GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 10, 2023

Mark Kincer
Conscious Senior Living Properties, LLC
29891 23 Mile Road
Chesterfield, MI 48047

RE: License #: AH500397098
Investigation #: 2023A0784041
Grace Premier Assisted Living

Dear Mr. Kincer:

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.

The corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan may result in disciplinary action.

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

Sincerely,

Aaron L. Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500397098
Investigation #:	2023A0784041
Complaint Receipt Date:	02/28/2023
Investigation Initiation Date:	03/01/2023
Report Due Date:	04/29/2023
Licensee Name:	Conscious Senior Living Properties, LLC
Licensee Address:	29891 23 Mile Road Chesterfield, MI 48047
Licensee Telephone #:	(989) 971-9610
Administrator:	Emily Granger
Authorized Representative:	Mark Kincer
Name of Facility:	Grace Premier Assisted Living
Facility Address:	29891 23 Mile Road Chesterfield, MI 48047
Facility Telephone #:	(586) 422-1600
Original Issuance Date:	01/14/2019
License Status:	REGULAR
Effective Date:	07/14/2021
Expiration Date:	07/13/2022
Capacity:	62
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Inadequate care provided to Resident A	Yes
No designated supervisor on duty and facility was short staffed	Yes
Late administration of resident medications	Yes
Additional Findings	Yes

III. METHODOLOGY

02/28/2023	Special Investigation Intake 2023A0784041
03/01/2023	Special Investigation Initiated - On Site
03/01/2023	Inspection Completed On-site
03/02/2023	Contact - Document Received Investigative documents received from administrator Emily Granger via email
03/13/2023	Contact - Document Received Email received from Ms. Granger confirming her start date as the facility administrator
4/10/2023	Exit Conference – Telephone Interview with administrator Emily Granger

ALLEGATION:

Inadequate care provided to Resident A

INVESTIGATION:

On 2/28/2023, the department received this complaint from adult protective services (APS).

According to the complaint, Resident A required repositioning every two hours. On 2/07/2023 she was not repositioned for nine hours and on 2/12/2023, she was not repositioned for several hours. On 2/20/2023, Resident A passed away.

On 3/01/2023, I interviewed administrator Emily Granger at the facility. Ms. Granger stated she was not aware of any complaints related to Resident A not being repositioned on 2/07/2023 but did receive a concern from a family member that on 2/12/2023, Resident A had not been repositioned for several hours. Ms. Granger stated the facility does not maintain cameras inside resident rooms but does have cameras in the common areas of the facility. Ms. Granger stated that she went back and reviewed camera footage for 2/12/2023 and that staff did regularly go into Resident A’s room throughout the day, presumably to provide care. Ms. Granger stated Resident A did require repositioning by staff every two hour which was also considered a “safety check”. Ms. Granger stated Resident A required staff assistance for several activities of daily living (ADLs) including personal hygiene care, showers, dressing and toileting. Ms. Granger stated staff track these cares provided by marking their initials on an ADL log for Resident A.

I reviewed Resident A’s *ADL Sheet* for February 2023, provided by Ms. Granger. There were four sections on the sheet including AM/PM Personal *Hygiene*, *Shower, Dressing*, *Toileting*, *Safety Checks* and *Room check*. Next to each section there were three rows denoting care provided in the morning, daytime and afternoon labeled *M, D* and *A* respectively. Each row included a box for each day of the month for staff to enter initials when care was provided. There were multiple sections, representing multiple days and times of day (times being represented by M, D and A), in which no initials were entered to indicate care was provided and several dates in which only a slash mark is provided with no staff initials entered. Notably, under the dates for 2/7/2023 and 2/08/2023, every box was empty of either staff initials or any kind of marking indicating no cares were provided on those days. Within the sections under 2/12/2023, no data entry boxes had staff initials and each section had no markings at all indicating several times of day of which cares were not provided.

I reviewed Resident A’s medication administration record (MAR) for February 2023. The MAR included a physician's order to “Reposition patient every 2 hours around the clock” with a start date of 2/10/2023. The MAR read consistency with statements provided by Ms. Granger regarding repositioning by staff in that staff noted consistently completing this task.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.

ANALYSIS:	The complaint alleged that, while living at the facility, Resident A required repositioning by staff and that on at least two dates, 2/07/2023 and 2/12/2023, staff did not reposition her for several hours. Evidence reviewed during the investigation did not support staffs alleged lack of repositioning for Resident A. While the MAR indicated consistency of repositioning by staff, review of Resident A's ADL Sheet revealed several dates within the denoted sections that did not include staff initials or did include non-specific markings with no initials. Notably, at least two dates included no initials or markings for either day to show that staff even provided care at all for those days. Based on this review, there is no way to confirm that, aside from being repositioned, Resident A was provided necessary care as needed on several days. Based on the findings, the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

No designated supervisor on duty and facility was short staffed

INVESTIGATION:

According to the complaint, on 2/18/2023, between 7pm and 10pm, the facility did not have a designated supervisor or a medication technician (med tech) duty.

When interviewed, Ms. Granger explained that on 2/18/2023, there were several staffing issues during the evening hours. Ms. Granger stated that she had a supervisor/medication technician (med tech), Associate 1, scheduled until 7pm with another supervisor/med tech, Associate 2, scheduled from 3pm to 11pm. Ms. Granger stated Associate 2 had contacted her earlier in the afternoon indicating she may walk off the job as she was concerned, she may be the only med tech on duty at 7pm believing that the other med tech, who is also a supervisor, associate 3, might not come in for her shift scheduled to start at 7pm. Ms. Granger stated that due to this concern, she began contacting med techs to see if someone would come in at 7pm to ensure she had coverage. Ms. Granger stated she was able to get someone to commit to the shift, supervisor/med tech, Associate 4, and communicated this to Associate 2 who then agreed to stay. Ms. Granger stated she was "suspicious" in that she thought Associate 3 might not come to work as she had been on vacation and had been sent her schedule but had not communicated with anyone in administration. Ms. Granger stated she still thought she had coverage since Associate 4 was coming in at 7pm and Associate 2 was still scheduled until 11pm. Ms. Granger stated that at approximately 9:15pm that evening, she had a

resident call her and report she had not received her medications. Ms. Granger stated she ultimately discovered that Associate 2 had walked off the job at 5:30pm, with no notice, Associate 3 did not show up to work, Associate 4 was reportedly in an accident and did not get to work until approximately 9:37pm and that Associate 1, who had been working since 7am that morning, ended up working until 7:30pm but left without letting her know that Associate 3 had not showed up and Associate 4 would be late leaving the facility without a supervisor or a med for at least an hour. Ms. Granger stated this did leave the facility short staffed during that time frame and as a result, several residents received medications late.

I reviewed the facilities staff schedule and corresponding *ASSIGNMENT SHEET* for February 2023, provided by Ms. Granger. When interviewed, Ms. Granger explained that the assignment sheets show specifically what areas of the facility scheduled staff work in and specify the times each staff worked their shift. When reviewing the sheets, Though the schedule provides the names of staff scheduled and what days, areas and general time frames they were schedule for, neither the schedule nor the assignment sheets were adjusted to reflect the specific times staff actually worked thus making it indistinguishable for that purpose. Specific to the date in question, the schedule and assignment sheet is not consistent in reflecting the statements provided by Ms. Granger.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(3) The home shall designate 1 person on each shift to be supervisor of resident care during that shift. The supervisor of resident care shall be fully dressed, awake, and on the premises when on duty. **(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.**
ANALYSIS:	The complaint alleged that on 2/18/2023, there was no supervisor or med tech on duty from 7pm to 10pm. Statements provided by Ms. Granger confirmed the facility was without a supervisor or a med tech for at least on hour on that day which she admitted left the facility short staffed for that time frame based on the staff needed to meet the needs of the residents at that time. Based on the finding, the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Late administration of resident medications

INVESTIGATION:

According to the complaint, on 2/08/2023, Resident A was not administered her morning medications or her afternoon heart medication. On 2/13/2023, Resident A did not receive her morning heart medications. On 2/18/2023 Resident A received her evening medications late, after 10pm. On 2/19/2023 Resident A, and other residents, received morning medications late. On 2/19/2023, Staff administered Resident A her morning and afternoon medications mixed together. Ms. Granger stated she is aware medications are supposed to be administered within one hour before or after the scheduled timeframe as dictated by the order and that many residents have medications scheduled for 8pm.

When interviewed, Ms. Granger stated she was unaware of Resident A having any issues with medication administration on 2/08/2023, 2/13/2023, or 2/19/2023. Ms. Granger reiterated that due to the previously discussed staffing issues on 2/18/2023 Resident A, and likely other residents, received their medications late that day. Ms. Granger stated that though medications may have been administered late, they were administered as soon as the med tech arrived. Ms. Granger stated that, other than on 2/18/2023, staff are consistent with medication administration.

I reviewed February MARs for Resident A and B, provided by Ms. Granger. The MARs read consistently with Ms. Granger statements with the records reflecting consistent administration of medication. There was no way to distinguish specific times of medication administration as this information was not provided on the MAR.

I reviewed the facilities February Med Variance tracking documentation, provided by Ms. Granger. Ms. Granger stated this document represents variances specific to medications administered outside of the allowed time frame, one hour before or after the scheduled administration time. The document consisted of 105 pages representing 2102 variances, on multiple dates throughout the month, for 42 residents, with 65 variances noted for Resident A and 31 for Resident B. While several Notes indicated a variance reason such as "late charting" or "documented late because computer was offline", a multitude of variance notes also indicated medications were administered "late" or "early, outside of the acceptable timeframe for medication administration.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
For Reference: R 325.1901	**Definitions**
	(14) "Medication management" means assistance with the administration of a resident's medication as prescribed by a licensed health care professional.
ANALYSIS:	The complaint alleged that Resident A received medications late on several dates and times in February 2023 and that on two of those dates, other residents were administered medications late. Ms. Granger admitted residents received medications late on 2/18/2023 as there was no med tech available to administer the medications on time. Additionally, review of the facilities Med Variance tracking for February 2023 revealed that a multitude of medications, relative to 42 residents, were administered outside of the acceptable time frame for administration. Based on the findings, the facility is not in compliance with this rule.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [Reference Special Investigation 2022A0585090]**

ADDITIONAL FINDINGS:

INVESTIGATION:

When interviewed, Ms. Granger she has served as the administrator of the facility for several months.

On 3/13/2023 I received an email from Ms. Granger confirming her start date as the administrator of the facility was 9/12/2022.

Review of the departments case management system revealed Ms. Granger has not been appointed as the administrator of the facility.

APPLICABLE RULE	
R 325.1913	**Licenses and permits; general provisions.**
	(2) The applicant or the authorized representative shall give written notice to the department within 5 business days of any changes in information as submitted in the

	application pursuant to which a license, provisional license, or temporary nonrenewable permit has been issued.
ANALYSIS:	The investigation revealed that although Ms. Granger has been serving as the administrator of the facility since 9/22/2022, the department has not received proper documentation required for this appointment. Based on the findings, the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

When interviewed, Ms. Granger stated Resident A was on hospice, prior to passing away, and had a personal caretaker with her a few days a week. Ms. Granger was unable to confirm what specific days or time frames the personal caretaker was scheduled with Resident A.

I reviewed Resident A's service plan, provided by Ms. Granger. Under a section titled *Safety*, the plan reads, "SafetyCheck-24hr: Staff will check on the resident's whereabouts and safety regularly throughout the day, around the clock" noting also this will happen "6 Times/Day". The plan does not provide specific times for these safety checks and provides no information specific to Resident A's needs for repositioning.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
For Reference: R 325.1901	**Definitions**
	(21) "Service plan" means a written statement prepared by the home in cooperation with a resident and/or the resident's authorized representative or agency responsible for a resident's placement, if any, and that identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical, social, and behavioral needs and well-being and the methods of providing the care and services while taking into account the preferences and competency of the resident.

ANALYSIS:	The investigation revealed that Resident A, prior to passing away, had a personal caretaker assigned to her for several days and several hours during those days. Review of Resident A's service plan revealed no information was provided within the plan indicating Resident A had a caretaker for any amount of time or what services the caretaker was there to provide. Additionally, while the facility did maintain tracking information specific to Resident A's repositioning needs, the plan provided no information specific to this need and the information provided regarding her safety check needs was not consistent with Resident A's reported 2-hour safety check needs. Based on the findings, the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

As previously noted regarding Resident A's February 2023 *ADL Sheet*, "There were multiple sections, representing multiple days and times of day (times being represented by M, D and A), in which no initials were entered to indicate care was provided and several dates in which only a slash mark is provided with no staff initials entered. Notably, under the dates for 2/7/2023 and 2/08/2023, every box was empty of either staff initials or any kind of marking indicating no cares were provided on those days. Within the sections under 2/12/2023, no data entry boxes had staff initials and each section had no markings at all indicating several times of day of which cares were not provided.

APPLICABLE RULE	
R 325.1942	**Resident records.**
	(2) A home shall assure that a current resident record is maintained and that all entries are dated and signed.
ANALYSIS:	Review of Resident A's ADL tracking documentation revealed the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

3/14/2023

Aaron Clum Date
Licensing Staff

Approved By:

04/10/2023

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section