GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 16, 2024

Ginger Nahikian
Clare MI OPCO, LLC.
3405 E Midland Rd
Bay City, MI 48706

RE: License #: AL180404676
Investigation #: 2024A1038046
Niche Aging Clare I

Dear Ms. Nahikian:

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 (616) 356-0100.

Sincerely,

Johnnie Daniels, Licensing Consultant
Bureau of Community and Health Systems
1999 Walden Dr.
Gaylord, MI 49735

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL180404676
Investigation #:	2024A1038046
Complaint Receipt Date:	07/30/2024
Investigation Initiation Date:	08/01/2024
Report Due Date:	08/29/2024
Licensee Name:	Clare MI OPCO, LLC.
Licensee Address:	3405 E Midland Rd Bay City, MI 48706
Licensee Telephone #:	(989) 386-7524
Licensee Designee:	Ginger Nahikian
Name of Facility:	Niche Aging Clare I
Facility Address:	684 Ann Arbor Trail Clare, MI 48617
Facility Telephone #:	(989) 386-7524
Original Issuance Date:	02/01/2021
License Status:	REGULAR
Effective Date:	08/01/2023
Expiration Date:	07/31/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility did not provide proper emergency and medical care for Resident A.	No

III. METHODOLOGY

07/30/2024	Special Investigation Intake 2024A1038046
08/01/2024	Special Investigation Initiated - Telephone call made to Complainant
08/06/2024	Contact - Face to Face interviews were conducted with manager Cheslea Blain and DCS Karmen Onweller.
08/16/2024	Contact - Telephone call made to DCS Tammi Warner
08/16/2024	APS Referral no required as there is no suspected abuse or neglect.
08/21/2024	Contact-Telephone call made To Ms. Blain
08/27/2024	Exit Conference- With LD

ALLEGATION:

The facility did not provide proper emergency and medical care for Resident A.

INVESTIGATION:

On 7/30/24, I received a complaint from the Bureau of Community and Health Systems Online complaint forms regarding the facility. The complaint alleged the facility did not get a resident proper emergency care while in the facility.

On 8/1/24, I interviewed the Complainant via telephone who verified the information.

On 8/1/24, I interviewed Guardian A1 who stated there was no community between themselves and the facility regarding Resident A's health. Guardian A1 stated they were at the facility on 2/2/24 and Resident A appeared to be in bad health. Guardian A1 stated they left the facility and Resident A died on 2/4/24 from declining health. Guardian A1 stated the facility did not get Resident A proper emergency care prior to his death.

On 8/6/24, I conducted an unannounced investigation at the facility. I interviewed home manager Cheslea Blain who stated she was not present for Resident A's death. Ms. Blain stated direct care staff (DCS) Karmen Onweller and DCS Tammy Warner were at the facility during the incident. Ms. Blain stated Resident A's family and Guardian was at the facility on 2/2/24 and spoke with staff about him not feeling well or eating. Ms. Blain stated at no point did the family or Guardian advise the facility to send Resident A to get medal attention. Ms. Blain stated on 2/4/24 the facility sent Resident A to the hospital to get medically checked due to him still not eating or feeling well. Ms. Blain stated Resident A died on the way to the hospital in the ambulance. Ms. Blain stated all staff followed their procedure of contacting the Guardian's and emergency personal.

On 8/6/24, I interviewed DCS Karmen Onweller who provided a statement consistent with those made by Ms. Blain. Ms. Onweller stated at no point during the time of 2/2/24 and 2/4/24 did the Guardian's advised the facility to send Resident A in for emergency care.

Ms. Blain provided me with Resident A's charting notes. The notes were from DCS Tammi Warner on 2/2/24 that read Ms. Warner spoke with facility doctor about Resident A not feeling well and was advised to set up a urinalysis. On 2/4/24, the notes read Resident A was not eating, dry heaving and not using the restroom. The notes stated Ms. Warner was instructed to send Resident A to the emergency room (ER) to be checked for a urinary tract infection. The notes stated Ms. Warner contacted Guardian A1 about sending Resident A to the ER. I reviewed Resident A's Health Care Appraisal, Adult Foster Care Assessment Plan, Resident Care Agreement, the facilities emergency plan and power or attorney and Guardian paperwork, which the facility was following all documents properly.

On 8/16/24, I interviewed DCS Tammi Warner who provided a statement consistent with those made by Ms. Onweller and Ms. Blain. Ms. Warner confirmed she contacted Guardian A1 and advised him of Resident A going to the ER. Ms. Warner also added at no time did any family member or guardian voice concerns to staff regarding Resident A needing more medical attention or need to go to the ER.

On 8/21/24, I interviewed Ms. Blain via telephone, to verify information regarding the urinalysis (UA). Ms. Blain stated Resident A's UA was done in house on 2/2 by the facility doctor. Ms. Blain stated they are able to determine the presence of a bacterial

infection but to get specific information regarding the infection they must then send out the UA to the Clare medical lab for an analysis. Ms. Blain stated that due to 2/2 was a Friday, the lab would not get the information back until the following week. Ms. Blain stated on 2/4/24, Resident A's decline warranted transportation to the hospital emergency department. Ms. Blain stated that Resident A's doctor was involved in his care up until the time the staff coordinated his transfer to the hospital.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Based on my interviews with staff, Guardian A1 and the review of documents, there was no corroborating evidence of the facility not providing proper emergency services or care for Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

I recommend the status of the license remain unchanged.

8/17/24

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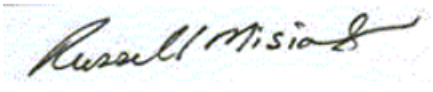
Johnnie Daniels Date
Licensing Consultant

Approved By:



8/27/24

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Russell B. Misiak Date
Area Manager