GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 31, 2023

Patrice Weber
Brighter Horizons Assisted Living Center
11920 W. Cutler Rd
Eagle, MI 48822

RE: License #: AS330405979
Investigation #: 2023A1033069
Brighter Horizons Assisted Living & Memory Ctr LLC

Dear Ms. Weber:

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 #:	AS330405979
Investigation #:	2023A1033069
Complaint Receipt Date:	09/06/2023
Investigation Initiation Date:	09/07/2023
Report Due Date:	11/05/2023
Licensee Name:	Brighter Horizons Assisted Living Center
Licensee Address:	5455 S. MLK Lansing, MI 48875
Licensee Telephone #:	(517) 643-2073
Administrator:	Patrice Weber
Licensee Designee:	Patrice Weber
Name of Facility:	Brighter Horizons Assisted Living & Memory Ctr LLC
Facility Address:	5455 S. MLK Blvd Lansing, MI 48911
Facility Telephone #:	(517) 643-2073
Original Issuance Date:	09/24/2021
License **Status:**	REGULAR
Effective Date:	03/24/2022
Expiration Date:	03/23/2024
Capacity:	6

Program Type:	AGED ALZHEIMERS

ALLEGATION(S)

	Violation Established?
Direct care staff are not providing for Resident A's personal care needs, specifically related to an ongoing yeast infection on Resident A's abdomen and legs.	Yes
Resident B has gone through Resident A's personal belongings without permission and direct care staff do not address this issue.	No
Direct care staff, Marie Akono, was not responsive to Resident A's stated abdominal pain on 9/5/23 and would not wake up to manage her needs. Ms. Akono was rude to Resident A and Citizen 1 during this interaction.	No

II. METHODOLOGY

09/06/2023	Special Investigation Intake 2023A1033069
09/07/2023	APS Referral- Denied APS referral.
09/07/2023	Special Investigation Initiated - Telephone Interview with Citizen 1 & Resident A, via telephone.
09/12/2023	Inspection Completed On-site Interviews with direct care staff, Wendy Morris, Resident B, and Resident C. Review of Resident A resident record initiated.
09/13/2023	Contact - Telephone call made Attempt to interview Tri County Office on Aging, RN Supports Coordinator, Jackie Fedewa. Voicemail message left, awaiting response.
09/13/2023	Contact - Telephone call made- Interview with direct care staff/Co-owner, Bernadette Whitney, via telephone.
09/13/2023	Contact - Document Sent- Email correspondence with direct care staff/Co-owner, Bernadette Whitney.

09/13/2023	Contact - Telephone call received- Interview with Tri County Office on Aging RN Supports Coordinator, Jackie Fedewa, via telephone.
10/23/2023	Contact - Telephone call made- Attempt to interview Careline Physician Service, Nurse Practitioner, Rachel Seavolt. Message left, awaiting response.
10/23/2023	Contact - Telephone call made- Attempts to interview direct care staff, Marie, via telephone on 10/20/23 & 10/23/23. Voicemail messages left, awaiting response.
10/23/2023	Contact - Telephone call received- Interview with direct care staff, Marie Akono, via telephone.
10/24/2023	Exit Conference- Conducted via telephone call with licensee designee, Patrice Weber. Voicemail message left.

ALLEGATION: Direct care staff are not providing for Resident A's personal care needs, specifically related to an ongoing yeast infection on Resident A's abdomen and legs.

INVESTIGATION:

On 9/6/23 I received an online complaint regarding the Brighter Horizons Assisted Living & Memory Ctr LLC, adult foster care facility (the facility). The complaint alleged that Resident A is not receiving adequate personal care and assistance from direct care staff in managing her ongoing yeast infection on her abdomen and her thighs. On 9/7/23 I interviewed Citizen 1, via telephone. Citizen 1 reported that Resident A had a chronic yeast infection on her abdomen and her thighs. She reported that she had given Resident A a shower on 9/6/23 and noticed that her yeast infection looked severely inflamed and not well cared for. Citizen 1 reported that it did not appear that the direct care staff were attending to Resident A's personal care and applying the necessary products to assist with healing of this yeast infection.

On 9/7/23 I interviewed Resident A, via telephone. Resident A reported that the yeast infection had increased in severity within the past week. She reported that the direct care staff did not assist her with showering, and she took showers on her own at the facility. She reported that, in the past four months the direct care staff only assisted her with her shower about four times. Resident A presented as forgetful during this telephone interview and had difficulty with recalling specific details of events, dates, and times.

On 9/12/23 I completed an unannounced, on-site investigation at the facility. I interviewed direct care staff, Wendy Morris. Ms. Morris reported that she has worked at the facility, on and off, since around 2011. Ms. Morris stated Resident A is currently on a leave of absence and staying with Citizen 1. Ms. Morris reported Resident A showered about one time per week at the facility. She reported that there were times when Resident A would refuse a shower. Ms. Morris reported that Resident A would not allow direct care staff to assist her when she was showering. She reported Resident A allowed direct care staff to set up the bathroom for the shower, but she did not want anyone observing her showering. Ms. Morris reported Resident A did have a yeast infection on her abdomen and legs and required Nystatin medication for this infection. She reported the physician prescribed the Nystatin and direct care staff administer this medication to Resident A's skin. Ms. Morris reported that when Resident A admitted to the facility the yeast infection was not well controlled and since moving in it has improved with direct care staff intervention. Ms. Morris reported Resident A had not made any verbal complaints about the yeast infection worsening to her knowledge. Ms. Morris reported that Resident A was prescribed both a Nystatin powder and a Nystatin cream for her yeast infection. She reported that the cream was added later as the powder was not effective and the cream was added as an as needed medication. She reported direct care staff were administering the cream instead of the powder due to the powder not being as effective as the cream.

On 9/12/23 I interviewed direct care staff/facility co-owner, Bernadette Whitney. Ms. Whitney reported she was aware that Resident A is currently residing with Citizen 1 and had a conversation with Citizen 1. She reported Citizen 1 stated she felt she was able to provide better personal care and hygiene for Resident A and she would be looking to move Resident A from the facility permanently. Ms. Whitney reported Resident A has showered herself since moving into the facility. She reported direct care staff need to set up the bathroom and get the shower running then Resident A showered independently, per her preference. Ms. Whitney reported Resident A had issues with a yeast infection on her abdomen and thighs and stated Resident A's physician, through Careline Physician Services, managed this issue and prescribed a Nystatin powder and cream for this issue. Ms. Whitney reported the cream works better than the powder. Ms. Whitney reported that the yeast infection is difficult to heal as Resident A always wants to wear a coat, even on hot summer days. She reported the physician has changed the Nystatin order to daily, instead of having the direct care staff use it for 14 days at a time. She reported direct care staff administer the Nystatin cream two times per day, daily.

On 9/13/23 I interviewed Tri County Office on Aging (TCOA), RN Supports Coordinator, Jackie Fedewa, via telephone. Ms. Fedewa reported she provides nursing case management services through the Medicaid Waiver Program through TCOA. Ms. Fedewa reported that she has no concerns about whether the direct care staff at the facility are providing personal care/hygiene services to manage Resident A's yeast infection. She reported she has received no complaints from Resident A or other parties regarding this care not being provided.

On 10/23/23 I interviewed direct care staff, Marie Akono, via telephone. Ms. Akono reported that she has worked at the facility for ten years and works the night shift. She reported that she works while the residents are sleeping. She reported she does not provide resident showers as this type of personal care is done on the day shift. She reported she was not aware of Resident A's yeast infection as she has not administered the Nystatin cream or powder as this is administered prior to her shift starting. Ms. Akono reported that Resident A is fairly independent with her physical needs, and she assists her to the bathroom but has not needed to provide personal care to Resident A on her shift.

On 9/12/23, during on-site investigation, I reviewed Resident A's resident record. I reviewed the document, *Assessment Plan for AFC Residents*, dated 2/4/23. On page 2 of this document, it is indicated that Resident A requires assistance in the following areas:

- Eating/Feeding
- Toileting
- Bathing
- Grooming (hair care, teeth, nails, etc.)
- Dressing
- Personal Hygiene

This document did not indicate any narrative information as to what assistance is required for these identified needs.

On 9/12/23 I reviewed the document, *Person-Centered Service Plan for [Resident A]*, dated 2/6/23, completed by Ms. Fedewa, and TCOA Supports Coordinator, Rebecca Decess, LMSW. On page 5 of this document, under section, *Clinical/My Important Issues*, subsection, *Continence*, it states, "Incontinent of bowel and uses briefs. Needs assistance to keep clothes clean and dry."

On 9/12/23, during on-site investigation, I reviewed Resident A's Medication Administration Records (MARs) for the months, April 2023 through August 2023. I noted the following observations on these MARs:

- April 2023:
    - "Nystatin 100000 POW: Apply topically to bilateral breasts, axillia, and groin twice a day for 14 days". There is no start date listed for this medication. The medication is recorded as administered, twice per day, every day of the month except unmarked administrations on: 4/2/23 at 5pm,
- May 2023:
    - "Nystatin 100000 Cre: Apply topically under breasts & abdominal folds twice a day as needed". There is no start date listed for this prescription and no documented administrations for the month of May 2023.
    - "Nystatin 100000 POW: Apply topically to bilateral breasts, axillia, and groin twice a day for 14 days". This medication is documented as being

administered twice a day, routinely, except unmarked administrations on: 5/2/23 & 5/3/23 at 5pm.

- June 2023:
  - “Nystatin 100000 CRE: Apply topically under breasts & abdominal folds twice a day as needed”. There are no documented administrations of this medication on the MAR.
  - “Nystatin 100000 POW: Apply topically to bilateral breasts, axillia, and groin twice a day for 14 days”. This medication is documented as being administered twice a day, routinely, on this MAR.
- July 2023:
  - “Nystatin 100000 CRE: Apply topically under breasts & abdominal folds twice a day as needed”. There are no documented administrations of this medication on the MAR.
  - “Nystatin 100000 POW: Apply topically to bilateral breasts, axillia, and groin twice a day for 14 days”. This medication is documented as being administered twice a day, routinely, except unmarked administrations on: 7/13/23 through 7/18/23 at 5pm, 7/26/23 at 5pm and 7/31/23 at 5pm.
- August 2023:
  - “Nystatin 100000 CRE: Apply topically under breasts & abdominal folds twice a day as needed”. There are no documented administrations of this medication on the MAR.
  - “Nystatin 100000 POW: Apply topically to bilateral breasts, axillia, and groin twice a day for 14 days”. This medication is documented as being administered twice a day, routinely, except unmarked administrations on: 8/10/23, 8/12/23 at 5pm, and 8/21/23, 8/23/23, 8/26/23, 8/28/23, 8/30/23 at 8am.

On 10/23/23 I attempted to interview Nurse Practitioner, Rachel Seavolt, with the Careline Physician Services medical group. I was not able to connect with Ms. Seavolt and have not received follow up correspondence at this time.

APPLICABLE RULE	
R 400.14303	**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 Resident A, Citizen 1, Ms. Whitney, Ms. Morris, Ms. Fedewa, and Ms. Akono as well as review of Resident A's resident record, it can be determined that there is not adequate evidence to suggest that Resident A did not receive adequate assistance with her personal care needs, specifically related to applying her Nystatin prescription for her ongoing yeast infection on her abdomen and legs. The direct care staff interviewed documented regular administration of the Nystatin prescription and verbally reported administering the medication to Resident A. There were also reports that Resident A would refuse direct care staff assistance with her showers, and only allow direct care staff to set up the shower for her to use independently. Although, Resident A, states she did not receive regular assistance with her personal care, it is not outlined in her assessment plan, what level of supervision she required with her showering.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based upon interviews with Ms. Whitney & Ms. Morris, as well as review of Resident A's MARs for April 2023 through August 2023 it can be concluded that it appears Resident A was receiving regular administrations of the Nystatin medication and the direct care staff were documenting the administration of the Nystatin Cream in the wrong section of Resident A's MARs. The Nystatin Cream, to be administered as needed, was added in May 2023, after the Nystatin Powder was reported to be deemed ineffective and requiring the change to a cream. Both, Ms. Whitney & Ms. Morris reported they started administering the Nystatin Cream instead of the Nystatin Powder due to ineffectiveness of the powder. It appears direct care staff continued to document the use of the Nystatin Cream in the area of the MAR which reflected administration of the Nystatin Powder. The direct care staff were documenting the use of the former Nystatin Powder product instead of the updated prescription for the Nystatin Cream, therefore causing the medication to be recorded as administered inaccurately.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident B has gone through Resident A's personal belongings without permission and direct care staff do not address this issue.

INVESTIGATION:

On 9/6/23 I received an online complaint regarding the facility. The complaint alleged that Resident B goes through Resident A's personal belongings without permission and the direct care staff do not address this issue. On 9/7/23 I interviewed Citizen 1. Citizen 1 reported Resident A told her that Resident B frequently goes through her closet at the facility. Citizen 1 reported that no items have come up missing, but Resident A does not feel comfortable with Resident B, "snooping" through her belongings.

On 9/7/23 I interviewed Resident A, via telephone. Resident A reported that her roommate at the facility, Resident B, frequently goes through her belongings and she is afraid her items are going to come up missing. She did not report any current missing items during this interview.

On 9/12/23 I completed an on-site investigation at the facility and interviewed Ms. Morris. Ms. Morris reported that Resident A has difficulty with her short-term memory and frequently misplaces her own belongings. She reported that on occasion she has given another resident her personal items and forgotten that she has done this. Ms. Morris reported that she has not observed Resident B taking items from Resident A.

On 9/12/23, during on-site investigation, I interviewed Resident B. Resident B denied going through Resident A's belongings and taking any of her belongings.

On 9/12/23 I interviewed Ms. Whitney, via telephone. Ms. Whitney reported the Resident A has advanced dementia. Ms. Whitney reported that Resident A has made statements that people have taken or "stolen" her personal items. Ms. Whitney reported that what she has found, after investigation of her own, is that Resident A will lend her items to other residents and then forget that she has done this. Ms. Whitney reported that she has found Resident A's personal items with other residents who made note that Resident A lent the items to them. Ms. Whitney reported that this has also occurred with the direct care staff, where Resident A will try to give items away and then later report that someone tried to steal from her.

On 9/13/23 I interviewed Ms. Fedewa, via telephone. Ms. Fedewa reported that Resident A has not shared with her that other residents are taking her personal belongings.

On 10/23/23 I interviewed Ms. Akono, via telephone. Ms. Akono reported that she has not been aware of any issues between Resident A and Resident B in terms of Resident B stealing or taking Resident A's personal items. She had no knowledge to offer to this allegation.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Based upon interviews with Resident A, Citizen 1, Ms. Morris, Resident B, Ms. Whitney, Ms. Fedewa, & Ms. Akono, there is not sufficient evidence to determine that Resident B has been going through Resident A's personal belongings and taking her personal items without permission. Therefore, a violation cannot be established at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Direct care staff, Marie Akono, was not responsive to Resident A's stated abdominal pain on 9/5/23 and would not wake up to manage her needs.

INVESTIGATION:

On 9/6/23 I received an online complaint regarding the facility. The complaint alleged that on 9/5/23 Ms. Akono, was not responsive to Resident A's stated abdominal pain and would not wake up to manage her needs. On 9/7/23 I interviewed Citizen 1, via telephone. Citizen 1 reported that on 9/5/23 Resident A had called her via a video chat and reported that she was not feeling well and had an upset stomach. Citizen 1 reported that she instructed Resident A to go find the direct care staff who was working and request assistance. Citizen 1 reported that she remained on video chat with Resident A and could see that she was walking through the dark facility to find the direct care staff who had been working and the direct care staff had stated to Resident A, "[Resident A], go potty, I'm sleeping". Citizen 1 reported that it was dark in the video but she could make out that the direct care staff, was Ms. Akono, and she did verbalize that she heard Ms. Akono make this statement to Resident A. Citizen 1 reported that she instructed Ms. Akono, to "get up and attend to [Resident A]". Citizen 1 reported that Ms. Akono started yelling back at Citizen 1, "You did not hear me say I was sleeping!" Citizen 1 reported that Resident A's upset stomach

symptoms persisted throughout the evening and Resident A continued to make video calls to Citizen 1. She reported video calls happening on 9/5/23 at the following times: 12:56am, 1:14am, 1:39am, 1:56am 4:01am, and 4:28am. I inquired whether Citizen 1 had recorded the video calls and she reported that she had not had the opportunity to record the calls. Citizen 1 reported that at some point during the evening/early morning, Ms. Akono did provide Resident A a tums medication for her upset stomach, but around 4am Resident A was “dry heaving” and Citizen 1 requested Resident A seek support from Ms. Akono, again. Citizen 1 reported that at this time Ms. Akono was, again, sleeping and Citizen 1 requested to send an Uber driver to pick up Resident A so that she could provide care to Resident A, herself.

On 9/7/23 I interviewed Resident A, via telephone. Resident A reported that Ms. Akono is frequently rude to her and the other residents. She reported that she is now feeling better, and she did not require medical intervention for her upset stomach, she reported, “It was just my nerves”. Resident A reported that Citizen 1’s accounting of the situation on 9/5/23 was accurate. She reported that she had an upset stomach and she tried to contact Citizen 1 as she was afraid to talk to Ms. Akono, as she has a history of being rude to residents. She reported that Ms. Akono just sleeps during her shift and she does not like to be disturbed when she is sleeping.

On 9/12/23 I completed an on-site investigation at the facility and interviewed Ms. Morris. Ms. Morris reported that she has not received any complaints from residents or other direct care staff that Ms. Akono is rude or speaks in a derogatory manner to the residents. Ms. Morris reported that Ms. Akono can be loud, and this can be misinterpreted as rude.

During on-site investigation on 9/12/23 I interviewed Resident B. When asked about Ms. Akono, Resident B reported that Ms. Akono has a rude tone when she speaks with others. Resident B reported that she does not have specific examples of Ms. Akono being rude to others. She reported that Ms. Akono does sleep during her shift until about 4am and then she gets up and starts doing her job duties for the day.

During on-site investigation, on 9/12/23, I interviewed Resident C. Resident C reported that she has resided at the facility for about ten years. She reported that that Ms. Akono does have a history of being rude to the residents, but she does not have any current examples of this. She reported that Ms. Akono does sleep at night but is able to be aroused if needed.

On 9/12/23 I interviewed Ms. Whitney, via telephone. Ms. Whitney reported that Ms. Akono has worked at the facility for about ten years. She stated that it was reported to her, by Citizen 1 and Ms. Akono, that on 9/5/23 Resident A had an issue with an upset stomach. Ms. Whitney reported that Citizen 1 was upset that Ms. Akono was not more responsive to Resident A’s needs on this date. Ms. Whitney reported that Ms. Akono reported she got up with Resident A, had Resident A go to the bathroom and then gave Resident A a popsicle. Ms. Whitney reported that people have made

comments about Ms. Akono's behaviors in the past due to her loud voice. She reported that there is a cultural component to this as Ms. Akono is African and tends to speak in a loud voice when communicating with others. Ms. Whitney reported that she has worked with Ms. Akono for ten years and she has witnessed her interacting with residents and does not feel she is being rude to the residents.

On 10/23/23 I interviewed Ms. Akono, via telephone. Ms. Akono reported that on 9/5/23 she was working the overnight shift at the facility. She reported she had been working when Resident A came to her with complaints of an upset stomach. Ms. Akono reported that Resident A came out of her bedroom and stated, "My stomach doesn't feel good". She reported she then got up and took Resident A to the bathroom, and while she was doing this, she heard Citizen 1 state, "why are you sleeping?" Ms. Akono reported that once she got Resident A to the bathroom, she went back to the front room of the facility as Resident A can be independent in the bathroom. After Resident A used the bathroom, she had continued complaints of an upset stomach. Ms. Akono reported that she then gave Resident A a tums medication and Resident A went back to bed. Ms. Akono reported that Resident A does have anxiety issues and was asking for marijuana at this time. She reported that Resident A did not have marijuana to be used. Ms. Akono reported that about ten to fifteen minutes later Resident A was still complaining of an upset stomach and she offered her a popsicle. Ms. Akono reported that after this Citizen 1 had offered to send an Uber driver to pick up Resident A. She reported that she then called Ms. Whitney, updated her to the situation, and assisted Resident A in getting ready to go with Citizen 1. Ms. Akono reported that she overheard Citizen 1 on the video chat with Resident A asking her if she was feeling better and she heard Resident A state that she was feeling better. Ms. Akono reported that then the Uber driver arrived, Ms. Akono confirmed that this was the transportation set up for Resident A, by Citizen 1, and helped Resident A into the vehicle. Ms. Akono denied being rude or mean to Resident A during this incident. She reported that she speaks loudly and she has been told she speaks loudly, but she reports this is how she has always spoken. She reported that she feels she managed Resident A's needs on this date and does not feel she was mean or spoke with Resident A in a derogatory manner on 9/5/23.

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:	Based upon interviews with Resident A, Resident B, Resident C, Citizen 1, Ms. Morris, Ms. Whitney, & Ms. Akono there is not sufficient evidence to determine that Ms. Akono did not attend to Resident A's stated needs on 9/5/23 as was noted by Citizen 1 and Resident A. Ms. Akono reported that she did get up to assist Resident A when Resident A had made this request. I cannot determine, through adequate evidence, that Ms. Akono did not in fact attend to Resident A on this date. I received multiple reports that Ms. Akono speaks in a loud voice which may be misconstrued. Ms. Whitney reported that Ms. Akono has worked at the facility for ten years and has always used a loud voice in communicating with others, but this has not been perceived to be rude or derogatory in nature. Therefore, a violation is not able to be established at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

III. RECOMMENDATION

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

10/24/23

_____

Jana Lipps Date
Licensing Consultant

Approved By:

10/31/2023

_____

Dawn N. Timm Date
Area Manager