GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 27, 2023

Jill Long
393 East Girard Road
Coldwater, MI 49036

RE: License #: AS130397946
Investigation #: 2024A0581008
Kerak

Dear Mrs. Long:

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,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS130397946
Investigation #:	2024A0581008
Complaint Receipt Date:	11/03/2023
Investigation Initiation Date:	11/08/2023
Report Due Date:	01/02/2024
Licensee Name:	Jill Long
Licensee Address:	393 East Girard Road Coldwater, MI 49036
Licensee Telephone #:	(269) 565-3109
Administrator:	Jill Long
Licensee Designee:	Jill Long
Name of Facility:	Kerak
Facility Address:	14077 Stone Jug Rd. Battle Creek, MI 49015
Facility Telephone #:	(931) 217-7606
Original Issuance Date:	09/23/2019
License Status:	REGULAR
Effective Date:	03/23/2022
Expiration Date:	03/22/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION

	Violation Established?
Resident A did not receive food or care from 10/26/2023 through 10/27/2023.	Yes

III. METHODOLOGY

11/03/2023	Special Investigation Intake 2024A0581008
11/03/2023	APS Referral APS received the allegations but denied investigating.
11/08/2023	Special Investigation Initiated - Telephone Interview with Complainant
11/08/2023	Contact - Telephone call made Interview with Sarah Howard, PACE RN
11/08/2023	Contact - Document Sent Contacted Wmed requesting medical examiner's investigation/ report
11/08/2023	Contact - Telephone call made Attempted contact with direct care staff, Katelyn Castelan. Call wouldn't go through.
11/09/2023	Contact - Telephone call made Interview with direct care staff, Scott Williams.
11/17/2023	Contact - Telephone call received Interview with licensee designee, Jill Long.
11/28/2023	Contact – Telephone call made Attempted to contact direct care staff, Erma Ogo and Albertson Poll, via telephone and email.
12/04/2023	Inspection Completed On-site Interview with staff.
12/04/2023	Contact - Telephone call made Interview with direct care staff, Talia Paul.

12/08/2023	Contact - Document Received Documentation received by Ms. Paul.
12/21/2023	Exit conference with the licensee designee, Jill Long.

ALLEGATION:

Resident A did not receive food or care from 10/26/2023 through 10/27/2023.

INVESTIGATION:

On 11/03/2023, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged on 10/25/2023, Resident A, who has a diagnosis of kidney failure, dialysis, vascular disease, pericarditis, Alzheimer's, and congestive heart failure, was discharged back to the facility after being in the local hospital for 12 days. The complaint alleged after hospital discharge, Resident A was transported to the facility and placed in his bedroom with the door closed. The complaint alleged on 10/27/2023, the facility's direct care staff reported to a Program of All-Inclusive Care for the Elderly (PACE) staff from Senior Care Partners that Resident A was not in the facility. The complaint alleged a phone call was made to the hospital, which confirmed Resident A had been discharged to the facility on 10/25/2023.

The complaint alleged Resident A was discovered in his room on either 10/26/2023 or 10/27/2023. The complaint alleged that while it was possible Resident A received care sometime on 10/26/2023, there was concern he didn't receive any care, food, or medications on 10/27/2023. It was also alleged Resident A was discovered in his hospital gown and covered in his own feces. The complaint documented Resident A returned to the hospital on 10/30/2023 and passed away on 10/31/2023.

On 11/08/2023, I interviewed Registered Nurse (RN) and care coordinator leader, Sarah Howard, from Senior Care Partners PACE. Ms. Howard's statement to me was consistent with the allegations. She stated Resident A returned to the facility around 7:30 pm on 10/25/2023 after he was discharged from the hospital. She stated per her review of Resident A's Medication Administration Records (MAR), Resident A received all his medications on 10/26/2023. Ms. Howard stated after speaking to direct care staff and identified property manager, Talia Paul, it was determined Resident A did not receive any personal care from direct care staff members after 7 am on 10/27/2023 until around 12:30 pm.

Ms. Howard stated she arrived at the facility around 11:30 am on 10/27/2023 and spoke to direct care staff, Scott Williams, and Katelyn "Kate" Castelan; however, both these direct care staff members reported to her Resident A wasn't in the facility. She stated they both reported to her Resident A was still in the hospital. Ms. Howard

stated she left the facility and contacted PACE's transportation liaison, Tina Karchoff, who confirmed Life EMS picked Resident A up at the hospital and dropped him off at the facility on 10/25/2023. Ms. Howard stated Ms. Karchoff contacted the facility on 10/27/2023 and spoke to the facility's home manager who reported to her Resident A was not in the home either. Ms. Howard stated when she returned to the facility around 12 pm or 12:30 pm, she observed not only Resident A's hospital gown on the floor covered in feces, but Resident A was also covered in feces. She stated it smelled like "bowel movement" in Resident A's bedroom. Ms. Howard stated she immediately arranged Resident A to be taken by ambulance to PACE where she had him evaluated by a PACE nurse, nurse practitioner, physical therapist, and occupational therapist. She stated Resident A was also provided with lunch. Ms. Howard stated Resident A reported to her that no staff visited with him that entire morning and staff neither provided him with any personal care nor administered his medications.

Ms. Howard stated Ms. Paul reported to her direct care staff members are expected to complete "rounding reports" during each shift, which she indicated meant direct care staff members go into each bedroom and lay eyes on every resident.

Ms. Howard stated after Resident A was sent to PACE on 10/27/2023, and he was assessed, he was then sent back to the facility; however, she stated he went back to the Emergency Room (ER) in the afternoon on 10/30/2023 while he'd been at the PACE center because he reported to PACE staff he wasn't feeling good, his feet and legs were swollen and he was in pain. She stated Resident A was discharged from the ER and sent back to the facility around 8:30 am on 10/31/2023; however, he suffered a heart attack in the evening on 10/31/2023 and passed away.

Ms. Howard emailed me a copy of PACE's incident report for Resident A, dated 10/27/2023, after she visited the facility at 11:45 am. Ms. Howard's incident report was consistent with her statement to me.

On 11/08/2023, I attempted to contact and interview direct care staff, Katelyn Castelan; however, the call would not go through.

On 11/09/2023, I interviewed direct care staff, Scott Williams. Mr. Williams stated on 10/27/2023 he arrived to work at the facility at approximately 7:30 am. He stated he worked by himself while Ms. Castelan worked upstairs in the attached licensed AFC facility. Mr. Williams stated after getting to work he got all the residents up for breakfast. He stated he did not get Resident A up for breakfast because he did not know Resident A was in the building. Mr. Williams stated direct care staff members Mr. Poll and Ms. Ogo, who worked the overnight shift, did not report to him during shift change that Resident A had returned to the facility. Mr. Williams stated he did not work on 10/25/2023 or 10/26/2023; therefore, he was unaware Resident A returned to the facility.

Mr. Williams' statement to me about discovering Resident A in the home was inconsistent. Mr. Williams originally stated to me he did not realize Resident A was in the home when he arrived at work, but later stated he discovered Resident A around 8 am or 9 am. He stated while walking towards another resident's bedroom he observed Resident A's bedroom door open and saw Resident A. Mr. Williams stated he administered Resident A's medications that morning and provided him with breakfast. He stated he asked Resident A if he needed toileting assistance or his incontinence briefs changed; however, Mr. Williams stated Resident A did not request any assistance. Mr. Williams stated he believed Resident A was wearing sweatpants and a t-shirt and not a hospital gown. He stated he did not recall Resident A being covered in feces at any point that morning; however, he later changed his statement by stating Resident A had a bowel movement right before PACE RN, Ms. Howard, arrived at the facility. He then indicated Resident A may have been covered in feces.

Mr. Williams stated he recalled PACE RN, Ms. Howard, visiting the facility that morning; however, he could not recall the time she arrived, the time they spoke, or what they talked about.

Upon me trying to determine time frames of Resident A being discovered in the facility, Mr. Williams then stated he was unable to recall the exact time he discovered Resident A in the facility. He then changed his statement by saying he could have discovered Resident A even later than 8 am or 9 am, but he was unable to recall the specific time. Mr. Williams was adamant he administered Resident A's morning medications after Ms. Howard left the facility.

On 11/17/2023, I interviewed the licensee designee, Jill Long, via telephone. Ms. Long was unable to provide any information relating to the complaint.

On 11/28/2023, I attempted to contact direct care staff members Erma Ogo and Albertson Poll, via telephone and email; however, I was unable to reach either of them.

On 12/04/2023, I conducted an unannounced inspection at the facility with Adult Foster Care consultant, Amanda Blasius. I interviewed direct care staff, Melberson Poll, who stated he had been working when Resident A was discharged to the facility from the hospital on 10/25/2023. Mr. Poll stated Ms. Paul informed all staff about Resident A coming back to the home via a "group chat". He stated he was unsure if Mr. Williams responded to the group chat or acknowledged the information that was relayed to all staff. I requested Resident A's adult foster care record; however, Mr. Poll didn't have access to past resident records.

On 12/04/2023, I talked Ms. Paul via telephone. Ms. Paul confirmed Resident A came back to the facility on 10/25/2023. She stated she informed all direct care staff via text he returned and the care he required. She stated she's asked direct care staff in the past to respond with a "thumbs up" to the message in order to confirm

direct care staff acknowledging the messages and information. She stated Mr. Williams did not acknowledge her messages about Resident A returning to the facility.

Ms. Paul stated direct care staff members, Albertson Poll and Erma Ogo, were working the overnight from 10/26/2023 through 10/27/2023, at Kerak and the attached licensed AFC facility. She stated direct care staff members Mr. Williams was scheduled to work at the facility at 7 am while Ms. Castelan was working upstairs at the attached licensed AFC facility. Ms. Paul stated Mr. Poll and Ms. Ogo had since returned to their country of origin, Saipan, on 10/28/2023; therefore, it was difficult to contact them. Saipan is located within the Chamorro time zone, which I established is 14 hours ahead of the Eastern time zone.

Ms. Paul stated upon her interviewing Mr. Poll and Ms. Ogo they both reported to her they relayed to Mr. Williams Resident A was in the facility and relayed that his needs changed. Ms. Paul stated Mr. Poll and Ms. Ogo reported to her they had relayed to Mr. Williams Resident A required oxygen and needed assistance getting around. Ms. Paul stated she received a phone call from PACE RN, Ms. Howard, at approximately 11 am on 10/27/2023 reporting she was confused because she'd just been in the facility to speak with Resident A; however, Ms. Castelan and Mr. Williams were reporting Resident A was not in the facility. Ms. Howard reported to Ms. Paul she was concerned Resident A was missing and had not taken his medication. Ms. Paul stated Ms. Howard reported to her she did not stop in Resident A's bedroom to double check if Resident A was in there at that time. Ms. Paul stated she went to the facility after speaking to Ms. Howard and observed Resident A at the facility. She stated, "he looked perfectly fine." She stated Resident A was sitting up and watching TV in his bedroom. She stated he did not report to her he was hungry.

Ms. Paul stated she completed a corrective action plan with Senior Care Partners PACE regarding the incident with Resident A, which she stated she would submit to me for my review. She stated Ms. Castelan was terminated and no longer working in the facility while Mr. Williams received a two-day suspension. Ms. Paul stated Mr. Williams "more or less blamed Kate [Castelan]"; however, Ms. Paul stated she informed Mr. Wiliams he did not complete rounds at the facility, as required, nor did he acknowledge her means of communication. Ms. Paul stated all direct care staff acknowledged her text except Ms. Castelan and Mr. Williams. Ms. Paul stated Ms. Castelan read her message, but she didn't respond to it. Ms. Paul stated she updated direct care staff members twice about Resident A coming back to the facility and how he now needed assistance with transferring and would be a one person transfer. She stated she believed she updated it a third time when he arrived in the facility.

On 12/08/2023, Ms. Paul provided me with copies of her texts to staff. Her texts documented she sent all direct care staff members a message on 10/25/2023 at 5:59 pm updating them on Resident A returning to the facility. She documented in her text to direct care staff members to be aware of changes with Resident A and

follow these new changes. The texts documented Resident A would be on oxygen, a soft food diet, and an antibiotic. Ms. Paul also provided a text message she sent to all direct care staff members on 10/27/2023 at 6:33 pm informing them Resident A was to be assisted during transfers and was utilizing a wheelchair. Her text documented Resident A needed reminders for meals, along with assistance, and requested staff now check on him as he needed assistance with toileting.

Ms. Paul also provided a copy of Resident A's October 2023 MAR; however, upon my review of the MAR, Resident A was administered all prescribed medications on 10/25/2023 through 10/27/2023.

Ms. Paul also provided copies of the facility's October 2023 shift notes. Upon my review of these notes, Resident A returned to the facility around 8 pm on 10/25/2023. Mr. Poll documented Resident A was inside his room with no issues during the overnight shift on 10/26/2023. He also documented Resident A had taken his medications. No shift notes were completed by Mr. Williams for 1st shift on 10/27/2023.

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 on my investigation, which included interviews with Senior Cares Partner PACE RN, Sarah Howard, direct care staff, Melberson Poll, Scott Williams, and Talia Paul, as well as, my review of the Senior Care Partners PACE incident report, dated 10/27/2023, Ms. Paul's text messages to staff on 10/25/2023, and the facility's shift notes, dated 10/25-10/27, there is evidence supporting Resident A's personal needs, protection and safety were not attended to at all times, as required, on 10/27/2023 when Mr. Williams arrived to work at approximately 7 am for his shift, until Resident A was discovered in the home at approximately 12 pm. During that time, Resident A was not provided with breakfast, toileted, or administered his medications; therefore, his personal needs were not attended to, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/21/2023, I conducted the exit conference with the licensee, Jill Long, via telephone explaining my findings. Ms. Long acknowledged the findings and indicated she would provide an acceptable plan of correction. I discussed with Ms. Long the

importance of following up with staff if they weren't going to acknowledge a group text relaying resident information.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

12/21/2023

Cathy Cushman — Date
Licensing Consultant

Approved By:

12/27/2023

Dawn N. Timm — Date
Area Manager