GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 7, 2023

Puja Borso
Creekside Place, INC.
2995 Weidemann Dr
Clarkston, MI 48348

RE: License #: AS630397523
Investigation #: 2023A0993036
Creekside Place

Dear Mrs. Borso:

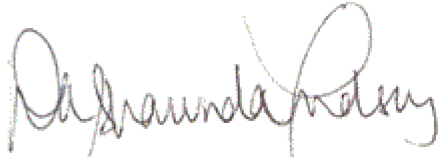
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste. 9-100
Detroit, MI 48202
(248) 505-8036

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630397523
Investigation #:	2023A0993036
Complaint Receipt Date:	08/16/2023
Investigation Initiation Date:	08/17/2023
Report Due Date:	10/15/2023
Licensee Name:	Creekside Place, INC.
Licensee Address:	7251 N. Briarcliff Knoll West Bloomfield, MI 48322
Licensee Telephone #:	(248) 346-4515
Administrator:	Puja Borso
Licensee Designee:	Puja Borso
Name of Facility:	Creekside Place
Facility Address:	7251 N. Briarcliff Knoll West Bloomfield, MI 48322
Facility Telephone #:	(877) 327-5484
Original Issuance Date:	08/20/2019
License Status:	REGULAR
Effective Date:	08/20/2022
Expiration Date:	08/19/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL TRAUMATICALLY BRAIN INJURED ALZHEIMERS; AGED

II. ALLEGATION(S)

	Violation Established?
• On 08/06/2023, Resident A had fingerprint and thumbprint shaped bruising on both of her arms, her right hand, and both of her legs. Home manager Donna Spears was working on this day. • Ms. Spears leaves Resident B in the bed all day. • In June 2023, staff Andrea Harrison accidentally dropped Resident B on the floor. • On an unknown date, Ms. Harrison intentionally hit Resident B.	No
On an unknown date, staff administered Resident A a double dose of her blood thinner medication.	Yes
On 08/05/2023, Resident A did not eat all day, but it is unclear why.	No
Additional Findings	Yes

III. METHODOLOGY

08/16/2023	Special Investigation Intake 2023A0993036
08/16/2023	APS Referral Received the allegations from adult protective services (APS). The assigned APS specialist is Candid Jameson.
08/17/2023	Special Investigation Initiated - Telephone Telephone call made to APS specialist Candid Jameson. Left a message.
08/17/2023	Contact - Telephone call received Telephone call received from APS specialist Candid Jameson
08/21/2023	Inspection Completed On-site Conducted an unannounced onsite investigation
08/22/2023	Contact - Telephone call made Telephone call made to home manager Donna Spears
08/22/2023	Contact - Telephone call made

	Telephone call made to staff Elana Earl
08/22/2023	Contact - Telephone call made Telephone call made to Resident A's guardian (and daughter)
08/22/2023	Contact - Telephone call made Telephone call made to Resident B's guardian (and daughter)
08/22/2023	Contact - Telephone call made Telephone call made to licensee designee Puja Borso
08/22/2023	Contact - Telephone call made Telephone call made to staff Andrea Harrison. The numer was not in service.
08/22/2023	Contact - Telephone call made Follow up call to licensee designee Puja Borso
08/22/2023	Contact - Telephone call made Telephone call made to APS specialist Candid Jameson. Left a message.
08/23/2023	Inspection Completed On-site Conducted an announced onsite investigation
08/23/2023	Contact - Telephone call made Telephone call made to AMAC Pharmacy. Left a message.
08/24/2023	Contact - Telephone call received Telephone call received from licensee designee Puja Borso
08/24/2023	Contact - Telephone call made Telephone call made to home manager Donnna Spears. Left a message.
08/24/2023	Contact - Telephone call made Telephone call made to AMAC Pharmacy
08/24/2023	Contact - Telephone call received Telephone call received from home manager Donna Spears
08/24/2023	Contact - Document Received Received a copy of Resident A’s weight chart
08/24/2023	Exit Conference

	Held with licensee designee Puja Borso

ALLEGATION:

- **On 08/06/2023, Resident A had fingerprint and thumbprint shaped bruising on both of her arms, her right hand, and both of her legs. Home manager Donna Spears was working on this day.**
- **Ms. Spears leaves Resident B in the bed all day.**
- **In June 2023, staff Andrea Harrison accidentally dropped Resident B on the floor.**
- **On an unknown date, Ms. Harrison intentionally hit Resident B.**

INVESTIGATION:

On 08/16/2023, I received the allegations from adult protective services (APS). The assigned APS specialist is Candid Jameson.

On 08/17/2023, I conducted a telephone interview with APS specialist Candid Jameson. Ms. Jameson stated she went to the facility yesterday. Everything seemed okay. She did not observe any abuse or neglect concerns. She spoke with Resident A's and Resident B's guardians, and they did not report any abuse or neglect concerns.

On 08/21/2023, I conducted an unannounced onsite investigation. I interviewed staff Jazzmyn Hunter. Ms. Hunter denied any knowledge of staff abusing or neglecting Resident A. Per Ms. Hunter, Resident A bruises easily. Ms. Hunter stated Resident A is transferred out of bed each morning, except on Mondays and Wednesdays. On those days, Resident B stays in bed until the hospice aide baths her. Ms. Hunter did not work in the facility in June 2023. She did not know if staff Andera Harrison accidentally dropped Resident B. In addition, she did not know if Ms. Harrison has intentionally hit Resident B.

During the unannounced onsite investigation, I interviewed Resident A. I was only able to get limited information due to Resident A's limited cognitive abilities. Resident A denied that anyone has abused her or hit her. The only issue she reported was having to wait an hour to receive assistance. Resident A stated she did not know if she must wait due to staff assisting another resident.

On 08/22/2023, I conducted a telephone interview with home manager Donna Spears. Ms. Spears denied that Resident A is being abused or neglected. Per Ms. Spears, Resident A bruises easily. Ms. Spears denied leaving Resident B in bed all day. Staff gets Resident B up each morning. On Mondays and Wednesdays, Resident B stays in bed until the hospice aide gives her a bath. After her bath, she may take a nap, and then staff gets her up for the day. Ms. Spears stated she was not working in the facility at the time, but she did not believe that Ms. Harrison accidentally dropped Resident B or intentionally hit Resident B. Ms. Spears stated the person who likely reported these

false allegations got mad and was fired due to creating a hostile work environment and lying on other staff. Ms. Spears denied knowledge of any staff being abusive or neglecting the residents.

On 08/22/2023, I conducted a telephone interview with staff Elana Earl. Ms. Earl denied knowledge of Resident A or Resident B being abused or neglected. She denied ever witnessing staff abuse or mistreat any of the residents. She denied knowledge of Resident B laying in bed all day.

On 08/22/2023, I conducted a telephone interview with Resident A's guardian (and daughter). Resident A's guardian stated Resident A bruises very easily and has extremely thin skin. She did not believe that staff were abusing or neglecting Resident A.

On 08/22/2023, I conducted a telephone interview with Resident B's guardian (and daughter). Resident B's guardian denied that Resident B was accidentally dropped in June 2023 and/or that Ms. Harrison hit Resident B. She stated she has never had a problem with the facility. She goes to the facility two to three days per week.

On 08/22/2023, I conducted a telephone interview with licensee designee Puja Borso. She denied all the allegations. She stated she fired someone recently due to causing problems and lying on other staff.

On 08/22/2023, I attempted to conduct a telephone interview with staff Andrea Harrison, but the number was disconnected. I followed up with Ms. Borso. She stated Ms. Harrison no longer works for the agency, and she did not have another contact number for Ms. Harrison.

On 08/23/2023, I conducted an announced onsite investigation. I attempted to interview Resident B with no success due to her limited cognitive abilities. While at the facility, I observed Resident A's hands, arms, and legs. I observed some bruising and/or skin discoloration. Resident A did not appear to be in pain. In addition, Resident A did not appear to be afraid to be in the facility.

APPLICABLE RULE	
R 400.14305	**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:	Ms. Hunter, Ms. Spears, Ms. Earl and Ms. Borso denied that Resident A and Resident are being abused or neglected. They stated staff gets Resident B up daily. On 08/23/2023, I observed Resident A's hands, arms, and legs. I observed some bruising

	and/or skin discoloration. Resident A did not appear to be in pain. In addition, Resident A did not appear to be afraid to be in the facility. Resident A's guardian stated Resident A bruises very easily and has extremely thin skin. She did not believe that staff were abusing or neglecting Resident A. Resident B's guardian denied that Resident B was accidentally dropped in June 2023 and/or that Ms. Harrison hit Resident B. She stated she has never had a problem with the facility.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14308	**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: **(a) Use any form of punishment.** **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	Ms. Hunter, Ms. Spears, Ms. Earl and Ms. Borso denied that Resident A and Resident are being abused or neglected. On 08/23/2023, I observed Resident A's hands, arms, and legs. I observed some bruising and/or skin discoloration. Resident A did not appear to be in pain. In addition, Resident A did not appear to be afraid to be in the facility. Resident A's guardian stated Resident A bruises very easily and has extremely thin skin. She did not believe that staff were abusing or neglecting Resident A. Resident B's guardian denied that Resident B was accidentally dropped in June 2023 and/or that Ms. Harrison hit Resident B. She stated she has never had a problem with the facility.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

On an unknown date, staff administered Resident A a double dose of her blood thinner medication.

INVESTIGATION:

On 08/21/2023, I conducted an unannounced onsite investigation. I interviewed staff Jazzmyn Hunter. Ms. Hunter denied any knowledge of staff administering Resident A a double dose of her blood thinner medication. Ms. Hunter stated she completed mediation administration training.

While at the facility I received a copy of Resident A's medication administration record (MAR). I observed the following:

- Resident A's Eliquis was reduced from 5mg to 2.5mg on 08/02/2023. Staff began administering the 2.5mg on 08/02/2023 at 8am.
- Staff did not initial the MAR on 08/07/2023 at 8pm to show administration of Latanoprost sol 0.005%.
- Staff did not initial the MAR on 08/14/2023 at 8am and 8pm to show administration of Clotrimazole Cream 1%.
- Staff did not initial the MAR on 08/19/2023 at 8pm to show administration of Omeprazole 20mg, Gabapentin 100mg, Latanoprost sol 0.005%, Risperidone 0.25mg, Lidocaine 4% patch, Metoprol 50mg, AZO Cranberry, Acidophilus, and Eliquis 2.5mg.
- Staff did not document the time PRN Acetaminophen was to Resident A on 08/20/2023.

On 08/22/2023, I conducted a telephone interview with home manager Donna Spears. Ms. Spears denied that staff administered Resident A a double dose of her blood thinner medication. Ms. Spears stated she completed mediation administration training.

On 08/22/2023, I conducted a telephone interview with staff Elana Earl. Ms. Earl denied any knowledge of staff administering Resident A a double dose of her blood thinner medication. Ms. Earl stated she completed mediation administration training.

On 08/22/2023, I conducted a telephone interview with licensee designee Purja Borso. Ms. Borso denied that staff administered Resident A a double dose of her blood thinner medication. Per Ms. Borso, all staff have been trained to administer medications.

On 08/22/2023, I conducted a telephone interview with Resident A's guardian (and daughter). Resident A's guardian denied any knowledge of staff administering Resident A a double dose of her blood thinner medication. Per Resident A's guardian, Resident A's Eliquis was reduced from 5mg to 2.5mg. She could not recall the date of the change.

On 08/23/2023, I conducted an announced onsite investigation. I reviewed a prescription changing Resident A's Eliquis from 5mg to 2.5mg on 08/02/2023. I reviewed verification that Ms. Hunter, Ms. Spears, and Ms. Earl completed in-house medication administration training.

On 08/24/2023, I conducted a follow up interview with Ms. Borso. Ms. Borso stated she followed up with AMAC Pharmacy and was informed the new medication was delivered to the facility on 08/03/2023 in the evening. Prior to receiving the new medication, staff cut the pill in half to ensure Resident A received the correct dosage.

On 08/24/2023, I conducted a follow up interview with Ms. Spears. Ms. Spears stated Resident A's new medication was delivered to the facility on 08/03/2023 in the evening. Prior to receiving the new medication, she cut the pill in half to ensure Resident A received the correct dosage.

On 08/24/2023, I conducted a telephone interview with AMAC Pharmacy staff Jennifer (last name unknown). Jennifer confirmed Resident A's Eliquis was reduced from 5mg to 2.5mg and delivered to the facility on 08/03/2023.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident A's Eliquis was reduced from 5mg to 2.5mg on 08/02/2023. Per the MAR, Staff began administering the 2.5mg on 08/02/2023 at 8am. The new dose was not delivered to the facility until 08/03/2023 in the evening. Prior to receiving the new medication, Ms. Spears stated she cut the pill in half to ensure Resident A received the correct dosage. I reviewed verification that Ms. Hunter, Ms. Spears, and Ms. Earl completed in-house medication administration training.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	Staff did not initial Resident A's MAR as follows: on 08/07/2023 at 8pm to show administration of Latanoprost sol 0.005%; on

	08/14/2023 at 8am and 8pm to show administration of Clotrimazole Cream 1%; on 08/19/2023 at 8pm to show administration of Omeprazole 20mg, Gabapentin 100mg, Latanoprost sol 0.005%, Risperidone 0.25mg, Lidocaine 4% patch, Metoprol 50mg, AZO Cranberry, Acidophilus, and Eliquis 2.5mg.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(c) Record the reason for each administration of medication that is prescribed on an as needed basis.**
ANALYSIS:	Staff did not document the time PRN Acetaminophen was administered to Resident A on 08/20/2023.
CONCLUSION:	**REPEAT VIOLATION ESTABLISED.** **Reference Renewal Licensing Study Report dated 08/19/2022; CAP dated 09/09/2022.**

ALLEGATION:

On 08/05/2023, Resident A did not eat all day, but it is unclear why.

INVESTIGATION:

On 08/21/2023, I conducted an unannounced onsite investigation. I interviewed staff Jazzmyn Hunter. Ms. Hunter denied any knowledge of Resident A not eating all day on 08/05/2023. Ms. Hunter stated the residents are fed three times daily. They are given snacks as well.

During the unannounced onsite investigation, I interviewed Resident A. I was only able to get limited information due to Resident A’s limited cognitive abilities. Resident A stated she eats every day.

On 08/22/2023, I conducted a telephone interview with home manager Donna Spears. Ms. Spears denied that Resident A did not eat all day on 08/05/2023. Ms. Spears stated the residents are fed three times daily. They are given snacks as well.

On 08/22/2023, I conducted an unannounced onsite investigation. I interviewed staff Elana Earl. Ms. Earl denied any knowledge of Resident A not eating all day on 08/05/2023. Ms. Earl stated the residents are fed three times daily. They are given snacks as well.

On 08/22/2023, I conducted a telephone interview with licensee designee Puja Borso. She denied the allegations.

On 08/23/2023, I conducted an announced onsite investigation. I observed an adequate food supply. While at the facility, I observed Resident A and Resident B at the table eating lunch.

On 08/24/2023, I reviewed Resident A's weight chart. I did not observe any weights listed. Instead, the chart listed next to each month the "UT" from January 2022 until now. I spoke with Ms. Borso who stated "UT" stood for unable to treat. She acknowledged Resident A had not been weighed.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.
ANALYSIS:	I reviewed Resident A's weight chart. I did not observe any weights listed. Instead, the chart listed next to each month the "UT" from January 2022 until now. I spoke with Ms. Borso who stated "UT" stood for unable to treat. She acknowledged Resident A had not been weighed.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14313	**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:	Ms. Hunter, Ms. Spears, and Ms. Earl stated the residents are fed three meals and snacks daily. Resident A stated she eats every day. On 08/23/2023, I observed an adequate food supply I the facility.

CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 08/21/2023, I conducted an unannounced onsite investigation. I interviewed staff Jazzmyn Hunter. Ms. Hunter stated she works in the facility from 9am on Sunday until 9pm on Monday. Per Ms. Hunter, staff Elana Earl works from Monday night until Tuesday night. Ms. Hunter did not provide Ms. Earl's exact shift time.

On 08/22/2023, I conducted a telephone interview with home manager Donna Spears. Ms. Spears stated she works from 9pm on Tuesday until 9am on Sunday.

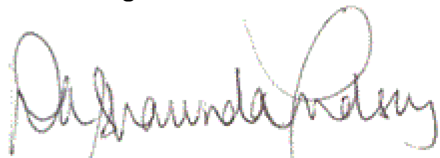
On 08/23/2023, I reviewed the Bureau Information Tracking System (BITS). No household members (or overnight guests) were listed.

On 08/24/2023, I conducted an exit conference with licensee designee Puja Borso. I informed her of the findings. She agreed to submit a corrective action plan.

APPLICABLE RULE	
R 400.14103	**Licenses; required information; fee; effect of failure to cooperate with inspection or investigation; posting of license; reporting of changes in information.**
	(5) An applicant or licensee shall give written notice to the department of any changes in information that was previously submitted in or with an application for a license, including any changes in the household and in personnel-related information, within 5 business days after the change occurs.
ANALYSIS:	Ms. Hunter and Ms. Spears works in the facility 36 and 108 hours consecutively, respectively. No household members (or overnight guests are listed in BITS.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

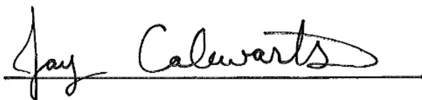
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



08/24/2023

DaShawnda Lindsey Date
Licensing Consultant

Approved By:



For 09/07/2023

Denise Y. Nunn Date
Area Manager