GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 30, 2023

Megan Fry
MCAP Holt Opco, LLC
Suite 115
21800 Haggerty Road
Northville, MI 48167

RE: License #: AL330404596
Investigation #: 2023A1033047
Prestige Way #1 (Cedar Cottage)

Dear Ms. Fry:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

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

Sincerely,

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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL330404596
Investigation #:	2023A1033047
Complaint Receipt Date:	05/17/2023
Investigation Initiation Date:	05/22/2023
Report Due Date:	07/16/2023
Licensee Name:	MCAP Holt Opco, LLC
Licensee Address:	Suite 115 21800 Haggerty Road Northville, MI 48167
Licensee Telephone #:	(517) 694-2020
Administrator:	Megan Fry, Designee
Licensee Designee:	Megan Fry, Designee
Name of Facility:	Prestige Way #1 (Cedar Cottage)
Facility Address:	4300 Keller Road Holt, MI 48842
Facility Telephone #:	(517) 694-2020
Original Issuance Date:	11/02/2020
License Status:	REGULAR
Effective Date:	05/02/2023
Expiration Date:	05/01/2025
Capacity:	20
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was not provided water and was being left alone at the facility.	No
Resident A's medications were not administered as prescribed.	Yes
Resident A did not have a bed in her bedroom.	No

III. METHODOLOGY

05/17/2023	Special Investigation Intake 2023A1033047
05/22/2023	APS Referral- Complaint stemmed from denied APS referral.
05/22/2023	Special Investigation Initiated - On Site Interviews with Executive Director/direct care staff, Zachary Fisher, direct care staff, Darlene Gonzalez & Noor Albarakat. Review of former Resident A's resident record completed.
05/22/2023	Inspection Completed-BCAL Sub. Compliance
06/02/2023	Exit Conference- Conducted via telephone with licensee designee, Megan Fry. Voicemail message left.

ALLEGATION:

Resident A was not provided water and was being left alone at the facility.

INVESTIGATION:

On 5/17/23 I received an online complaint regarding the Prestige Way #1 (Cedar Cottage) adult foster care facility (the facility). The complaint alleged that Resident A did not receive proper supervision and was not given water during her short stay at the facility. On 5/22/23 I completed an on-site investigation at the facility. I interviewed Executive Director/direct care staff, Zachary Fisher. Mr. Fisher reported that he did not recall Resident A as he was relatively new to the facility. He reported beginning his employment at the facility in early February 2023 and Resident A resided at the facility for a brief period from 2/6/23 to 2/11/23. Mr. Fisher reported Resident A had admitted to the facility under hospice care through Heart to Heart Hospice of Lansing after being hospitalized at Sparrow Hospital in Lansing, MI.

During on-site investigation on 5/22/23 I interviewed Residential Care Coordinator/direct care staff, Darlene Gonzalez. Ms. Gonzalez reported Resident A admitted to the facility on 2/6/23, from Sparrow Hospital. She reported Resident A was alert and talking upon arrival from the hospital and able to make her needs known. She reported Resident A was medically frail and was admitted to hospice services through Heart to Heart Hospice on 2/6/23. Ms. Gonzalez reported all residents are checked on routinely and offered water with every meal and throughout the day. She also reported the facility has a hydration station in the main living room area where residents who are capable of self-serve can obtain water. Ms. Gonzalez further reported residents are checked on routinely and fluids are pushed by direct care staff if a resident is not able to voice this need. She clarified that direct care staff will offer to assist the resident with drinking if needed. Ms. Gonzalez reported that Resident A died under hospice care on 2/11/23.

During on-site investigation on 5/22/23 I interviewed direct care staff, Noor Albarakat. Ms. Albarakat reported she recalled Resident A as she had provided care to her while she was a resident at the facility. Ms. Albarakat reported Resident A was in a weakened condition when she admitted to the facility and food and water had to be offered to her. She reported she would offer food, but this was often refused by Resident A. She also reported Resident A would drink with the use of a straw, but even this was a struggle due to weakness and lethargy.

During on-site investigation on 5/22/23 I reviewed the resident record for Resident A. I reviewed the document, *Sparrow Trauma Services Discharge Summary*, dated 2/6/23. On page 2 of this document, under section, *Indication for Admission*, it noted, "[Resident A] is 76 y.o. female that presented after a fall from standing." On page 2 , under section, Hospital Course, it states, "Pt. admitted to trauma service for further management of traumatic injuries listed above. Orthopedics evaluated pt x L pubic rami fx, recommended no acute surgical intervention, WBAT BLE, f/u OP including repeat XR pelvis s/p 40' ambulation. Neurosurgery evaluated x T12 fracture, no acute surgical intervention, non-custom TLSO brace OOB and f/u OP. Neuropsychology evaluated pt. not competent to make medical decisions, son [Citizen 1] was activated at DPOA." Also, in this section was documented, "Pt had multiple behavioral disturbances and psychiatry evaluated pt, appreciate medication regimen. Given pt stagnant progress, palliative team was consulted, d/w family and pt was made comfort care. Pt had multiple insurance barriers for hospice placement that were eventually resolved and pt discharged hospice."

When reviewing Resident A's resident record I reviewed the document, *Assessment Plan for AFC Residents*. On page 2 under section, *II. Self Care Skill Assessment*, subsection, *A. Eating/Feeding*, it is selected, "Yes" that Resident A required assistance with this, with the following notation, "Extensive: Resident requires regular encouragement to select menu items compliant with ordered diet; may require assistance with feeding appliances."

On 5/22/23, during on-site investigation I also reviewed the document, *Hospice Certification and Plan of Care*, for Resident A, dated 2/6/23. On page 2 under the section, *Goals*, the following was noted, “Demonstrates offering, but not forcing food/fluids to patient.”

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:	Based upon interviews with Mr. Fisher, Ms. Gonzalez, Ms. Albarakat, in addition to review of Resident A’s resident record it can be determined that there was not adequate evidence to suggest that Resident A was not offered food or provided supervision during her six-day admission to the facility. It is noted in her hospital records, hospice records, and facility records that she did admit to the facility in a weakened condition and had difficulty accepting food/hydration due to this condition. It cannot be determined at this time that the direct care staff were not providing adequate support, supervision, and personal care to Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A’s medications were not administered as prescribed.

INVESTIGATION:

On 5/17/23 I received an online complaint which alleged that Resident A’s medications were not administered as prescribed while she was a resident at the facility from 2/6/23 to 2/11/23. I completed an on-site investigation on 5/22/23 and interviewed Mr. Fisher. Mr. Fisher reported that the direct care staff utilize the Pharma Script pharmacy for resident medications. Mr. Fisher reported that prior to a resident’s admission to the facility they have the resident’s medication list sent to Pharma Script and have resident medications available for administration once the resident is admitted. Mr. Fisher reported that he is unaware of any issues obtaining Resident A’s medications while she was a resident at the facility.

During on-site investigation on 5/22/23, I reviewed the *Mediation Administration Record* (MAR) for Resident A for the month of February 2023. The following medications were listed on Resident A’s MAR.

- Diltiazem Cap 240Mmg ER: Take 1 capsule by mouth once daily for hypertension.
- Divalproex Cap 125mg: Take 2 capsules by mouth twice daily for dementia.
- Duloxetine Cap 60mg: Take 1 capsule by mouth twice daily for depression.
- Hydroco/APAP Tab 5-325mg: Take 1 tablet by mouth three times daily.
- Lorazepam Tab 1mg: Take 1 tablet by mouth twice daily.
- Metoprol TAR Tab 100mg: Take 1 tablet by mouth twice daily for A-FIB.
- Senna Plus 8.6-50mg: Take 2 tablets by mouth twice daily for constipation.
- Trazodone Tab 50mg: Take 1 tablet by mouth daily at bedtime for sleep.
- Haloperidol CON 2MG/ML: Take 0.5ML (1MG) by mouth every 6 hours as needed for agitation.
- Lorazepam Tab 0.5mg: Take 1 tablet by mouth every 4 hours as needed for anxiety.
- Morphine Sulfate 20mg/ml: Give 1 prefilled syringe (0.25ml/5mg) by mouth every hour as needed for pain/dyspnea.

During on-site investigation on 5/22/23, I reviewed the document titled, *Hospice Certification and Plan of Care*, dated 2/6/23. On pages 2 & 3 of this document the following medications were prescribed for Resident A, by the Heart to Heart Hospice provider, Dr. Phillip Eisenberg:

- Albuterol Sulfate 2.5mg/3ml: Every 4 hours/PRN; Inhalation/Wheezing
- Diltiazem ER 240mg Capsule 24 hr extended release: daily.
- Divalproex 125mg Capsule: Delayed Release Sprinkle, Every 8 hours/Dementia.
- Gabapentin 100mg Capsule: 2 times daily/pain.
- Haloperidol 2mg tablet: every 6 hours/agitation.
- Haloperidol Lactate 2mg/ml Oral Concentrate: Every 6 hours PRN/Agitation.
- Lorazepam 1mg tablet: every 4 hours PRN/Agitation.
- Metoprolol Tartrate 100mg Tablet: 2 times daily.
- Morphine Concentrate 100mg/5ml (20mg/ml) oral solution: Pain.
- Ondansetron 4 mg Disintegrating tablet: every 8 hours PRN/Nausea.
- Senna-S 8.6mg-50mg tablet: 2 times daily/Constipation.
- Trazodone 50mg tablet: Bedtime/Sleep.

After review of Resident A's February 2023 MAR and the *Hospice Certification and Plan of Care* document, the following medications were ordered by the Heart to Heart Hospice provider, Dr. Eisenberg, and were not reflected on the MAR as medications available to be administered to Resident A:

- Albuterol Sulfate 2.5mg/3ml: Every 4 hours/PRN; Inhalation/Wheezing
- Gabapentin 100mg Capsule: 2 times daily/pain.
- Haloperidol 2mg tablet: every 6 hours/agitation.
- Ondansetron 4 mg Disintegrating tablet: every 8 hours PRN/Nausea.

During on-site investigation on 5/22/23, I interviewed Ms. Gonzalez, Mr. Fisher, and Ms. Albarakat, regarding the discrepancy between Resident A's MAR for February 2023 and the medications that were listed on the hospice plan of care for Resident A. Neither, Ms. Gonzalez, Mr. Fisher, nor Ms. Albarakat, were able to offer reasoning for the discrepancy.

On 5/31/23 I received a telephone call from direct care staff/Regional Clinical Director for the facility, Ericka Zoerhof. Ms. Zoerhof reported that she had researched the discrepancy between Resident A's February 2023 MAR and the missing medications that had been ordered by the Heart to Heart Hospice provider, Dr. Eisenberg. She reported that she spoke with the Pharma Script pharmacy, and the individual (name not provided) she spoke with noted that the pharmacy had never received the order for the Gabapentin medication. She reported that she is unsure where the error occurred in the system and has put into place an action plan to ensure, going forward, they are able to properly review the medications ordered on the hospice plan of care to ensure these medications have been ordered, correctly, and appear on the resident MARs.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based upon interviews with Mr. Fisher, Ms. Gonzalez, Ms. Albarakat and Ms. Zoerhof, as well as review of Resident A's MAR and the *Hospice Certification and Plan of Care* document, it can be determined that Resident A was ordered four medications, by Dr. Eisenberg, that were not available to administer to Resident A based on these medications not appearing on Resident A's February 2023 MAR. Since the medications did not appear on the MAR, the direct care staff administering medications were not aware of medications that were prescribed for Resident A's use. Two of the missing medications were ordered to be administered routinely. Two of the missing medications were ordered to be available for administration on an as needed basis.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A did not have a bed in her bedroom.

INVESTIGATION:

During on-site investigation on 5/22/23 I interviewed Mr. Fisher regarding the allegation that Resident A did not have a bed when she resided at the facility between the dates of 2/6/23 and 2/11/23. Mr. Fisher reported that there is always a bed in each resident bedroom. He reported the facility even has extra beds in a storage shed if a resident is ordered a hospital bed and needs to have the bed removed from their room for this circumstance. Mr. Fisher reported that it had not been brought to his attention that Resident A did not have a bed in her bedroom during her stay at the facility.

During on-site investigation on 5/22/23 I interviewed Ms. Gonzalez. Ms. Gonzalez reported that all resident bedrooms are equipped with beds. Ms. Gonzalez reported that if a resident were to be waiting for a hospital bed the direct care staff would not take down the facility provided bed until the hospital bed had been delivered by the durable medical equipment company. Ms. Gonzalez reported that Resident A did have a bed and she recalled seeing the hospital bed in Resident A's room.

During on-site investigation on 5/22/23 I interviewed Ms. Albarakat. Ms. Albarakat reported that for the most part, Resident A was bedbound. She reported that Resident A did have a hospital bed in her room during her stay at the facility.

During on-site investigation on 5/22/23, I reviewed Resident A's resident record. I reviewed the document, *Hospice Certification and Plan of Care,* dated 2/6/23. On page 2 of this document under section, *DME and Supplies*, is the following notation, "DME-Fall Mat; DME-Hospital Bed; DME-Nebulizer; DME-O2 Concentrator; DME-Rails/Grab bars; DME-Wheelchair."

During on-site investigation on 5/22/23, I reviewed the document, *Carelinc Medical Equipment*, with a noted "Scheduled Del. Time: 02/03/2023" with the following durable medical equipment listed on the invoice for [Resident A]:

- Hospital Full Electric Bed
- Hospice Group Mattress
- Hospice Half Rails
- Hospice Wheelchair Lightweight

APPLICABLE RULE	
R 400.15410	**Bedroom furnishings.**
	(5) A licensee shall provide a resident with a bed that is not less than 36 inches wide and not less than 72 inches long.

	The foundation shall be clean, in good condition, and provide adequate support. The mattress shall be clean, comfortable, in good condition, well protected, and not less than 5 inches thick or 4 inches thick if made of synthetic materials. The use of a waterbed is not prohibited by this rule.
ANALYSIS:	Based upon interviews with Mr. Fisher, Ms. Gonzalez, Ms. Albarakat, and review of the resident record it can be determined the Resident A had a hospital bed ordered for her use and it was delivered to the facility via Carelinc Medical Equipment on 2/3/23.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the status of the license recommended at this time.

06/15/23

_____

Jana Lipps Date
Licensing Consultant

Approved By:

06/30/2023

_____

Dawn N. Timm Date
Area Manager