GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 31, 2024

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

RE: License #: AH410407276
Investigation #: 2024A1010059
Commonwealth Senior Living at East Paris

Dear Licensee:

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 authorized representative 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) 241-1970.

Sincerely,

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa NW Unit 13 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410407276
Investigation #:	2024A1010059
Complaint Receipt Date:	06/04/2024
Investigation Initiation Date:	06/06/2024
Report Due Date:	08/04/2024
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:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident D did not receive an updated admission contract after a change of ownership occurred.	Yes
The facility did not provide Resident D's responsible person(s) with her discharge notice.	Yes
Staff stopped providing care to Resident D due to her discharge notice.	No

III. METHODOLOGY

06/04/2024	Special Investigation Intake 2024A1010059
06/06/2024	Special Investigation Initiated - Telephone Interviewed the complainant by telephone
06/18/2024	Inspection Completed On-site
06/18/2024	Contact - Document Received Received resident discharge notices and service plan
07/31/2024	Exit Conference

ALLEGATION:

Resident D did not receive an updated admission contract after a change of ownership occurred.

INVESTIGATION:

On 6/4/24, the Bureau received the allegations from the online complaint system. The complaint read, "The executive director and business office made zero effort to have an updated agreement signed despite numerous attempts on my part to do so."

On 6/6/24, I interviewed the complainant by telephone. The complainant reported Relative D1 and Relative D2 were granted guardianship of Resident D in October 2023. The complainant stated there was a change of ownership that took place at the facility, however an updated admission contract with the new ownership was never established or presented to Relative D1 and Relative D2.

On 6/18/24, I interviewed the facility's authorized representative Ellen Byrne at the facility. Ms. Byrne reported there was a change of ownership that occurred at the facility. Ms. Byrne stated this change of ownership occurred before Relative D1 and Relative D2 were granted guardianship of Resident D. Ms. Byrne explained when the change of ownership occurred, Resident D had a power of attorney (POA) in place. Ms. Byrne said the new admission contract under the facility's new ownership was sent to Resident D's former POA. Ms. Byrne reported the signed new admission contract was not completed by Resident D's former POA, therefore the facility did not have an updated admission contract in Resident D's resident record. Ms. Byrne denied knowledge regarding whether the updated admission contract was sent to Relative D1 and Relative D2.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(3) At the time of an individual's admission, a home or the home's designee shall complete a written resident admission contract between the resident, the resident's authorized representative, or both, and the home. The resident admission contract shall, at a minimum, specify all of the following: **(a) That the home shall provide room, board, protection, supervision, assistance, and supervised personal care consistent with the resident's service plan.** **(b) The services to be provided and the fees for the services.** **(c) The notice to be provided by the home to the resident, the resident's authorized representative, or both, upon any change in fees.** **(d) The transportation services that are provided, if any, and the fees for those services.** **(e) The home's admission and discharge policy.** **(f) The home's refund policy.** **(g) The resident's rights and responsibilities, which shall include those rights and responsibilities specified in section 20201(2) and (3), MCL 333.20201(2) and (3) of the public health code and section 20202, MCL 333.20202, of the code.**

ANALYSIS:	The interview with Ms. Byrne, along with review of Resident D's resident record, revealed she did not have a signed updated resident admission contract after a change of ownership occurred at the facility. The facility was not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility did not provide Resident D's responsible person(s) with her discharge notice.

INVESTIGATION:

On 6/4/24, the compliant read Relative D1 and Relative D2 were "blindsided by Resident D's eviction."

On 6/6/24, the complainant reported that after Relative D1 and Relative D2 got guardianship of Resident D in the fall of 2023, the facility's administrator Mackenzie Ferguson advised them to apply for Medicare and Medicaid funding for Resident D to be able to pay for a continued stay in the facility. The complainant said Relative D1 and Relative D2 learned Resident D owed the facility approximately $50,000 in back pay. The complainant reported Ms. Ferguson mislead Relative D1 and Relative D2 by leading them to think Resident D could stay at the facility once she was approved for the Medicaid waiver program.

The complainant stated Relative D1 and Relative D2 "were blindsided" by Resident D's "eviction" in April because there was little to no communication with Ms. Ferguson and other management staff at the facility. The complainant reported Relative D1 and Relative D2 were never given any billing statements for Resident D.

On 6/18/24, Ms. Byrne reported Ms. Ferguson and business office staff persons were in communication with Relative D1 and Relative D2 regarding Resident D's discharge notices. Ms. Byrne reported Resident D stayed over the 30 days outlined in her notices to ensure she had an appropriate placement to move to. Ms. Byrne said Resident D's discharge notices were initially sent to Relative D2 who requested they also be sent to Relative D1. Ms. Byrne reported after Relative D2's request, the notices were also sent to Relative D1.

Ms. Byrne provided me with copies of Resident D's *NOTICE OF NONPAYMENT FOR [Resident D]* dated 7/10/23 and 8/17/23 and the *NOTICE OF PENDING DISCHARGE FOR [Resident D]* dated 4/10/24 for my review. *NOTICE OF PENDING DISCHARGE FOR [Resident D]* dated 4/10/24 read, "This notice is sent to inform you that despite previous repeated attempts, we have been unable to

resolve the continuing issue of nonpayment of past-due charges. AS a result, we have begun the process of discharge planning. The failure to pay the amount due is a violation of the Commonwealth Senior Living at East Paris Resident and Care Agreement. Please be advised that we intend to discharge [Resident D] within 30 days of this letter's date unless extenuating circumstances prevent placement in a new setting within that time frame. Please also be advised that as a result of your failure to fulfill your contractual obligations and either pay the balance due or work out a payment plan with us." The document read Resident D owed a balance of $58,345.39. Ms. Byrne reported Resident D has moved out of the facility. Ms. Byrne said Resident D's balance has still not been paid.

On 6/18/24, I was unable to interview Resident D as she has moved out of the facility.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(13) A home shall provide a resident and his or her authorized representative, if any, and the agency responsible for the resident's placement, if any, with a 30-day written notice before discharge from the home. The written notice shall consist of all of the following: **(a) The reasons for discharge.** **(b) The effective date of the discharge.** **(c) A statement notifying the resident of the right to file a complaint with the department. The provisions of this subrule do not preclude a home from providing other legal notice as required by law.**
ANALYSIS:	Review of Resident D's *NOTICE OF PENDING DISCHARGE FOR [Resident D]* dated 4/10/24 revealed there was no statement informing the resident and their responsible person of the right to file a complaint with the department. There was also no effect date of Resident D"s discharge outlined. The facility was not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff stopped providing care to Resident D due to her discharge notice.

INVESTIGATION:

On 6/4/24, the complaint read, “The executive director and business office staff are completely incompetent at running this facility. Their management and incompetence are effecting the care of the residents.”

On 6/6/24, the complainant reported because Resident D owed the facility a lot of money, staff “stopped providing care to” Resident D. The complainant reported staff stopped cleaning Resident D’s room, stopped making her bed, and stopped changing her briefs and soiled sheets. The complainant stated Resident D also had items missing from her room, such as shoes, clothes, and a mattress cover.

On 6/18/24, Ms. Byrne reported care staff did not stop providing care to Resident D consistent to her service plan. Ms. Byrne stated Resident D received the care she needed from staff until the day she moved out of the facility. Ms. Byrne denied knowledge regarding Resident D missing any belongings while she resided in the facility.

Ms. Byrne reported housekeeping staff clean resident rooms at least once a week and more often as needed. Ms. Byrne explained this cleaning includes dusting, moping resident bathroom floors, cleaning resident bathrooms, sanitizing surfaces, and sweeping. Ms. Byrne stated staff are trained to change a resident or their bedding immediately if they are found soiled. Ms. Byrne said staff would not intentionally leave a resident or their bedding soiled. Ms. Byrne stated residents bedding is changed at least twice a week on their scheduled days to bathe or more often as needed.

Ms. Byrne stated Resident D resided in the secured memory care unit in the facility. Ms. Byrne provided me with a copy of Resident D’s service plan for my review. The *Housekeeping and Laundry* section of the plan read, “Level of Assistance-Laundry: Moderate staff provides routine laundry services 2-3x per week.” The *Toileting* section of the plan read, “Level of Assistance-Toileting: Moderate [Resident D] requires stand by assistance for toileting tasks.” The *Psychosocial* section of the plan read, “Occasional behavioral issues. [Resident D] has current or history of occasional disruptive, aggressive, or socially inappropriate decisions, can solve problems, and respond to major life changes. No hallucination/delusion issues [Resident D] does not have current or history of hallucinations/delusions.” The *Bathing* section of the plan read, “Level of Assistance-Bathing: Moderate [Resident D] requires assistance with bathing, requires assistance or cueing with parts of bathing including assistance getting in/out of tub/shower, twice weekly.”

On 6/18/24, I interviewed Staff Person 1 (SP1) at the facility. SP1’s statements were consistent with Ms. Byrne and Resident D’s service plan. SP1 reported Resident D “changed her clothes often” during the day and “threw them on the floor.” SP1 stated because of this, care staff were in her room often “tidying” it daily, therefore it was cleaned regularly. SP1 said Resident D toileted and changed her brief herself with cueing from staff. SP1 reported Resident D did not have any skin breakdown.

SP1 reported Resident D often walked around the memory care unit with items from her room, and sometimes items from the common areas. SP1 stated staff attempted to return the items to where they belonged when Resident D put them down. SP1 said staff never received any complaints from Resident D's family regarding Resident D having any missing items.

On 6/18/24, I interviewed housekeeping staff SP2 at the facility. SP2's statements were consistent with Ms. Byrne and SP1.

On 6/18/24, I observed SP2 with her cleaning cart cleaning resident rooms in the secured memory care unit in the facility. I observed the common areas and resident rooms in the secured memory care unit were clean and free from hazards. I did not detect any foul odors within the unit and had no concerns.

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:	The interview with Ms. Byrne, SP1, SP2, along with my review of Resident D's service plan and inspection of the secured memory care unit revealed residents and their bedding are not intentionally left soiled. I observed Resident D's service plan adequately outlined her care needs. There is insufficient evidence to suggest the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

I shared the findings of this report with the facility's licensee authorized representative on 7/31/24.

IV. RECOMMENDATION

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

07/18/2024

Lauren Wohlfert Date
Licensing Staff

Approved By:

07/30/2024

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