08 on 11/17 and at 15:15 on 11/20/22. Resident F– Escitalopram tab 10mg was given at 14:20 on 11/20/22 and 14:15 on 11/17/22. Quetiapine tab 25mg was given at 14:20 on 11/20/22 and 14:15 on 11/17/22 and acetaminophen tab 325 mg was given at 14:21 on 11/20/22 and 14:15 on 11/17/22. I found several medication errors specifically medications given at the incorrect time. Ruby Buckner and Sherry Skivba could not provide a reason for the errors. Both Sherry Skivba and Ruby Buckner stated that they do not pass medication and were unfamiliar the resident's medications. However, Ms. Sherry Skivba's initials were observed as the staff person that administered several resident's medications on several occasions.
CONCLUSION:	**VIOLATION ESTABLISHED**

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: **(b) Complete an individual medication log that contains all of the following information:**

	(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given
ANALYSIS:	Manager Sherry Skivba forces staff to pass out the medication and fill out a paper MAR (Medication Administration Record). Then after 6pm, Sherry Skivba will enter the information into the computer system to make it seem like the medications were given at the appropriate time. Both Sherry Skivba and Ruby Buckner stated that they do not pass medication and were unfamiliar the resident's medications. However, Ms. Sherry Skivba's initials were observed as the staff person that administered several resident's medications on several occasions as follows: Resident C - Donepezll HCI tablet 10 MG, Quetiapine Fumarate tab 25mg, Carvedilol tab 12.5mg, and Hyralazine HCI tab 25mg on 11/09/22; Resident G - Docusate Sodium Tab 100mg, Omeprazole 20mg, Zoloft Tab 100mg, and Acetaminophen 325mg on 11/09/22 and 11/10/22; Resident J's - Ativan Tab 1mg, Artificial Tears Solution 1.4%, on 11/10/22 and 11/09/22 and Resident H's - Mematine HCI Tab 10mg, Colace Capsule 100MG, Trazodone HCI tab 50MG, Lamotrigine tab 100MG, and Tylenol tab 325mg on 11/09/22 and 11/10/22.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15103	**Licenses; required information; fee; effect of failure to cooperate with inspection or investigation; posting of license; reporting of changes in information.**
	(3) The failure of an applicant or licensee to cooperate with the department in connection with an inspection or investigation shall be grounds for denying, suspending, revoking, or refusing to renew a license.
ANALYSIS:	On 11/22/22, during the unannounced onsite investigation, management from the skilled nursing home onsite told me to stop reviewing the medication records that were in the computer system. I was also told I could not continue reviewing the documents in the system, as well as continue to take photo records with my state issued cell phone. I specifically said that I need to review the medication administration records and I need to see the times that the medications were actually given (which is shown in the computer system details). The management team still denied me the opportunity to continue reviewing the

	records in detail, as well as take pictures of the records. The licensee did not cooperate during this investigation by denying me the opportunity to take pictures of the required information and for forcing me to stop my investigation for approximately 30 minutes and by not providing a printed copy of the information I requested.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend revocation of the license, which is also being made in Special Investigation Report #2023A0617007.

12/12/22

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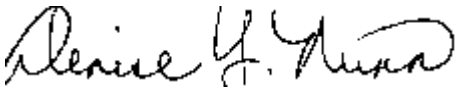
Eric Johnson Date
Licensing Consultant

Approved By:



12/13/2022

_____

Denise Y. Nunn Date
Area Manager