GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 11, 2023

Toni LaRose
AH Spring Lake Subtenant LLC
6755 Telegraph Rd Ste 330
Bloomfield Hills, MI 48301

RE: License #: AL700397742
Investigation #: 2023A0350021
AHSL Spring Lake Timberbrook

Dear Ms. LaRose:

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 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 (616) 356-0100.

Sincerely,

Ian Tschirhart, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 644-9526

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL700397742
Investigation #:	2023A0350021
Complaint Receipt Date:	05/02/2023
Investigation Initiation Date:	05/02/2023
Report Due Date:	06/01/2023
Licensee Name:	AH Spring Lake Subtenant LLC
Licensee Address:	One SeaGate, Suite 1500 Toledo, OH 43604
Licensee Telephone #:	(248) 203-1800
Administrator:	Toni LaRose
Licensee Designee:	Toni LaRose
Name of Facility:	AHSL Spring Lake Timberbrook
Facility Address:	17383 Oak Crest Parkway Spring Lake, MI 49456
Facility Telephone #:	(616) 844-2880
Original Issuance Date:	03/18/2019
License Status:	REGULAR
Effective Date:	09/18/2021
Expiration Date:	09/17/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A's urinalysis and blood work were not scheduled in a timely manner.	Yes
Resident A did not receive her Quetiapine for two days, causing her to have anxiety.	Yes
Resident A's prescription eyedrops were used on another resident. In addition, the eyedrops were not stored according to pharmaceutical instructions.	No
Food trays with food still on them are left in Resident A's room for long periods of time. Because of her dementia, there is a concern that she may eat food that is old and potentially poisonous.	Yes
Resident A's food is being served in large pieces that need to be cut, but a knife is often not provided.	Yes
Resident A is not being visually checked on as often as her Assessment Plan states she needs to be.	No
Resident A's Assessment Plan was not updated when it should have been.	No
The designated responsible person is not being contacted when serious things happen to Resident A.	No

III. METHODOLOGY

05/02/2023	Special Investigation Intake 2023A0350021
05/02/2023	Special Investigation Initiated - Letter I sent an email to the Executive Director, Toni LaRose
05/02/2023	Contact - Document Received I received an email from Ms. LaRose
05/02/2023	Contact - Document Sent I sent an email to Relative 1
05/02/2023	Contact - Document Received I received an email from Relative 1

05/03/2023	Contact - Document Sent I sent an email to Ms. LaRose
05/03/2023	Contact - Document Received I received an email from Ms. LaRose
05/03/2023	Contact - Face to Face I met with Ms. LaRose, and Kelsey Bramer, Wellness Director
05/03/2023	APS referral
05/03/2023	Contact - Face to Face I met with Resident A and Relative 3
05/04/2023	Contact – Telephone call received I spoke Erin Wallace, APS investigator
05/04/2023	Contact - Telephone call made I spoke with LaToya White, DCW
05/04/2023	Contact - Document Received I received two emails from Ms. Bramer
05/05/2023	Contact - Telephone call made I spoke with Relative 1
05/05/2023	Contact - Document Sent I sent Relative 1 an email
05/05/2023	Contact - Document Sent I sent a couple of emails to Ms. Bramer
05/05/2023	Contact - Document Received I received a couple of emails from Ms. Bramer
05/08/2023	Contact - Document Sent I sent an email to Ms. Bramer
05/08/2023	Contact - Document Received I received an email from Ms. Bramer
05/09/2023	Contact - Document Received I received an email from Relative 1
05/09/2023	Contact – Document sent I sent an email to Relative 1

05/09/2023	Contact – Telephone call made I spoke with Melissa DeWitt, private care provider
05/09/2023	Contact – Document sent I sent an email to Ms. Bramer
05/09/2023	Contact – Document received I received an email and text message from Ms. Bramer
05/11/2023	Exit conference – Held with Toni LaRose, Licensee Designee

ALLEGATION: Resident A's urinalysis and blood work were not scheduled in a timely manner.

INVESTIGATION: On 05/02/2023, I sent an email to Toni LaRose, Executive Director, informing her that a complaint was made and to arrange a day and time for me to meet with her, and Kelsey Bramer, Wellness Director.

On 05/02/2023, I received an email reply from Ms. LaRose, stating that I could meet with her anytime.

On 05/02/2023, I received several emails and text messages with pictures attached from Relative 2.

On 05/03/2023, I sent another email to Ms. LaRose, informing her of what time I would be there, and requested that she have certain documents available for me.

On 05/03/2023, I received another email from Ms. LaRose, confirming that she received my previous email, and was expecting me.

On 05/03/2023, I made an onsite inspection and met with Ms. LaRose and Ms. Bramer. I went over the allegation with them. Ms. Bramer explained that Resident A's family (not sure who) requested the order for the urinalysis and bloodwork from Resident A's Primary Care Physician (PCP) without telling anyone at American House. Ms. Bramer then reported that she exchanged a few emails back and forth about this with Relative 2, who told her that the orders were faxed to her by the PCP's office. Ms. Bramer told Relative 2 that American House's fax machine had not been working properly for several days, so she didn't know if this fax was sent to her or not. Ms. Bramer informed me that once the fax machine was repaired, she checked for this particular fax and it wasn't there. She said she called the PCP's office and they confirmed that it was sent, but because Ms. Bramer didn't get it, they would send it again. She finally did receive this fax. Ms. Bramer then faxed the order for the bloodwork and arranged to have Resident A's urine sample sent to the clinic; however, the staff member who was supposed to take the urine sample forgot to do so, and it had to be redone. The urine sample was finally taken to the clinic and the

results came to American House on 05/03. The results were that Resident A's urinalysis did not show any issues. Ms. Bramer stated that a blood sample was drawn from Resident A on 05/03, and they were waiting for the results. Ms. Bramer provided me with copies of the emails she sent and received from Relative 2, as well as the results of the urinalysis.

On 05/03/2023, I reviewed the emails and urinalysis report. I noted that a urinalysis test was ordered on 04/25 and the results were sent to American House on 05/03 and showed no issues. There was also and an order for a urinalysis on 04/14 and that test was done the same day, and again no concerns were noted. As stated in the paragraph above, Ms. Bramer informed me that their fax machine had not been working properly for several days around this period, accounting for the delay in her getting the order on 04/25. On 04/28, Resident A's Legal Guardian and relative, Relative 1, sent Ms. LaRose and Ms. Bramer an email in which she stated:

'On TUESDAY April 25,2023 Dr. Hatt's office faxed over an order for a urine and a blood test for (Resident A). As of today, April 28th this hasn't been done. This needs to be done ASAP.

(Relative 2) is asking the Dr's office to REFAX the orders. I know that staff have inquired with you about this order. There is NO reason why it has not been done. Please resolve this and get these samples sent in ASAP. This is a medical issue and lack of attention to this is completely unacceptable and neglectful.

Please let me know if you have questions and please advise when this has been completed.'

Ms. Bramer sent the following email to Relative 1 on the same day, 04/28:

'Upon receiving the fax today at 11:37am from my executive director's fax machine, I delivered the orders and supplies to the staff to complete the urine collection.'

Relative 1 then sent Ms. Bramer another email on 04/28, in which she stated:

'Please refer to the above email for any questions- I followed the above email up with a phone call this morning. You were made aware of the fact that the order was faxed over Tuesday. That the dr wanted these tests. This was again brought to your attention yesterday by your staff and this morning by me. Here we are over 4 hrs after we spoke and a test still has not been administered. this is unacceptable and again, I will point out NEGLECTFUL. We need the results to see if there is STILL an infection. IF there is, it needs to be treated so it doesn't progress to something more serious. The reason I was on the phone first thing today, was so this could be taken and we could get the results ASAP (before everyone was gone for the weekend). Delaying the test is making that nearly impossible and it is delaying any possible treatment that is necessary. Please advise when this test will be taken. I am very disappointed in the care that is given to the residents.'

Ms. Bramer responded to Relative 1 with an email on 04/28, stating, *'It was sent over to the lab. They come every Monday, so it should be completed this coming Monday. Have a great weekend!'*

Relative 1 then responded on the same day with: *'What about the blood test? When will that be done?'*

On May 1, Relative 1 sent this email to Ms. Bramer:

'Please refer to the above email where you indicate the blood test for (Resident A) would happen today, as they (whoever they is) come to do the blood draws on Monday. It's after 6pm and a blood draw wasn't done. Why? The Doctor requested these tests last TUESDAY. This is unacceptable and the test needs to be completed ***immediately.***

Also, I want confirmation that the urine test WAS SENT to the lab and I want to know what day and time it went out? I find it very unusual that we don't have the results yet.'

Relative 1 sent this email on 05/02: *'Please answer my questions from yesterday!'*

Ms. Bramer responded on 05/02:

'(Relative 1)

You must allow up to 48 business hours for me to respond. Unfortunately, I do not sit at my desk all day as I monitor staff and residents day to day.

The urine sample was indeed collected on Friday, but unfortunately, there was a miscommunication between staff. Another sample was collected today, dropped off, and the lab threw it out. My staff just came in my office approximately 10 minutes ago stating they collected another sample and are headed to the lab.

I spoke with one of the nurses at NOCH palliative, and one of the phlebotomists from the lab will be coming this evening to draw the bloodwork.

I am sorry for the inconvenience. Technology is a bummer sometimes. We rely on receiving most orders through fax. Sometimes, our faxes or the other facilities faxes may not be received. If you are ever expecting labs to take place, do not hesitate to reach out to me to confirm I have received them. If I have not, then I will reach out to the physician as I did with these orders.'

On 05/05/2023, I reviewed an entry on the Progress Notes report that was made on 04/28/2023 by Ms. Bramer. The entry states:

'The night shift med tech contacted me last night asking about blood work, and UA orders. I informed her I was unaware of any orders but I would look in the morning when I arrived. UA orders in had from 2 weeks ago with results. Planned to call POA, (Relative 1), after morning meeting. During rounds, at approximately 0900, (Relative 1) called the campus, and I spoke with her. (Relative 1) asked about the lab orders, and I informed her that I was planning to contact her after my meeting. (Relative 1) stated the doctor's office faxed me the orders on Tuesday. I informed (Relative 1) that I have not received a fax or any orders regarding labs for (Resident A). (Relative 1) stated that there's a problem because I have not received emails and now faxes. I informed (Relative 1) that it is a technology issue, not something on my end, but I would be happy to contact the physician to have them refax the orders. (Relative 1) kept stating they needed to be completed ASAP. I informed (Relative 1) that I would contact the office and have the labs completed as soon as I received the orders. At approximately 1215, I was leaving Timber on my way to Willow when (Relative 2)…drove up to me in her vehicle. She stated she was coming to see me. I asked how I could help her. She asked if I had the stuff for the labs. I asked what stuff. (Relative 2) said the cup and everything for the urine sample. I informed (Relative 2) that I spoke with (Relative 1) this morning, and I do not have orders from the physician yet. I informed her that I am just now getting back to my office after meetings and rounds this morning, and I am going to call the physician's office. (Relative 2) stated, "That's bullshit. You're not getting emails and now you're not getting faxes. I just talked to the office, and they said they faxed it over again just now. That's bullshit." I walked away back into Timber to again check the fax machine. No faxes. I walked out and back to Willow when (Relative 2) approached me walking asking is she could follow me. I told her no and I would call the physician's office. At approximately 1225, I spoke with the nurse at Dr. Hatt's office who said they did fax orders over Tuesday and again today. I informed her that we have no(t) received them. The nurse stated she would try again and I gave her another fax number to try as well.'

On 05/05/2023, I received an email from Ms. Bramer with the results of Resident A's bloodwork analysis. The report shows that the clinic received the referral on 05/03, and that the only thing of concern was that her B/C (BUN-creatinine) ratio was a little high. I checked the internet and learned that BUN-creatinine is related to a person's level of kidney functioning.

On 05/11/2023, I called and held an exit conference with Toni LaRose, Licensee Designee. I informed Ms. LaRose that I was citing a violation of this rule. Ms. LaRose pointed out that their fax machine not working for a few days was a circumstance beyond their control and that Resident A's family did not alert them that a fax was being sent.

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:	Relative 1, who is also Resident A's Legal Guardian, did not inform Kelsey Bramer, Wellness Director at American House, that Resident A's PCP ordered a urinalysis and blood work on 04/25 until 04/28. The orders were faxed to American House from Resident A's PCP's office on 04/25/2023, but due to American House's fax not working for several days, Wellness Director Kelsey Bramer did not get the orders until 04/28, after she called the PCP's office to have them resent. Ms. Bramer stated that a urine sample was taken from Resident A on 04/28 but the staff member who was supposed to take the urine sample to the clinic for evaluation forgot to do so. Another sample was taken on 05/02 and sent to the lab the same day and the results were received by American House on 05/03. The delay in getting the blood work done was due to the fax not working at American House. Ms. Bramer arranged to have a blood sample drawn from Resident A on 05/03. The results were sent to and received by American House on 05/08. The fax machine has since been repaired. As a result of this facility's fax machine not working and a staff member failing to deliver the urine sample the first time, Resident A's blood work and urinalysis tests were not done in a timely manner. Therefore, my findings support that this rule had been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A did not receive her Quetiapine for two days, causing her to have anxiety.
INVESTIGATION: During my onsite inspection on 05/03/2023, I asked Ms. Bramer if Resident A was not given her Quetiapine for two days in a row, around 11/30/2022, causing her to become agitated. Ms. Bramer stated that she was not informed that Resident A did not receive her Quetiapine for two days as indicated, and reported that her dosage of this medication was increased from 50 mg to 100 mg on 03/19,

and she has been receiving 100 mg since 03/20. Ms. Bramer informed me that whenever a medication is discontinued, it is immediately removed from the medication cart. She also told me that she has the Medication Technicians audit the medication carts once a month. I requested copies of the eMARs (electronic Medication Administration Record) for November 2022 and March and April 2023 and Ms. Bramer provided them to me. I also requested a copy of the Progress Notes for this same time frame and she gave me those as well.

On 05/05/2023, I reviewed the eMARs and Progress Notes. I observed that there were initials in the boxes for Resident A's Quetiapine for every day except on 11/30/2022. The eMARs has "DNG" in that box, which stands for "Drug Not Given." An entry in the Progress Notes on 12/01/2022 states, *'Contacted pharmacy about 9pm Quetiapine for resident being missing. Pharmacy did not have order for medication. Hospice nurse was contacted and she informed med tech that prescription will be sent over to pharmacy. Pharmacy did let med tech know that medication will be sent out with meds for tomorrow. Resident will not be receiving again tonight.'* There was no entry in the Progress Notes about Resident A experiencing any difficulties as a result of her not receiving her Quetiapine on 11/30 and 12/1.

On 05/05/2023, I called and spoke with Relative 1, who is also Resident A's Legal Guardian. Relative 1 informed me that when Resident A was not given her Quetiapine on 11/30 and 12/1, Relative 2, who was spending time with Resident A, noticed that Resident A was "more anxious and restless and had nightmares."

On 05/05/2023, I sent an email to Ms. Bramer, inquiring as to the reason Resident A did not receive her Quetiapine on 11/30 and 12/01/20222.

On 05/05/2023, I received an email reply from Ms. Bramer. She stated that, "It looks like it ran out and was awaiting delivery from the pharmacy. I was not the wellness director during that time. I started in mid-December (2022). The facility had also recently switched pharmacies around that time. I would have to check when the exact date was. Everyone was still learning how the new pharmacy worked, so that may have been part of the issue.

On 05/11/2023, I called and held an exit conference with Toni LaRose, Licensee Designee. I informed Ms. LaRose that I was citing a violation of this rule. Ms. LaRose stated that their switching pharmacies may have added to the delay of getting this prescription filled, and felt this was another circumstance beyond their control.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	Although Resident A did not receive her Quetiapine for two days in a row, it was during a time when the facilities at the American House Spring Lake campus were switching to a different pharmacy. Provisions should have been made so that Resident A would not have missed her scheduled doses of this medication. Therefore, my findings support that this rule had been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A's prescription eyedrops were used on another resident. In addition, the eyedrops were not stored according to pharmaceutical instructions.

INVESTIGATION: On 05/03/2023, I met with Ms. Bramer who stated that Resident A's eyedrops were being stored properly. She said that when the eyedrops are unopened, they are kept in the refrigerator, but once they are opened, they may stay in the medication cart, as stated in the storage instructions.

On 05/03/2023, Relative 2 sent me an email with the following emails included:

On 04/24/2023, Relative 1 sent the following email to Ms. Bramer:

'On 4-12-23 (Relative 2) emailed you inquiring about (Resident A's) Lanaprost eyedrops not being stored properly. They need to be refrigerated until they are opened, they were not. (Relative 2) requested that another bottle be ordered at your expense. As of Monday 4-24-23 it will be 12 days that she hasn't heard from you.

As I live out of town, please show (Relative 2) the new bottle so we know the Lanaprost is being stored properly, so it can work properly, to keep the pressure in (Resident A's) eye under control. We would also like to see the record of who checked the Lanaprost in and if it was put in the refrigerator for proper storage in the last 12 days.

(Relative 2) is usually at AH after 2 pm on any given day.

We look forward to your reply in a timely manner as this is a medication issue that needs to be addressed.'

On 04/24, Ms. Bramer sent Relative 1 this response:

'I never received an email from (Relative 2) regarding this issue. (Resident A's) eyedrops are being stored properly. When eyedrops are unopened, they are kept in the fridge. Once opened, they may stay in the med cart, per medication storage

recommendations. We continue to follow these instructions per manufacturer guidelines. If you have any further concerns, please reach out.'

On 05/04/2023, I called and spoke with LaToya White, Direct Care Worker (DCW). I asked Ms. White if Resident A's eyedrops were ever used on another resident, as far as she knew. Ms. White reported that some former DCWs who were Med Techs did use Resident A's eyedrops on another resident and that all of the DCWs who did that no longer work there. Ms. White confirmed that the eyedrops were kept in the refrigerator until first used, then kept in the medication cart per storage instructions.

On 05/04/2023, I received an email from Ms. Bramer with the storage instructions from the pharmacy for the eyedrops Resident A was prescribed. The instructions state that the eyedrops, Latanoprost, need to be refrigerated until opened, then once opened, they must be kept at room temperature, and their efficacy will expire at six weeks, or 42 days.

On 05/04/2023, I received another email from Ms. Bramer in which she stated, *'We do not share eyedrops, and we educate staff about not sharing medication between residents. We store all residents' eyedrops properly according to pharmacy regulations. I frequently check eyedrops in each building, and they are stored in the fridge until they are opened.'*

On 05/11/2023, I called and held an exit conference with Toni LaRose, Licensee Designee. I informed Ms. LaRose that I was not citing a violation of this rule. Ms. LaRose did not have any comments regarding this matter.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	LaToya White, DCW and Med Tech, stated that some Med Techs did use Resident A's eyedrops on another resident, but that none of them who did so work there any longer. Ms. White did, however, confirm that Resident A's eyedrops were refrigerated until opened, and then they were kept on the med cart according to instructions.

	Kelsey Bramer, Wellness director, insisted that Resident A's eyedrops were not used on another resident, and also confirmed that Resident A's eyedrops were refrigerated until opened, and then they were kept on the med cart according to instructions. As I cannot confirm with former Med Techs whether Resident A's eyedrops were used on another resident or whether this medication was properly stored, my findings do not support that this rule had been violated.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Food trays with food still on them have been left in Resident A's room for long periods of time. Because of her dementia, there is a concern that she may eat food that is old and potentially poisonous.

INVESTIGATION: On 05/02/2023, Resident 2 texted me several pictures to my phone of in Resident A's room. One of the pictures shows a closed Styrofoam container with a clock in the background that displayed "Saturday 11:35pm February 11" and another photo showing a taco salad in a Styrofoam container with the clock in that picture showing "Sunday 6:46pm February 12," indicating that the leftovers of this meal were left in Resident A's room for about 19 hours. Another picture shows a plate with thin strips of steak about 3-4 inches long but with no knife in which to cut them.

On 05/03/2023, I made an onsite inspection and met with Ms. LaRose and Ms. Bramer. I informed them of this allegation, and Ms. LaRose stated that this was the first time there was a complaint about the food service at this facility. As it was lunchtime during my onsite inspection, I requested to inspect a couple of random resident rooms, including Resident A's. Ms. LaRose and I went into Resident C's room. I found a food tray with plates and bowls on it and saw that it was uneaten breakfast food: cereal, bacon, and toast. I asked Resident C if staff were removing trays in a timely manner, and she hesitated to answer, and then said something like, "They do an okay job." Ms. LaRose picked up the breakfast food tray, and Resident C snapped at her and told her to leave it, which she did. We then went into Resident A's room and she was just being served her lunch by a staff member. I observed that all of the necessary eating utensils were on the tray. I also observed that her room was clean and organized and did not observe any food trays, with or without food on them, in her room.

On 05/05/2023, I called and spoke with Relative 1, who is also Resident A's Legal Guardian. Relative 1 expressed concern about food being left in Resident A's room for long periods of time. She told me that recently some taco salad was left in her

room for more than 24 hours. Relative 1 said that because Resident A “has memory problems,” she may think that food that has been in her room for a long time was just delivered and may eat it,” and if it were dairy or meat, she could get food poisoning.

On 05/09/2023, I called a spoke with Caregiver 1, who provides personal care and supervision services for Resident A. Caregiver 1 confirmed that food trays are sometimes left in the Resident A’s room for a long time. Sher reported that one time recently a food tray with food still on it was left in Resident A’s room for two days.

On 05/11/2023, I called and held an exit conference with Toni LaRose, Licensee Designee. I informed Ms. LaRose that I was not citing a violation of this rule. Ms. LaRose did not have any comments regarding this matter.

APPLICABLE RULE	
R 400.15401	**Environment health.**
	(4) All garbage and rubbish that contains food wastes shall be kept in leakproof, nonabsorbent containers. The containers shall be kept covered with tight-fitting lids and shall be removed from the home daily and from the premises at least weekly.
ANALYSIS:	It has happened that food trays with food still on them have been left in Resident A’s room for several hours, perhaps as long as two days. Due to Resident A’s dementia, she may digest meat or dairy products left in her room for too long, thinking they were recently served and was fresh. My findings support that this rule had been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A’s food is being served in large pieces that need to be cut, but a knife is often not provided.

INVESTIGATION: On 05/02/2023, Relative 2 texted me several pictures to my phone of Resident A’s room. One of the pictures shows a plate with thin strips of steak about 3-4 inches long but with no knife to cut them, and there was another picture of an entree that appeared to require needing to be cut. However, since meals are not served with knives, Resident A would be unable to cut it.

On 05/03/2023, I made an onsite inspection and met with Ms. LaRose and Ms. Bramer. I informed them of this allegation. As it was lunchtime during my onsite

inspection, I requested to see the kitchen, food being served, and Resident A's room and Ms. LaRose accompanied me to all of these places. I observed at least a dozen residents eating in the dining area and saw that the meals were served with the necessary utensils, and the dishware and hot plate covers appeared to be clean. I spoke with the culinary dietician, Brian Schweifler, and he informed me that there was a card for each resident kept in the kitchen that has their dietary likes and dislikes and specific needs written on it, such as whether the food needs to be cut into small pieces, etc. We then went into Resident A's room and she just being served her lunch by a staff member. I observed that all of the necessary eating utensils were on the tray. I also observed that her room was clean and organized.

On 05/09/2023, I sent an email to Ms. Bramer, requesting a picture of Resident A's culinary needs and preferences card and the answer to whether it was American House's policy not to provide knives to residents in their memory care unit for their safety.

On 05/09/2023, I received the picture of Resident A's culinary needs and preferences card, which shows that she has no known food allergies, likes the texture of her food to be "regular," and needs to have the consistency of her liquids to be "thin." Ms. Bramer also confirmed that it is American House's policy not to provide knives to residents in their memory care unit, where Resident A lives, for their safety.

On 05/11/2023, I called and held an exit conference with Toni LaRose, Licensee Designee. I informed Ms. LaRose that I was citing a violation of this rule. Ms. LaRose did not have any comments regarding this matter.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Resident A is sometimes served food that is in too large of pieces to eat without being cut, but no knife is provided and she can't eat it. Relative 2 sent me pictures of meals served to Resident A, and in two of the pictures I observed that part of what was being served would need to be cut in order to be consumed; however, a knife was not provided. My findings support that this rule had been violated.

CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: Resident A is not being visually checked on as often as her Assessment Plan states she needs to be.

INVESTIGATION: On 05/03/2023, I made an onsite inspection and met with Ms. LaRose and Ms. Bramer. Ms. Bramer informed me that residents are visually checked on every two hours unless they are with family members or other visitors so that those visits would not be interrupted. I asked if a log is kept of when residents are checked on, and Ms. Bramer said there is. I requested of copy of that log for Resident A starting at 01/01/2023 and going to the present. Ms. Bramer said she would print that out for me.

On 05/04/2023, I reviewed the visual check log that American House calls "Toileting/Rounding Schedule." The log has boxes for every two hours between 7 a.m. and 6 a.m. I observed that most of the boxes were marked, indicating that Resident A was checked on, with the occasional box not marked. This would mean that she was not checked on for four hours, unless she was checked on but the staff member forgot to mark the box. I observed that no more than one box was left unmarked from 01/01/2023 to 04/30/2023, the last date in the printout I requested. The allegations stated that on 03/01/2023, no one checked on Resident A "all that night." However, the log has a mark in every box except at 7 a.m., which ostensibly means she was not checked on for four hours.

On 05/08/2023, I reviewed Resident A's Assessment Plan and her Service Plan, and neither indicate that she needs to be visually checked every two hours, or within any timeframe, for that matter. Resident A does, however, require assistance with grooming, toileting, bathing, dressing, etc. These activities are done with staff assistance; and, as mentioned, she is checked on every two hours to assess for toileting needs.

On 05/09/2023, I spoke with Melissa DeWitt, CNA, who is a private caregiver for Resident A that the family hired. Ms. DeWitt informed me that she is with Resident A on weekdays from 7 a.m. to 2 p.m. Ms. DeWitt stated that "Nobody comes down there, ever," referring to staff not checking in on Resident A. She said that sometimes the only one she sees is the med tech, not any of the DCWs.

On 05/11/2023, I called and held an exit conference with Toni LaRose, Licensee Designee. I informed Ms. LaRose that I was not citing a violation of this rule. Ms. LaRose did not have any comments regarding this matter.

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:	There is no mention in either Resident A's Assessment Plan or Service Plan that indicates she requires to be visually checked on at any certain time interval. It is American House's policy to visually check on every resident every two hours; however, this may not happen if a resident is being visited by a family member, friend, or other person. I reviewed Resident A's Toileting/Rounding Schedule and it indicated that she has been visually checked on every two hours, with a few exceptions, but never has more than four hour gone by without her being checked on. My findings do not support that this rule had been violated.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A's Assessment Plan was not updated when it should have been.

INVESTIGATION: During my onsite inspection on 05/03/2023, I asked Ms. Bramer when Resident A's Assessment Plan was completed and she told me that it was done "before her admission," which was on 10/31/2022. Ms. Bramer informed me that the protocol for assessments was that another assessment, after the one done upon admission, is done at 30-Days, and then every six months, unless there is a "change of condition" before six months. In that case, a new assessment is done. I requested copies of Resident A's Assessment Plans, and Ms. Bramer provided them to me. I was also provided with a Service Plan for Resident A dated 03/13/2023. I observed that the last Assessment Plan was dated 03/10/2023. The Assessment Plan and Service Plan contain extensive information about Resident A's medical, physical, mental health, and educational histories, in addition to her current care needs. They also include plans of action to address a wide variety of her social, physical, and personal care needs.

On 05/05/2023, I reviewed the entries on the Progress Notes report for the dates of 02/27/2023, made by Berri Darrow, and 03/16/2023, made by Ms. Bramer.

The entry made on 03/16/2023 states:

'(Resident A's) grandson (Relative 3) observed (Resident A) lying on the floor in her room. (Relative 3) pulled (Resident A's) call light. Caregiver quickly went to the Resident's room and observed the Resident laying on the floor, on her left side, next to her bed. The Resident stated she was trying to water her plant. Caregiver assisted to a sitting, and then standing position, and into her chair. (Resident A's) vitals were taken. Staff asked (Resident A) if she had pain anywhere, and (Resident A) stated she was not experiencing any pain or discomfort. Vital signs were taken and charted. Staff reported incident to Supervisor and daughter. Staff faxed cover sheet to the Resident's physician.'

The entry made on 03/16/2023 states:

'Care conference today over the phone with Kelsey, Toni, Connor (Culinary Director), (Relative 2), and (Relative 1/Legal Guardian). Family mentioned (Resident A) being assessed for hospice and/or palliative care. AHSL is unaware or either of these referrals being sent or assessments being performed. (Relative 2) stated, "the physician thinks she has a fractured hip." Spoke with nurse at Dr. Hatt's office – On March 2, family wanted set up referral for hospice, (Resident A) did not meet the criteria, so family wanted palliative care referral. Palliative referral was sent March 7 for dementia. Nurse stated the office has no further information on a palliative consult. Office has no record of physician fx dx (fracture diagnosis). Nurse pulled records of an urgent care visit on March 1 for shoulder pain – xray was negative…'

On 05/05/2023, I called and spoke with Relative 1 who stated that Relative 2 made an appointment for Resident A to see a hospice nurse after she fell in March (2023). That doctor found that Resident A had a fractured hip and a broken rib, but they were in such a state of healing that the doctor said she didn't require any medical treatment for these wounds. The doctor prescribed Tylenol and that was it.

On 05/11/2023, I called and held an exit conference with Toni LaRose, Licensee Designee. I informed Ms. LaRose that I was not citing a violation of this rule. Ms. LaRose did not have any comments regarding this matter.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) 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 A's initial Assessment Plan was done before she was admitted to American House. I observed that another Assessment Plan was done on 03/10/2023, which was after Resident A's fall on 02/27/2023. Resident A's Assessment Plans were completed within the timeframes set according to this rule. Therefore, no violation of this rule is being cited.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: The designated responsible person is not being contacted when serious things happen to Resident A.

INVESTIGATION: On 05/05/2023, I called and spoke with Relative 1, who is also Resident A's Legal Guardian. I informed Relative 1 who I was and that I was investigating allegations made against American House. I told her that one of the allegations was that she was not being notified when incidents of concern happen regarding Resident A. Relative 1 stated that she was not informed when Resident A fell in March (2023). I asked if Resident A was taken to the hospital as a result of that fall, and she said she was not. I informed Relative 1 that in that case, the licensee did not have an obligation to notify her. I asked if Resident A had been taken to the hospital since she's been at this facility (October 2022) and she said she has not. I went over the reasons a licensee must contact designated responsible person and told her that I would send a copy of this rule in an email.

On 05/05/2023, I sent an email to Relative 1/Legal Guardian with the licensing rule number 400.15311 which pertains to Investigation and reporting of incidents, accidents, illnesses, absences, and death.

On 05/11/2023, I called and held an exit conference with Toni LaRose, Licensee Designee. I informed Ms. LaRose that I was not citing violation of this rule. Ms. LaRose did not have any comments regarding this matter.

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(a) The death of a resident.**

	(b) Any accident or illness that requires hospitalization. **(c) Incidents that involve any of the following:** **(i) Displays of serious hostility.** **(ii) Hospitalization.** **(iii) Attempts at self-inflicted harm or harm to others.** **(iv) Instances of destruction to property.** **(d) Incidents that involve the arrest or conviction of a resident as required pursuant to the provisions of section 1403 of Act No. 322 of the Public Acts of 1988.**
ANALYSIS:	Resident A has not been hospitalized, nor has there been an occasion of any of the other reporting requirements regarding Resident A since her admission on 10/31/2022. Therefore, there has been no incident that would have obligated the licensee to contact resident's designated representative. My findings do not support that this rule had been violated.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend that the status of this facility's license remain unchanged, and that this special investigation be closed.

May 11, 2023

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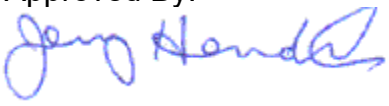
Ian Tschirhart, Licensing Consultant Date

Approved By:



May 11, 2023

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Jerry Hendrick, Area Manager Date