GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 22, 2023

Meaghan Rinaldi
Emmaus Corp.
2447 N Williamston Rd
Williamston, MI 48895

RE: License #: AL330093906
Investigation #: 2023A0466016
Haven of Rest

Dear Ms. Rinaldi:

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) 284-9727.

Sincerely,

Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL330093906
Investigation #:	2023A0466016
Complaint Receipt Date:	12/27/2022
Investigation Initiation Date:	12/29/2022
Report Due Date:	02/25/2023
Licensee Name:	Emmaus Corp.
Licensee Address:	2447 N Williamston Rd Williamston, MI 48895
Licensee Telephone #:	(517) 655-8953
Administrator:	Meaghan Rinaldi
Licensee Designee:	Meaghan Rinaldi
Name of Facility:	Haven of Rest
Facility Address:	2447 N Williamston Williamston, MI 48895
Facility Telephone #:	(517) 655-8953
Original Issuance Date:	03/13/2001
License Status:	REGULAR
Effective Date:	02/18/2022
Expiration Date:	02/17/2024
Capacity:	18
Program Type:	ALZHEIMERS AGED

II. ALLEGATION

	Violation Established?
Resident A fell on 12/10/2021 because she was using a walker and not her wheelchair.	No
Additional Findings	Yes

III. METHODOLOGY

12/27/2022	Special Investigation Intake-2023A0466016.
12/28/2022	Contact - Telephone call made to Complainant, message left.
12/29/2022	Special Investigation Initiated – Telephone call, Complainant interviewed.
12/29/2023	Contact- Telephone call made to Relative A1, interviewed.
12/30/2022	Contact- Documents received from Complainant.
01/04/2023	Inspection Completed On-site.
01/04/2023	Contact- Document received from licensee designee Meaghan Rinaldi.
02/15/2023	Contact- Telephone call made to Annie Cor
02/15/2023	APS referral- not required as Resident A was deceased at time allegation was received.
02/16/2023	Exit Conference with licensee designee Meaghan Rinaldi.

ALLEGATION: Resident A fell on 12/10/2021 because she was using a walker and not her wheelchair.

INVESTIGATION:
On 12/29/2022, Complainant reported Resident A was admitted to Haven of Rest on 12/08/2021. Complainant reported he gave the facility a two-page typed document listing Resident A's medications and instructions that Resident A she must use her four wheeled transport chair (with smaller wheels) and not to use a walker. Complainant reported on 12/10/2021 he received a telephone call from a direct care staff member informing him Resident A had fallen in the middle of the night. Complainant reported he was told on 12/10/2021 Resident A had a slight cut on her

right shin from the fall so a nurse put a dressing on it. Complainant reported on 12/12/2021 Resident A had a 4x4 gauze dressing on her front leg with the date 12/10/2021 written on the gauze. Complainant reported Resident A stated she was given a walker to go to the bathroom despite telling a direct care worker she uses a wheelchair. Complainant reported on 12/13/2021 Resident A had a routine appointment with her heart doctor and Complainant reported asking the nurse to remove Resident A's bandage to look at the cut. Complainant reported Resident A had to immediately go to the emergency room (ER) for cellulitis as the cut was infected.

On 12/29/2022, I interviewed Complainant who confirmed being a concerned about a fall that occurred in December 2021. Complainant expressed concern Resident A used a walker while at the facility and not the four wheeled transport chair which contributed to her fall. Complainant expressed concern about Resident A's shin becoming infected after the fall. Complainant reported he had pictures of the wound but no medical documentation about the laceration or the infection. Complainant reported Resident A stayed at the facility for five days from 12/7/2021 through 12/12/2021. Complainant reported that aside from the five days Resident A stayed at the facility, that he was Resident A's primary caretaker and she lived with him. Complainant reported Resident A passed away in June 2022 at the age of 102.

On 12/30/2022, Complainant sent a copy of an *Incident/Accident Report* dated 12/09/2021 that was not signed by anyone but documented direct care worker (DCW) Annie Cor was on duty. The report documented the incident occurred on 12/09/2021 at 1:00am. In the "Explain what happened" section of the report it stated, "Found resident by the side of her bed. She kept talking about her purse. I believe that she was trying to get near her purse. She scraped her ankle. I cleaned it with wound cleaner and put a band aid on." In the "Action taken by staff" section of the report it stated, "I cleaned her up and put her back to bed. I put her purse near her." In the "Corrective measures" section of the report it stated, "Bed alarm is needed."

On 01/04/2023, I conducted an unannounced investigation and DCW Karen Jones, DCW Pam Algright, DCW Alexus Bell and DCW Jody McCartney were on duty. DCW Jones, DCW Algright and DCW McCartney did not remember Resident A. DCW Bell reported she remembered Resident A was a pivot transfer that used a wheelchair and that she had a neck brace.

I interviewed administrator/licensee designee Meaghan Rinaldi who reported Resident A was at the facility a very short time only. Licensee designee Rinaldi reported she recalled Resident A having a fall so a bed alarm was installed after the fall. Licensee designee Rinaldi reported having no reason to believe Resident A was a fall risk however she reported Resident A came with a four wheeled transport chair. Licensee designee Rinaldi reported Resident A was at the facility for five days and fell only one time.

I reviewed Resident A's record which contained a *Face Sheet*, *Resident Contact Information*, *Michigan Medicine University of Michigan Department of Radiology* report dated 11/24/2021, *Durable Power of Attorney* documents, *medication administration record* (MAR) and a two-page typed document submitted by Relative A1. Resident A's record did not contain a *Health Care Appraisal*, a written *Assessment Plan* nor a written *Resident Care Agreement*. Resident A's record did not contain any medical documentation about the use of assistive devices.

Resident A's record contained a two-page typed document that I reviewed which documented that Resident A can pivot into a wheelchair. Nowhere in this document did it state Resident A can or cannot use a walker.

On 02/15/2023, I interviewed DCW Cor who reported she did not remember Resident A. DCW Cor reported she did not remember her falling nor did she recall completing an *Incident/Accident Report* in December 2021.

APPLICABLE RULE	
R 400.15303	**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:	Although Resident A's record did not contain a written assessment plan, nor did it contain any medical documentation authorizing the use of any assistive device, there also is not any information to verify she was or was not using any assistive device at the time of the fall.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 01/04/2023, I conducted an unannounced investigation and DCW Jones, DCW Algright, DCW Bell and DCW McCartney were on duty. DCW Bell provided me a copy of the *Resident Register* however Resident A's name was not listed on the form. DCW Bell reported Resident A was "respite" and that she did not stay at the facility long. According to the *Face Sheet*, Resident A was admitted to the facility on 12/07/2021.

APPLICABLE RULE	
R 400.15210	**Resident register.**
	A licensee shall maintain a chronological register of residents who are admitted to the home. The register shall include all of the following information for each resident: **(a) Date of admission.** **(b) Date of discharge.** **(c) Place and address to which the resident moved, if known.**
ANALYSIS:	I reviewed the *Resident Register* on 01/04/2022 and it did not contain Resident A's name, her admission date or her discharge date therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 01/04/2023, I conducted an unannounced investigation and I reviewed Resident A's record which did not contain a written assessment plan. According to the *Face Sheet*, Resident A was admitted to the facility on 12/07/2021.

APPLICABLE RULE	
R 400.15301	**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: **(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.** **(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.** **(c) The resident appears to be compatible with other residents and members of the household.**
ANALYSIS:	Resident A's record did not contain a written assessment plan therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 12/29/2022, I interviewed Relative A1 who reported and provided a copy of the check that showed that he paid the facility $900 for Resident A to stay there from 12/07/2021 through 12/12/2021.

On 01/04/2023, I conducted an unannounced investigation and I reviewed Resident A's record which did not contain a *Resident Care Agreement*. According to the *Face Sheet*, Resident A was admitted to the facility on 12/07/2021.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following: **(a) An agreement to provide care, supervision, and protection, and to assure transportation services to the resident as indicated in the resident's written assessment plan and health care appraisal.** **(b) A description of services to be provided and the fee for the service.** **(c) A description of additional costs in addition to the basic fee that is charged.** **(d) A description of the transportation services that are provided for the basic fee that is charged and the transportation services that are provided at an extra cost.** **(e) An agreement by the resident or the resident's designated representative or responsible agency to provide necessary intake information to the licensee, including health-related information at the time of admission.** **(f) An agreement by the resident or the resident's designated representative to provide a current health care appraisal as required by subrule (10) of this rule.** **(g) An agreement by the resident to follow the house rules that are provided to him or her.** **(h) An agreement by the licensee to respect and safeguard the resident's rights and to provide a written copy of these rights to the resident.**

	(i) An agreement between the licensee and the resident or the resident's designated representative to follow the home's discharge policy and procedures. **(j) A statement of the home's refund policy. The home's refund policy shall meet the requirements of R 400.15315.** **(k) A description of how a resident's funds and valuables will be handled and how the incidental needs of the resident will be met.** **(l) A statement by the licensee that the home is licensed by the department to provide foster care to adults.**
ANALYSIS:	Resident A's record did not contain a resident care agreement therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 01/04/2023, I conducted an unannounced investigation I reviewed Resident A's record which did not contain a *Health Care Appraisal*. According to the *Face Sheet*, Resident A was admitted to the facility on 12/07/2021.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	Resident A's record did not contain a *Heath Care Appraisal* therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 12/29/2022, Complainant reported Resident A stated she was given a walker to go to the bathroom despite telling a direct care worker she uses a wheelchair.

On 01/04/2023, I conducted an unannounced investigation and I interviewed DCW Bell who reported she remembered Resident A was a pivot transfer who used a wheelchair and that she had a neck brace

I interviewed licensee designee Rinaldi who reported that Resident A came with a four wheeled transport chair.

I reviewed Resident A's record which contained a *Face Sheet*, *Resident Contact Information*, *Michigan Medicine University of Michigan Department of Radiology* report dated 11/24/2021, *Durable Power of Attorney* documents, *medication administration record* (MAR) and a two-page typed document submitted by Relative A1. Resident A's record did not contain a *Health Care Appraisal*, a written *Assessment Plan* nor a written *Resident Care Agreement*. Resident A's record did not contain any medical documentation authorizing the use of assistive devices.

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:	Resident A's record did not contain a written assessment plan, nor did it contain any medical documentation authorizing the use of any assistive device. DCW Bell, licensee designee Rinaldi, and Complainant all reported Resident A used a four wheeled transport chair/wheelchair while at the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

02/16/2023

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Julie Elkins Date
Licensing Consultant

Approved By:

02/22/2023

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Dawn N. Timm Date
Area Manager