GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 9, 2023

Timothy Adams
Lakeshore Care Corp.
7280 Belding Rd. NE
Rockford, MI 49341

RE: License #:	AM610080832
Investigation #:	2023A0356026
	Cedar Creek Personal Care 2

Dear Mr. Adams:

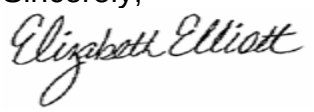
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,



Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM610080832
Investigation #:	2023A0356026
Complaint Receipt Date:	03/09/2023
Investigation Initiation Date:	03/09/2023
Report Due Date:	05/08/2023
Licensee Name:	Lakeshore Care Corp.
Licensee Address:	7280 Belding Rd. NE Rockford, MI 49341
Licensee Telephone #:	(616) 813-5471
Administrator:	Timothy Adams
Licensee Designee:	Timothy Adams
Name of Facility:	Cedar Creek Personal Care 2
Facility Address:	8842 Cedar Creek Drive Holton, MI 49425
Facility Telephone #:	(616) 821-0281
Original Issuance Date:	05/21/1998
License Status:	REGULAR
Effective Date:	06/27/2022
Expiration Date:	06/26/2024
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's medical care needs are not being properly attended to at the facility.	No
Resident A has not been taken to appointments by staff at the facility.	No
Resident A's medication Glucerna is not being administered as prescribed and blood sugar readings are not completed.	No
The home's physical plant is in disrepair.	Yes
Resident A's funds are not handled properly.	Yes

III. METHODOLOGY

03/09/2023	Special Investigation Intake 2023A0356026
03/09/2023	APS Referral Denied.
03/09/2023	Special Investigation Initiated - Telephone APS-Gene Gray
03/14/2023	Contact-Document Received Office of Recipient Rights Complaint received (#2).
03/20/2023	Contact - Telephone call made. Home Manager, Sheila Patterson.
03/20/2023	Contact - Telephone call made. Interview with Ms. Patterson & Melissa Gekeler Office of Recipient Rights, Network 180.
03/21/2023	Contact-Document Received. BCAL Complaint (#3).
04/04/2023	Inspection Completed On-site
04/04/2023	Contact - Face to Face Resident A, Melissa Gekeler, Kassie Davis, home manager.

04/04/2023	Contact - Face to Face Nicole Bidwell, Cody Califf, staff.
04/04/2023	Contact - Document Received Facility documents reviewed.
04/04/2023	Contact - Telephone call made. Tim Adams, Licensee designee, Jessica Adams, Admin.
04/21/2023	Contact - Telephone call made. Beverly St. John, Community Care Home Care Agency, nurse.
04/24/2023	Contact - Telephone call received. Beverly St. John, nurse.
04/28/2023	Contact - Telephone call made. Melissa Gekeler, ORR.
05/02/2023	Contact - Telephone call made. Beverly St. John, nurse.
05/02/2023	Contact - Telephone call made. Melissa Gekeler, ORR. Sheila Patterson, home manager.
05/02/2023	Contact - Document Received pictures from M. Gekeler provided by Resident A's guardian.
05/02/2023	Contact-Telephone call made/received. Health West nurse, Jessica Sobers.
05/02/2023	Contact-Telephone call made. Health West supports coordinator, Kara Kile.
05/03/2023	Contact-Telephone call made. Tasha Mitchell, Network 180 supports coordinator.
05/05/2023	Contact-Telephone call made. Kara Kile, HW.
05/09/2023	Exit Conference-Tim and Jessica Adams, Licensee Designee.

ALLEGATION: Resident A's medical care needs are not being properly attended to at the facility.

INVESTIGATION: On 03/09/2023, I received a BCAL (Bureau of Children and Adult

Licensing) Online Complaint. The complainant reported that Resident A has a catheter that got infected multiple times, Resident A was admitted to the hospital due to the infections and one time, the infection got so bad, it turned septic. The complainant reported Resident A was referred to a urologist and staff at the facility never followed-up with the referral and the catheter continues to be infected.
On 03/09/2023, I interviewed Gene Gray, Muskegon County DHHS (Department of Health and Human Services) APS (Adult Protective Services) Worker via telephone. Mr. Gray stated he had a previous open complaint and at this time, the case is open.

On 03/14/2023, I received a Recipient Rights Complaint dated 03/14/2023 from Larry Spataro, Health West, Office of Recipient Rights. In this complaint, the complainant reported upon assessment of Resident A's catheter, it was not safely anchored to his thigh nor was Resident A wearing any underwear. The Health West nurse, Jessica Sobers resecured the catheter tubing to Resident A's leg so it was not pulling on his bladder and penis. In addition, the complainant reported that on 03/09/2023, Resident A had a canceled urology appointment due to the home not completing the kidney ultrasound that had been ordered by West Shore Urology.

On 03/20/2023, I interviewed Sheila Patterson, home manager and Melissa Gekeler, Office of Recipient Rights Representative via telephone. Ms. Patterson stated Resident A was placed in this facility in July 2022, at that time, he had case management through Network 180. Ms. Patterson stated the case management for Resident A dropped and from October 2022 until March 2023, Resident A had no case management to assist with facilitating care for Resident A. Ms. Patterson stated Resident A had an RN (registered nurse), Beverly St. John, from Community Home Care that came into the facility and oversaw the care of Resident A's catheter. Ms. Patterson stated staff at the facility sent Resident A to the hospital on 02/04/2023-02/13/2023 with a UTI (urinary tract infection), sepsis and acute renal failure. Ms. Patterson stated Resident A was sent back to the facility and on 02/23/2023, they sent him back to the hospital where Resident A was hospitalized until 02/25/2023 with acute kidney injury and a UTI. Ms. Patterson stated when Resident A was in the hospital on 02/04/2023, his catheter was changed but the catheter was not placed in the correct position and staff noticed that Resident A's urine was not emptying fully, and his abdomen was extended so they sent him back in for evaluation and treatment. Ms. Patterson stated Ms. St. John replaced Resident A's catheter once a month, saw Resident A at the facility once a week, and is in the facility 2-3 times a week and available for questions or to assist staff if they need help with Resident A's catheter care. Ms. Patterson stated Resident A did not wear underwear because he wore adult briefs. Ms. Patterson stated Resident A was admitted to this facility with the catheter in place. Resident A has had repeated UTI's, but his care is overseen by Ms. St. John, RN, and Dr. Daniel Carrel, DO, medical professionals and staff at the facility assist Resident A with catheter care in between medical visits. Ms. Patterson stated Resident A's catheter could not be removed because he did not have a guardian and Ms. Patterson's attempts to get a urology appointment for Resident A were unsuccessful because no urologist that

she contacted would see Resident A because he did not have a POA (power of attorney) or a guardian. Ms. Patterson stated the kidney ultrasound was not completed because Resident A did not have a legal guardian in place for medical decision making. Ms. Patterson stated somewhere in Resident A's move from services with Network 180 to Health West, the guardianship for Resident A was dropped and a new form from the doctor needed to be completed because the previous one was too old.

On 04/04/2023, I interviewed Resident A with Ms. Gekeler and Kassie Davis, home manager at Resident A's new placement. Resident A stated that staff at the facility assisted him with catheter care, then Resident A stated staff had him empty his own catheter bag, but he did not know if he put the urine in the toilet or what he did with it. Resident A stated he did not know if staff were there assisting him or not. Ms. Davis stated since his placement in this facility, Resident A has been to the ER two times for his catheter. The doctor at the hospital said when Resident A comes to the hospital, he is usually "septic." Ms. Davis stated now, Resident A has a legal guardian and will have monthly urology appointments and a scope done in May 2023 to either remove the catheter or get it changed to a supra pubic catheter.

On 04/04/2023, I conducted an unannounced inspection at the facility and interviewed Nicole Bidwell and Cody Califf, direct care workers. Ms. Bidwell stated they continuously tried to get Resident A an appointment with West Shore urology but they would not see Resident A because at the time, he did not have a legal guardian. Ms. Bidwell and Mr. Califf stated Ms. St. John was Resident A's nurse through Community Home Care and she changed Resident A's catheter regularly. Ms. Bidwell stated staff at the facility supervised Resident A and he would empty his own urine bag. Ms. Bidwell stated Resident A's catheter was taped to his leg to keep it in place, but it would often come off because when he pulled his pants up and down, the catheter line would end up coming out the top of his pants rather than down and out the bottom leg of his pants, so they had to assist him with this often.

On 04/04/2023, I reviewed Resident A's assessment plan for AFC residents at the facility. The assessment plan is dated 07/20/2022 and signed by Ms. Patterson and Resident A. The assessment plan documented Resident A needed assistance from staff with toileting and described, '*verbal reminder to use the toilet.*'

On 04/04/2023, I interviewed Tim Adams, Licensee Designee and Jessica Adams, Administrator via telephone. Ms. Adams stated Resident A has been in their care for the past 20 years, initially at their facility in Grand Rapids and as of July 2022, moved to this facility because he was unable to navigate the stairs at the previous facility. Ms. Adams stated Resident A had case management through Network 180 but after the transfer, there was a lapse in service because he did not have case management set up with Health West. Ms. Adams stated they are the ones who got the new letter from the doctor for guardianship and Ms. Patterson is the one who initiated case management services for Resident A with Health West. Ms. Adams stated Resident A had in-home medical care throughout the time he was at this

facility from Community Home Care and Harmony Home Health Care but without case management through the local CMH (Community Mental Health) and legal guardianship, it was impossible for Ms. Patterson to set up doctor's appointments with specialists such as a urologist. Ms. Adams stated they tried to set these appointments but were unable to.

On 05/02/2023, I interviewed Beverly St. John, RN with Community Home Care via telephone. Ms. St. John stated she changed Resident A's catheter every month and checked on Resident A on a weekly basis while in the facility. Ms. St. John stated anyone with a catheter has the risk of infection all the time and each time there was concern of infection, Resident A was sent out for evaluation and treatment. Ms. St. John stated during one recent hospitalization, Resident A was prescribed antibiotics while in the hospital but upon discharge, was sent back to the facility without antibiotics which told her the infection was not bad enough to warrant antibiotics beyond hospitalization. Ms. St. John stated she and staff at the facility safely anchored the catheter tubing to Resident A's thigh, but he often would take it off. Ms. St. John stated she heard Ms. Patterson attempting to set up urology appointments for Resident A but because he did not have a legal decision maker, she (Ms. Patterson) was unable to make the appointment.

On 05/02/2023, I interviewed Jessica Sobers, RN with Health West (Community Mental Health). Ms. Sobers stated Resident A does not take the catheter anchor off in the new placement, he has case management, a legal guardian and has appointments to see a urologist for further evaluation regarding the catheter. Ms. Sobers stated Ms. Patterson informed Network 180 that Resident A had an appointment set up with Health West for the purpose of case management, so Network 180 closed their services to Resident A but Health West had no appointment with Resident A and therefore, services were never started, leaving Resident A with no case management or services to assist with his care.

On 05/09/2023, I conducted an exit conference with Tim and Jessica Adams, Licensee Designee via telephone. Mr. and Mrs. Adams agree with the information, analysis, and conclusion of this applicable rule.

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:	The complainant reported staff at the facility failed to follow-up with Resident A's catheter care and continued infections ensued.

	Ms. Patterson, Mr. & Mrs. Adams, Ms. Bidwell, Mr. Califf and Ms. St. John stated Resident A's catheter care was provided at the facility. Resident A stated that staff at the facility assisted him with catheter care, but he did not know if staff were there assisting him or not. Resident A's assessment plan documented Resident A needed assistance from staff with toileting and described, 'verbal reminder to use the toilet.' Ms. Sobers stated services were never started leaving Resident A with no or minimal services to assist with his care. Based on investigative findings, Resident A was seen by medical professionals for catheter care and Resident A's personal care as specified in the written assessment plan was followed and therefore, a violation of this applicable rule is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A has not been taken to medical appointments by staff at the facility.

INVESTIGATION: On 03/09/2023, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaint. The complainant reported Resident A's glasses were broken, and he has not been taken to an eye appointment. The complainant reported the home was responsible for taking him to the dentist and he has not been to one. The complainant reported that in October 2022, the home was supposed to coordinate with Muskegon CMH (Health West), but they did not do it until last week. Resident A is supposed to receive psychiatric services, therapy, and case management, but has not received any services since October 2022. The complainant reported Resident A has medications prescribed by his primary care physician, but the home set up an appointment but did not take Resident A to the appointment.

On 03/14/2023, I received a Recipient Rights Complaint dated 03/14/2023 from Larry Spataro, Health West, Office of Recipient Rights. In this complaint, the complainant reported Resident A said he was missing his glasses and the home didn't know where they were, no eye appointment has been made. Resident A has no teeth, and the home could not provide an answer if he had dentures or when his last dental appointment was. In addition, documentation from Network 180 (community mental health Kent County) in July 2022 stated Resident A must

complete intake at Health West and this was not done. The complainant reported Network 180 stated again in October 2022 that intake needed to be completed at Health West and again, it was not done. The complainant reported the home did not reach out to Health West until March of 2023 and so from October 2022 until March 2023, Resident A did not have case management, nor was guardianship completed which was a “notable” need in July 2022. The complainant reported Resident A was unable to receive urology surgery to address urinary retention due to the delay in guardianship.

On 03/20/2023, Ms. Gekeler and I interviewed Sheila Patterson, home manager. Ms. Patterson stated Resident A received medical care and oversight by Dr. Carrell, DO with Harmony Home Health Care and nursing services through Community Home Care, Ms. St. John. Ms. Patterson stated she did not know Resident A wore glasses and does not think he came to this facility with glasses. Ms. Bidwell (direct care worker) added that Resident A did have glasses when he came to this facility in July 2022, but the glasses were broken at the time he was admitted to this facility. Ms. Bidwell stated she called Excellence in Vision in Fremont to make an appointment for Resident A but was told Resident A was not a patient and she (Ms. Bidwell) could not make an appointment at that time. Ms. Patterson stated Resident A has not been to an eye doctor since his placement at this facility. Ms. Patterson stated since Resident A has lived in this facility, he has not had dentures. Ms. Patterson stated Resident A has Medicaid and there are only certain dentists that accept Medicaid so every couple of months, she would call to try and set up an appointment for Resident A with a dentist that accepts Medicaid. Ms. Patterson stated either Resident A was “on a list” or she was told they could not take any new patients. Ms. Patterson stated she was hoping to get Resident A into Reliance Community Care Partners or Health West for case management and that those agencies would be able to get Resident A into a dentist. Ms. Patterson stated getting Resident A services through Reliance took too long so Ms. Adams told Ms. Patterson to pursue case management through Health West because getting appointments for Resident A was nearly impossible without the oversight of case management. Ms. Patterson stated they did not fail to take Resident A to appointments. They could not set up services for Resident A without a legal guardian and case management in place and the responsibility to pursue those services was left to staff at the facility.

On 04/04/2023, I interviewed Resident A with Ms. Gekeler and Kassie Davis, home manager at Resident A’s new placement. Resident A stated he did not see an eye doctor or a dentist while a resident at the facility. Resident A stated his eyeglasses broke a long time ago, not while he was living at Cedar Creek. Ms. Davis stated now Resident A has a legal guardian and case management so all the necessary services will be followed-up on.

On 04/04/2023, I conducted an unannounced inspection at the facility and interviewed Nicole Bidwell and Cody Califf, direct care workers. Ms. Bidwell reiterated the same information provided on 03/20/2023. Ms. Bidwell and Mr. Califf

stated they did not take Resident A to appointments because he did not have any appointments.

On 04/04/2023, I reviewed the Resident Care Agreement dated 07/20/2022 and signed by Ms. Patterson and Resident A. The RCA documented, '*The basic fees include the following transportation services, one doctors visit annually for a current healthcare appraisal.'*

On 04/04/2023, I interviewed Tim Adams, Licensee Designee and Jessica Adams, Administrator via telephone. Ms. Adams stated there were no appointments made for Resident A because of the lack of guardianship.

On 05/02/2023, I interviewed Beverly St. John, RN with Community Home Care via telephone. Ms. St. John stated all the appointments she had with Resident A were met as she saw Resident A at the facility.

On 05/02/2023, I interviewed Jessica Sobers, RN with Health West (Community Mental Health). Ms. Sobers stated staff at Network 180 told her that Ms. Patterson reported to them that Resident A had an appointment set up at Health West for case management services, so Network 180 closed their case management case for Resident A. Ms. Sobers stated this was in October 2022 and Resident A never received case management services until March 2023 and during that time, no appointments for Resident A were made or followed-up on by staff at the facility.

On 05/03/2023, I interviewed Tasha Mitchell, Network 180 case manager via telephone. Ms. Mitchell stated Ms. Patterson had appointments for Resident A for an initial visit with either Health West and/or My Choice Waiver services for the purpose of case management, and she neglected to follow up on both of those appointments to set up case management. Ms. Mitchell stated the transfer of services from Network 180 to Health West, or My Choice Waiver should have been smooth and easy.

On 05/09/2023, I conducted an exit conference with Tim and Jessica Adams, Licensee Designee via telephone. Mr. and Mrs. Adams agree with the information, analysis, and conclusion of this applicable rule.

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:	The complainants reported the home was responsible for taking Resident A to appointments and he has not been to one. Ms. Patterson, Mr. & Mrs. Adams stated no other appointments, aside from in-home nursing and doctor's care were made for Resident A due to lack of guardianship and case management. Resident A stated he did not see an eye doctor or a dentist while a resident at the facility. Ms. Bidwell and Mr. Califf stated they did not take Resident A to appointments because he did not have any appointments. The Resident Care Agreement documented, '*The basic fees include the following transportation services, one doctors visit annually for a current healthcare appraisal.'* Ms. St. John stated all the appointments she had with Resident A were met as she saw Resident A at the facility. Ms. Sobers stated from October 2022 to March 2023, no appointments for Resident A were made or followed-up on by staff at the facility. Ms. Mitchell stated Ms. Patterson did not follow through on appointments to set up case management services which would have helped getting appointments made for Resident A. Resident A's Resident Care Agreement documented one appointment on an annual basis would be provided for the purpose of the completion of a current health care appraisal. While there were issues with who was supposed to be following-up on case management and legal guardianship, there is not a preponderance of evidence to show that staff at the facility failed to take Resident A to medical appointments. Therefore, a violation of this applicable rule is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A's medication Glucerna is not being administered as prescribed and blood sugar readings are not completed.

INVESTIGATION: On 03/09/2023, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaint. The complainant reported Resident A should be given Ensure (Glucerna) but the home has not been giving him Ensure (Glucerna). When asked about Resident A's Ensure (Glucerna) and diet restrictions, the home stated there was none. In addition, the complainant reported that Resident A has diabetes, and his blood sugar is not being monitored properly. When the home was asked to provide a tracker of Resident A's blood sugars, a forged sheet was provided.

On 03/20/2023, I interviewed Sheila Patterson, home manager and Melissa Gekeler, Office of Recipient Rights Representative via telephone. Ms. Patterson stated Resident A did not use Glucerna, they did not have a doctor's order for it, and he ate food just fine with no dietary restrictions and did not need a dietary supplement. Ms. Patterson stated Glucerna does show up on Resident A's MAR (medication administration record) but it is marked N/A because since he has lived in this facility (July 2022), Resident A has never had Glucerna. Ms. Patterson stated they had a glucometer, took Resident A's blood sugar reading one time per week as instructed and documented it on the MAR and on a sheet of paper. Ms. Patterson stated a medication called Januvia was administered, one tab daily as prescribed for Type II diabetes to control high blood sugar and when Resident A moved from the facility, his glucometer was sent with him.

On 04/04/2023, I interviewed Resident A with Ms. Gekeler and Kassie Davis, home manager at Resident A's new placement. Resident A stated he took the medications staff gave him at the facility but did not know if he took Glucerna or blood sugar readings. I reviewed the MAR for the month of April 2023 at this new facility and Glucerna is not on the MAR as a prescribed medication, Januvia and weekly blood sugar readings are on this MAR.

On 04/04/2023, I conducted an unannounced inspection at the facility and interviewed Nicole Bidwell and Cody Califf, direct care workers. Ms. Bidwell stated they did not have Glucerna in the facility for Resident A and they did not have a doctor's order for it either, yet it still showed up on the MAR during the months that he lived at the facility. Ms. Bidwell stated it is possible Resident A was using Glucerna at the previous placement and so it had continued to these MARs. Ms. Bidwell stated Resident A was a good eater and did not need a dietary supplement. In addition, Resident A was seen regularly by Dr. Carrel, and he did not write an order for Resident A to have a meal supplement. Ms. Bidwell and Mr. Califf stated they administered Resident A's Januvia as prescribed and took Resident A's blood sugar readings once weekly as prescribed. Ms. Bidwell and Mr. Califf stated both are documented on the MAR. Ms. Bidwell and Mr. Califf stated when Resident A was moved from this facility, the glucometer used to measure his blood sugars was sent with his belongings.

On 04/04/2023, I reviewed Resident A's health care appraisal (HCA) dated 10/26/2022 and signed by Dr. Daniel Carrel. The HCA documented that Resident A has a general diet with no special dietary requirements documented.

On 04/04/2023, I reviewed Resident A's assessment plan for AFC residents dated 07/20/2022 and documents that Resident A does not have a special diet.

On 04/04/2023, I reviewed the MAR for the months of February and March 2023. The MAR showed 'Glucerna, Liq Vanilla, drink one can once daily prescribed by Dr. Amanda Huver.' The Glucerna has 'N/A' marked next to the instructions and in February 2023 it shows staff signature on the MAR as given for several dates but then those signatures are scribbled out. The March 2023 MAR again shows Glucerna with an 'N/A' marked next to the instructions with no staff signatures showing this was administered to Resident A.

On 04/04/2023, I reviewed the MAR for the month of February 2023 and documented on the MAR was 'True Metrix Tes Glucose, use to test blood sugar once per week (fill at Benson's pharmacy).' The MAR documented Resident A's blood sugars as taken weekly, and the blood sugar level is documented on the MAR. The MAR documented 'Januvia, tab 100 mg, take one tablet by mouth once daily,' the MAR documented the medication administered once daily at 8:00a.m. except for dates when Resident A was in the hospital. The March MAR documented Resident A's blood sugar levels on a weekly basis and the prescribed Januvia as administered every morning at 8:00a.m. until the date of discharge.

On 05/02/2023, I interviewed Beverly St. John, RN with Community Home Care via telephone. Ms. St. John stated Resident A had a very good appetite and ate very well. Ms. St. John stated she did not see Resident A ever take a dietary supplement such as Glucerna. Ms. St. John stated she checked staff documentation of Resident A's blood sugar readings, and they always had it documented on a sheet of paper.

On 0502/2023, I interviewed Ms. Sobers via telephone. Ms. Sobers stated staff did not have the blood sugars when they asked for them and then staff came up with a handwritten sheet of paper with blood sugar readings on it. Ms. Sobers stated they did not have a glucometer to give them when Resident A was moved out of the facility.

On 05/09/2023, I conducted an exit conference with Tim and Jessica Adams, Licensee Designee via telephone. Mr. and Mrs. Adams agree with the information, analysis, and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.14312	**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 §333.1101 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:	The complainant reported Resident A's Ensure/Glucerna, was not administered as prescribed and Resident A's blood sugar readings were not documented as they should have been. Ms. Patterson, Ms. Bidwell, and Mr. Califf stated all Resident A's medications and treatments were administered as prescribed. Resident A stated he took the medications staff gave him at the facility but did not know if he took Glucerna or blood sugar readings. The HCA documented that Resident A has a general diet with no special dietary requirements documented. Resident A's assessment plan documents that Resident A does not have a special diet. The MAR for February and March 2023 document Glucerna as N/A or discontinued, Januvia is documented as administered as prescribed as is the weekly documentation of Resident A's blood sugar readings. Ms. St. John stated she did not see Resident A take a dietary supplement such as Glucerna. Ms. St. John stated she checked staff documentation of Resident A's blood sugar readings, and they always had it documented on a sheet of paper. Ms. Sobers stated staff did not have the blood sugars when they asked for them and then staff came up with a handwritten sheet of paper with blood sugar readings on it. Based on investigative findings, there is not a preponderance of evidence to show that Resident A was not administered medications as prescribed. Therefore, a violation of this rule is not established.

CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: The facility's physical plant is in disrepair.

INVESTIGATION: On 03/21/2023, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaint. The complainant reported the housing conditions as this facility are horrible. Resident A was recently moved from the facility and there was medication on the floor behind Resident A's bed, bed bugs were noticed on the bed, the faucet in Resident A's room, one side of the faucet did not work and the side that put water out, the water flowed down the drain and straight onto the floor. The complainant reported the facility is filthy.

On 03/20/2023, I interviewed Sheila Patterson, home manager and Melissa Gekeler, Office of Recipient Rights Representative via telephone. Ms. Patterson stated the facility is constantly battling bed bugs and they have a professional heat treat machine, that they own, and use to heat treat each affected room and the rooms next to them when bed bugs are discovered. Ms. Patterson stated in addition to the heat treatment, they use Crossfire Spray as a method of maintenance to keep bed bugs away. Ms. Patterson stated they are currently treating for bed bugs. Ms. Patterson stated Resident A's roommate, (Resident B) broke the sink in the bathroom located inside the room they share. Ms. Patterson stated this is not the first time Resident B broke the sink and it was repaired on Saturday, 03/18/2023. Ms. Patterson stated when Health West staff were moving Resident A, they discovered two pills under Resident A's bed, there was an unknown white tablet that turned out to be a tack and the 2nd pill appeared to be a Chlorpromazine tablet that was not Resident A's but Resident B's pill. Ms. Patterson stated Resident B can be "sneaky" and may have hidden the pill or spit it out in the room. Ms. Patterson stated staff at the facility are constantly cleaning and mopping but patient care is the first matter staff tend to and cleaning is done around patient care and during evening hours when residents are at rest. Ms. Patterson stated they have recently hired a maintenance person which should help with the maintenance of the facility.

On 04/04/2023, I interviewed Resident A with Ms. Gekeler and Kassie Davis, home manager at Resident A's new placement. Resident A stated Resident B "threw things around and broke things" in their room. Resident A stated the sink in his room was "broke but Cody tried to work on it." Resident A stated the toilet in his room worked. Resident A stated there were lots of bed bugs in his room and his room was never treated for bed bugs that he knows of. Resident A stated he took his medications and swallowed them. Staff placed the medications in a cup and staff watched him as he took his medications.

On 04/04/2023, I conducted an unannounced inspection at the facility and interviewed Nicole Bidwell and Cody Califf, direct care workers. Ms. Bidwell stated two bed bugs were seen when Health West staff were moving Resident A out. Ms. Bidwell stated there was no other evidence of bed bugs and stated when they see

bed bugs, they treat the room. Ms. Bidwell explained that they treat the rooms with a professional heat treat machine and follow-up with Crossfire spray each time a resident moves out of a room, the room is treated, and new mattresses are purchased. Ms. Bidwell stated Resident B often “trashed” the room he shared with Resident A including breaking the sink more than once. Ms. Bidwell acknowledged that medications were found on the floor in Resident A & B’s room. Ms. Bidwell stated she does not know what happened or how the pills ended up in the residents room because staff watch the residents take their medications.

On 04/04/2023, I inspected the room Resident A & B shared and inspected the beds. I did not find any live bed bugs. I saw old bed bug activity on the mattress protector of Resident B’s bed. I inspected the sink in the bathroom in the room Resident A & B shared. The cold water did not work at all, but the hot water worked. I looked under the sink while the hot water was running, and it did not leak from under the sink.

On 04/04/2023, I inspected the medication room and did not see any medications that were out of the packaging or loose. Mr. Califf and Ms. Bidwell stated they have the residents come to the medication room where they dispense and watch each resident individually take their medications. I interviewed Residents B, C, D, E, F & G individually and all residents stated they went one at a time to the medication room and took their medications, dispensed, and supervised by staff while at the medication room.

On 04/04/2023, I inspected every room in this facility and did not find any live or dead bed bugs at this time. The rooms were in varying degrees of cleanliness depending on the resident who resides in the room. None of the rooms were grossly negligent at this time and the one that could use more attention was discussed with Ms. Patterson and Ms. Bidwell. Ms. Patterson and Ms. Bidwell were aware of the room and will inspect and clean the area I noticed around the residents bed.

On 05/02/2023, I received and reviewed pictures and a video sent to me from Ms. Gekeler. The pictures were taken when Resident A was moved out of the facility on 03/17/2023. I viewed a video where the cold-water handle was turned and no water came out, the hot water handle was turned, and the water ran down the drain and directly out the bottom of the sink and onto the floor. I reviewed pictures that appeared to be two different pills, orange in color, one on the floor and the other appeared to possibly have been spit up on what appeared to be a mattress. I received and reviewed a picture of a large bed bug on a mattress and several pictures of dirty clothing or linens on the floor, a dirty adult brief on the floor, various items strewn on the floor of a room and a black substance dripping from a window ledge, possibly in the dining room, down the wall and onto the floor.

On 05/02/2023, I interviewed Jessica Sobers, RN with Health West (Community Mental Health). Ms. Sobers stated the living conditions at the facility is “dirty”. Ms. Sobers stated there was BM on Resident A’s clothing when he was moved and BM

on the floor. Ms. Sobers stated there were bedbugs in the home and all Resident A's clothing was replaced upon placement at a different facility. Ms. Sobers stated condition of the facility is poor.

On 05/09/2023, I conducted an exit conference with Tim and Jessica Adams via telephone. Mr. and Mrs. Adams stated they do not agree with the information, analysis, and conclusion of this applicable rule. Mr. and Mrs. Adams stated upon finding out about the issues addressed in this complaint, they took action to fix the problems. Mr. and Mrs. Adams stated they should not be penalized because the maintenance of a facility is constant and when they are made aware of things that are broken or in disrepair, they take action to get them fixed and did their due diligence to fix these issues.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	The complainant reported the conditions at this facility are poor. There was medication on the floor, bed bugs and a broken sink that leaks water onto the floor. Ms. Patterson, Ms. Bidwell, and Mr. Califf acknowledged that medication was found on the floor of Resident A's room, bed bugs are a constant issue and treated each time they are discovered, and Resident B broke the sink, but it was repaired. Resident A stated Resident B broke things in their room, the sink was broken but staff worked on it, there were bed bugs in his room, and his room was never treated. I inspected every room in this facility and did not find any live or dead bed bugs at this time. I inspected the sink in question. The cold water still did not work, but the hot water worked and with the water running, the sink did not leak onto the floor underneath. I viewed a video, and the cold water did not work, the sink leaked onto the floor when the hot water was on. I reviewed pictures of two different pills in a room at the facility. I received and reviewed a picture of a bed bug on a mattress and pictures of dirty conditions.

	Ms. Sobers stated the overall condition of the facility is poor. Based on investigative findings, there is a preponderance of evidence to show that when the staff from Health West moved Resident A from the facility, the conditions of the facility at that time were not maintained to provide adequately for the health, safety, and wellbeing of the residents and therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A's funds are not handled properly.

INVESTIGATION: On 03/21/2023, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaint. The complainant reported Resident A had $128.00 in "petty cash" that was collected upon moving and his money bag was short an unknown amount. The complainant reported that the home manager, Sheila Patterson went into other resident's money bags to make up the difference.

On 04/04/2023, I interviewed Resident A with Ms. Gekeler and Kassie Davis, home manager at Resident A's new placement. Ms. Davis stated Resident A's representative payee is Threshold's and he now has a legal guardian. Ms. Davis stated Resident A came to his new placement with $128.00 and Resident A's Health West case manager, Kara Kile told her (Ms. Davis) staff at the facility were scrambling around to get $128.00 together, taking money from other resident funds to do so. Ms. Davis stated Resident A reportedly had a check issued in January 2023 for $320.00 and the home deposited the money into a Huntington Bank account and Resident A does not have an account at that bank. Ms. Davis stated the $320.00 is unaccounted for. Ms. Gekeler acknowledged that she received information that Resident A had a check or some more money that is unaccounted for as part of her recipient rights complaint.

On 04/04/2023, I conducted an unannounced inspection at the facility and interviewed Nicole Bidwell and Cody Califf, direct care workers. Ms. Bidwell stated Ms. Patterson is the only person that handles resident funds and at this time, Ms. Patterson is in the hospital and unavailable for an interview. Ms. Bidwell stated she could not get into the resident funds because they were locked in the safe and only Ms. Patterson had access to resident funds. Ms. Bidwell stated they would not have deposited resident funds into their own personal accounts, the rent and any other resident fund checks are stamped and deposited into each resident's account at the facility. Ms. Bidwell stated she does not know anything about a check or money in the amount of $320.00 and they would not keep any more than $200.00 in resident accounts. Ms. Bidwell stated the check could have gone to Mr. & Mrs. Adams and they handled those funds. Ms. Bidwell stated they keep resident funds in a safe in the office, the funds are kept separate and, in each resident's, individual money

pouches. Ms. Bidwell stated Ms. Patterson would not have gone into another resident's money pouch to make up resident funds for Resident A.

On 04/04/2023, I reviewed Resident A's Funds II form. Each transaction is signed by Resident A and Ms. Patterson. The form documented that Resident A had $80.00 upon admission to the facility. Resident A's Funds II shows deposits of $44.00 for 5 months, $40.00 for 2 months for spending and as of 02/07/2023, Resident A had $88.00 documented on the Funds II document. On 03/17/2023, the date Resident A moved from the facility, a deposit of $44.00 was documented by Ms. Patterson for a total of $128.00 cashed out and sent with Resident A to his new placement. The form does not show a deposit of $320.00 into the account for the entire time Resident A was at the facility. Upon further review of the Funds II record, on 11/07/2022, Resident A had $100.00 documented in his account. On 11/07/2022, there were three transactions documented on the form all on the same date that showed a $50.00 withdrawal of funds for 'spending-shopping,' another $50.00 withdrawal for 'spending', and then a $105.35 withdrawal documented for 'spending.' This would have left Resident A with a $-105.35 balance, but the balance documented on the Funds II form is $0.00. The Resident Funds I form section B documented that Ms. Patterson handled the payment for AFC and resident cash and is signed by Ms. Patterson on 07/20/2022.

On 04/04/2023, I interviewed Tim Adams, Licensee Designee and Jessica Adams, Administrator via telephone. Ms. Adams stated Resident A had several checks for transportation during COVID that Resident A did not use. Those checks were sent back to Thresholds and the checks totaled approximately $320.00. Ms. Adams stated she requested Thresholds reissue a check to Resident A that could be used for personal items and clothes. Ms. Adams stated it is possible that Resident A received the check and Ms. Patterson assisted Resident A with cashing the check and assisted him with buying personal items and clothes with it.

On 05/02/2023, I interviewed Ms. Patterson via telephone. Ms. Patterson stated she was not short on the $128.00 given to Resident A upon discharge from the facility. Ms. Patterson stated she occasionally does not fully zip up the money pouches and money can fall out to the bottom of the safe. Ms. Patterson stated she had to gather some money that fell out of Resident A's pouch from the bottom of the safe and did not pull money from other resident accounts to make up for missing funds. Ms. Patterson stated Resident A received $330.00 cash that she gave Resident A to go shopping with. Ms. Patterson stated staff, either Ms. Bidwell or Mr. Califf would have taken Resident A shopping to buy shoes, clothes, and snacks. Ms. Patterson stated she did not put the funds into Resident A's account because they are not allowed to have over $200.00 in any resident funds accounts, so the cash went right to Resident A. Ms. Patterson stated the check probably (but is not sure) went into the corporate account and cash sent or given to her by Mr. & Mrs. Adams for resident spending. Ms. Patterson stated she does not have an account at Huntington bank and never deposited a check for $320.00 for Resident A into a personal account.

Ms. Patterson acknowledged that the $320.00 funds are not documented on a Resident Funds II form for Resident A.

On 05/02/2023, I interviewed Tasha Mitchell at Network 180. Ms. Mitchell stated Shari (last name unknown), the home manager at Resident A's AFC prior to this AFC, which also is owned by Mr. & Mrs. Adams, gave the transportation checks to her (Ms. Mitchell) and Ms. Mitchell talked to on the telephone and mailed the transportation checks to Mrs. Adams. Ms. Mitchell stated the checks were supposed to be sent back to Hope Network for re-issuance. Ms. Mitchell stated this all took place while Resident A was residing in this facility. Ms. Mitchell stated the checks were supposed to be direct deposited into Resident A's account for his own spending. Ms. Mitchell stated Ms. Patterson knew about the transportation funds because she (Ms. Mitchell) had a video call with Ms. Patterson and Resident A and talked about getting him jeans, shoes, and a new radio. Ms. Mitchell stated at this time, Thresholds was Resident A's representative payee.

On 05/05/2023, I interviewed Kara Kile, Health West case manager via telephone. Ms. Kile stated $128.00 was documented on the Resident Funds II form as the amount Resident A should have had in his account upon discharge. Ms. Kile stated she witnessed Ms. Patterson count Resident A's money and then take money out of other resident funds to make up the $128.00 Resident A was given upon discharge. Ms. Kile stated she did not know how much Resident A's account was short or which resident's funds Ms. Patterson pulled money from. Ms. Kile stated she reviewed the Funds II ledger and noted several errors including the fact that Resident A did not get $44.00 in spending each month as documented on the Funds II form but instead got $40.00 a month sent to him by Thresholds as his payee. In addition, Ms. Kile stated a check was made out to Resident A on 01/17/2023 in the amount of $320.00. Resident A did not sign the back of the check, but instead the check was stamped and deposited into an account that is unknown on 01/23/2023, and never recorded on any documents at the facility including the Resident Funds II form. Ms. Kile stated it is assumed that staff at the facility cashed/deposited that check for Resident A.

On 05/05/2023, I reviewed the Thresholds ledger dated 01/03/2022 through 03/27/2023. The ledger documented Resident A received $40.00 personal allowance funds every month. The ledger documented on 01/17/2023, Resident A was cut a check in his name in the amount of $320.00 as personal allowance funds. The document showed on 01/23/2023, the check was stamped, had no resident signature, and was deposited. The ledger does not show what bank the check was deposited in to or what information the stamp had on it.

On 05/09/2023, I conducted an exit conference with Tim and Jessica Adams via telephone. Mr. and Mrs. Adams stated the $320.00 in funds for Resident A was deposited into the corporate account and the funds given to Ms. Patterson in cash for Resident A to spend. They stated they would not keep those funds or document them on the Funds II form because it is over the $200.00 allowable amount to keep

for residents. Mr. and Mrs. Adams stated Ms. Patterson would never take from one resident account to make up funds for another resident. Mrs. Adams stated Ms. Patterson did not zip Resident A's funds pouch all the way and his funds fell out onto the bottom of the safe so she had to retrieve the funds, count it, and make sure it was all there. Mr. and Mrs. Adams stated they will follow-up with Ms. Patterson regarding the discrepancies documented on the Funds II form and submit a corrective action plan.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(2) The care of any resident funds and valuables that have been accepted by a licensee for safekeeping shall be treated by the licensee as a trust obligation.
ANALYSIS:	The complainant reported Ms. Patterson did not have the correct amount of funds to give Resident A and used other residents funds to make up the difference. Ms. Davis stated Ms. Kile, told her staff at the facility were scrambling around to get $128.00 together, in addition a $320.00 check for Resident A is unaccounted for. Ms. Bidwell and Mr. Califf stated they keep resident funds in a safe in the office, the funds are kept separate and, in each resident's, individual money pouches. Ms. Bidwell stated Ms. Patterson would not have gone into another resident's money pouch to make up resident funds for Resident A. Upon review of Resident Funds II form, there are transactions that are not correct on the form. Ms. Adams stated it is possible that Resident A received a $320.00 check and Ms. Patterson assisted Resident A with cashing the check and assisted him with buying personal items with the money. Ms. Patterson stated she was not short on the $128.00 given to Resident A upon discharge and she did not go into other residents funds to get $128.00 for Resident A. Ms. Patterson stated the Funds II form does not document the $320.00 funds for Resident A as it's over the $200.00 limit.

	Ms. Mitchell stated the $320.00 check was supposed to be direct deposited into Resident A's account for his own spending. Ms. Kile stated she witnessed Ms. Patterson take money out of other resident's funds to make the $128.00 to give to Resident a upon discharge from the facility. Ms. Kile stated a check was made out to Resident A on 01/17/2023 in the amount of $320.00, the check was stamped and deposited on 01/23/2023, but the funds are not documented anywhere. The Thresholds ledger documented Resident A received $40.00 personal allowance funds every month and not $44.00 as documented on the Resident Funds II. The ledger documented on 01/17/2023, Resident A was cut a check for $320.00 as personal allowance funds. Based on investigative findings, there is a preponderance of evidence to show that Resident A's funds were not properly documented on the Resident Funds II form therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

Elizabeth Elliott

05/09/2023

Elizabeth Elliott — Date
Licensing Consultant

Approved By:

Jerry Hendrick

05/09/2023

Jerry Hendrick — Date
Area Manager