GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

Connie Clauson
Assured Care Assisted Living, LLC
Suite 203
3196 Kraft Ave SE
Grand Rapids, MI 49512

March 1, 2023

RE: License #: AL110283726
Investigation #: 2023A0579020
The Willows Assisted Living #3

Dear Mrs. Clauson:

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 (616) 356-0183.

Sincerely,

Cassandra Duursma

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(269) 615-5050

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

I. IDENTIFYING INFORMATION

License #:	AL110283726
Investigation #:	2023A0579020
Complaint Receipt Date:	01/06/2023
Investigation Initiation Date:	01/10/2023
Report Due Date:	03/07/2023
Licensee Name:	Assured Care Assisted Living, LLC
Licensee Address:	Suite 203, 3196 Kraft Ave SE, Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Lori Copeland
Licensee Designee:	Connie Clauson
Name of Facility:	The Willows Assisted Living #3
Facility Address:	3440 Niles Road, St. Joseph, MI 49085
Facility Telephone #:	(269) 428-0715
Original Issuance Date:	12/11/2007
License Status:	REGULAR
Effective Date:	09/26/2022
Expiration Date:	09/25/2024
Capacity:	20
Program Type:	AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive adequate care.	No
Resident A did not receive her medication.	Yes

III. METHODOLOGY

01/06/2023	Special Investigation Intake 2023A0579020
01/10/2023	Special Investigation Initiated - Face to Face Resident A Lori Copeland, Administrator
01/10/2023	Contact - Document Received Lori Copeland, Administrator
01/11/2023	Contact - Document Received Lori Copeland, Administrator
02/09/2023	Contact - Document Received Two new complaint intakes.
02/15/2023	Contact- Face to Face Resident A, Relative A1, Latesha Townsend (Direct Care Worker/DCW), Lori Copeland (Administrator)
2/27/2023	Contact- Document Sent Lori Copeland, Administrator
02/27/2023	Contact- Telephone call made Dequarius Robinson, DCW
02/27/2023	Contact- Telephone call made Dequarius Robinson, DCW
02/28/2023	Contact- Telephone call made Taletha Hudson, DCW
03/01/2023	Exit Conference Lori Copeland, Administrator

ALLEGATION:

Resident A did not receive adequate care.

INVESTIGATION:

On 1/6/23, I received this referral through the Bureau of Information Tracking System on-line complaint system. The referral alleged at approximately 3:20 a.m. on 12/3/22, Resident A needed assistance and used her call button, but no one responded. Resident A reported it was “unusually quiet”, so she began yelling for assistance and no one responded. Resident A became upset and called 911. The 911 operator called The Willows and a worker from a different building came over and assisted Resident A. Resident A was observed visibly upset during the day on 12/3/22. There is concern that direct care workers (DCWs) were not in the home as they were supposed to be and were not appropriately caring for residents overnight. There is also concern that home administrator, Lori Copeland, asked DCW, Latesha Townsend, to speak to Resident A about “confidential matters in violation of HIPAA” and “coerced” Resident A “inhumanely” for Ms. Townsend to report information back to Ms. Copeland instead of speaking to the family herself.

On 1/10/23, I completed an unannounced on-site investigation. I interviewed Ms. Copeland and Resident A. Interviews were completed privately.

Ms. Copeland stated she was made aware of the allegations that Resident A made regarding two DCWs not responding to her call button. She stated she spoke to Resident A and her relatives and Resident A reported she woke up in the middle of the night and needed assistance from staff, so she pressed her call button. She stated, Resident A reported staff did not respond to her call button, so she began yelling and staff continued to not respond. She stated, staff did not respond to Resident A’s yelling, so Resident A called 911, the 911 operator called The Willows, and a female staff person from a different building came over to assist Resident A.

Ms. Copeland stated two male DCWs were working overnight when the incident occurred, and they reported when they checked on Resident A a few times, she refused help from them. She stated, Resident A pressed her call button and the senior DCW advised the training DCW, not to respond to the call because Resident A refused assistance. She stated once the 911 operator spoke to a DCW in a different home, a female DCW came over and assisted Resident A. She stated both workers reported they were in the home but did not respond to Resident A because she refused their assistance.

Ms. Copeland stated it was the senior DCW’s last night employed at the home, he had voluntarily ended his employment with notice prior to this incident, so she is not certain he was performing his job requirements to the best of his abilities that night and not modeling appropriate care for residents, although he denied any wrongdoing

when she spoke to him. She stated she spoke with the training DCW and informed him that he should have continued to respond to Resident A, not ignored her call button, even if she refused assistance from them initially. He reported he was advised by the senior DCW not to respond so, being new, he followed that instruction. She stated Resident A does have a history of refusing care from DCWs at times, but it is not necessarily based on DCW gender, rather it seems to vary by her mood.

Regarding the additional allegations, Ms. Copeland stated Ms. Townsend previously had an excellent relationship with Resident A and her relatives. She stated after how upset Resident A and her relatives were after this incident, she felt it may be better if Ms. Townsend spoke with Resident A and her relatives and not Ms. Copeland because relatives are regularly upset with Ms. Copeland. She requested Ms. Townsend inquire if Resident A would like a medical evaluation given how upset she was after this incident. She stated in this situation though, there was a conflict of interest because the senior DCW working the night of the incident was Ms. Townsend's son. She stated because Resident A and her relatives were so upset, they accused Ms. Townsend of violating HIPAA by "attempting to arrange medical treatment" for Resident A without their consent. She stated all Ms. Townsend asked was whether Resident A would like to go to the hospital because she was upset. She stated the family was also upset that Ms. Townsend was speaking to them and not Ms. Copeland which they reported was inappropriate. She stated she felt Ms. Townsend speaking to the family would be most helpful but the family was so upset, and possibly due to Ms. Townsend's son's involvement in the incident, they now are targeting Ms. Townsend which she did not intend to happen. She stated Ms. Townsend did nothing wrong in speaking with the family at her request.

Resident A primarily wanted to discuss how she does not like the food in the home because it lacks seasoning and is not food that she would eat prior to living at this home. She reported she gets sufficient, nutritious food and has additional seasonings in her room, but she wishes the food was made how she would make it at home. When prompted to discuss the allegations, Resident A stated she remembers waking up one night and no one was available to assist her. She stated she pressed her call button, and no one responded. She stated she felt that no one was in the home, so she started yelling for help and no one responded. She stated since no one was responding, she called 911 and a female DCW from another home came over and assisted her. She stated there were two male DCWs in the home that night, but she denied refusing assistance from them, she reported they just did not respond to her. She reported she does not mind if male DCWs assist her. She stated she will refuse assistance from staff and tell them, "Get out of my room" if she does not like them. She then discussed multiple DCWs she has told to get out of her room who were both male and female.

On 1/11/23, I received an email from Ms. Copeland reporting relatives of Resident A are upset "someone from Lansing" spoke to Resident A without a relative present. I responded advising Ms. Copeland that, as I had told relatives during a previous

investigation, I do not schedule interviews with residents as it is best practice to speak to residents on their own without time for anyone to prompt or coach residents in preparation for my interview. I also reminded Ms. Copeland that I had met a relative of Resident A's multiple times and they previously did not have concern for me speaking to Resident A. Ideas for completing best practice interviews while trying to not upset Resident A's family were discussed.

On 2/9/23, I received an additional referral that reported Ms. Copeland allowed "someone from Lansing" to interview Resident A without a relative present which is not appropriate, and that Ms. Townsend made "inhumane" comments that it is difficult to move the Hoyer lift in Resident A's room because the room is small and the room across the hall that opened is bigger. It was reported Ms. Townsend discussing the rooms was "threatening and abrasive" given that Resident A has anxiety due to pain.

On 2/15/23, I completed an on-site investigation at the home. Interviews were completed with Ms. Copeland, Ms. Townsend, and Resident A. Resident A's interview was completed with Relative A1 present for the latter half of the interview.

Ms. Copeland stated she would be contacting Resident A's relatives when I go to interview Resident A. She stated there was a recent incident with APS where Resident A's relatives became upset the APS worker did not wait for a relative to arrive to interview Resident A reporting that was not APS best practice either. She stated since that time, relatives and Resident A have been extremely upset about anyone, even DCWs speaking to Resident A. She stated relatives have also complained that DCWs are not speaking enough to Resident A and therefore providing "inhumane" treatment. She stated at this point she does not believe that Resident A will speak to me and has been coached to say, "I can't speak to you until my daughter is here." She stated because of this dynamic she would prefer to notify relatives when I begin interviewing Resident A. I agreed.

Ms. Copeland stated it was reported to her that relatives were upset that DCWs made a comment about it being difficult to move the Hoyer lift in Resident A's room because there is a lot of furniture and items in the room and not a lot of space. She stated it was reported Resident A brought up moving across the hall and DCWs advised Resident A should speak to Ms. Copeland regarding that. She stated it is difficult to move the Hoyer lift through Resident A's room and it is limited to one corner where Resident A can be lifted from her bed to her chair because of the other furniture and belongings in the room. She stated where the Hoyer lift currently is allows for appropriate movement of Resident A, it just cannot be moved elsewhere because there is not room for it. She stated discussion of the Hoyer was not done maliciously as was reported, it was just a conversation that occurred.

Ms. Copeland reported she anticipates new allegations will be reported because Resident A is upset that she cannot be showered when she immediately requests to be showered. She stated today one person left sick and two people did not arrive for

their shift. She stated due to other residents needing their medications within a certain timeframe, DCWs who were present needed to immediately pass medication and then could shower residents. She stated Resident A did not get her shower at 6:00 a.m. like she requested, but rather got it closer to 9:30 a.m. She stated efforts have been made to shower Resident A immediately when she wants a shower, such as having third shift shower Resident A, but for various reasons none of the solutions they have tried have worked. She ensured Resident A continues to get showers twice a week on Wednesday and Saturday mornings, but she gets upset that staff cannot always immediately shower her when she requests them to.

Ms. Townsend stated she has never spoken inappropriately to Resident A, nor has she witnessed any other DCW speak inappropriately to Resident A. She stated Resident A was discussing how there was limited space for her Hoyer lift in her room which the DCWs in her room agreed with. She stated Resident A then began discussing the open room across the hall. Ms. Townsend stated because Resident A's relatives have become upset with her involvement in Resident A's care before, she advised Resident A would need to discuss the concerns for her room and inquire about the room across the hall with Ms. Copeland, she could not discuss it any further. She stated nothing about that conversation was inappropriate or "inhumane."

During interviewing, Resident A preferred to discuss that she was upset that there is not sufficient staff to shower her immediately this morning. She stated she wanted to shower at 6:15 a.m. today but got her shower closer to 9:35 a.m. I advised her that Ms. Copeland reported three people who were on the schedule today were not actually in the home so that was likely why there was a delay this morning. She stated the home needs to hire more staff because showering immediately when she wakes up helps with her pain so she should not have to wait for assistance. Resident A continued to discuss this concern throughout the interview. When Relative A1 arrived, Relative A1 attempted to explain that residents need their medications, and the home was short-staffed so it was understandable that she could not shower immediately when she wanted to and had to wait a few hours. Resident A would not respond to redirecting.

When prompted to discuss comments made by Ms. Townsend, Resident A expressed concern that Ms. Townsend used to go beyond the basic requirements for her and was very involved in her care. She expressed that she is upset that Ms. Townsend is no longer as involved in her care and she does not feel "that is right." She stated Ms. Townsend typically would have showered her or made another DCW shower her so she did not have to wait this morning, and she does not know why Ms. Townsend will not shower her or will not make DCWs shower her immediately anymore. She denied recollection of anyone discussing a bigger room with her. At this point, Relative A1 intervened and stated Resident A previously said Ms. Townsend discussed the bigger room with her which she reported to Ms. Copeland because Ms. Townsend should not be making comments about Resident A's room, that is between her family and Ms. Copeland.

On 2/27/23, I attempted a telephone interview with Dequarius Robinson who was reported to be the senior DCW working on the night Resident A reported not being attended to on 12/3/22. A voicemail message was left requesting a return phone call. A return call was not received at the time of the completion of this report.

On 2/27/23, I completed a telephone interview with Robert Molo who reported he does not remember much about his brief time working at the home. He stated he did remember one night when a DCW from another home came over and said the police had called about a resident and that DCW came over to check on and care for her. He stated he was new and had worked with Resident A during the day previously and she had told him she did not want him to care for her. He stated he reported to Mr. Robinson that he had not worked a night shift in this home before and that Resident A previously told him she did not want him caring for her, so he was concerned. He stated he is not sure where Mr. Robinson went but he was gone several hours during the shift that night. He stated he ended up having to care for Resident A every two hours since he was working alone, and two times Resident A told him she did not want him caring for her. He stated he does not recall Resident A using her call button and denied ignoring her call button. He stated he is certain she did not yell as he would have heard her yelling from where he was in the nurse's station. He stated he remembers being surprised that the DCW from the other home came over and reported the police had called because he had just checked on Resident A and she appeared fine although she reported she did not want assistance and wanted him to leave. He stated Resident A did not appear upset or in need of care either time, in compliance with the two-hour toileting requirement, he checked on her that night.

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:	During the investigation concerns were reported that Resident A was not cared for appropriately overnight on 12/3/23 and that Ms. Townsend discussed medical care and a larger room with Resident A which was reportedly "inhumane" treatment by Ms. Townsend. Mr. Molo reported he provided adequate supervision for Resident A on 12/3/22 by checking on her every two hours. He reported twice Resident A appeared fine and refused his assistance. He denied Resident A calling or yelling for assistance and reported being surprised when another DCW

	came to the home because the police reported Resident A needed assistance. Mr. Robinson who was also present at times on 12/3/22 did not respond to a telephone request for interviewing. Ms. Copeland reported she requested Ms. Townsend speak to Resident A and her relatives because she previously had a very positive relationship with them. She stated it was at her request Ms. Townsend asked if Resident A would like to go to the hospital on 12/3/22. She stated because of Ms. Townsend's son's involvement overnight on 12/3/22, she feels relatives are now targeting Ms. Townsend. Ms. Townsend denied ever speaking inappropriately to Resident A. She stated when Resident A inquired about a bigger room because there is limited space for her Hoyer lift, she directed Resident A to bring her concerns to Ms. Copeland. Resident A reported she used her call button, yelled, and then called 911 when no one responded on 12/3/22. She reported she does tell DCWs to get out of her room but denied saying that to Mr. Robinson or Mr. Molo on 12/3/22. Resident A denied concern for Ms. Townsend aside from that Ms. Townsend used to be very involved in her care and she is not anymore. Relative A1 reported Resident A stated Ms. Townsend discussed a bigger room with her which is not appropriate as that should be discussed between Resident A, her relatives, and Ms. Copeland. Based on the interviews completed, there is insufficient evidence to support that Resident A did not receive adequate care.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A did not receive her medication.

INVESTIGATION:

On 2/9/23, I received an additional referral which reported on 1/14/23, DCW Taletha Hudson, did not give Resident A her evening dose of Gabapentin for her leg pain

because Ms. Hudson reported she could not locate the medication and believed it was not available. The lack of medication left Resident A having “severe leg spasms” that required Resident A to be taken to the hospital. The referral source reported they felt Ms. Hudson acted with “gross negligence” by not double-checking the prescription, asking another worker, or calling Resident A’s relatives. The referral included an “After Visit Summary” from Lakeland Hospital reporting Resident A was seen at the hospital for leg pain on 1/14/23.

On 2/15/23, Ms. Copeland stated Ms. Hudson did accidentally make a medication error. She stated Ms. Hudson does not typically work overnight and does not normally pass Resident A’s Gabapentin. She stated the first name on the label is the brand name Neurontin but further down on the bottle it also said Gabapentin. She stated Ms. Hudson incorrectly assumed the medication was out of stock because she did not see Gabapentin and did not ask another DCW for assistance. She stated Ms. Townsend reviewed the medication with Ms. Hudson the next day and Ms. Hudson realized the error she made the night before and was apologetic. She stated Resident A was very agitated from not getting her medication and requested to go to the hospital that night to get her medication. DCWs later complied with calling an ambulance to transport Resident A at her request.

Ms. Townsend stated Ms. Hudson accidentally misread the label for Resident A’s Gabapentin, seeing the first title says “Neurontin” and not seeing further down it also said Gabapentin. She stated the next day she discussed the error with Ms. Hudson who immediately realized her mistake and apologized to Ms. Townsend stating she was not familiar with the overnight medications as she typically works during the day and reporting she was embarrassed she made that error. She stated Ms. Hudson also apologized to Resident A and her relatives who were extremely vulgar to the point she had to intervene and take Ms. Hudson off the floor because she was crying, and the family was continuing to berate her saying “awful, awful things.”

Resident A reported there was one incident where a DCW did not give her the medication she takes at night for her leg pain. She stated the worker told her the medication was out, but she knew it was not out because her relatives keep her medication in stock. She told the DCW to call her relatives or ask another DCW because she knew her medication was in the home, and she needed it, but the DCW insisted the medication was out. She stated she requested to go to the hospital because she needed her medication for her leg pain and would get it at the hospital.

On 2/28/23, I attempted a telephone interview with Ms. Hudson. Her voicemail inbox was reported to be full so a message could not be left requesting a return phone call.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's

	physician or other health care professional with regard to such items as any of the following: **(a) Medications.**
ANALYSIS:	Ms. Copeland, Ms. Townsend, and Resident A acknowledge Ms. Hudson accidentally made a medication error in reading the label “Neurontin”, which was the name brand of Resident A’s Gabapentin, not realizing “Gabapentin” was also listed lower on the label. Due to this, Ms. Hudson assumed Resident A’s Gabapentin was not available in the home that night. Resident A requested to go to the hospital to receive Gabapentin which Ms. Hudson complied with. Based on the interviews completed, there is sufficient evidence to support that the instructions from Resident A’s physician or health care professional were not followed regarding her medication, Gabapentin on 1/14/23.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 2/15/23, I discussed my anticipated findings with Ms. Copeland who did not dispute my findings or recommendations. On 3/1/23, I confirmed my findings with Ms. Copeland.

IV. RECOMMENDATION

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

Cassandra Duursma 3/1/23

Cassandra Duursma Date
Licensing Consultant

Approved By:

Russell Misiak 3/1/23

Russell B. Misiak Date
Area Manager