GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 28, 2024

Colleen Cassidy and Caroline Anderson
22467 Paddington Ct
Novi, MI 48374

RE: License #: AS630390815
Investigation #: 2024A0612012
Essence Memory Care LLC

Dear Colleen Cassidy and Caroline Anderson:

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

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (248) 975-5053.

Sincerely,

Johnna Cade, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
Phone: 248-302-2409

enclosure

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

## I. IDENTIFYING INFORMATION

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| **License #:** | AS630390815 |
| | |
| **Investigation #:** | 2024A0612012 |
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| **Complaint Receipt Date:** | 01/12/2024 |
| | |
| **Investigation Initiation Date:** | 01/16/2024 |
| | |
| **Report Due Date:** | 03/12/2024 |
| | |
| **Licensee Name:** | Colleen Cassidy and Caroline Anderson |
| | |
| **Licensee Address:** | 22467 Paddington Ct<br>Novi, MI 48374 |
| | |
| **Licensee Telephone #:** | (248) 506-1634 |
| | |
| **Administrator:** | Colleen Cassidy |
| | |
| **Name of Facility:** | Essence Memory Care LLC |
| | |
| **Facility Address:** | 20800 Chigwidden St<br>Northville, MI 48167 |
| | |
| **Facility Telephone #:** | (248) 308-9607 |
| | |
| **Original Issuance Date:** | 02/01/2018 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 08/01/2022 |
| | |
| **Expiration Date:** | 07/31/2024 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | AGED<br>ALZHEIMERS |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Families must come out of our pockets to purchase things for their family member however they are paying $8,000 per month for rent. | No |
| Direct Care Staff, Samantha Brettelle force fed Resident E causing her to throw up. Ms. Brettelle made her throw up in a cup and left the cup in her bedroom. Resident E died the following week due to aspiration. | No |
| The new owners want all the residents to have hospital beds so they can put the residents on hospice and receive medical supplies by the case. | Yes |
| There is a resident who is on a special diet, the home does not have meals to provide for her. | Yes |

## III. METHODOLOGY

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| 01/12/2024 | Special Investigation Intake<br>2024A0612012 |
| 01/16/2024 | Special Investigation Initiated - Telephone<br>I made a referral to Adult Protective Services (APS) via Centralized Intake. |
| 01/16/2024 | APS Referral<br>I made a referral to Adult Protective Services (APS) via Centralized Intake. |
| 02/12/2024 | Contact - Telephone call made<br>Telephone interview competed with home manager Misty Novakowski and direct care staff Savanah Novakowski. |
| 02/14/2024 | Inspection Completed On-site<br>I completed an unscheduled onsite investigation. I interviewed three direct care staff Tiffany Green, Samantha Brettelle, and Amanda Compton. I also interviewed Open Arms aid Cindy Korol, Resident A's Power of Attorney, Resident D's Family Member, Resident D's Guardian, and Resident C. |

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| 02/14/2024 | Contact - Telephone call made<br>Telephone interview completed with Mike Kruckederg. |
| 02/21/2024 | Contact - Document Received<br>Facility documents received via email. |
| 02/28/2024 | Contact - Telephone call made<br>Telephone interview completed with Safe Hands Hospice Director, Julie Rogers. |
| 02/27/2024 | Contact - Document Sent<br>Facility documents requested via email. |
| 03/01/2024 | Contact - Document Received<br>Facility documents received via email. |
| 03/04/2024 | Contact – Telephone call made<br>Telephone interview completed with home manager, Misty Novakowski. |
| 03/04/2024 | Telephone call Received<br>Telephone interview completed with Resident B's family member. |
| 03/04/2024 | Exit Conference<br>I completed an exit conference via telephone with licensee designee Caroline Anderson, home manager Misty Novakowski and owner Mike Kruckederg. |

**ALLEGATION:**

**Families must come out of our pockets to purchase things for their family member however they are paying $8,000 per month for rent**.

**INVESTIGATION:**

On 01/16/24, I received an anonymous complaint that alleged the home has new owners, the new owners want all the residents to have hospital beds so they can put the residents on hospice and receive medical supplies by the case. They are scamming hospice for the products. The families must come out of pockets to purchase things for their family member however they are paying $8,000 per month for rent. There is a resident who is on a special diet, the home does not have meals for her. The families have requested to see the menu and further asked that that the home has fresh fruit.

On 01/22/24, I received a second anonymous complaint with additional allegations. The complaint alleged Resident E died. An unknown staff said Resident E died due to aspiration. The compliant further indicated that the facility has no house doctor.

On 02/08/24, I received a third anonymous complaint with additional allegations. The complaint alleged direct care staff Samantha Brettelle force fed Resident E causing her to throw up. Ms. Brettelle made her throw up in a cup and left the cup in Resident E's bedroom on purpose. Resident E told Ms. Brettelle to take it out of her room and she wouldn't. The smell of the vomit made Resident E become even more sick. It is believed that Resident E died the following week. On 01/16/24, I initiated my investigation by making a referral to Adult Protective Services (APS) via Centralized Intake. APS denied the referral for investigation.

On 02/12/24, I interviewed home manager, Misty Novakowski and direct care staff, Savanah Novakowski. Ms. Novakowski stated she and Mike Kruckederg are the new owners of Essence Memory Care. They are currently in a contract agreement with the current licensee designees. Savanah is Ms. Novakowski's daughter, and she is responsible for administrative tasks as the facility. Ms. Novakowski and Savanah consistently stated since taking over the facility they have had serious issues with three employees. Two of them were terminated and the other one chose to end her employment. These employees verbally threatened to make a licensing complaint. These employees have vandalized and broke property at the facility and slashed tires of staff cars. Ms. Novakowski has made police report, obtained a restraining order, and a cease-and-desist order.

Ms. Novakowski and Savanah consistently stated each resident's monthly cost of care varies between $6,800 - $8,000. Families sign a Resident Care Agreement which includes an agreement to the cost of care. The monthly fee covers room and board and 24/7 supervision and protection. Clothing is not provided. Currently, the care plan states that briefs are included so the facility has been providing briefs for residents who do not get briefs from hospice. The families are not asked to pay for additional out of pocket costs. Some families choose to purchase special items for their family member however, they are not asked to.

I reviewed the following Resident Care Agreements. The monthly cost of care includes room & board, supervision, and protection. Transportation is not included.

- Resident A - $7,500 a month – signed by licensee and Resident A's guardian on 02/06/2024.
- Resident B - $8,500 a month – signed by licensee and Resident B's guardian on 03/05/2023.
- Resident C - $8,000 a month – signed by licensee and Resident C's guardian on 07/02/2023.
- Resident D - $7,300 a month - signed by licensee and Resident D's guardian on 04/13/2023.

I reviewed Essence Memory Care's care plans. Resident A and Resident C's care plan states "personal care toiletries not included along with briefs wipes and pads." Resident A is now on hospice, medical supplies are provided every 14 days from her hospice provider, Open Arms. Resident D's contract was inherited from the previous owners/licensee designee her personal care items including briefs, wipes, and pads are provided by the facility. Resident B is on hospice with Henry Ford Hospice. Henry Ford Hospice would supply personal care supplies however, Resident B's family declined these supplies. Therefore, the facility is providing them.

On 02/14/24, I completed an unscheduled onsite investigation. I interviewed three direct care staff Tiffany Green, Samantha Brettelle, and Amanda Compton. I also interviewed Open Arms aid Cindy Korol, Resident A's Power of Attorney, Resident D's family member, Resident D's guardian, and Resident C. Resident A, Resident B, and Resident D were home at the time of the onsite investigation. However, do to their respective cognitive abilities and verbal delays they were unable to be interviewed for this investigation. All the residents were well groomed and appropriately dressed at the time of my inspection. They were observed sitting in the common area socializing.

On 02/14/24, I interviewed direct care staff, Tiffany Green. Ms. Green started working at Essence Memory Care in December 2023. Ms. Green stated she does not know how much each resident pays per month. Ms. Green explained that the cost of care covers 24/7 staffing, food, and utilities. Families provide personal care supplies such as toothpaste, briefs, and wipes if necessary or if a resident is on hospice, then hospice will provide briefs and wipes for that resident.

On 02/14/24, I interviewed direct care staff, Samantha Brettelle and direct care staff, Amanda Compton. Ms. Brettelle and Ms. Compton consistently stated that they are unaware of what each resident pays per month. They are further unaware of what the monthly payment covers.

On 02/14/24, I interviewed Open Arms aid Cindy Korol. Ms. Korol stated she visits the home twice a week. Resident A is on hospice with Open Arms. She has no concerns about this home and stated it is run very well. Ms. Korol stated Open Arms provides Resident A with briefs, pads, and wipes. Ms. Korol is unaware of how much Resident A pays monthly or what that payment covers.

On 02/14/24, I interviewed Resident A's Power of Attorney (POA). Resident A moved into the home ten days ago, she is on hospice. Resident A's POA stated they provide good care and Resident A is being treated well. The monthly cost of care covers all Resident A's needs. He has not been asked to make any additional purchases.

On 02/14/24, I interviewed Resident D's family member, he placed a telephone call to Resident D's guardian who also participated in the interview via telephone. Resident D's family member and Resident D's guardian consistently stated that they have not been asked to purchase additional items outside of the monthly cost of care.

On 02/14/24, I interviewed Resident C. Resident C stated she stated she has no issues or concerns with the care that she receives. She has access to any personal care items that she needs. If she is to run out of something her son brings her more.

On 2/14/24, I interviewed Mike Kruckederg via telephone. Mr. Kruckederg is one of the new owners and will be the new licensee. Mr. Kruckederg stated they recently let go of two employees due to performance. The employees threated to make complaints against the facility. Mr. Kruckederg stated families are asked to supply briefs in addition to their monthly cost of care.

On 03/04/24, I interviewed Resident B's family member via telephone. Resident B's family member stated personal care items are provided by the facility. Resident B is on hospice with Henry Ford. Henry Ford hospice will provide adult diapers for Resident B however, her family has declined these supplies as the adult diapers are "standard size" and will not fit Resident B appropriately.

| **APPLICABLE RULE** | |
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| **R 400.14305** | **Resident protection.** |
| | (1) A resident shall be assured privacy and protection from moral, social, and financial exploitation. |
| **ANALYSIS:** | Based on the information gathered through my investigation there is insufficient information to conclude any resident is being financially exploited. I reviewed the resident care agreements for Resident A, B, C, and D. The documents indicate an agreed upon monthly rate for the cost of care and the form is signed by the licensee and the resident's respective guardian. The monthly cost of care includes room & board, supervision, and protection. I reviewed Essence Memory Care's care plans. Resident A and Resident C's care plan states "personal care toiletries not included along with briefs wipes and pads." Resident A is now on hospice, medical supplies are provided every 14 days from her hospice provider, Open Arms. Resident D's contract was inherited from the previous owners/licensee designee her personal care items including briefs, wipes, and pads are provided by the facility. Resident B is on hospice with Henry Ford Hospice. Henry Ford Hospice would supply personal care supplies however, Resident B's family declined these supplies. Therefore, the facility is providing them. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

**ALLEGATION:**

**Direct Care Staff, Samantha Brettelle force fed Resident E causing her to throw up. Ms. Brettelle made her throw up in a cup and left the cup in her bedroom. Resident E died the following week due to aspiration.**

**INVESTIGATION:**

On 02/12/24, I interviewed home manager, Misty Novakowski and direct care staff, Savanah Novakowski. Ms. Novakowski and Savanah consistently stated Resident E died on January 20, 2024. She was on hospice with Safe Hands. Resident E was diagnosed with dysphagia which means she had difficulty swallowing. On 01/12/24, direct care staff, Alissa Hayes reported that Resident E was coughing during the night shift. She placed a chucks pad on her chest to catch any discharge. At 7:45 am direct care staff, Samantha Brettelle arrived on day shift. She reported that she observed some discharge on the chucks pad, she cleaned Resident E up. The next day Resident E started her prescribed comfort pack medication for end-of-life care. Ms. Novakowski and Savanah consistently stated Resident E did not have any aspiration events. Resident E was never forced to throw up in a cup. Ms. Novakowski and Savanah consistently stated Ms. Brettelle is a five-star employee, they have no concerns with the care that she provides to the residents.

On 02/14/24, I completed an unscheduled onsite investigation. I interviewed three direct care staff Tiffany Green, Samantha Brettelle, and Amanda Compton. I also interviewed Open Arms aid Cindy Korol, Resident A's Power of Attorney, Resident D's family member, Resident D's guardian, and Resident C. Resident A, Resident B, and Resident D were home at the time of the onsite investigation. However, do to their respective cognitive abilities and verbal delays they were unable to be interviewed for this investigation.

On 02/14/24, I interviewed direct care staff, Tiffany Green. Ms. Green stated Resident E was declining. She had broken her hip and could not walk. She had a pressure ulcer and acid reflux. During a night shift Resident E was throwing up. She was placed on the couch so that she could sit comfortably in an upright position. A chucks pad was placed on her chest to protect her clothing. Ms. Green notes, direct care staff Ms. Brettelle was not on shift when this occurred. The next morning there was a quarter size amount of vomit on the chucks pad. Ms. Green stated there was no cup near Resident E and she never witnessed Resident E throwing up in a cup. Ms. Green stated hospice was notified and five days later Resident E died.

On 02/14/24, I interviewed direct care staff, Samantha Brettelle. Ms. Brettelle stated she arrived on day shift and observed Resident E in her bed, positioned on her side. Resident E had vomited onto a chucks pad. Ms. Brettelle stated she was not present when Resident E vomited, but she cleaned her up. Ms. Brettelle stated there was no cup in Resident E's bedroom. Ms. Brettelle denied the allegation stating she would never force feed Resident E and/or force her to vomit into a cup.

On 02/14/24, I interviewed direct care staff, Amanda Compton. Ms. Compton stated she did not work in the home when Resident E was alive. However, she stated Ms. Brettelle is a good staff, she loves the residents, and would never hurt them. She has no concerns with the care that Ms. Brettelle provides to the residents.

On 02/14/24, I interviewed Resident D's family member, he placed a telephone call to Resident D's guardian who also participated in the interview via telephone. Resident D's family member and Resident D's guardian consistently stated Resident E was Resident D's roommate. Resident E seemed "very together." Resident D's family member and Resident D's guardian stated they were concerned with how quickly Resident E died. She was placed onto hospice and a few days later she died.

On 02/14/24, I interviewed Resident C. Resident C stated she stated she has no issues or concerns with the care that she receives.

On 2/14/24, I completed a telephone interview with Mike Kruckederg. Mr. Kruckederg stated Ms. Brettelle is a diligent caregiver. He denied the allegation, stating he has no concern that the allegation would be true.

On 02/28/24, I completed a telephone interview with Safe Hands Hospice Director, Julie Rogers. Ms. Rogers denied the allegation. She stated Resident E had been dying slowly. She visited the home many times a week. Resident E stopped eating and her mouth and to be cleaned out by staff. If Resident E was to have vomited it would have only been phellem. Ms. Rogers stated she never observed any cups of vomit in Resident E's bedroom. Ms. Rogers stated Resident E did not die from aspiration. She started to get wounds and she developed an infection. Resident E's body stopped absorbing protein. Resident E's condition changed quickly. Ms. Rogers remarked, she died overnight. The staff kept hospice adequately informed and provided Resident E with exceptional care. Ms. Rogers stated in addition to her regular visits to the home, Safe Hands social worker, and Chaplin also went to the home. There were never any reports of wrongdoing. The home manager, Misty Novakowski has high standards. She has a zero-tolerance policy and as a result there has been a high turnover of staff. Ms. Rogers stated the residents are well cared for at this home, they are clean, well groomed, and socialized. Ms. Rogers stated if she had to send one of her loved ones to any home it would be Essence Memory Care.

| APPLICABLE RULE | |
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| **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 the information gathered through my investigation there is insufficient information to conclude Resident E died of aspiration because direct care staff, Samantha Brettelle force fed Resident E causing her to throw up in a cup and then left the cup in her bedroom. Safe Hands Hospice Director, Julie Rogers denied the allegation. She explained that Resident E did not die from aspiration. Ms. Rogers stated Resident E received exceptional care. She has no concerns about the care provided to the residents who live in this home. No Safe Hands staff has observed any wrongdoing at this facility. It was consistently reported that during the night shift Resident E vomited. A chucks pad was placed on her chest to catch any discharge. Direct care staff, Samantha Brettelle arrived the next morning on day shift. She observed discharge on the chucks pad, and she cleaned Resident E up. There was no report of a cup with vomit being observed in Resident E's bedroom at any time. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

**ALLEGATION:**

**The new owners want all the residents to have hospital beds so they can put the residents on hospice and receive medical supplies by the case.**

**INVESTIGATION:**

On 02/12/24, I interviewed home manager, Misty Novakowski and direct care staff, Savanah Novakowski. Ms. Novakowski and Savanah consistently stated Resident A is on hospice. She receives hospice services from Open Arms. Resident A has a prescription for a hospital bed. Resident A receives medical supplies from Open Arms hospice every 14 days. This includes briefs, wipes, chucks pads, and perineal care which includes items such as no rinse soap and barrier cream. Resident A is the only resident who receive medical supplies by the case from her hospice provider. Ms. Novakowski and Savanah consistently stated Resident B is also on hospice. She receives hospice services from Henry Ford. Resident B does not receive medical supplies from her hospice provider, and she does not use a hospital bed. Ms. Novakowski discussed the use of hospital bed with Resident B's guardian however she

declined stating it was stripping Resident B of her dignity. Resident B has a fall matt near her bed, and she recently got a new walker and a new wheelchair. Resident B's family has chosen to seek spiritual care for her. Ms. Novakowski and Savanah consistently stated Resident D was using a queen size bed, which only allowed her to lay flat. Resident D uses a wheelchair, and she cannot transfer in and out of bed without assistance. Resident D was vomiting and needed to be on an incline. As an aspiration precaution, they obtained permission from Resident D's guardian to put Resident D into a hospital bed. Ms. Novakowski stated she does not have a prescription for the use of a hospital bed however, one has been requested. Ms. Novakowski and Savanah explained Resident D's current primary care physician is Dr. Mario De Meireles. An order for a hospital bed was not requested from Dr. De Meireles because Resident D was going to transfer to a new primary care physician. This change was being made because Dr. De Meireles indicated that he no longer wanted to provide care in the AFC setting. Resident D's family selected Dr. Jason Setsuda however, he refused Resident D as a client stating she was out of his territory.

On 02/14/24, I completed an unscheduled onsite investigation. I interviewed three direct care staff Tiffany Green, Samantha Brettelle, and Amanda Compton. I also interviewed Open Arms aid Cindy Korol, Resident A's Power of Attorney, Resident D's family member, Resident D's guardian, and Resident C. Resident A, Resident B, and Resident D were home at the time of the onsite investigation. However, do to their respective cognitive abilities and verbal delays they were unable to be interviewed for this investigation.

On 02/14/24, I interviewed direct care staff, Tiffany Green, Samantha Brettelle and Amanda Compton. Ms. Green, Ms. Brettelle, and Ms. Compton consistently stated Resident A is on hospice she is prescribed a hospital bed. Resident D is currently using a hospital bed as she is at risk of choking. Resident C has a regular bed in her bedroom however she prefers to sleep in her recliner chair. Resident B is on hospice it has been suggested to Resident B's guardian that she use a hospital bed. Her guardian has declined. Ms. Green, Ms. Brettelle, and Ms. Compton consistently stated in addition to risk of aspiration all the residents require brief changes, assistance with transferring in and out of bed, and some residents receive bed baths. The use of a hospital bed that moves up, down, and tils makes providing personal care easier and safer for both the resident and the staff.

On 02/14/24, I interviewed Open Arms aid Cindy Korol. Ms. Korol stated she visits the home twice a week. Resident A is on hospice with Open Arms. She has no concerns about this home and stated it is run very well. Ms. Korol stated Open Arms provides Resident A with briefs, pads, and wipes.

On 02/14/24, I interviewed Resident A's Power of Attorney (POA). Resident A's POA stated Resident A is on hospice, she is prescribed a hospital bed. He is okay with Resident A using a hospital bed.

On 02/14/24, I interviewed Resident D's family member, he placed a telephone call to Resident D's guardian who also participated in the interview via telephone. Resident D's family member and Resident D's guardian consistently stated that they were asked if Resident D could use a hospital bed because it would be easier for her to be transferred in and out of bed as staff complained that Resident D is too heavy. Resident D's guardian agreed to the use of the hospital bed if Resident D's insurance would cover it. Resident D's guardian stated there is no prescription for the hospital bed at this time. Resident D's family member and Resident D's guardian consistently stated the provider is pushing for Resident D to be placed on hospice. The family is willing to have an evaluation completed but they would like to use someone other than the Open Arms hospice physician, Dr. Jason Setsuda, whom the new owners suggested.

On 02/14/24, I interviewed Resident C. Resident C stated she stated she has no issues or concerns with the care that she receives.

On 02/14/24, I interviewed Mike Kruckederg via telephone. Mr. Kruckederg stated there are two residents on hospice and they are both using hospital bed. Hospital beds allow the staff to transfer, reposition, and provide personal care to residents. It is safer and easier for both the staff and the resident.

I reviewed Resident A's Open Arms Hospice physician order for a hospital bed and hospice care. Resident A's diagnosis is senile degeneration of the brain/decline in health. The orders are dated 02/07/2024.

On 03/04/24, I interviewed Resident B's family member via telephone. Resident B's family member stated personal care items are provided by the facility. Resident B is on hospice with Henry Ford. Henry Ford hospice will provide adult diapers for Resident B however, her family has declined these supplies as the adult diapers are "standard size" and will not fit Resident B appropriately. Resident B's family member stated the use of a hospital bed has been discussed because Resident B is becoming stiffer, and a hospital bed was requested for the safety of staff and Resident B. However, Resident B's family has declined. Her current bed is low to the ground, and they want Resident B to move more. Resident B is familiar and most comfortable in her regular bed, so they wish to keep it. Resident B's family has spoken to the hospice provider, and they indicated that it was okay to keep a regular bed.

| **APPLICABLE RULE** | |
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| **R 400.14306** | **Use of assistive devices.** |
| | (1) An assistive device shall only be used to promote the enhanced mobility, physical comfort, and well-being of a resident. |
| **ANALYSIS:** | Based on the information gathered through my investigation there is insufficient information to conclude residents must use |

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| | hospital beds so they can be put on hospice and receive medical supplies by the case.<br><br>Resident A receives hospice services from Open Arms. Resident A has a prescription for hospice care and a hospital bed. These medical supplies are included with Resident A's hospice care. Resident A's POA authorizes the use of hospice and a hospital bed. Resident B is the only other resident on hospice. Resident B receives hospice services from Henry Ford. Resident B does not receive medical supplies from her hospice provider. Resident B does not use a hospital bed per her guardian's request. As an aspiration precaution Resident D uses a hospital bed with permission from her guardian. Resident C does not use a hospital bed.<br><br>Medical rational for the recommendation of hospital beds was consistently reported which includes but is not limited to alleviating the risk of aspiration, allowing the staff to transfer, reposition, and provide personal care safer and easier on both the staff and the resident. As such, there is sufficient information to concluded that the assistive device is being used to promote enhanced mobility, physical comfort, and well-being of the residents. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14306** | **Use of assistive devices.** |
| | (3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization. |
| **ANALYSIS:** | Based on the information gathered through my investigation there is insufficient information to conclude that a physician authorized the use of a hospital bed for Resident D. Home manager, Misty Novakowski and direct care staff, Savanah Novakowski stated Resident D was vomiting and needed to be on an incline. As an aspiration precaution, they obtained permission from Resident D's guardian to put Resident D into a hospital bed. A prescription for the use of a hospital bed was not obtained. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION:**

**There is a resident who is on a special diet, the home does not have meals to provide for her.**

**INVESTIGATION:**

On 02/12/24, I interviewed home manager, Misty Novakowski and direct care staff, Savanah Novakowski. Ms. Novakowski and Savanah consistently stated Resident D is on a gluten free diet. There is a menu for Resident D's gluten free meals. She has her own food in the home that is mostly prepackaged because her family was concerned about cross contamination. Resident D's food is kept in a separate drawer in the kitchen.

On 02/14/24, I completed an unscheduled onsite investigation. While onsite I completed a walkthrough of the facility. I observed the refrigerator, freezer, and kitchen cabinets. There was a drawer in the kitchen that contained several gluten free prepackaged foods. The home had a variety of fresh fruit including grapefruit, lemons, strawberries, banana, and watermelon. There was a menu onsite and available for review. The fridge and freeze were fully stocked with a variety of options for food and beverages that were consistent with the meals on the menu. The unscheduled onsite investigation was conducted during lunch time. I observed staff serving sloppy joes and potato chips for lunch. The food appeared appropriately prepared and appetizing.

On 02/14/24, I interviewed direct care staff, Tiffany Green. Ms. Green stated Resident D is the only resident with a special diet, she is gluten free. There is a menu of gluten free meals to serve Resident D. Resident D has her own condiments and her own drawer to keep her gluten free foods in to avoid cross contamination. Resident D has a variety of frozen meals that she can eat. The home also always has fresh fruits available usually strawberries, blueberries, and bananas.

On 02/14/24, I interviewed direct care staff, Samantha Brettelle and direct care staff, Amanda Compton. Ms. Brettelle and Ms. Compton both consistently stated Resident D is gluten free. Resident D has a separate menu and there are a variety of gluten free options in the home. Resident D has pantry items and frozen meals. The home always has fresh fruit that is available at any time.

On 02/14/24, I interviewed Resident A's Power of Attorney (POA). Resident A's POA stated the food that is offered to the resident's poor. He stated that he come to the home during mealtime to observe what is being served. One day during mealtime Resident A did not want to eat she said, "I am not going to eat that shit." Resident A's POA remarked the meal looked terrible. He was unable to recall what the meal consisted of. Resident A's POA stated the residents are often served frozen meals and sandwiches.

On 02/14/24, I interviewed Resident D's family member, he placed a telephone call to Resident D's guardian who also participated in the interview via telephone. Resident D's family member and Resident D's guardian consistently stated Resident D is gluten free the family has chosen to provide a variety of gluten free food options because the home was serving frozen TV dinners. They are often without fresh fruit, and they frequently run out of coffee, milk, and/or pop. Residents must ask for salads with meals. Water is not always offered during meals. If a resident chooses not to eat staff just say okay, they do not encourage the resident to eat their meal. There are times that lunch is not served until 1:30 pm.

On 02/14/24, I interviewed Resident C. Resident C stated she is satisfied with the food that is available to her.

On 2/14/24, I completed a telephone interview completed with Mike Kruckederg. Mr. Kruckederg stated the food budget for the home is above average. The home has a menu that is followed. The home is aways well stocked with a variety of food options and when he completes onsite visits, he always observes the residents eating quality meals.

I reviewed Essence House gluten free menu and regular menu for November 2023 – February 2024. The menus offer a variety of balanced meals for breakfast, lunch, and dinner.

I reviewed Resident D's health care appraisal completed on 06/27/23. It does not indicate that Resident D is on a gluten free diet. On 02/27/24, I requested a copy of the prescription for Resident D's gluten free diet. On 03/01/24, I was informed via email from direct care staff, Savanah that Resident D was a part of the new ownership purchase and had a preexisting contract with the previous owners, who honored her gluten free preferences without a prescription. Home manager, Ms. Novakowski and direct care staff, Savanah advised Resident D's family that a prescription for the special diet is needed. An appointment with Avalon Visiting Physicians was scheduled for 03/04/24, with a timeframe of 11am-3pm. On 03/04/24, I spoke to Ms. Novakowski and was informed that she received notification for Resident D's family that the appointment was rescheduled for 03/06/24. The reason for rescheduling is unknown. Ms. Novakowski confirmed they do not have a current prescription on file for Resident D's gluten free diet.

On 03/04/24, I interviewed Resident B's family member via telephone. Resident B's family member stated the home has not had menus since September or October. The residents are fed frozen TV dinners. Resident B's family has chosen to bring in food for Resident B to ensure she receives proper nutrition. Resident B's family member had additional concerns that do not fall under licensing rules and regulations. I will advise the licensee designee of these concerns during the exit conference and encourage them to follow up with Resident B's family.

On 03/04/24, I completed an exit conference via telephone with licensee designee Caroline Anderson to review my findings and discuss reported issues. Ms. Anderson stated that she did not know a prescription was required for a gluten free diet. Ms. Anderson acknowledged her understanding that a corrective action plan would be required. The current license designee, Colleen Cassidy and Caroline Anderson are in a contract agreement with Misty Novakowski and Mike Kruckederg. As such, I placed a telephone call to Ms. Novakowski and Mr. Kruckederg to review my findings and discuss reported issues. Ms. Novakowski and Mr. Kruckederg understand that a corrective action plan is required. Ms. Novakowski and Mr. Kruckederg stated they will work to increase conversation with families and implement a better means of communication. Resident D has an appointment scheduled with her physician on 03/06/24 and they will request a prescription for her special diet and hospital bed.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14310** | **Resident health care.** |
| | (1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following:<br>(b) Special diets. |
| ANALYSIS: | Based on the information gathered through my investigation there is insufficient information to conclude that Resident D's gluten free diet is not being followed. Resident D's family member and Resident D's guardian consistently stated the family has choose to provide a variety of gluten free foods so that Resident D has food available to her that meets her dietary needs. I observed these foods onsite. During an unscheduled onsite investigation on 02/14/24, I observed the refrigerator, freezer, and kitchen cabinets at this facility. There was a drawer in the kitchen that contained several gluten free prepackaged foods. The home had a variety of fresh fruit. There was a regular and gluten free menu onsite and available for review. The fridge and freeze were fully stocked with a variety of options for food and beverages that were consistent with the meals on the menu. I observed staff serving sloppy joes and potato chips for lunch. The food appeared appropriately prepared and appetizing. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

| APPLICABLE RULE | |
|---|---|
| **R 400.14313** | **Resident nutrition** |
| | (3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet. |
| **ANALYSIS:** | Based on the information gathered through my investigation there is sufficient information to conclude that there is no prescription on file for Resident D's gluten free diet. I reviewed Resident D's health care appraisal completed on 06/27/23. It does not indicate that Resident D is on a gluten free diet. Resident D's family member and Resident D's guardian consistently stated that Resident D is gluten free. The home has a gluten free menu and is upholding Resident D's dietary needs. However, direct care staff, Savanah and home manager, Ms. Novakowski confirmed they do not have a current prescription on file for Resident D's special diet. An appointment has been made with Resident D's physician to obtain a prescription. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

Upon receipt of an acceptance corrective action plan, I recommend that this special investigation be closed with no change to the status of the license.

Johnna Cade

03/04/2024

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Johnna Cade Date
Licensing Consultant

Approved By:

Denise Y. Nunn

03/28/2024

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Denise Y. Nunn Date
Area Manager