GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 19, 2024

Achal Patel & Vivek Thakore
Divine Life Assisted Living Center 3 LLC
2045 Birch Bluff Drive
Okemos, MI 48864

RE: License #: AL330404952
Investigation #: 2024A1033050
Divine Life Assisted Living Center 3 LLC

Dear Mr. Patel & Mr. Thakore:

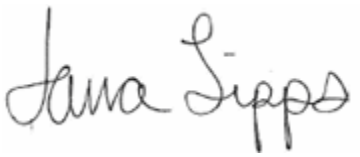
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AL330404952
Investigation #:	2024A1033050
Complaint Receipt Date:	07/28/2024
Investigation Initiation Date:	08/01/2024
Report Due Date:	09/26/2024
Licensee Name:	Divine Life Assisted Living Center 3 LLC
Licensee Address:	2045 Birch Bluff Drive Okemos, MI 48864
Licensee Telephone #:	(517) 339-2390
Administrator:	Achal Patel, Designee
Licensee Designee:	Achal Patel & Vivek Thakore, Co-Designee
Name of Facility:	Divine Life Assisted Living Center 3 LLC
Facility Address:	2077 Haslett Road Haslett, MI 48840
Facility Telephone #:	(517) 339-2390
Original Issuance Date:	11/09/2020
License **Status:**	REGULAR
Effective Date:	05/09/2023
Expiration Date:	05/08/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Direct care staff, Dasheona Holland & Kaitlynn Johnigan, are restricting residents' liquid intake on third shift, without written directives.	Yes
Direct care staff, Dasheona Holland & Kaitlynn Johnigan, do not treat residents with dignity and respect, by yelling at residents and belittling residents verbally.	Yes
Direct care staff, Dasheona Holland, forced Resident F to self-administer her medications and left the resident unattended with her crushed medications.	Yes
ADDITIONAL FINDINGS	Yes

III. METHODOLOGY

07/28/2024	Special Investigation Intake- 2024A1033050
08/01/2024	Special Investigation Initiated - On Site- Interviews conducted with Resident A, B, C, D, & E, direct care staff/home manager, Rose Benavidez. Review of resident records initiated today.
08/09/2024	APS- Referral made per protocol.
08/15/2024	Contact – Telephone call made- Attempt to interview direct care staff, Zionae White. Message left awaiting response.
08/15/2024	Contact – Telephone call made- Attempt to interview direct care staff, DaSheona Holland, via telephone. Received an automated recording that the individual could not receive calls and there was no way to leave a message.
08/15/2024	Contact – Telephone call made- Telephone call made to direct care staff, Kaitlynn Johnigan. Message left and awaiting response.
08/15/2024	Contact – Telephone call received- Interview with direct care staff, Zionae White, via telephone.
08/15/2024	Contact – Telephone Call Received- Interview conducted with direct care staff, Kaitlynn Johnigan, via telephone.
08/19/2024	Contact – Document Received- Email correspondence received from Rose Benavidez containing additional documentation to review.
08/20/2024	Exit Conference

	Conducted via telephone. Voicemail message left, as well as email sent.

ALLEGATION: Direct care staff, Dasheona Holland & Kaitlynn Johnigan, are restricting residents' liquid intake on third shift, without written directives. Ms. Holland and Ms. Johnigan are not following directives in resident written assessment plans.

INVESTIGATION:

On 7/28/24 I received an online complaint regarding the Divine Life Assisted Living Center 3 LLC, adult foster care facility (the facility). The complaint alleged that direct care staff, Dasheona Holland & Kaitlynn Johnigan, were restricting fluid intake of residents during the overnight shift at the facility because they did not want residents to urinate in their beds. On 8/1/24 I conducted an unannounced on-site investigation at the facility. I interviewed direct care staff/home manager, Rose Benavidez, on this date. Ms. Benavidez reported that she was aware of these allegations as it had been brought to her attention by Resident A. Ms. Benavidez reported that Resident A had expressed concerns about activities occurring on the overnight shift with Ms. Holland & Ms. Johnigan's treatment of the residents. Ms. Benavidez reported that Resident A reported his concerns to the Tri County Office on Aging (TCOA) case manager as he is currently connected with TCOA for his care. Ms. Benavidez reported that she has worked the overnight shift on a couple of occasions with Ms. Holland and Ms. Johnigan and had not witnessed them restricting resident fluid intake. She reported she had no direct knowledge of this allegation. She further reported that there are not currently any residents at the facility who have a physician's order to restrict their fluid intake at any time during the day or night. Ms. Benavidez reported that she did have a conversation with Ms. Holland & Ms. Johnigan regarding the allegations and shortly after this conversation Ms. Holland vacated her position with the facility and is no longer employed at the facility.

During the unannounced on-site investigation, I interviewed Resident A. Resident A reported that he has not been told he cannot have drinks during the overnight shift, but he is aware that other residents who are incontinent have been told they cannot have drinks due to their incontinence issues. Resident A reported that he has observed Ms. Holland force Resident F to self-administer her mediations. He reported that Ms. Holland has also forced Resident F to walk all the way down the hallway to her resident bedroom instead of using Resident F's wheelchair which she is ordered to use for mobility assistance.

During the unannounced on-site investigation, I interviewed Resident B. Resident B reported Ms. Johnigan has restricted her fluid intake at night citing her urinary incontinence and that she might, "pee the bed." Resident B reported that Ms. Johnigan will embarrass her by shouting out, "Look at that you peed the bed again!"

Resident B reported that the direct care staff are also supposed to assist her with getting undressed at night and into her night clothes. Resident B reported that Ms. Johnigan will tell her, “You don’t need help, you can do it yourself!”

During the unannounced on-site investigation, I interviewed Resident C. Resident C reported that she has not been told she cannot have fluids to drink during the overnight shifts. She reported that she has observed Ms. Holland leave Resident F to self-administer her medications and she has observed Ms. Holland force Resident F to walk down the hallway to her resident bedroom when Resident F is ordered a wheelchair for mobility assistance.

During the unannounced on-site investigation, I interviewed Resident D. Resident D reported she was having issues with receiving personal care during the overnight shifts but this has been corrected since Ms. Holland is no longer employed at the facility. Resident D reported that she would be left unattended for hours in the same soiled undergarment during the overnight shift. Resident D reported that she has not been told she cannot have drinks during the overnight shift at the facility. She noted she has only been a resident at the facility for about three weeks.

During the unannounced on-site investigation, I interviewed Resident E. Resident E reported that there are periods during the night where it takes multiple hours for someone to answer her call light and provide assistance. Resident E reported that she would like to use the restroom during the overnight hours, but this request has been denied to her by Ms. Holland and Ms. Johnigan. She reported that they prefer she wear an incontinence brief during the night hours, and she is not incontinent and would prefer to use the toilet.

I was not able to interview Resident F during this on-site investigation as I was presented with two documents indicating that Resident F no longer possessed the cognitive capacity to participate in her daily decision making due to a diagnosis of dementia.

During the on-site investigation I reviewed the following documents:

- *Assessment Plan for AFC Residents* form, dated 1/8/24 for Resident B. On page 2 under section, *II. Self Care Skill Assessment*, subsection, *B. Toileting*, the document is marked, “no”, regarding whether Resident B requires assistance with toileting. Under subsection, *E. Dressing*, the document is marked, “yes”, regarding whether Resident B requires assistance with dressing, with the narrative, “1 person assist”.
- *Assessment Plan for AFC Residents* form, dated 7/12/24 for Resident D. On Page 2 under section, *II. Self Care Skill Assessment*, subsection, *B. Toileting*, the document is marked, “no”, regarding whether Resident D requires assistance with toileting. There is no narrative written and no commentary on Resident D using incontinence briefs at night. Under subsection, *G. Walking/Mobility*, the document indicates, “yes”, Resident D does need

assistance with walking/mobility, and includes the narrative, “Requires walker and wheelchair.”

- *Assessment Plan for AFC Residents* form, dated 7/9/24, for Resident E. On Page 2 under section, *II. Self Care Skill Assessment*, subsection, *B. Toileting*, the document is marked, “yes”, regarding whether Resident E requires assistance with toileting, with the narrative, “Will require bathrooming assistance and cues.” Under subsection, *G. Walking/Mobility*, the document is marked, “yes”, indicating Resident E does require assistance with walking/mobility with the narrative, “uses walker and wheelchair”.
- *Assessment Plan for AFC Residents* form, dated 1/15/24 for Resident F. One page 2 under section, *II. Self Care Skill Assessment*, subsection, G*. Walking/Mobility*, the document is marked, “yes”, regarding whether Resident G requires assistance with walking/mobility, with the following narrative, “Uses wheelchair”.
- *Careline Physician Services* document regarding Resident F, dated 7/3/24, signed by Nicholas Kielhorn, MD. This document notated the following, “[Resident F] has severe mental incapacity, which is a permanent condition. The patient is not able to manage financial affairs or make health care decision or herself or others.”
- *Careline Physician Services* document regarding Resident F, dated 7/3/24, signed by Raymond Hansen, MD. This document notated the following, “[Resident F] has severe mental incapacity, which is a permanent condition. The patient is not able to manage financial affairs or make health care decision or herself or others.”
- *Divine Living Centers, Documentation of, “written warning”,* for Ms. Holland, dated 7/22/24. This document noted, “On Monday 7/22/24 I spoke with [Ms. Holland] about the complaints from a few of our residents. It was reported that [Ms. Holland] told [Resident F] to “leave me the fuck alone”, that other residents complained of no one answering their call lights. These issues were over the weekend, unacceptable. I have spoken with [Ms. Holland] about the way to speak with the residents and that we are here for whatever they need when they need it. Any further infractions could result in termination.” This document was signed by Ms. Benavidez on 7/29/24.
- *Divine Living Centers, Documentation of, “written warning”,* for Ms. Johnigan, dated 7/22/24. This document noted, “On Monday 7/22/24 I spoke with [Ms. Johnigan] about some complaints over the weekend about staff not helping them. Specifically [Resident D & Resident E]. They both indicated that no one answered their call lights thru out the night. It was @ 2am and 4am that someone went into their room. I have spoken to [Ms. Johnigan] about the complaints and she will be more mindful when working. Will continue to answer all call lights. Any further infraction may result in termination.” This document was signed by Ms. Benavidez on 7/29/24.

On 8/15/24 I had email correspondence with Ms. Benavidez regarding direct care staff documentation of resident care needs. Ms. Benavidez reported that documentation of resident activities of daily living is kept on the computer at the

facility with hourly checks for each resident and a two-hour check completed for residents who use incontinence briefs. She further reported that residents have a care plan which demonstrates whether they utilize an incontinence brief, and this care plan is updated monthly and each employee signs that they have read the care plans for the month.

On 8/15/24 I interviewed direct care staff, Zionae White, via telephone. Ms. White reported that she has been employed at the facility for about 1.5 months. She reported she works the night shift which is scheduled from 6pm to 6am. She reported that Ms. Holland and Ms. Johnigan trained her on this shift. Ms. White reported that she has not observed Ms. Holland force Resident F to walk to her resident bedroom without the use of her wheelchair. Ms. White reported that while working with Ms. Johnigan she did observe her restrict fluid intake for Resident E. She reported that Resident E has frequent urination during the night and Ms. Johnigan told her she could not have any more water due to this issue. Ms. White reported that Ms. Holland and Ms. Johnigan trained her to conduct regular incontinence checks on all residents at 12am, 2am, and 4am, throughout the evening.

On 8/15/24 I interviewed Ms. Johnigan via telephone. Ms. Johnigan reported she no longer works at the facility and recently quit her job about one week prior to this interview. Ms. Johnigan reported that she did work the 6pm to 6am shift at the facility with Ms. Holland. Ms. Johnigan reported that she has observed Ms. Holland place medication in front of Resident F, walk away, and leave resident F to self-administer her medications. Ms. Johnigan reported that Ms. Holland did this because Resident F called Ms. Holland a “bitch”. Ms. Johnigan reported that she did observe Ms. Holland force Resident F to wheel herself in her wheelchair to her resident bedroom because Resident F directed profanity toward Ms. Holland. Ms. Johnigan reported that she did not restrict the fluid intake for any of the residents at the facility. Ms. Johnigan reported that she and Ms. Holland would perform regular incontinence care checks on residents who needed it every two hours during their shifts. She reported that there were certain residents who did not require every two-hour checks on their incontinence briefs as they did not generally have soiled briefs that frequently. She reported that these residents included, Resident B, D, E, & F. Ms. Johnigan reported that in this case they would only change an incontinence brief if the resident requested it from the direct care staff. She reported that she and Ms. Holland would wait for those residents to push their call lights for assistance before they changed their incontinence briefs.

On 8/15/24 I received the following documents, via email, from Ms. Benavidez:

- *Resident Care Plan*, dated 1/2/24, for Resident B. Under the section, *Grooming*, it indicates that Resident B requires staff assistance with dressing. Under the section, *Bladder*, the document indicates that Resident B is incontinent and requires assistance with brief changes. Under the section, *Diet*, the area titled, *Fluid restriction*, is not marked.

- *Resident Care Plan*, dated 7/12/24, for Resident D. Under the section, *Bladder*, the document indicates that Resident D is continent and wears incontinence briefs. Under the section, *Diet*, the area titled, *Fluid restriction*, is not marked.
- *Resident Care Plan*, dated 7/9/24, for Resident E. Under the section, *Bladder*, the document notes that Resident E is incontinent, wears incontinence briefs, and requires assistance. Under the section, *Bowel*, the document notes that Resident E is incontinent, wears incontinence briefs, and requires assistance. Under the section, *Diet*, the area titled, *Fluid restriction*, is not marked.
- *Resident Care Plan*, dated 1/2/24, for Resident F. Under the section, *Bladder*, the document notes that Resident F is incontinent, wears incontinence briefs, and requires assistance. Under the section, *Bowel*, the document notes that Resident F is incontinent, wears incontinence briefs, and requires assistance. Under the section, *Mobility/DME*, the document notes that Resident F utilizes a wheelchair and requires assistance with this device. Under the section, *Diet*, the area titled, *Fluid restriction*, is not marked.

On 8/19/24 I received the following documents via email from Ms. Benavidez:

- *ADL Log* for Resident D for the month of July 2024. On page 3 of this document under the section, *DLC ADL Library: Every 2 Hours Bathroom Check*, it reads, “Check resident’s brief to see if wet/soiled. If resident needs to be changed take to bathroom, wash, dry and apply new brief. If resident is dry, take to bathroom and attempt toileting while awake. Record if brief was wet and/or soiled (if bowel movement please document in MAR as well) And resident’s brief was changed in note.” In reviewing this ADL Log I observed 12 times during the month of July 2024 when it was not documented whether the bathroom check was completed for Resident D.
- *ADL Log* for Resident F for the month of July 2024. On page 2 of this document, under the section, *DLC ADL Library: Every 2 Hours Bathroom Check*, it reads, “Check resident’s brief to see if wet/soiled. If resident needs to be changed take to bathroom, wash, dry and apply new brief. If resident is dry, take to bathroom and attempt toileting while awake. Record if brief was wet and/or soiled (if bowel movement please document in MAR as well) And resident’s brief was changed in note.” In reviewing this ADL Log I observed 12 times during the month of July 2024 when it was not documented whether the bathroom check was completed for Resident F.
- *ADL Log* for Resident E for the month of July 2024. On page 3, under section, *DLC ADL Library: Every 2 Hours Bathroom Check*, it reads, “Check resident’s brief to see if wet/soiled. If resident needs to be changed take to bathroom, wash, dry and apply new brief. If resident is dry, take to bathroom and attempt toileting while awake. Record if brief was wet and/or soiled (if bowel movement please document in MAR as well) And resident’s brief was changed in note.” In reviewing this ADL Log I observed 13 times during the month of July 2024 when it was not documented whether the bathroom check was completed for Resident E.

- *Training Sign in Sheet: Training Topic: Care Plan Reviews 2024*. This document was provided by Ms. Benavidez as proof that direct care staff were educated to resident care plans each month. The first date on this document was 5/14/24. Ms. Johnigan's signature appears on this document on 6/4/24 & 7/2024. Ms. Holland's signature appears on this document on 6/6/24.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	Based upon interviews conducted with Residents A, B, C, D, & E, Ms. Benavidez, Ms. White, & Ms. Johnigan, as well as resident records reviewed, it can be determined that Ms. Johnigan & Ms. Holland were not providing supervision, protection, and personal care as identified in the resident written assessment plans/Resident Care Plans/ADL Logs for Resident B, D, E & F. Resident B reported that Ms. Johnigan refused to provide assistance with helping her undress and change into her night time clothing. Resident B's assessment plan, resident care plan documents both indicate that Resident B requires at a minimum a one person assist with this activity of daily living. Resident F's assessment plan and resident care plan both indicate that Resident F requires assistance with mobility, and requires a wheelchair, with at minimum a one person assist. It was reported by Resident A, Resident C, & Ms. Johnigan that they all observed Ms. Holland force Resident F to either walk down the hallway to her resident bedroom, or wheel herself down the hallway, which does not align with the written assessment plan and resident care plan established by the facility staff for Resident F's mobility needs. The resident care plans reviewed for Residents B, D, E, & F had no stipulation for fluid restrictions for these residents, nor did their written assessment plans, however Resident B reported having her fluid intake restricted by Ms. Johnigan & Ms. White reported observing Ms. Johnigan restrict the fluid intake for Resident E. In addition I reviewed the ADL Logs for Residents B, D, E, & F who all have ADL Logs that require every 2 hour bathroom checks, whether the resident uses their call button or not. Ms. Johnigan reported that for Residents B, D, E, & F she would wait for them to use their call lights to indicate they needed to use the restroom or have their incontinence brief changed instead of following the written directive in the ADL Logs for these residents. Having noted these discrepancies in the written assessment plans, ADL Logs, and resident care plans with the actions of the direct care staff members, Ms. Holland & Ms. Johnigan, it can be determined that a preponderance of evidence has been established to determine a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct care staff, Dasheona Holland & Kaitlynn Johnigan, do not treat residents with dignity and respect, by yelling at residents and belittling residents verbally.

INVESTIGATION:

On 7/28/24 I received an online complaint regarding the facility. The complaint alleged that Ms. Holland & Ms. Johnigan do not treat residents with dignity and respect, by yelling at residents and belittling residents verbally. On 8/1/24 I conducted an unannounced, on-site investigation at the facility. I interviewed Ms. Benavidez at this time. Ms. Benavidez reported that she was aware of the allegations as Resident A had reported these allegations to her. Ms. Benavidez reported that she has worked a couple of shifts with Ms. Holland and Ms. Johnigan and she has not observed them treating residents in a derogatory manner. Ms. Benavidez reported that she spoke with Ms. Holland and Ms. Johnigan about the allegations on 7/22/24. She reported that they neither confirmed nor denied that these allegations were accurate. Ms. Benavidez reported that she has a new night shift direct care staff member, Zionae White, and she interviewed Ms. White regarding the allegations. Ms. White reported to Ms. Benavidez that she has not observed these behaviors from Ms. Holland or Ms. Johnigan. Ms. Benavidez reported that she held a direct care staff meeting on 7/29/24 and addressed resident rights issues with the direct care staff and planned to serve Ms. Holland and Ms. Johnigan with their written disciplinary action regarding the allegations, but Ms. Holland quit on this day and Ms. Johnigan was on vacation. Ms. Benavidez reported that she has instituted a new training for the overnight shift and has placed direct care staff/Assistant Manager, Kaylynn Mitchell, on the overnight shift to properly train the overnight staff to resident care.

During the on-site investigation on 8/1/24, I interviewed Resident A. Resident A reported that he observed Ms. Holland force Resident F to walk down the hallway, unattended, when Resident F is normally a wheelchair transfer for mobility purposes. Resident A could not recall the exact date of this incident. Resident A also reported that he observed Ms. Holland, “throw” Resident F’s crushed medications on the table in front of her and tell her to take them herself. Resident A stated that Ms. Holland then walked away from Resident F and left the medications in front of her. Resident A reported that Ms. Johnigan yells at the residents each night she works. He reported he can hear her yelling from his resident bedroom, which is located near the front of the facility. Resident A reported that Ms. Johnigan does not swear at the residents or call them names, but she does yell and belittle the residents on a regular basis.

During the on-site investigation on 8/1/24 I interviewed Resident B. Resident B reported that Ms. Johnigan, “yells at me all the time”. Resident B further reported that Ms. Johnigan makes her feel “terrible” and that she is embarrassed by the remarks Ms. Johnigan makes about her incontinence. Resident B reported that Ms. Johnigan will make statements in a very loud manner, such as, “Look at that you

peed the bed again!" Resident B reported that Ms. Johnigan becomes upset with her if she pushes her call button too much. She reported that Ms. Johnigan "became furious" with her for pushing her call button. Resident B stated that she reported this information to Ms. Benavidez. Resident B reported, "she's rude to everyone, except for [Ms. Benavidez]," referring to Ms. Johnigan's behaviors.

During the on-site investigation on 8/1/24 I interviewed Resident C. Resident C reported that Ms. Johnigan makes her feel uncomfortable and embarrassed when she provides personal care to her. She reported that Ms. Johnigan has made statements about her, "big booty" and made unpleasant remarks about Resident C's menstrual cycle. Resident C reported that she is younger than most of the residents in the facility and continues to have a menstrual cycle. She reported that Ms. Johnigan showed Resident C her blood covered glove, while providing Resident C's personal care and made inappropriate comments about "blood clots" from Resident C's menstrual cycle. Resident C reported that these comments are extremely insensitive and embarrassing to her. Resident C further reported that Ms. Johnigan yells at the other residents and she can hear the yelling from her resident bedroom. Resident C reported that she observed Ms. Holland force Resident F to walk down the hallway unattended, instead of using her wheelchair as ordered for her mobility. Resident C reported that she has observed Ms. Holland leaving crushed medications in front of Resident F and forcing her to self-administer these medications. She further reported that she has observed Ms. Holland being rude to the other residents and treating them in a derogatory manner. Resident C reported that she feels the resident call lights are left for too long on the overnight shift and it could be hours before a call light is attended to. She reported that she is aware of this because the call lights make an alarm sound, and they will continue to go off until they are answered by a direct care staff member.

During the on-site investigation on 8/1/24 I interviewed Resident D. Resident D reported that Ms. Holland was making her wait a prolonged period to answer her call lights and change her incontinence brief. She reported that this issue is resolving now that Ms. Holland is no longer employed at the facility. She reported that prior to Ms. Holland quitting, she was being left in the same incontinence brief for the entire night.

During the on-site investigation on 8/1/24 I interviewed Resident E. Resident E reported that she did not have any comments about the direct care staff being verbally abusive to the residents, but she did feel that residents are made to wait too long when they push their call lights, and it can be hours before the call lights are answered.

During the on-site investigation I reviewed the following documents:

- *Divine Living Centers, Documentation of, "written warning"*, for Ms. Holland, dated 7/22/24. This document noted, "On Monday 7/22/24 I spoke with [Ms. Holland] about the complaints from a few of our residents. It was reported that

[Ms. Holland] told [Resident F] to “leave me the fuck alone”, that other residents complained of no one answering their call lights. These issues were over the weekend, unacceptable. I have spoken with [Ms. Holland] about the way to speak with the residents and that we are here for whatever they need when they need it. Any further infractions could result in termination.” This document was signed by Ms. Benavidez on 7/29/24.

- *Divine Living Centers, Documentation of, “written warning”,* for Ms. Johnigan, dated 7/22/24. This document noted, “On Monday 7/22/24 I spoke with [Ms. Johnigan] about some complaints over the weekend about staff not helping them. Specifically [Resident D & Resident E]. They both indicated that no one answered their call lights thru out the night. It was @ 2am and 4am that someone went into their room. I have spoken to [Ms. Johnigan] about the complaints and she will be more mindful when working. Will continue to answer all call lights. Any further infraction may result in termination.” This document was signed by Ms. Benavidez on 7/29/24.
- *Michigan Workforce Background Check* eligibility letter, for Ms. Holland & Ms. Johnigan. Both Ms. Holland and Ms. Johnigan had current MWBC letters in their employee files.
- *Divine Living Centers, New Hire Training* documents for Ms. Holland & Ms. Johnigan. Both documents indicated that training was completed in the area of resident rights.
- *Assessment Plan for AFC Residents* form, dated 1/15/24 for Resident F. One page 2 under section, *II. Self Care Skill Assessment*, subsection, *G. Walking/Mobility*, the document is marked, “yes”, regarding whether Resident G requires assistance with walking/mobility, with the following narrative, “Uses wheelchair”.
- *Careline Physician Services* document regarding Resident F, dated 7/3/24, signed by Nicholas Kielhorn, MD. This document notated the following, “[Resident F] has severe mental incapacity, which is a permanent condition. The patient is not able to manage financial affairs or make health care decision or herself or others.”
- *Careline Physician Services* document regarding Resident F, dated 7/3/24, signed by Raymond Hansen, MD. This document notated the following, “[Resident F] has severe mental incapacity, which is a permanent condition. The patient is not able to manage financial affairs or make health care decision or herself or others.”

On 8/15/24 I interviewed Ms. White, via telephone, Ms. White reported that she has trained and worked with Ms. Holland and Ms. Johnigan at the facility. Ms. White reported that Ms. Johnigan, “Is not kind.” Ms. White reported that Ms. Johnigan was not kind to any of the residents or the direct care staff. She reported that she had observed, firsthand, Ms. Johnigan refuse to give Resident E water as she did not want her to be incontinent in her bed during the night. She reported that Ms. Johnigan would become angry with Resident E and state that Resident E could not have any more water because she was too incontinent. Ms. White reported that Ms. Holland was nice but had a stern demeanor. She reported that Ms. Holland would become upset with Resident F,

because Resident F would call her a “bitch”. She reported that she did not observe Ms. Holland state to Resident F, “shut the fuck up”, but she does believe this could have occurred as she had heard Ms. Holland speak in a derogatory manner about Resident F.

On 8/15/24 I interviewed Ms. Johnigan, via telephone. Ms. Johnigan reported that she did observe Ms. Holland become upset with Resident F and throw her medications in front of her and tell her to take them on her own. She reported that Ms. Holland did not handle Resident F’s verbal aggressions very well and would become easily frustrated with Resident F. Ms. Johnigan reported that she observed Resident F call Ms. Holland a “bitch”. She reported that when this occurred, Ms. Holland made a statement to the effect of, “if you’re going to call me a bitch, you can take your own meds.” Ms. Johnigan further reported that Ms. Holland would make Resident F wheel herself down to her bedroom because Resident F had upset Ms. Holland. Ms. Johnigan reported that she did observe Ms. Holland stated to Resident F, “shut up!”. Ms. Johnigan denied the allegation that she had made derogatory statements to the residents, such as “look at that you peed the bed again”. When I asked Ms. Johnigan if she ever felt she was rude or treated the residents in a derogatory manner she reported, “I’m sure I may have come across as rude.” She further reported that she never said anything to deliberately humiliate or embarrass the residents, but she did feel that near the end of her employment at the facility she was stressed and was acting rudely.

APPLICABLE RULE	
R 400.15304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**

ANALYSIS:	Based upon interviews conducted with Ms. Benavidez, Residents A, B, C, D, & E, Ms. White, & Ms. Johnigan, it can be determined that there is a preponderance of evidence that direct care staff members Ms. Holland & Ms. Johnigan were not treating residents with dignity and respect by noted occurrences of the two direct care staff, yelling at residents, belittling residents with verbal commentary which includes derogatory statements about their incontinence needs, menstrual cycles, and physical form, forcing non-ambulatory residents to walk or wheel themselves, to their resident bedroom instead of utilizing their wheelchair, and forcing residents to self-administer their medications. Residents were also found to be treated in a derogatory manner by being forced to wait multiple hours for call lights to be answered and being forced to wear soiled incontinence briefs for prolonged periods of time.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct care staff, Dasheona Holland, forced Resident F to self-administer her medications and left the resident unattended with her crushed medications.

INVESTIGATION:

On 7/28/24 I received an online complaint regarding the facility. The complaint alleged that on an unknown date, Ms. Holland forced Resident F to self-administer her medications and left the resident unattended with her crushed medications. On 8/1/24 I conducted an unannounced investigation at the facility and interviewed Ms. Benavidez. Ms. Benavidez reported that Resident F does have an order to receive her medications in a crushed form. She reported that she had no direct knowledge of this event occurring but did receive report from Resident A that he observed this alleged event.

During the on-site investigation on 8/1/24 I interviewed Resident A. Resident A reported that he could not recall the exact date, but recently he observed Ms. Holland crush up Resident F's medications and "throw" them down on the table in front of Resident F and tell her to take the medication herself. Resident A reported that Ms. Holland then walked away and left Resident F with the container of crushed medications.

During the on-site investigation on 8/1/24 I interviewed Resident C. Resident C reported that on an unknown date she did observe Ms. Holland crush Resident F's medications and put the container of crushed meds on the table in front of Resident F and tell her to administer her own medications. Resident C reported that Ms.

Holland then walked away and left the medications on the table in front of Resident F.

During the on-site investigation I reviewed the following documents:

- Careline Physician Services, Order Form, for Resident F, dated 5/25/23. The document was signed by, Matthew Basham, NP-C, and reads, “Crush patients medications.”

On 8/15/24, I interviewed Ms. Johnigan, via telephone. Ms. Johnigan reported that she did observe Ms. Holland become upset with Resident F and throw her medications in front of her and tell her to take them on her own. She reported that Ms. Holland did not handle Resident F’s verbal aggressions very well and would become easily frustrated with Resident F. Ms. Johnigan reported that she observed Resident F call Ms. Holland a “bitch”. She reported that when this occurred, Ms. Holland made a statement to the effect of, “if you’re going to call me a bitch, you can take your own meds.”

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(3) Unless a resident's physician specifically states otherwise in writing, the giving, taking, or applying of prescription medications shall be supervised by the licensee, administrator, or direct care staff.
ANALYSIS:	Based upon interviews conducted with Ms. Benavidez, Ms. Johnigan, Resident A, and Resident C it can be determined that there is a preponderance of evidence that Ms. Holland crushed Resident F’s medications and left the medications on the table in front of Resident F for the resident to self-administer. It can be determined that Ms. Holland did not supervise the taking of these medications by Resident F.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 8/15/24 I reviewed training records for Ms. Holland and Ms. Johnigan that were supplied via email from Chief Operating Officer, Cheri Lynn Weaver, on 8/1/24. There was no record of cardiopulmonary resuscitation training in Ms. Holland's employee file. Ms. Johnigan's employee file contained a certificate for cardiopulmonary resuscitation training which was completed on 6/6/24.

On 8/15/24 I had email correspondence with Ms. Benavidez and requested documentation of completed cardiopulmonary resuscitation training for Ms. Holland. Ms. Benavidez responded to this request and noted that they did not have any documentation available of completed cardiopulmonary resuscitation training for Ms. Holland.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(c) Cardiopulmonary resuscitation**
ANALYSIS:	Based upon review of the employee files and my conversation with Ms. Benavidez it can be determined that Ms. Holland had been providing direct care to residents without having documentation of completing a cardiopulmonary resuscitation training and receiving certification in this area. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the status of the license recommended at this time.

8/19/24

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Jana Lipps Date
Licensing Consultant

Approved By:

08/20/2024

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Dawn N. Timm Date
Area Manager