GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 9, 2024

Jasween Jagjit-Webb
Auburn Heights Senior Care, Inc.
110 Auburn Road
Auburn, MI 48611

RE: License #: AL090260028
Investigation #: 2024A0572025
Auburn Heights Senior Care, Inc.

Dear Ms. Jagjit-Webb:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 643-7960.

Sincerely,

Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL090260028
Investigation #:	2024A0572025
Complaint Receipt Date:	02/14/2024
Investigation Initiation Date:	02/14/2024
Report Due Date:	04/14/2024
Licensee Name:	Auburn Heights Senior Care, Inc.
Licensee Address:	110 Auburn Road Auburn, MI 48611
Licensee Telephone #:	(989) 662-2099
Administrator:	Jasween Jagjit-Webb
Licensee Designee:	Jasween Jagjit-Webb
Name of Facility:	Auburn Heights Senior Care, Inc.
Facility Address:	110 Auburn Road Auburn, MI 48611
Facility Telephone #:	(989) 545-9462
Original Issuance Date:	01/27/2004
License **Status:**	REGULAR
Effective Date:	06/13/2022
Expiration Date:	06/12/2024
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
On 02/08/2024, Resident A was admitted to the hospital due to an infection from an amputation. On 02/13/2024, the home stated that Resident A is not allowed back due to alleged narcotic use. There has been speculation that Resident A was snorting meds rather than taking them orally but there has been no witness to that. Resident A is concerned the facility is attempting to evict Resident A due to past being a registered sex offender.	No

III. METHODOLOGY

02/14/2024	Special Investigation Intake 2024A0572025
02/14/2024	APS Referral APS made referral.
02/14/2024	Special Investigation Initiated - Letter
03/12/2024	Inspection Completed On-site Administrator, Johanna Rueda.
03/12/2024	Contact - Face to Face Staff, Makenna Korte and Staff, Haylee Lewis.
04/04/2024	Contact - Telephone call made Resident A's Case Manager.
04/04/2024	Contact - Telephone call made Resident A.
04/08/2024	Contact - Telephone call made Resident A's Case Manager.
04/08/2024	Contact - Telephone call made Resident A.
04/08/2024	Contact - Telephone call made Licensee Designee, Jasween Jagjit-Webb.

04/09/2024	Contact - Telephone received Resident A's Case Manager, Diana Mersman.
04/09/2024	Contact - Telephone call made Licensee Designee, Jasween Jagjit-Webb.
04/09/2024	Contact - Telephone received Licensee Designee, Jasween Jagjit-Webb and Administrator, Johanna Rueda.
04/09/2024	Exit Conference Licensee Designee, Jasween Jagjit-Webb.

ALLEGATION:
On 02/08/2024 Resident A was admitted to the hospital due to an infection from an amputation. On 02/13/2024 the home stated that Resident A is not allowed back due to alleged narcotic use. There has been speculation that Resident A was snorting meds rather than taking them orally but there has been no witness to that. Resident A is concerned the facility is attempting to evict Resident A due to past being a registered sex offender.

INVESTIGATION:
On 02/14/2024, the local licensing office received a complaint for investigation. Adult Protective Services (APS) dismissed their complaint and referred to licensing for further investigation.

On 03/12/2024, I conducted an unannounced onsite at Auburn Heights Senior Care, Inc., located in Bay County Michigan. Interviewed were, Administrator, Johanna Rueda, Staff, Makenna Korte and Staff, Haylee Lewis. Resident A was not seen as Resident A was discharged.

On 03/12/2024, I interviewed Administrator, Johanna Rueda, regarding the allegation. Johanna Rueda informed that Resident A was evicted due to abusing Resident A's narcotic medications. Resident A was snorting the medications. Resident A's doctor informed that this was the same issue at Resident A's previous facility, but they could not provide any proof of it. Johanna Rueda informed that they were able to provide proof through pictures of powder residue on the ink pens that Resident A would use to snort the medications. Resident A was able to pocket the medication even when the staff would check. There was a time when Resident A was in wound care, it was found that Resident A had bedbugs, so they had to strip Resident A's room down and deep clean all of Resident A's belongings. That's when they found many of Resident A's narcotics in a black fanny pack. Resident A was given a verbal warning and a written notice while Resident A was in wound care.

Resident A's Case Manager, Diana Mersman was notified, but said she couldn't do anything about it and advised her to contact Resident A's doctor. Diana Mersman initially thought they were evicting Resident A due to Resident A being a sex offender. They were not aware that Resident A was a registered sex offender as it was never mentioned by Resident A or the Case Manager, Diana Mersman. Johanna Rueda then provided Resident A's doctor with proof of substance abuse. Resident A was offered substance abuse treatment by the doctor, but Resident A refused.

On 03/12/2024, I reviewed Resident A's file and the Assessment Plan dated for 11/01/2023 indicates that Resident A does not use illicit drugs or alcohol. ~~What was the date of Resident A's discharge from the facility?~~

On 03/12/2024, I interviewed Staff, Makenna Korte, regarding the allegation. Makenna Korte informed that Resident A was discharged due to crushing Resident A's medications and snorting them. Resident A was able to hide the medication in mouth. Staff began checking Resident A's mouth during med pass, but Resident A was still able to hide them. The eviction came about when Resident A was in wound care. Staff found pill residue on 2 of Resident A's mirrors and residue on the inside of an ink pen.

On 03/12/2024, I interviewed Staff, Haylee Lewis, regarding the allegation. Resident A would pocket medication that was administered. Haylee Lewis would observe Resident A take the medication, but somehow, Resident A would still have them and then would go in Resident A's bedroom and snort them. Haylee Lewis has observed white residue on Resident A's desk. Haylee Lewis indicated that she had caught Resident A putting pills in Resident A's pockets. When she confronted Resident A, Resident A denied it, but refused to empty his pockets. Haylee Lewis indicated that Resident A was evicted due to snorting the medications.

On 03/12/2024, I reviewed an Incident Report dated for 02/13/2024 which indicates that Staff, Makenna Korte and Administrator, Jahanna Rueda went into Resident A's room to deep clean, when they found crushed pills on a picture frame glass and inside of a pen. Pictures were taken and Resident A was giving a written and verbal warning due to this happening multiple times.

On 03/12/2024, I reviewed an email message from Administrator, Jahanna Rueda to Resident A's doctor back on 11/14/2024. In the email, Jahanna Rueda is informing the doctor that Resident A is snorting Hydrocodone & Oxycodone, and provided pictures of the crushed medications on a pen and on a mirror.

On 03/12/2023, I reviewed a 7-day discharge notice that indicates that on 02/13/2024, Resident A was given a discharge notice due to snorting medications and not properly taking medication with more than three occurrences and drug abuse. The date that the 7-day discharge notice was to expire was on 02/20/2024. A suitable placement was secured on 02/17/2024. ~~Did the facility provide a 30-day~~

~~discharge notice to Resident A? Was this discharge notice also sent to Resident A's case manager? Did the facility meet all the requirements for an emergency discharge per Rule 302(5)?~~

On 04/04/2024, I made an attempt to contact Resident A's case manager. During my call, a text was sent that stated, "Sorry I can't talk right now." I responded with my own text informing who I am and why I was calling. I also asked that she give me a call later today or tomorrow so that I can discuss the investigation and obtain the phone number of a family member. There was no response.

On 04/04/2024, I made an attempt to contact Resident A by phone, but did not get an answer.

On 04/08/2024, I made another attempt to contact Resident A's case manager. I left a voicemail message informing her who I was and to return my call.

On 04/08/2024, I made another attempt to call Resident A. I left a message for Resident A to call me. Resident A called me back a few hours later. When I answered the phone and identified myself, Resident A hung up the phone. I called Resident A back and left a message for Resident A to call me.

On 04/08/2024, I called Licensee Designee, Jasween Jagjit-Webb to see if she could get a hold of Resident A's case manager. Jasween Jagjit-Webb informed that she would have Administrator, Johanna Rueda contact the case manager and indicate that it is urgent.

On 04/09/2024, I was contacted by Resident A's case manager, Diana Mersman. Diana Mersman informed that Resident A went to the hospital for wound care on February 8th and was admitted. On February 17th, Resident A was transferred to a rehabilitation center where Resident A remains. Diana Mersman denied that the facility did an improper discharge. Diana Mersman was unaware that Resident A was being discharged due to improper use of medication. Diana Mersman also denied knowing anything about allegations that the facility will be discharging Resident A due to past sexual abuse history. She informed that she had spoken with Administrator, Johanna Rueda and it was decided that Resident A needed more care than the facility could provide as Resident A needed skilled nursing. There was a skilled nurse who came to the facility to see Resident A, but only twice per week.

On 04/09/2024, I contacted Licensee Designee, Jasween Jagjit-Webb. I asked for clarification if they had given Resident A's case manager, Diana Mersman a discharge notice for improper use of medication and she informed that they did, and she was aware of everything that was going on. Jasween Jagjit-Webb indicated that Diana Mersman came to the home yesterday for another client and the Administrator told her to give me a call regarding the investigation. Jasween Jagjit-Webb said that she will get in touch with the administrator, and they will call me back.

On 04/09/2024, Licensee Designee, Jasween Jagjit-Webb and Administrator, Johanna Rueda called me back on a 3-way call. Johanna Rueda informed that Resident A's case manager, Diana Mersman has been in the loop for months regarding Resident A. Resident A's case manager even told her that she will need to speak with Resident A regarding this issue because she knew that Resident A could possibly be evicted. When the facility decided that they were going to evict Resident A, they informed the Diana Mersman and she advised them to contact LARA to see if they could evict on that basis. When LARA confirmed that they could, she informed the Diana Mersman of this and that they will be moving forward with the eviction. Diana Mersman came to the facility yesterday (04/08/2024) to visit another client. She was informed to contact LARA because the investigator has been trying to reach her. Diana Mersman informed that she seen the message but took a few days off. Diana Mersman said she was going to call the worker but wasn't going to tell the worker anything. Johanna Rueda wasn't sure what the case manager meant by that.

~~Please change the rule below to Rule 400.14302(3) or add on the additional rule 400.14302(5)(b)(i) below which requires an appropriate placement must be available for any discharge that occurs before 30 days.~~

APPLICABLE RULE	
R 400.15302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(a) The licensee shall notify the resident, the resident's designated representative, the responsible agency, and the adult foster care licensing consultant not less than 24 hours before discharge. The notice shall be in writing and shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the licensee.** **(iii) The location to which the resident will be discharged, if known.** **(b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge.**

	If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply: **(i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.** **(ii) The resident shall have the right to file a complaint with the department.** **(iii) If the department finds that the resident was improperly discharged, the resident shall have the right to elect to return to the first available bed in the licensee's adult foster care home.**
ANALYSIS:	Based on the interviews and documents reviewed in during my investigation, there is not enough evidence to establish a rule violation. Staff were interviewed and they all informed that Resident A was evicted due to pocketing medications and snorting them in bedroom. This was confirmed by an incident report, discharge notice and an email with pictures that was sent to Resident A's doctor. Resident A's case manager denied that Resident A was improperly discharged and informed that Resident A was transferred to rehabilitation due to the facility not being able to meet the needs of Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 04/09/2024, I held an Exit Conference with Licensee Designee, Jasween Jagjit-Webb regarding the results of the special investigation.

IV. RECOMMENDATION

I recommend that no changes be made to the licensing status of this large adult foster care facility (Capacity 1-20).

04/09/2024

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Anthony Humphrey Date
Licensing Consultant

Approved By:

_____

Mary E Holton Date
Area Manager