GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 9, 2023

Clarence Rivette
The Cottage of Davison Inc
8121 Broken Ridge East
Harbor Springs, MI 49740

RE: License #: AL250337633
Investigation #: 2023A0779039
The Cottage of Davison

Dear Mr. Rivette:

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,

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL250337633
Investigation #:	2023A0779039
Complaint Receipt Date:	05/01/2023
Investigation Initiation Date:	05/01/2023
Report Due Date:	06/30/2023
Licensee Name:	The Cottage of Davison Inc
Licensee Address:	8121 Broken Ridge East Harbor Springs, MI 49740
Licensee Telephone #:	(810) 653-7343
Administrator:	Melissa Taylor
Licensee Designee:	Clarence Rivette
Name of Facility:	The Cottage of Davison
Facility Address:	Suite A 1515 Cal Drive Davison, MI 48423
Facility Telephone #:	(810) 653-7343
Original Issuance Date:	05/24/2013
License **Status:**	REGULAR
Effective Date:	11/23/2021
Expiration Date:	11/22/2023
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A's adult briefs are not being changed as often as needed.	No
There was an employee (name unknown) who was caught on a recording being verbally aggressive with Resident A.	Yes
Resident A's alarm for her belt has been found on the side of her wheelchair.	No
Resident A is not being fed properly and has lost weight.	No

III. METHODOLOGY

05/01/2023	Special Investigation Intake 2023A0779039
05/01/2023	Special Investigation Initiated - Telephone Spoke to APS worker, Shwanda Lee.
05/01/2023	APS Referral Complaint was received from APS worker.
05/02/2023	Inspection Completed On-site
05/02/2023	Contact - Telephone call made. Spoke to Resident A's nurse practitioner.
05/04/2023	Contact - Telephone call made. Interview conducted with administrator, Melissa Taylor.
05/04/2023	Contact - Telephone call made. Voicemail message left for staff person, LaQuisha Patrick.
06/05/2023	Exit Conference Held with administrator, Melissa Taylor.
06/09/2023	Contact - Telephone call made. Spoke with administrator, Melissa Taylor.

ALLEGATION:

Resident A's adult briefs are not being changed as often as needed.

INVESTIGATION:

On 5/1/23, a phone conversation took place with APS worker, Shwanda Lee, who confirmed that she is investigating the same allegations. She stated that she had already visited the facility and seen Resident A to be clean and well groomed. Ms. Lee reported that she was informed by staff that they check and/or change Resident A's adult brief every 2 hours or as needed.

On 5/2/23, an unannounced on-site inspection was conducted. Resident A was viewed to be clean, well-groomed, and wearing a clean and dry adult brief. Multiple other residents were also viewed to be clean and well groomed. Due to her dementia and cognitive deficiencies, Resident A was not able to be interviewed.

During the on-site inspection, several staff persons were interviewed, including administrative assistant, Jordan Taylor. Ms. Taylor stated that Resident A receives all her medical services through the PACE program. She stated that Resident A utilizes a wheelchair, is non-mobile, and requires total care from staff. Ms. Taylor reported that staff are checking and/or changing Resident A's brief every 2 hours or as needed and that Resident A has no skin breakdown that would occur from sitting in wet briefs for long periods of time.

A review of Resident A's written assessment plan confirms that she has dementia and utilizes a wheelchair. It states that Resident A requires full assistance from staff to complete all her activities of daily living, including bathing and toileting.

On 5/2/23, staff persons, Amie Shanks, Allbreyale Crawford, and Rebecca Robinson were all interviewed separately but reported the same information. They all reported that they check and/or change Resident A's brief at least every 2 hours or sooner if needed. They all deny that Resident A is left in wet or dirty briefs for long periods of time and that they initial and date the brief each time it is changed. They all believe that Resident A is well taken care of and stated that she has no skin breakdown.

On 5/2/23, a phone call was made to Resident A's nurse practitioner through PACE, Stephanie Thomas, who confirmed that Resident A was seen at PACE twice just recently and had a full body assessment completed on 4/24/23. Ms. Thomas stated that the assessment did not find that Resident A had any skin breakdown or any signs of neglect. She stated that the facility staff are checking Resident A's brief every 2 hours, but if she is dry, they are not always changing the brief. Ms. Thomas reported that she has requested that the staff change Resident A's brief at least every 3 hours, whether it is dirty or not. Ms. Thomas stated that PACE has plans to do random weekly visits with Resident A at this facility moving forward.

On 5/4/23, a phone interview was conducted with administrator, Melissa Taylor, who confirmed that Resident A's briefs are being checked by staff at least every 2 hours. She stated that she is not aware of Resident A ever having sat in a wet and/or dirty brief for any extended length of time. Ms. Taylor reported that although there is no physician order in place to enforce it, she has been encouraging her staff to initial and date Resident A's brief at every change. Ms. Taylor stated that Resident A does not have any skin breakdown or redness that would suggest that she is not being changed frequently enough. She stated that Resident A shares a room with a roommate and that both residents were being provided briefs by PACE, but Resident A's daughter has recently started supplying the briefs herself and she counts them daily. Ms. Taylor stated that some of the staff may be still putting the PACE briefs on Resident A making it appear that Resident A is not being changed enough when the daughter counts the briefs she is supplying. Ms. Taylor stated that she has not seen any evidence to suggest that Resident A is being neglected and/or not being changed frequently enough.

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:	It was confirmed that Resident A wears adult briefs and requires full assistance from staff for bathing and toileting. Five staff were interviewed separately and all stated that Resident A's brief is being checked and/or changed at least every 2 hours. All the staff, including Resident A's nurse practitioner, stated that Resident A does not have any skin breakdown that would suggest that she has been being left in wet briefs. On 5/2/23, an unannounced on-site inspection was conducted, and Resident A was viewed to be clean, well-groomed, and wearing a clean brief. There was no evidence found to prove that Resident A is not being provided adequate personal care.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

There was an employee (name unknown) who was caught on a recording being verbally aggressive with Resident A.

INVESTIGATION:

On 5/1/23, APS worker, Ms. Lee, stated that the facility is aware of an audio recording where staff person, LaQuisha Patrick, can be heard making threats to hit Resident A. She stated that it is unclear if any physical abuse took place as there is no physical evidence to support that. Ms. Lee stated that the facility has terminated Ms. Patrick's employment.

On 5/2/23, administrative assistant, Jordan Taylor, stated that Resident A's daughter had an audio recording device in Resident A's room that they were not aware of. She stated that in a recent recording, Ms. Patrick could be heard yelling at Resident A and threatening to hit Resident A a few times. Ms. Taylor stated that she is not aware of any evidence that Ms. Patrick ever actually hit Resident A.

On 5/2/23, Resident A was viewed to clean, well-groomed and with no visible bruises or injuries. Due to her dementia and cognitive deficiencies, Resident A was not able to be interviewed.

On 5/2/23, nurse practitioner, Stephanie Thomas, confirmed that PACE was aware of the audio recording in question. She stated that after learning of the recording, they brought Resident A to PACE on 4/24/23 and did a full body assessment on her. Ms. Thomas reported that there were no unusual bruising or signs of physical abuse on Resident A and she was returned to the facility the same day.

On 5/4/23, administrator, Melissa Taylor, stated that on 4/24/23 she received a phone call from Resident A's daughter with concerns that Resident A may be being abused. She stated that the daughter had an audio recording in Resident A's room without their knowledge and recorded an incident between Resident A and a staff person working 2nd shift on 4/23/23. She stated that it was determined that the staff person in question was Ms. Patrick. Ms. Taylor reported that there was clear verbal abuse by Ms. Patrick, as she could be heard yelling at Resident A and making a verbal threat to hit Resident A. Ms. Taylor stated that a sound was heard on the recording that may have been a slap, but there was no physical evidence found of physical abuse. Ms. Taylor stated that Ms. Patrick was suspended on 4/24/23 and that after an internal investigation into the matter, she was terminated on 4/25/23.

A review of an AFC Licensing Division Incident/Accident Report (IR) regarding Resident A was reviewed. The information on the IR matched the information obtained during the interview with administrator Melissa Taylor. The IR stated that an audio recording of staff person, LaQuisha Patrick on 4/23/23, revealed that Ms. Patrick yelled at and threatened to hit Resident A and that Ms. Patrick was immediately suspended. The IR stated that Resident A was taking to PACE on 4/24/23, that a full body assessment was done and that no signs of physical abuse were found. The corrective measures listed on the IR were that Ms. Patrick's employment with this facility was terminated on 4/25/23.

On 5/4/23, a voicemail was left on the phone of staff person, LaQuisha Patrick. She was informed of the reason for the investigation and asked to return the call to give her side of the story. As of the date of this report, Ms. Patrick has not returned the call.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(f) Subject a resident to any of the following:** **(ii) Verbal abuse.** **(iv) Threats.**
ANALYSIS:	It has been confirmed that there was an audio recording of a staff person yelling at and making a threat to hit Resident A. Administrator, Melissa Taylor, stated that clear verbal abuse and threats could be heard on the recording and that it has been determined that the staff on the recording was LaQuisha Patrick. A voicemail message was left for Ms. Patrick as an opportunity for her to dispute these allegations, but Ms. Patrick has not returned the call. There was sufficient evidence found to support that on 4/23/23, staff person, LaQuisha Patrick, verbally abused and made threats of physical harm towards Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A's alarm for her belt has regularly been found on the side of her wheelchair.

INVESTIGATION:

On 5/2/23, administrative assistant, Jordan Taylor, confirmed that Resident A does have what is called a “tab alarm”. She stated that the alarm itself hooks onto the back of Resident A’s wheelchair, with a clip that attaches to the back of Resident A’s shirt, which will go off if Resident A attempts to stand up. Ms. Taylor reported that the alarm is not meant to hook to Resident A’s belt and is not effective if done so. Ms. Taylor stated that Resident A has been known to remove the alarm clip from her clothing. She stated that she is not aware of staff frequently leaving the alarm unattached. She reported that Resident A has not had any known falls as a result of her standing up out of her wheelchair.

During the unannounced on-site inspection on 5/2/23, Resident A was observed to be sitting in her wheelchair with the alarm attached to her wheelchair and clipped onto the back of her shirt. A demonstration of the alarm confirmed that the alarm was in good working order.

On 5/2/23, staff persons, Amie Shanks, Allbreyale Crawford, and Rebecca Robinson were all interviewed separately and all stated that they are aware of the use of Resident A’s alarm and how to properly use it. They stated that the alarm has always clipped to the back of Resident A’s shirt and never to her belt. All 3 staff reported that they check the alarm daily to make sure it is working and that the alarm is always used when she is sitting in her wheelchair. They stated that they have all witnessed the alarm go off and then prevented Resident A from trying to stand on her own. They stated that they have witnessed Resident A messing with and/or removing the alarm clip on occasion and that they will reattach it to her shirt if found to be unclipped. All 3 staff deny that they have intentionally not used or have unclipped the alarm. They reported to not be aware of Resident A having any recent falls out of her wheelchair.

On 5/2/23, nurse practitioner, Stephanie Thomas, confirmed that as a preventative measure, Resident A should have the alarm attached to her while sitting in her wheelchair. Ms. Thomas stated that Resident A’s daughter has voiced her concern to them that Resident A’s alarm is on her wheelchair but not always attached to her. Ms. Thomas reported that she is not aware of Resident A having any recent falls from out of her wheelchair.

On 5/4/23, administrator, Melissa Taylor, confirmed that PACE provided the facility with an order for an alarm for Resident A to use while sitting in her wheelchair, but stated that there were no specific instructions provided on how to use it. She stated that the alarm is quite simple to use. Ms. Taylor reported that Resident A does know how to remove the alarm clip and that staff have forgotten to reattach it on occasion, but that Resident A has not had any falls out of her wheelchair. She stated that the alarm does not prevent Resident A from attempting to stand, just goes off when she attempts to do so. She stated that there are many new staff that are quite anxious and nervous when dealing with Resident A, due to continued verbal abuse they are subjected to from Resident A’s daughter. She stated that this contributes to them making simple mistakes

at times like not always attaching the alarm to Resident A's shirt, although Ms. Taylor does not believe that is happening on a frequent basis. Ms. Taylor stated that she has many new staff that she is continuing to provide on-going education and training too.

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: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	This facility does have a physician order for Resident A to have an alarm for her wheelchair. Staff state that they check to make sure that the alarm is working daily and that they are using it daily. Staff claim that Resident A knows how to take the alarm clip off her and that they will reattach it when seen that it is off. They deny that they ever intentionally not use the alarm. Administrator, Melissa Taylor, admits that staff may occasionally forget to reattach the alarm to Resident A's shirt, but that she is not aware of this happening on a frequent basis. Resident A has not had any recent falls from out of her wheelchair. There was insufficient evidence found to prove that staff are frequently not utilizing the prescribed wheelchair alarm for Resident A or that as a result she is having falls from her wheelchair.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A is not being fed properly and has lost weight.

INVESTIGATION:

On 5/2/23, administrative assistant, Jordan Taylor, stated that Resident A seems to eat well at every meal. She stated that the amount of food she consumes is documented on a food acceptance record form and that her eating habits have been consistent for several months. Ms. Taylor reported that Resident A tends to like to eat with her hands, but Resident A's daughter does not like her doing that so Resident A was just recently

placed on having 1-on-1 staff during meals, where staff directly feed her. She reported that Resident A's daughter is at the facility for at least one meal daily and feeds Resident A herself. Ms. Taylor stated that Resident A has had some weight loss, but that what they were finding when weighing her did not match what they were physically seeing with Resident A. She stated that Resident A can be difficult to get an accurate weight on because she wiggles around a lot, and it is hard to get her to sit still. Ms. Taylor stated that they are also questioning how accurate their scale is. Ms. Taylor reported that Resident A is seen by PACE staff and physicians frequently and that they have not reported having any concerns regarding her weight. She reported that another factor in Resident A's weight loss is that when she first moved into this facility, she was mobile and she has become strictly wheelchair bound, which contributes to her losing weight due to loss of muscle mass.

During the on-site inspection on 5/1/23, staff was observed weighing Resident A. The facility's scale is one that staff have to place the resident in a chair that is the actual scale. Resident A was observed not wanting to stay in the scale chair and was wiggling around quite a bit. She was weighed at 125 pounds. Resident A's weight record form was reviewed. The record does show some up and down weight patterns over the last few months as Resident A lost several pounds one month, gained it all back the next month and then lost it again the following month. This tends to lead one to determine that the scale itself and/or technique used is not effective/accurate. Resident A's food acceptance record form was also reviewed. This form is where staff track how much food, broken down by protein, vegetables, starch, liquids, etc.… she eats at every meal. The form shows that Resident A has been eating an adequate amount if not all of each meal and that her food consumption has been quite consistent over the last several months.

On 5/2/23, staff persons, Amie Shanks, Allbreyale Crawford, and Rebecca Robinson were all interviewed separately, and all stated they feed Resident A and that Resident A eats fairly well at every meal. Ms. Shanks stated that Resident A recently has lost her bottom dentures and that they have a physician order to be able to puree her food as needed, but that Resident A's daughter insists that Resident A's food remain in chopped bite size pieces. Ms. Shanks stated that this makes her eating a little more difficult, but that Resident A still likes to eat.

On 5/2/23, PACE nurse practitioner, Stephanie Thomas, stated that Resident A's weight loss has just recently become a topic of conversation, but that has had more to do with adjusting a certain medication to her current weight. She stated that they weighed Resident A in November 2022 at 133 and just recently on 4/27/23 at 125 pounds. Ms. Thomas reported that some weight loss is common in later stages of dementia and that Resident A's recent weight loss will continue to be monitored, but it is not a concern at this time. Ms. Thomas stated that the facility is reporting that Resident A is eating well at every meal. She stated that they just found out that Resident A has lost her bottom dentures and that situation will have to be further assessed, as this could contribute to trouble eating and weight loss. Ms. Thomas confirmed that lack of mobility due to becoming wheelchair bound can contribute to loss of muscle mass and weight. She

stated that at the physical exam on 4/24/23, Resident A did not appear to be malnourished.

On 5/4/23, administrator, Melissa Taylor, confirmed that the facility has noticed some weight loss on Resident A, but that they believe that is more of a reflection of their scale not being accurate and that they have ordered a new one. She stated that Resident A is a slow but good eater and that staff have not reported any significant change and/or decrease in the amount of food she is eating at each meal. Ms. Taylor reported that per Resident A's daughter's request, Resident A now has 1-on-1 staffing for each meal and is being directly fed by staff. Ms. Taylor stated that they commonly see some weight loss in later stages of dementia, which is Resident A's case. She stated that she has spoken to PACE whenever their scale showed more than a 5-pound weight loss for Resident A but PACE's records did not show as much weight loss as their records did and PACE has not expressed any significant concerns on the matter. Ms. Taylor confirmed that Resident A recently lost her bottom dentures and that they are continuing to search the facility for them. She stated that Resident A has a history of not wanting to keep them in, but that the lack of bottom dentures has not appeared to decrease the amount of food that Resident A is consuming at each meal.

On 6/9/23, a phone call was made to administrator, Melissa Taylor, to gain more clarification regarding the fluctuation of Resident A's weight and the scale the facility uses. Ms. Taylor stated that they have found that other residents that have to use their sitting scale have also had similar fluctuation and/or erratic changes in their weight. She reported that the residents that are able to use their standing scale, their monthly weights are much more consistent. Ms. Taylor reported that the wide range of weights using the siting scale just have not matched what they are physically seeing for those residents. Ms. Taylor stated that the current scale has too much leeway for operator error as weights will be off if staff forget to zero the scale out which recalibrates the scale. She stated that she has ordered a new scale that is digital and meant for the use with wheelchairs.

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Staff at this facility claim that Resident A is being fed 3 nutritious meals daily and that she is a fairly good eater. The facility has provided documentation to support those claims. Resident A has appeared to have lost some weight recently but does not appear to be a result of lack of food consumption. Resident A's nurse practitioner stated that their records show that Resident A

	has only lost 8 pounds over the last 5 months and that they have no concerns regarding this issue at this time. It appears that the use of a faulty scale that the facility has been using has also contributed to the erratic monthly weights the facility was getting. There was a lack of evidence found to support the allegation that this facility is not providing Resident A with a minimum of 3 regular nutritious meals daily.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 6/5/23, an exit conference was held with administrator, Melissa Taylor. Ms. Taylor stated that Resident A's family moved Resident A out of this facility on 5/4/23. She was informed of the outcome of this investigation and that a written corrective action plan is required.

IV. RECOMMENDATION

Upon receipt of an approved written corrective action plan, it is recommended that the status of this facility's license remain unchanged.

6/9/2023

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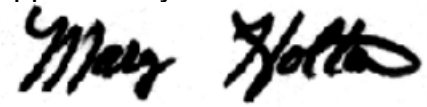
Christopher Holvey Date
Licensing Consultant

Approved By:



6/9/2023

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Mary E. Holton Date
Area Manager