GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 7, 2023

Madiha Zeeshan
Grand Blanc Assisted Living, LLC
219 Church St.
Auburn, MI 48611

RE: License #: AL250390289
Investigation #: 2023A0569036
Grand Blanc Fields Assisted Living

Dear Ms. Zeeshan:

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) 643-7960.

Sincerely,

Kent W Gieselman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 931-1092

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL250390289
Investigation #:	2023A0569036
Complaint Receipt Date:	04/12/2023
Investigation Initiation Date:	04/12/2023
Report Due Date:	06/11/2023
Licensee Name:	Grand Blanc Assisted Living, LLC
Licensee Address:	12628 Pagels Drive Grand Blanc, MI 48439
Licensee Telephone #:	(810) 606-0823
Administrator:	Madiha Zeeshan
Licensee Designee:	Madiha Zeeshan
Name of Facility:	Grand Blanc Fields Assisted Living
Facility Address:	12628 Pagels Drive Grand Blanc, MI 48439
Facility Telephone #:	(810) 606-0823
Original Issuance Date:	08/03/2018
License Status:	REGULAR
Effective Date:	02/03/2023
Expiration Date:	02/02/2025
Capacity:	20
Program Type:	DEVELOPMENTALLY DISABLED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
• **Resident A did not receive needed wound care.**	No
• **Residents are not being served nutritious meals and are served small portions.**	Yes
• **Resident hygiene is not being addressed.**	Yes
Additional Findings	Yes

III. METHODOLOGY

04/12/2023	Special Investigation Intake 2023A0569036
04/12/2023	Special Investigation Initiated - Letter Email to APS.
05/22/2023	Contact - Document Sent Email to POA requesting documentation.
05/23/2023	Contact - Telephone call made. Contact with FM1.
05/24/2023	Inspection Completed On-site
05/25/2023	Contact - Telephone call made. Attempted contact with Caryn Knappan, hospice nurse.
05/25/2023	Contact - Telephone call received. Contact with Caryn Knappan.
05/25/2023	Contact - Telephone call made. Contact with POA 6.
05/25/2023	Contact - Telephone call made. Contact with POA 7.
05/25/2023	Contact - Telephone call made. Contact with POA 8.
05/30/2023	Contact - Telephone call made.

	Contact with Witness 1.
05/30/2023	Contact - Telephone call made. Contact with POA 1.
05/30/2023	Contact - Telephone call made. Contact with POA 2.
05/30/2023	Contact - Telephone call made. Contact with POA 3.
05/30/2023	Contact - Telephone call made. Contact with POA 4.
05/30/2023	Contact - Telephone call made. Contact with POA 5.
05/30/2023	Contact - Telephone call made. Contact with POA 9.
05/30/2023	Contact - Telephone call made. Contact with POA 10.
05/30/2023	Contact - Telephone call made. Contact with Witness 2
05/30/2023	Contact - Telephone call made. Contact with Witness 3.
05/30/2023	Contact - Telephone call made. Contact with Tamber Townsend, physician assistant.
06/01/2023	Contact - Telephone call made. Contact with staff 1.
06/01/2023	Contact - Telephone call made. Contact with Witness 4.
06/01/2023	Contact - Document Received Received email from POA 10.
06/02/2023	Inspection Completed On-site second on-site inspection.
06/05/2023	Inspection Completed-BCAL Sub. Compliance

06/05/2023	Exit Conference Exit conference with Madiha Zeeshan, licensee designee.
06/05/2023	APS referral Referral made to APS.

ALLEGATION:

Resident A did not receive needed wound care.

INVESTIGATION:

This complaint was received via the on-line complaint portal. The complainant reported that Resident A resided in this facility for about six months. The complainant reported that Resident A developed a bed sore while residing in this facility that progressed to a stage 4 wound. The complainant reported that Resident A did not receive the wound care needed while residing at this facility.

Resident A's family member (FM1) stated on 5/23/23 that Resident A was her own guardian and passed away on 4/2/23. FM1 stated that Resident A was admitted to this facility following a stroke, and a power of attorney was being processed, but was not executed prior to Resident A's death. FM1 stated that after Resident A had been admitted to this facility Resident A was "tricked" into receiving hospice services. FM1 stated that the hospice company used was Mid-Michigan Home Health Care and Hospice. FM1 stated that the hospice company is owned by Asif Zeeshan, husband of Licensee Designee, Madiha Zeeshan. FM1 stated that Resident A was supposed to be receiving nursing care from a hospice nurse which included bathing and wound care. FM1 stated that the hospice nurse did not come to the facility daily, as needed, to care for and dress Resident A's bed sore. FM1 stated that Resident A was placed on hospice care in February 2023, but the nurse only came to the facility a few times. FM1 stated that Resident A's bed sore quickly deteriorated into a stage 4 wound and became infected. FM1 stated that Resident A had also developed several bruises on her body. FM1 stated that the bruising could have been a side effect of blood thinning medication that Resident A was prescribed, but FM1 is not sure. FM1 stated that Resident A was overweight and needed staff assistance to reposition her so FM1 purchased "wedges" for the staff to use to that Resident A would not be left lying on the pressure points causing the bed sore. FM1 stated that staff never used the wedges, and never moved Resident A to reposition her. FM1 stated that Resident A had frequent diarrhea that would get into the bed sore, causing the infection. FM1 stated that she then decided to take Resident A to the hospital in March 2023 because Resident A's stool was black and there was a "red color" in Resident A's urine. FM1 stated that she arrived at the facility and found Resident A in a dark room, lying in her bed and that Resident A was "half dead". FM1 stated that Resident A was treated for sepsis, and a kidney stone. FM1

stated that Resident A then passed away on 4/2/23 from sepsis and pneumonia. FM1 stated that she believes that the hospice company used did not provide the services that Resident A needed, and that the result was Resident A's death.

FM1 submitted a copy of Resident A's death certificate. The certificate documents that Resident A's manner of death was "natural." The death certificate documents that the contributing factors to Resident A's death were sepsis, pneumonia, and UTI. Resident A's written assessment documents that Resident A requires staff assistance with toileting and bathing/ grooming and that these needs will be addressed by the hospice nurse/ aid.

Caryn Knappan, hospice nurse, stated on 5/25/23 that hospice services for Resident A started in February 2023. Ms. Knappan stated that the hospice company was responsible for providing wound care for Resident A's bed sore as well as providing bathing services for Resident A. Ms. Knappan stated that Resident A's wound dressing was changed every five days or more often if needed. Ms. Knappan stated that the facility staff were calling her every day to come to the facility to change the dressing because Resident A had "loose stool" and would soil the dressing. Ms. Knappan stated that usually, facility staff would remove the soiled dressing and cleaned the area by the time she arrived at the facility to apply clean dressings and provide wound care. Ms. Knappan stated that she observed the staff at this facility utilizing the "wedges" to reposition Resident A, and that she also observed staff consistently assisting Resident A to transfer to a recliner from her bed to relieve the pressure points of Resident A's bed sore. Ms. Knappan stated that she always observed the facility staff to be "very attentive" to Resident A's needs and that the staff were "very patient" with Resident A because Resident A had a difficult time communicating due to the stroke she had. Ms. Knappan stated that Resident A was bathed twice a week. Ms. Knappan stated that she did not observe the facility staff neglect Resident A's needs in any way. Ms. Knappan stated that FM1 then decided to send Resident A to the hospital on 3/21/23 due to Resident A's decline and Resident A then passed away on 4/2/23.

Tamber Townsend, Resident A's physician assistant, stated on 5/30/23 that she examined and treated Resident A monthly. Ms. Townsend stated that Resident A was also receiving hospice services and that the hospice nurse was providing wound care and bathing services. Ms. Townsend stated that she observed the facility staff turning Resident A and transferring Resident A as they were instructed to treat Resident A's bed sore. Ms. Townsend stated that the bruising observed on Resident A was a result of the medication that Resident A was prescribed, and not the result of mistreatment by the staff. Ms. Townsend stated that Resident A had been diagnosed with Type II diabetes in addition to the other health issues that she had, and the medications that were prescribed to Resident A were causing the loose stools and other compounding issues for Resident A. Ms. Townsend stated that Resident A was "very overweight" which exacerbated her health conditions. Ms. Townsend stated that she believes that the staff of this facility were providing the care for Resident A that they were responsible to provide. Ms. Townsend stated that she has no concerns regarding the level of care provided by the staff at this facility.

Staff statements in this report will be coded. The staff interviewed requested that they be coded out of fear that they would be subject to retaliation from Madiha Zeeshan, licensee designee, if they were identified.

Staff 1 stated on 5/24/23 that Resident A was “bed bound” and in poor health when she was admitted. Staff 1 stated that the staff were always attentive to Resident A and checked on her every 30 minutes to see if she needed assistance or to have her brief changed. Staff 1 stated that if Resident A had a soiled brief, staff would immediately change it, and Resident A’s dressing as well if needed. Staff 1 stated that staff also have Resident A” sponge baths” weekly to try to keep her clean as well. Staff 1 stated that Resident A was receiving hospice care, and that the hospice nurse was supposed to be responsible for bathing Resident A and provide wound care. Staff 1 did not want to give any additional information.

Witness 1 stated on 5/30/23 that they were a former employee of this facility. Witness 1 stated that Resident A did not have any bed sores when she was admitted to this facility. Witness 1 stated that the staff at this facility were very diligent in providing care to Resident A. Witness 1 stated that Resident A was very heavy and confined to her bed when she was admitted to the facility. Witness 1 stated that the staff at this facility would turn and assist Resident A in repositioning throughout each shift. Witness 1 stated that staff would also assist Resident A in transferring from her bed to a recliner in her room so that she could sit up and not lie down all day.

Witness 2 stated on 5/30/23 that they are a former employee of this facility. Witness 2 stated that Resident A did develop a bed sore after being admitted to this facility. Witness 2 stated that staff did follow all wound care instructions, but that the hospice nurse was supposed to be doing the wound care and changing the dressing as needed. Witness 2 stated that at one point, the hospice nurse demanded that staff “not touch” Resident A when she had a soiled brief and needed to be changed and cleaned. Witness 2 stated that staff would try to clean Resident A when she was soiled because the hospice nurse did not come to the facility as needed. Witness 2 stated that the staff at this facility transferred and assisted Resident A in repositioning several times throughout each shift. Witness 2 stated that they did not have any concerns regarding the staff providing appropriate care to Resident A.

Witness 3 stated on 6/1/23 that they were a former employee at this facility. Witness 3 stated that Resident A was placed on hospice care, and that the hospice nurse was responsible for Resident A’s hygiene and wound care. Witness 3 stated that the hospice nurse would come to the facility one or two times a week, and Resident A’s bed sore got progressively worse. Witness 3 stated that staff would constantly assist Resident A in repositioning and transferring to her chair to help alleviate Resident A’s bed sore. Witness 3 stated that at one point, the hospice company sent instructions to the staff that the staff were not to do any wound care or assist Resident A in changing her brief when the brief was soiled. Witness 3 stated that the staff at this facility were doing everything that they could to address Resident A’s bed sore.

Madiha Zeeshan stated on 5/24/23 that Resident A was receiving hospice services. Ms. Zeeshan stated that the hospice nurse was coming to the facility daily to provide wound care and to bathe Resident A on a weekly basis. Ms. Zeeshan stated that Resident A was admitted to this facility with a stage 2 bed sore and that Resident A was bed bound and type II diabetic. Ms. Zeeshan stated that Resident A's family constantly brought in food that Resident A should not have, and Resident A would not eat a healthy diet. Ms. Zeeshan stated that because of Resident A's poor diet, her condition deteriorated quickly, and the family decided to admit Resident A to the hospital.

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:	The complainant reported that Resident A had a bed sore that degraded to a stage 4 wound resulting in a hospitalization. FM1 stated that Resident A was supposed to be receiving hospice services and that a hospice nurse was supposed to be providing bathing and wound care services, but the hospice nurse was not coming to the facility and providing the needed care. FM1 stated that the wound got so bad, that they had Resident A taken to the hospital for treatment, which required surgery to remove infected material. FM1 stated that Resident A passed away due to sepsis and pneumonia on 4/2/23. Witness 1, Witness 2, Witness 3. Staff 1, Ms. Knappan, and Ms. Townsend all stated that the facility staff did assist Resident A as needed with transferring Resident A, repositioning Resident A, changing Resident A's brief and cleaning Resident A. All the statements also indicate that staff did try to clean the wound when they found Resident A's brief soiled. Based on the statements given, it is determined that the staff of this facility did provide the care that they were responsible to provide and there has been no violation of this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents are not being served nutritious meals and are served small portions.

INVESTIGATION:

The complainant reported that the residents are not being served nutritious meals. The complainant reported that the Residents also are being served small portions because Ms. Zeeshan wants to save money on the facility food bill.

FM1 stated on 5/23/23 that the residents are served meals that often have no fruits or vegetables, very little protein, and some form of pasta or rice. FM1 stated that staff in this facility have stated that Ms. Zeeshan does not provide enough money on a weekly basis to purchase groceries to feed all the residents. FM1 stated that she had to purchase food for Resident A because resident A would express that she was hungry. FM1 stated that most of the meals that they observed served to the residents were "gross" and FM1 stated that she frequently observed residents refuse to eat what was being served. FM1 stated that she has observed staff members go to the store and purchase food with their own money so that the residents would have something for dinner.

An unannounced inspection of this facility was conducted on 5/24/23, and a second inspection was conducted on 6/2/23. All the food storage areas were inspected on 6/2/23. The food storage areas were observed to have minimal perishable and non-perishable foods for the residents. The non-perishable foods in the pantry area were prepackaged pastas and other foods. There were seven cans of fruit, five boxes of cereal, spices, three cake mixes, and five cans of vegetables. The perishable food storage areas were also inspected. There were six gallons of milk, two boxes of eggs, two bags of coleslaw mix, two bags of shredded cheese, eight bags of frozen vegetables, 8 cans of frozen juice, 4 loaves of bread, and two bags of frozen potatoes. The food observed in the food storage areas was the amount to feed 13-15 residents. The lunch meal was being served during the inspection on 6/2/23. The meal consisted of 10 small chicken breasts to be divided between all the residents. Each resident was served a piece of chicken breast about 3 oz. in size, approximately ½ cup of broccoli, and boxed pasta. The menu listed the lunch meal as "fish, steamed broccoli, seasoned rice." The menu had "fish" crossed out with "no fish" written beside it. Other meals on the menu were "Grilled Cheese, tomato soup," "chicken noodle soup, crackers," and "tacos, corn, rice." None of the meals listed on the menu had the ingredients observed in the food storage areas. Most of the meals on the menus had the protein option crossed out with a written message of "not enough" or "not available."

Resident B's Power of attorney (POA1) stated on 5/30/23 that Resident B has dementia and does not always remember things accurately. POA1 stated that she has been present when meals are served to the residents. POA1 stated that the meals served to the residents are not balanced and are not nutritious. POA1 stated that fruit is rarely available to the residents, and they are served few vegetables. POA 1 stated that they have observed meals consist of nothing more than a few chicken nuggets and some rice or pasta. POA1 stated that they have observed other residents not eat the meal served to them because the meal was of poor quality.

Resident C's POA (POA2) stated on 5/30/23 that Resident C has been diagnosed with dementia and does not always remember what is served to the residents for meals. POA2 stated that the meals they have observed are not nutritious and the food served to the residents is "bad". POA2 stated that the residents rarely get fruits or vegetables, and they have observed many meals that were over cooked or burnt. POA2 stated that typical meals consist of hot dogs, boxed pasta or rice, and boxed mash potatoes. POA2 stated that she has reported the poor quality of meals to Ms. Zeeshan, but Ms. Zeeshan does not seem to care. POA2 stated that she has observed there to be no milk for the residents, so staff have had to go to the store and purchase milk and other items just so that the residents can be served a meal. POA2 stated that Resident C has asked for an apple or some fruit, and there was nothing in the facility to give to Resident C. POA2 stated that they spend their own money to buy fruit for Resident C because there is none available or provided. POA2 stated that they have gone into the kitchen area looking for something to give Resident A because Resident C was hungry, and there was "almost nothing" in the refrigerator.

Resident D's POA, POA3, stated on 5/30/23 that they have observed the meals served to the residents in this facility. POA3 stated that breakfast usually consists of cold cereal and nothing else. POA3 stated that the meal quality is poor and that the residents frequently do not get vegetables and almost no fruit. POA 3 stated that the residents are also given "small portions" and frequently residents will not eat the food because it tastes "bad".

Resident E's POA, POA4, stated on 5/30/23 that they have to take food to Resident E because the residents are not served enough food and Resident E will complain of being hungry. POA4 stated that typical meals will be small bowls of soup, rice, boxed pasta, grilled cheese, and tomato soup, and if the residents get meat, it is often tough and hard for the residents to chew. POA4 stated that they have observed other residents complain about the food quality or small portions, but staff do not seem to have enough food to feed the residents a full meal. POA4 stated that the residents often are not given vegetables or fruits.

Resident F's POA, POA5, stated on 5/25/23 that Resident F has dementia requiring her placement in this facility. POA5 stated that the food served in this facility is "horrible". POA5 stated that when they placed Resident F in this facility Ms. Zeeshan "made a lot of promises" and does not follow through. POA5 stated that they were promised that the residents will be served well balanced meals, but the meals being served are not nutritious. POA5 stated that a typical meal is tomato soup in a small bowl and toast, or macaroni and cheese with unmelted chunks of cheese. POA5 stated that they must bring food in for Resident F because Resident F is not getting what she needs. POA5 stated that they bring in chicken or some other protein, fruits, vegetables, and other things because Resident F is usually hungry. POA5 stated that they have observed other residents push their plates of food away and refuse to eat what is served because the food is "gross".

Resident G's POA, POA6, stated on 5/25/23 that Resident G has not resided in this facility very long. POA6 stated that Resident G tends to eat in her room and the meals are typically served on time. POA6 stated that they think the meals are ok, but that Resident G does complain about being hungry at times. POA6 stated that she will bring snacks for Resident G. POA6 stated that they do not have any specific complaints about the meals being served in this facility.

Resident H's POA, POA7, stated on 5/25/23 that they have observed meals served to the residents in this facility. POA7 stated that meals frequently consist of small bowls of soup, rice, or pasta, and sometimes a roll. POA7 stated that the residents are not being served vegetables or fruits on a consistent basis. POA7 stated that they have had to purchase snacks, bottled water, and fruit juice for Resident H because Resident H complains of being hungry. POA7 stated that the residents are given small portions, and usually there is nothing more to feed the residents.

Resident I's POA, POA8, stated on 5/25/23 that Resident I was admitted to this facility due to a diagnosis of dementia. POA8 stated that they have not observed the residents being served meals, so they do not know if the meals being served are nutritious. POA8 stated that they do not have any comments regarding the resident meals.

Resident J's POA, POA9, stated on 5/30/23 that They do not know if the residents are being served nutritionally balanced meals. POA9 stated that They have observed the residents being served "a lot" of boxed pastas. POA9 did not have any further comments regarding the meals being served in this facility.

Resident K's POA, POA10, stated on 5/30/23 that that they have observed meals served to the residents in this facility. POA10 stated that meals frequently consist of small bowls of soup, rice, or pasta, and sometimes a roll. POA10 stated that the residents are not being served vegetables or fruits on a consistent basis. POA10 stated that they have had to purchase snacks, bottled water, and fruit juice for Resident H because Resident H complains of being hungry. POA10 stated that the residents are given small portions, and usually there is nothing more to feed the residents.

Witness 1 stated on 5/30/23 that they would order groceries for a week for the facility using the Kroger website, then Ms. Zeeshan would go into the account and pay for the food. Witness 1 stated that they would order enough food to match the meals listed on the menus and the cost would usually be around $500-$600. Witness1 stated that Ms. Zeeshan would then delete items from the account and reduce the cost to around $300 before purchasing the order. Witness 1 stated that there was never enough food to prepare meals for the residents. Witness 1 stated that staff members would frequently spend their own money to purchase groceries so that there was food to serve the residents. Witness 1 stated that most of the food available to serve was not nutritious and consisted of boxed pastas, rice, and soups.

Witness 2 stated on 5/30/23 that they were responsible for ordering the facility groceries on a weekly basis, then Ms. Zeeshan would have to approve and pay for the food.

Witness 2 stated that Ms. Zeeshan usually reduced the amount spent on the food by $200-$300. Witness 2 stated that there is rarely enough food to make balanced and nutritious meals for the residents. Witness 2 stated that the residents rarely get vegetables or fruits, and the serving sizes are not enough for the residents. Witness 2 stated that the residents are served a lot of pasta and rice, and nothing but cold cereal for breakfast. Witness 2 stated that she told Ms. Zeeshan several times, that there was not enough food being ordered to feed the residents for a week, and Ms. Zeeshan "didn't care".

Witness 3 stated on 6/1/23 that they were embarrassed to serve the meals to the residents that were provided. Witness 3 stated that meals were not nutritious, and Residents were served small amounts of food. Witness 3 stated that meals were usually a small bowl of soup, or a sandwich and chips. Witness 3 stated that Ms. Zeeshan instructed the staff to serve "a light breakfast, a heavy lunch, and a light supper". Witness 3 stated that Residents would ask for more food, but often there was no more food to serve them.

Witness 4 stated on 5/30/23 that they observed the meals served to the residents in this facility. Witness 4 stated that the meals are not balanced or nutritious and the residents are given small portions. Witness 4 stated that meals were usually some type of packaged pasta or rice and very little meat. Witness 4 stated that residents are not given vegetables very often and seldom are served fruits. Witness 4 stated that she has observed family members and staff must purchase groceries for the residents with their own money because Ms. Zeeshan does not give the staff enough money for adequate groceries.

Staff 2 stated on 6/1/23 that "everything is fine" Staff 2 stated that the residents are given plenty of "good food". Staff 2 did not have any additional information regarding the meals.

Staff 3 stated on 6/2/23 that the residents do not get enough food and the meals are not nutritious. Staff 3 stated that the groceries that are ordered each week are not enough to feed all the residents good meals for a week. Staff 3 stated that Ms. Zeeshan tells staff to keep the food budget under $500 for a week, but that is not enough. Staff 3 stated that residents will often ask for more food at mealtimes, but there is not enough food to given them a second helping. Staff 3 stated that they have spent their own money to buy food for the residents because there has not been enough food to make a meal for the residents.

Staff 4 stated on 6/2/23 that there is never enough food purchased in a week to prepare good meals for the residents. Staff 4 stated that the staff "stretch things as far as they will go", but it is never enough. Staff 4 stated that staff tell Ms. Zeeshan "All of the time" that more food needs to be purchased and that the meals are not good, but nothing changes.

Madiha Zeeshan, licensee designee, stated on 6/5/23 that she purchases groceries weekly and that they are delivered on Saturdays. Ms. Zeeshan stated that no one has ever complained about the food being served in this facility or that the residents were not being given enough.

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(2) Meals shall meet the nutritional allowances recommended pursuant to the provisions of "Appendix I: Recommended Dietary Allowances, Revised 1980" contained in the publication entitled "Basic Nutrition Facts: A Nutrition Reference," Michigan Department of Public Health publication no. H-808, 1/89. This publication may be obtained at cost from The Division of Research and Development, Michigan Department of Public Health, P.O. Box 30195, Lansing, Michigan 48909.
ANALYSIS:	All the witnesses, 8 of the POA's, and three of the staff interviewed all gave a similar account of the meals served in this facility. The witnesses and POAs consistently stated that residents were not being served fruits and vegetables or meats in sufficient amounts. Appendix I of the Recommended Daily Dietary Allowances suggest that adults aged 19-76+ need to have six servings of fruits and vegetables per day of ½ cup. The recommended amount of meat is 2 ½ servings of 2oz. The inspection of the food storage areas on 6/2/23 indicated that there was not enough fruits and vegetables in the facility to provide the resident with the total of 3 cups of fruits and vegetables or enough meat to provide the residents a total of 5oz per day. The menus being used by the staff that were observed on 6/2/23 also did not document that the residents would be served the three-cup amount per day and several days did not document the recommended amount of meat. The meal prepared for lunch on 6/2/23 also did not meet the recommended amount of meat or vegetables consistent with the statements given. Based on the statements given, documentation reviewed, and observations made it is determined that there has been a violation of this rule due to the facility failing to provide nutritious meals.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident hygiene is not being addressed.

INVESTIGATION:

The complainant reported on 4/12/23 that Resident A's hygiene was not maintained while she lived at this facility. The complainant reported that Residents who refuse to shower or bathe are not receiving grooming assistance.

FM1 stated on 5/23/23 that Resident A was supposed to receive bathing services from a hospice aid while she resided at this facility. FM1 stated that they do not believe that Resident A ever received a bath in the six months that she resided at this facility. FM1 stated that Resident A was observed with body odor and dirty hair on several occasions.

POA1 stated on5/30/23 that Resident B is not bathed on a consistent basis. POA1 stated that on one occasion, they observed Resident B to have, what looked like mold on the bottom of Resident B's feet. POA1 submitted a photo of Resident B's feet to confirm the condition of Resident B's feet. POA1 stated that Resident B often "looks like a bum" and that Resident B frequently is observed wearing dirty and soiled clothing. POA1 stated that Resident B will be left in the same clothing for several days in a row. POA1 stated that Resident B is not receiving oral care.

POA2 stated 5/30/23 that Resident C is not being showered and exhibits bad hygiene. POA2 stated that Resident C's hair is always dirty, and his teeth are not being cleaned. POA2 stated that Resident C frequently has bad body odor, and the body odor has been so bad that POA2 has not been able to take Resident C places in their car. POA2 stated that they have had to assist Resident C with showering because staff are told by Ms. Zeeshan that if a resident refuses to be showered, there is nothing that staff can do.

POA3 stated 5/30/23 that they have visited Resident D at the facility and found Resident D to have not been showered. POA3 stated that they gave Resident D a shower a week prior and a week later they returned and Resident D had not been showered again. POA 3 stated that Resident D's hair has "looked horrible" at various times. POA stated that Ms. Zeeshan has told them that "staff don't do nail care." POA3 had no further concerns regarding hygiene.

POA4 stated on 5/30/23 that a hospice worker showers Resident E. POA4 stated that they have observed residents in this facility wearing the same clothing for several days in a row, and that the clothing is sometimes soiled. POA4 stated that Resident E seems to be showered regularly.

POA5 stated on 5/30/23 that Resident F is incapacitated and requires total staff assistance with bathing and hygiene. POA5 stated that they must brush Resident F's

teeth because staff do not do it. POA5 stated that They have had to assist Resident F with cleaning herself after having a bowl movement because staff had not assisted Resident F. POA5 stated that Resident F is on hospice care and that hospice staff assist Resident F with bathing, but POA5 stated that they have found Resident F in the same clothing for two or three days in a row.

POA6 stated on 5/25/23 that Resident G typically is given 2 showers a week. POA6 stated that they have been told by staff that if a resident refuses to be showered, then staff cannot force the resident to shower or bathe. POA 6 stated that Resident G usually looks like she is clean.

POA7 stated on 5/25/23 that Resident H seems to be getting bathed weekly, but Resident H is not receiving oral care. POA7 stated that Resident H has lost several teeth recently due to poor oral hygiene. POA7 stated that Resident H has dementia but is still fairly independent and can take a shower with verbal reminders.

POA8 stated on 5/25/23 that they do not have specific concerns regarding Resident I's hygiene. POA8 stated that Resident I has dementia but is "mobile" and does not require a lot of staff assistance for daily hygiene.

POA9 stated 5/30/23 that they are only able to visit Resident J about once a month. POA9 stated that they have not observed anything to indicate that Resident J is not receiving assistance as needed with hygiene.

POA 10 stated on 5/30/23 that Resident K is highly independent and does not require staff assistance with hygiene. POA10 stated that Resident K has never appeared to have poor hygiene.

Witness 1 stated on 5/30/23 that they observed Residents on hospice care frequently not being bathed by hospice staff as was promised to the families. Witness 1 stated that hospice staff would quit, or not come to the facility as often as needed to provide hygiene services. Witness 1 stated that the facility staff worked hard to provide bathing and toileting assistance to the residents.

Witness 2 stated on 5/30/23 that they observed mostly residents on hospice care not receiving the bathing assistance that was promised when a resident signs up for hospice services. Witness 2 stated that the hospice staff would not provide shower or hygiene assistance to the residents. Witness 2 stated that the facility staff did work hard to provide assistance with bathing and hygiene for the non-hospice residents.

Witness 3 stated on 5/30/23 that there were some residents who were not showered because the resident would refuse a shower. Witness 3 stated that the staff were instructed by Ms. Zeeshan that if a resident refused a shower, then the staff could not force a resident to shower, and the resident was not showered.

Witness 4 stated that on 6/1/23 residents were left in the same soiled clothing for days at a time. Witness 4 stated that there were residents who were seldom given assistance with showering or hygiene and have had “horrible body odor.” Witness 4 stated that they visited a resident on one occasion and found feces and cleaning wipes in the resident’s garbage can. Witness 4 stated that they visited the resident and found the resident had spit phlegm all over himself from coughing, and the resident’s eye was “crusted shut” due to an illness he had at the time.

Ms. Knappan stated on 5/25/23 that she has always found the residents in this facility to be clean and exhibit good hygiene. Ms. Knappan stated that she has no concerns regarding resident hygiene at this facility.

Staff 1 stated on 6/1/23 that the staff give each resident a shower or bathe the residents twice a week. Staff 1 stated that the hospice residents receive hygiene assistance from a hospice aid, but the facility staff provide assistance to the remaining residents.

Staff 2 stated on 6/1/23 that the residents are assisted by staff with hygiene and bathing. Staff 2 stated that there are no issues with Resident hygiene in this facility.

Madiha Zeeshan, licensee designee, stated on 6/5/23 that she disagrees with this allegation. Ms. Zeeshan stated that all the residents receive assistance with bathing, but one resident becomes combative with staff when they attempt to assist the resident, so the staff can not get the resident to take a shower. Ms. Zeeshan stated that each resident is scheduled for two showers a week or more if needed.

Asif Zeeshan, Ms. Zeeshan’s husband, stated on 6/6/23 that he is very concerned about this allegation and stated that the allegation is false. Mr. Zeeshan stated that he treats the residents as family and would never neglect their needs. Mr. Zeeshan is not the licensee designee, administrator, or a staff person at this facility.

All the residents were observed during the inspections on 5/24/23 and 6/2/23. Most of the residents in this facility are diagnosed with dementia and could not give reliable statements. None of the residents were observed to exhibit poor hygiene during the inspections.

Resident K was alert and oriented to person, place, and time. Resident K was appropriately dressed and groomed with no visible injuries. Resident K stated that he can take showers without staff assistance. Resident K stated that he takes showers at least twice a week but could take one every day if he wished to. Resident K stated that he did not know how often the other residents are showered.

APPLICABLE RULE	
R 400.15314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	The complainant reported that the residents in this facility do not consistently receive staff assistance with showering and hygiene. FM1, POA1, POA2, POA3, witness 3, and witness 4 stated that they have observed residents not being showered at least weekly and have had other hygiene issues related to oral hygiene and wearing the same clothing for multiple days. Based on the consistency of the statements given by FM1, POA1, POA2, POA3, Witness 3, and Witness 4, it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Witness 1 stated on 5/30/23 that several of the staff working in this facility have not completed fingerprints. Witness 1 stated that Ms. Zeeshan did not send newly hired staff to have their fingerprints completed.

Witness 2 stated on 5/30/23 that when she worked at this facility, several of the staff did not have completed fingerprints. Witness 2 stated that there was no system in place to fingerprint new staff.

Witness 3 stated on 5/30/23 that they were never sent for fingerprints when working in this facility. Witness 3 stated that they worked in this facility for seven months and was never sent to have fingerprints completed.

Staff 3 stated on 6/2/23 that they have worked at this facility for two months and have not submitted fingerprints. Staff 3 stated that new staff hires are not being fingerprinted.

Staff 4 stated on 6/2/23 that they have not been fingerprinted. Staff 4 stated that they have worked at this facility for several months.

During the inspection on 5/24/23 and 6/2/23, several files that were identified as staff files were reviewed. I was unable to locate any proof of fingerprints, consistent with the statements given.

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain employees providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; failure to conduct criminal history check; automated fingerprint identification system database; report to legislature; costs; definitions.**
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no

	longer exempt and shall be terminated from employment or denied employment.
ANALYSIS:	All the statements given were consistent indicating that there are previous and current staff who have not been fingerprinted in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Witness 1 stated on 5/30/23 that staff are not being properly trained prior to working at this facility. Witness 1 stated that new staff will be trained for one day, then will be scheduled to work directly with the residents. Witness 1 stated that the new staff are not receiving training in reporting requirements, personal care, supervision, protection, resident rights, safety and fire prevention and communicable diseases. Witness 1 stated that several staff have started working with no CPR/first aid trainings.

Witness 2 stated on 5/30/23 that staff do not receive any of the trainings required in this rule. Witness 2 stated that new staff will be trained for one day, then scheduled to work with the residents. Witness 2 stated that there was no documentation in the staff files confirming that the staff had received the trainings.

Witness 3 stated on 5/30/23 that they did not receive any of the training required by this rule. Witness 3 stated that they were hired on a Thursday, and they began working with the residents on their first day which was a Monday. Witness 3 stated that they were passing medications and providing full care to the residents. Witness 3 stated that none of the staff hired when they were hired received any training as required by this rule. Witness 3 stated that Ms. Zeeshan “cuts a lot of corners” and that is why there is a high staff turnover rate at this facility.

Staff 3 further stated on 6/2/23 that staff are not receiving training as required by this rule when they are hired. Staff 3 stated that there is no documentation to show that any of the trainings have been provided.

The files identified as staff files were reviewed on 5/24/23 and 6/2/23. There was no record of staff trainings located in the files.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**
ANALYSIS:	Witness 1, Witness 2, Witness 3, and Staff 3 all stated that staff are not receiving the trainings required by this rule. No documentation was located during the inspections on 5/24/23 and 6/2/23 to confirm that staff are receiving the trainings required by this rule. Based on the statements given and lack of documentation, it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

A Resident register was requested for review during the inspection completed on 6/2/23. Staff 3 stated that there is no resident register.

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:	No Resident register was available during the inspection on 6/2/23. Based on this observation, it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

The resident files were reviewed during the inspection on 5/24/23 and 6/2/23. Resident D's file contains a written assessment dated 11/25/22, but the assessment has not been signed by Ms. Zeeshan or POA3.

Resident E's file contains a written assessment dated 10/26/21. The written assessment is not signed by Ms. Zeeshan.

Resident J's file contains a written assessment dated 5/22/23. The written assessment is not signed by Ms. Zeeshan.

Resident N's file contains a written assessment dated 2/13/19. The written assessment is not signed by Ms. Zeeshan.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(3) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.

ANALYSIS:	Resident D, Resident E, Resident J, and Resident N's files contain written assessments that are not signed by Ms. Zeeshan an Resident E, Resident J and Resident N's written assessments are overdue for review. Based on the documentation reviewed, it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Resident D's file contains a care agreement dated 11/25/22. The care agreement is not signed by Ms. Zeeshan.

Resident E's file contains a care agreement dated 10/26/21. The written care agreement is not signed by Ms. Zeeshan.

Resident N's file contains a care agreement dated 2/13/19. The care agreement is not signed by Ms. Zeeshan.

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 R400.15315.** **(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:	Based on the documentation reviewed, it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

POA1 stated on 5/30/23 that several of the residents sit in their rooms all day because there are no activities offered at this facility. POA1 stated that a music therapist used to visit the facility but has not been to the facility in many months. POA1 stated that the

Residents just sit around and do not get any exercise or activities to stimulate their minds.

POA2 stated on 5/30/23 that they visit the facility several times a week, and the residents are not offered any activities. POA 2 stated that several residents just sit in their rooms all day, and a few will sit on the couch in the living room area, watching TV all day long. POA 2 stated that there are no other activities being offered to the residents.

POA7 stated on 5/30/23 that they visit the facility every other day, and that the residents are not provided any activities. POA7 stated that the residents sit in the rooms all day, and some will sit on the couch in the living room watching television.
POA8 stated that there are no activities for the resident at this facility. POA8 stated that they would like to see the residents offered something to do other than just watching television. POA stated that there does not seem to be anything for the residents to do.

Witness 4 stated on 6/1/23 that the residents in this facility are not offered any activities. Witness 4 stated that a music therapist used to come to the facility, but she quit coming several months ago. Witness 4 stated that the residents just sit in their rooms or slumped on the couch in the living room watching television.

Mr. Zeeshan stated on 6/6/23 that he goes to this facility all the time because the residents are like family to him. Mr. Zeeshan stated that he “always” does activities with the residents.

During the inspections on 5/24/23 and 6/2/23, the residents were observed sitting in their bedrooms or sleeping. Three Residents were observed sitting on the couch in the living room watching television. There were no other activities observed during either on-site inspection.

APPLICABLE RULE	
R 400.15317	**Resident recreation.**
	(1) A licensee shall make reasonable provision for a varied supply of leisure and recreational equipment and activities that are appropriate to the number, care, needs, age, and interests of the residents.

ANALYSIS:	POA1, POA2, POA7, POA8, and Witness 4 all stated that the residents just sit in their rooms or on the couch in the living room watching television and no other activities are offered. This was confirmed by observations made during two on-site inspections. Based on the statements given and observations made, it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

An exit conference was conducted with Madiha Zeeshan, licensee designee, on 6/5/23. The findings in this report were reviewed and a corrective action plan was requested. Ms. Zeeshan stated that she does not agree with the findings in this report, and that the residents are well cared for at this facility.

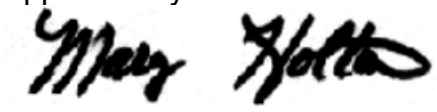
IV. RECOMMENDATION

I recommend that the status of this license remain unchanged with the receipt and implementation of an acceptable corrective action plan.

06/06/2023

Kent W Gieselman — Date
Licensing Consultant

Approved By:



06/07/2023

Mary E. Holton — Date
Area Manager