GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 24, 2024

Ellen Byrne
Commonwealth Senior Living at East Paris
3956 Whispering Way, SE
Grand Rapids, MI 49546

RE: License #: AH410407276
Investigation #: 2024A1021042
Commonwealth Senior Living at East Paris

Dear Ellen Byrne:

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

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

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action. Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,
Kimberly Horst

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410407276
Investigation #:	2024A1021042
Complaint Receipt Date:	03/13/2024
Investigation Initiation Date:	03/14/2024
Report Due Date:	05/12/2024
Licensee Name:	MCAP East Paris Opco, LLC
Licensee Address:	Suite 301 915 E. High Street Charlottesville, VA 22902
Licensee Telephone #:	(434) 963-2421
Administrator:	Mackenzie Ferguson
Authorized Representative:	Ellen Byrne
Name of Facility:	Commonwealth Senior Living at East Paris
Facility Address:	3956 Whispering Way, SE Grand Rapids, MI 49546
Facility Telephone #:	(616) 949-9500
Original Issuance Date:	08/16/2023
License Status:	REGULAR
Effective Date:	03/08/2024
Expiration Date:	07/31/2024
Capacity:	90
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A care needs are not met.	Yes
Resident A nutritional needs are not met.	No
Additional Findings	No

III. METHODOLOGY

03/13/2024	Special Investigation Intake 2024A1021042
03/14/2024	Special Investigation Initiated - On Site
03/14/2024	Contact - Telephone call made left message with complainant
03/18/2024	Contact-Telephone call made Interviewed Administrator
04/24/2024	Exit Conference

ALLEGATION:

Resident A care needs are not met.

INVESTIGATION:

On 03/13/2024, the licensing department received a complaint with allegations Resident A care needs are not met. The complainant alleged Resident A's hearing aids are not put in. The complainant alleged Resident A is left covered in feces and urine which has resulted in a pressure sore on Resident A's buttocks.

On 03/14/2024, the licensing department received additional information on Resident A with same concerns. The complainant also alleged Resident A has been found on the floor soaked in urine.

On 03/18/2024, the licensing department received additional information from Adult Protective Services on Resident A with same concerns. The complainant alleged Resident A was admitted to the hospital with weakness and multiple falls. APS denied investigating the complaint.

On 03/14/2024, I called and left a message with the complainant. The complainant did not return my telephone call.

On 03/14/2024, I interviewed administrator Mackenzie Ferguson at the facility. Ms. Ferguson reported Resident A has resided at the facility for approximately one year. Ms. Ferguson reported Resident A has difficulty hearing and has hearing aids. Ms. Ferguson reported Resident A will take the hearing aids out and caregivers have a difficult time finding them. Ms. Ferguson reported the family has recently hired a companion service for Resident A. Ms. Ferguson reported she believes the companion does not provide any hands-on care. Ms. Ferguson reported Resident A is to be checked on every two hours.

On 03/14/2024, I interviewed staff person 1 (SP1) at the facility. SP1 reported Resident A has no skin breakdown. SP1 reported caregivers are to check on Resident A every two hours and encourage her to use the restroom. SP1 reported Resident A is incontinent if she is not assisted to the bathroom every two hours. SP1 reported Resident A prefers to sleep in her lift chair. SP1 reported no knowledge of Resident A left in urine or feces.

On 03/14/2024, I interviewed Interim caregiver Trisha Nickols at the facility. Ms. Nickols reported the family hired her agency to assist with Resident A's care. Ms. Nickols reported she is at the facility Monday, Tuesday, and Thursday 9:00-1:30am. Ms. Nickols reported when she arrived this morning, she found Resident A on the floor in front of her couch. Ms. Nickols reported Resident A's room was a mess and it appeared she had fallen. Ms. Nickols reported Resident A was soaked in urine. Ms. Nickols reported she is unsure how long Resident A was on the floor. Ms. Nickols reported she has found Resident A covered in urine and not properly cared for. Ms. Nickols reported when she is at the facility, she has not observed any staff coming in to assist Resident A. Ms. Nickols reported Resident A does have a sore on her bottom and bandages are to be placed on her buttocks. Ms. Nickols reported Resident A does not use her call light to call for assistance. Ms. Nickols reported one time she used the call light and after pushing it five times she went to find assistance. Ms. Nickols reported she believes Resident A is active with Corso Home Care. Ms. Nickols reported Resident A uses a four-wheel walker for ambulation.

On 03/14/2024, I interviewed SP2 at the facility. SP2 reported Resident A is incontinent and is to be checked on every two hours. SP2 reported caregivers try to check on her every two hours but it is difficult to do. SP2 reported Resident may benefit from increased checks. SP2 reported she has a sore on her bottom and patches are to be placed on her bottom. SP2 reported it is difficult to find the hearing aids but if they can be found, she will place them in Resident A's ears. SP2 reported this morning around 9:00am, Resident A's private duty caregiver requested assistance in getting Resident A off the floor. SP2 reported she is unsure if Resident A was rounded on in the morning as she was not assigned to Resident A's room. SP2 reported Resident A is confused and hallucinates. SP2 reported Resident A has not had many falls.

On 03/14/2024, I interviewed SP3 at the facility. SP3 reported she tries to round every hour on Resident A. SP3 reported Resident A is incontinent. SP3 reported Resident A has difficult hearing and her hearing aids do not work.

At the facility I attempted to interview Resident A. However, Resident A was a poor historian and unable to provide information.

On 03/18/2024, I interviewed Ms. Ferguson by telephone. Ms. Ferguson reported Resident A had two falls on 03/14/2024. Ms. Ferguson reported Resident A fell in the morning and in the afternoon. Ms. Ferguson reported Fox Rehab visited Resident A and she was not at her baseline. Ms. Ferguson reported she observed Resident A in her room and eight minutes later she had fallen. Ms. Ferguson reported Resident A was not at her baseline and it was determined to send Resident A to the hospital for an evaluation. Ms. Ferguson reported Resident A is still at the hospital and is having difficulty walking. Ms. Ferguson reported the hospital is still running tests as they are unsure what is happening with Resident A. Ms. Ferguson reported prior to these falls, Resident A has not had many falls.

I reviewed Resident A's service plan. The service plan read,

> *"(Resident A) uses cane with ambulation. Member uses a wheelchair for long distance. (Resident A) requires verbal prompts/cues for toileting tasks."*

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	Interviews conducted revealed Resident A has hearing aids, is to be checked on at least every two hours, is incontinent, requires hand on assistance with using the bathroom, has a sore on her buttocks that staff are to apply a bandage, and is current with home therapy services. Review of Resident A's service plan revealed this information was omitted which results in Resident A not receiving appropriate care.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A nutritional needs are not met.

INVESTIGATION:

The complainant alleged Resident A's food is to be cut up and Resident A requires verbal cues to eat. The complainant alleged Resident A's dinner food is found uneaten in Resident A's room. The complainant alleged Resident A has lost weight. The complainant alleged Resident A is dehydrated at the facility.

Ms. Ferguson reported on 03/13/2024, the facility received an order for Resident A's food to be cut up. Ms. Ferguson reported Resident A's family had spoken with her physician on the revised diet order. Ms. Ferguson reported the diet order was not faxed to the facility and therefore the facility had no knowledge of this new diet order. Ms. Ferguson reported the facility has not observed any need for a diet change. Ms. Ferguson reported Resident A's family prefers for Resident A to eat in her room. Ms. Ferguson reported the facility will now encourage Resident A to eat in the dining room so that caregivers can provide verbal cues for Resident A to eat. Ms. Ferguson reported in August 2023 Resident A weighed 107.8 pounds and now in March 2024 Resident A weighs 115 pounds. Ms. Ferguson reported last month there was a concern Resident A had a urinary tract infection, but the urine sample collected at the facility was negative. Ms. Furguson reported caregivers pass water to the residents every morning and residents receive water.

SP2 reported Resident A's diet order was recently changed and caregivers are now to cut up food for Resident A. SP2 reported the diet order also stated caregivers are to provide cues to Resident A to eat. SP2 reported this will be implemented today.

I reviewed diet order for Resident A. The order was received by the facility on 03/13/2024 at 5:00pm. The order read,

> *"It is in my medical opinion that (Resident A) will need staff to assist her with cutting up food, ques to at, and recliner set up. Please provide (Resident A) with the necessary nutrition assistance."*

SP3 reported Resident A's diet order recently changed and these changes will be implemented today.

APPLICABLE RULE	
R 325.1951	**Nutritional need of residents.**
	A home shall meet the food and nutritional needs of a resident in accordance with the recommended daily dietary allowances of the food and nutrition board of the national research council of the national academy of sciences, adjusted for age, gender, and activity, or other national authority acceptable to the department, except as ordered by a licensed health care professional.

ANALYSIS:	Interviews conducted and documents revealed Resident A had a diet order change on 03/13/2024 and these changes were implemented on 03/14/2024. Review of documentation revealed lack of evidence to support the allegation Resident A's nutritional needs are not met.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

03/18/2024

Kimberly Horst Date
Licensing Staff

Approved By:

04/23/2024

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section