GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 28, 2024

Colleen Cassidy AND Carolyn Anderson
22467 Paddington Ct
Novi, MI 48374

RE: License #: AS630390815
Investigation #: 2024A0602019
Essence Memory Care LLC

Dear Colleen Cassidy and Carolyn Anderson:

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:

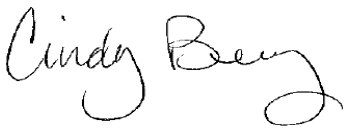
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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 (248) 975-5053.

Sincerely,



Cindy Berry, Licensing Consultant
Bureau of Community and Health Systems
3026 West Grand Blvd
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 860-4475

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630390815
Investigation #:	2024A0602019
Complaint Receipt Date:	03/18/2024
Investigation Initiation Date:	03/19/2024
Report Due Date:	05/17/2024
Licensee Name:	Colleen Cassidy and Carolyn Anderson
Licensee Address:	22467 Paddington Ct Novi, MI 48374
Licensee Telephone #:	(248) 506-1634
Administrator:	Colleen Cassidy
Licensee Designee:	Colleen Cassidy and Carolyn Anderson
Name of Facility:	Essence Memory Care LLC
Facility Address:	20800 Chigwidden St Northville, MI 48167
Facility Telephone #:	(248) 308-9607
Original Issuance Date:	02/01/2018
License Status:	REGULAR
Effective Date:	08/01/2022
Expiration Date:	07/31/2024
Capacity:	6
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident D has bed sores that are not healing properly with double briefing.	No
Resident A is on medication that she should not be on and is heavily medicated.	No
There is a resident who had a very serious fall in the shower.	No
Additional Findings	Yes

III. METHODOLOGY

03/18/2024	Special Investigation Intake 2024A0602019
03/19/2024	Special Investigation Initiated - Telephone Call made to the home
03/28/2024	Inspection Completed On-site No response.
04/18/2024	Inspection Completed On-site No response.
05/14/2024	Inspection Completed On-site Interviewed staff member, Savannah Novakowski.
05/14/2024	Contact – Telephone call made Spoke with Misty Novakowski and requested resident documents.
05/17/2024	Contact – Document sent Text message sent to Misty requesting documentation.
06/14/2024	Contact – Telephone call made Call made to Misty Novakowski; voicemail full, unable to leave a message.
07/02/2024	Contact – Document sent Email sent to Misty Novakowski and Michael requesting documents.

07/06/2024	Contact – Document received Received some resident documents by email.
07/08/2024	Contact – Document sent Email sent to Misty and Michael requesting remaining documents.
07/30/2024	Inspection Completed On-site Interviewed staff member Erika Eldridge.
08/28/2024	Exit Conference Held with the licensee designee, Carolyn Anderson and Michael Kruckeberg by telephone.

ALLEGATION:

- **Resident D has bed sores that are doubled briefed and not healing properly.**
- **Resident A is on medications that she should not be on and is heavily medicated.**
- **There is a resident who had a very serious fall in the shower.**

INVESTIGATION:

On 3/18/2024, a complaint was received and assigned for investigation alleging that Resident D has bed sores that are not healing properly with double briefing, Resident A is on medication that she should not be on and is heavily medicated and there is a resident who had a very serious fall in the shower.

On 3/28/2024 and 4/18/2024, I attempted to conduct unannounced on-site investigations but there was no response. On 5/14/2024 I conducted another unannounced on-site investigation at which time I spoke with Savannah Novakowski. Ms. Novakowski identified herself as the administrator and said there were no residents in care. She stated she was only at the home to pick up a few things and did not know when she would be back. Ms. Novakowski would not allow me into the home and advised that I speak with her mother, Misty Novakowski.

On 5/14/2024 while at the home, I called Misty Novakowski from my vehicle. She stated the home was vacant and had been for a couple of weeks. According to Ms. Novakowski, a management/purchase agreement was established between herself, Colleen Cassidy, Carolyn Anderson and Michael Kruckeberg until a new license is issued under the new owners. Ms. Novakowski stated there were some family members who were not happy with the change in ownership and were not very cooperative with her. Ms. Novakowski said when she and Mr. Kruckeberg took over as the new owners/operators, Resident D's family member was not happy with the change. She went on to state that Resident D's family member did not want to use the visiting physician that was already coming to the home and refused referrals for physical therapy, a hospital bed, a Hoyer lift (as Resident D was wheelchair bound), wound care

(Resident D had three stage three wounds), and hospice care. Ms. Novakowski denied that Resident D was doubled briefed but said she would wear a brief with a bed pad underneath as she often had loose stool. It was recommended that a hospital bed be ordered as Resident D had a queen size bed that laid flat and would sometimes vomit in the middle of the night. A private physician was obtained by Resident D's family and made a visit to the home to assess Resident D's needs (exact date unknown). It was recommended that Resident D be placed under hospice care, but her family refused and accused the physician of being a death doctor. She did however agree to a hospital bed. Resident D's family member stated another physician would be obtained but Ms. Novakowski issued a discharge notice due to the family not adhering to the physician's recommendation and Resident D not being under the care of a physician.

Ms. Novakowski stated Resident A was admitted to the facility on hospice and all her medication was prescribed through hospice. She had no knowledge of Resident A being on any medication that was not prescribed for her or being overmedicated. Ms. Novakowski went on to state that Resident C was the only resident who got into the shower, and she had no knowledge of her falling while in the shower. Ms. Novakowski stated she had documentation to support the information she provided and agreed to send it to me along with the resident registry, each residents health care appraisal, assessment plan, and the guardian/power of attorney/responsible person contact information.

On 5/14/2024, I was able to determine that an application for licensure was submitted to the department on 12/29/2023, Essence Memory Care LLC - AS630418131 listing Mr. Kruckeberg as the licensee designee and administrator.

On 7/06/2024, I received (by email) the following documents:

- Resident A's resident care agreement (signed and dated 1/26/2024 and 2/06/2024), care plan, policies and agreement and the discharge policy all dated 2/01/2024.
- Resident B's resident care agreement, (signed and dated 3/05/2023).
- Resident C's resident care agreement (signed and dated 1/14/2024), care plan dated 1/21/2024, incident reports dated 2/16/2024 and 2/21/2024.
- Resident D's resident care agreement (signed and dated 4/14/2023). According to the documents received.

On 7/08/2024, I sent an email to Misty Novakowski, Shannon Novakowski, and Micheal Kruckeberg requesting the following additional information:

- Resident registry
- Health care appraisals for each resident
- Documentation for Resident D (staff notes, hospital treatment/admit/discharge summary, physician notes etc.).
- Name and contact number for Resident D's physician and/or any home care provider (PT/OT) and hospice care notes.

- Employee names and contact numbers.
- Name and contact number for the visiting physician who serviced the home.

As of this date, I have not received the requested documentation or a response to the email I sent from either party.

On 7/30/2024, I conducted another unannounced on-site investigation at which time I interviewed Eryka Konayara who identified herself as a staff member. Ms. Konayara stated she worked full-time for 8 months at a home in Farmington Hills that was operated by Misty Novakowski. Ms. Novakowski informed her three days ago that the home was being closed and her employment was terminated. She went on to state that she is now working full time at this location. Currently there are two residents who reside in the home. Resident F is there for respite care and will be returning to his home with his wife in another week or so and Resident G is on hospice. Ms. Konayara went on to state that she picked up extra shifts at this home earlier in the year before the other residents died or moved out. At that time there were four residents residing in the home, Resident A, Resident B, Resident C, and Resident D. Ms. Konayara stated Resident A, Resident B, and Resident C died (exact dates unknown) and Resident D moved as she was given a discharge notice. Ms. Konayara had no knowledge of any resident who had a very serious fall, bed sores that did not heal properly with double briefing, or any resident being on medication they should not have been on. I requested to review the resident files for Resident A, Resident B, Resident C, and Resident D. Ms. Konayara stated the resident files were not at the home. There was an issue between Misty Novakowski and Mr. Kruckeberg resulting in the police issuing a no trespass notice to Ms. Novakowski. Ms. Konayara believes it is possible that Ms. Novakowski took the resident files with her.

On 7/30/2024, I inspected the staff office and did not observe any files for Resident A, Resident B, Resident C, or Resident D I was able to locate a copy of the resident registry listing the following residents along with their admission and discharge dates:

Resident A – Admit 2/01/2024, Discharge 3/24/2024 (no forwarding address listed)
Resident B – Admit 3/05/2024, Discharge 5/09/2024 (deceased)
Resident C – Admit 1/14/2024, Discharge 4/03/2024 (deceased)
Resident D – Admit 6/07/2018, Discharge 3/28/2024 (moved to hospice)

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on the information obtained during the investigation there is insufficient information to determine if any resident had bed

	sores that were doubled briefed and did not heal properly or if a resident had a serious fall while in the shower. On 5/14/2024, Shannon Novakowski stated the home was vacant and would not allow me to enter. On this same date, Misty Novakowski denied that Resident D was doubled briefed but said she would wear a brief with a bed pad underneath as she often had loose stool. According to Misty Novakowski, Resident C was the only resident who got into the shower, and she had no information regarding her falling.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14312	**Resident medication.**
	(2) Medication shall be given, taken, or applied pursuant to label instruction.
ANALYSIS:	Based on the information obtained during the investigation, there is insufficient information to determine if Resident A was on any medication that she should not have been on or if she was heavily medicated. On 5/14/2024 I spoke with Misty Novakowski by telephone and was informed that Resident A was admitted to the facility on hospice and all her medication was prescribed through hospice. She had no knowledge of Resident A being on any medication that was not prescribed for her or being overmedicated. Ms. Novakowski agreed to provide documentation regarding each resident who resided in the home. As of this date, I have not received Resident A's medication administration records.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

On 7/30/2024, I conducted an unannounced on-site investigation at which time I interviewed staff member Eryka Konayara. Ms. Konayara stated she began working full-time three days ago but picked up extra shifts at this home earlier in the year when there were four residents residing in the home, Resident A, Resident B, Resident C, and Resident D. Ms. Konayara stated Resident A and Resident B, Resident C died (exact dates unknown) and Resident D moved as she was given a discharge notice.

On 8/28/2024 I conducted an exit conference with the licensee designee, Carolyn Anderson by telephone. I informed Ms. Anderson of the investigative findings and recommendation documented in this report. Ms. Anderson apologized for the lack of communication from Mr. Kruckeberg and Ms. Novakowski and said she was very sorry things ended this way. Ms. Anderson went on to state that she would like to request an administrative closure. I informed Ms. Anderson that the recommendation stands as written in the report and that she would receive notification regarding a compliance conference.

On 8/28/2024 I conducted an exit conference with Michael Kruckeberg by telephone as he is currently operating the facility under Ms. Anderson and Ms. Cassidy's name and license. I informed Mr. Kruckeberg of the investigative findings and recommendation documented in this report. Mr. Kruckeberg stated he was in a partnership with Misty Novakowski and the agreement was for her and Savannah to operate the day-to-day operations at the facility. Once he determined that things were not operating as agreed upon, he had their partnership dissolved. He requested consideration to move forward with the licensing process without any involvement from Ms. Novakowski. I informed Mr. Kruckeberg that the recommendation stands as written in the report and that he would receive notification regarding a compliance conference.

On 09/04/2024, I contacted the licensee designee, Carolyn Anderson regarding our recommendation of a six-month provisional license. Ms. Anderson acknowledged and stated she will submit a corrective action plan requesting to voluntarily close the license due to no residents currently residing at this home.

APPLICABLE RULE	
R 400.14316	**Resident records.**
	Resident records shall be kept on file in the home for 2 years after the date of a resident's discharge from the home.
ANALYSIS:	Based on the information obtained during the investigation, there is sufficient information to determine that resident records were not kept on file in the home for 2 years after being discharged from the home. On 7/30/2024 I did not observe any resident records for Resident A (discharged 3/24/2024 – no forwarding address) Resident B (discharged 5/09/2024 - deceased) Resident C (discharged 4/03/2024 - deceased) Resident D (discharged 3/28/2024 - moved to hospice)
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14103	**Licenses; required information; fee; effect of failure to cooperate with inspection or investigation; posting of license; reporting of changes in information.**
	(3) The failure of an applicant or licensee to cooperate with the department in connection n with an inspection or investigation shall be grounds for denying, suspending, revoking, or refusing to renew a license.
ANALYSIS:	Based on the information or lack thereof, there is sufficient information to determine that Michael Kruckberg and Misty Novakowski did not provide resident records to me as requested on 5/14/2024, 5/17/2024, 7/02/2024 and 7/08/2024. On 5/14/2024, I spoke with Ms. Novakowski by telephone, and she agreed to provide resident records for each resident who resided in the home. On 5/17/2024, I sent Ms. Novakowski a text message requesting the documents she agreed to provide (no response). On 6/14/2024, I called Ms. Novakowski and was unable to leave a message as her voicemail was full. On 7/02/2024, I sent Ms. Novakowski and Mr. Kruckberg an email requesting resident records. On 7/06/2024, I received some resident records from Ms. Novakowski. On 7/08/2024, I sent Ms. Novakoski and Mr. Kruckberg an email requesting the remaining resident records that were requested on 5/14/2024 (no response). As of this date, I have not received any further documents from Ms. Novakowski or Mr. Kruckberg.
CONCLUSION:	**VIOLATION ESTABLISHED**

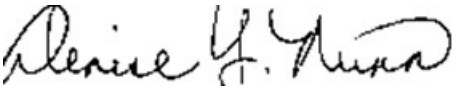
IV. RECOMMENDATION

Contingent upon receiving an acceptable corrective action plan, I recommend modification of the license to a six-month provisional license.

8/28/2024

Cindy Berry Date
Licensing Consultant

Approved By:



08/28/2024

Denise Y. Nunn Date
Area Manager