GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 23, 2024

Achal Patel & Vivek Thakore
Divine Life Assisted Living Center 5 LLC
2045 Birch Bluff Drive
Okemos, MI 48864

RE: License #: AL230404954
Investigation #: 2024A1033056
Divine Life Assisted Living Center 5 LLC

Dear Mr. Patel & Mr. Thakore:

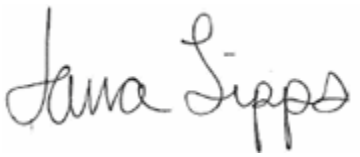
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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

I. IDENTIFYING INFORMATION

License #:	AL230404954
Investigation #:	2024A1033056
Complaint Receipt Date:	08/20/2024
Investigation Initiation Date:	08/20/2024
Report Due Date:	10/19/2024
Licensee Name:	Divine Life Assisted Living Center 5 LLC
Licensee Address:	2045 Birch Bluff Drive Okemos, MI 48864
Licensee Telephone #:	(517) 708-8745
Administrator:	Achal Patel, Designee
Licensee Designee:	Achal Patel & Vivek Thakore, Co-Designees
Name of Facility:	Divine Life Assisted Living Center 5 LLC
Facility Address:	1020 Eastbury Drive Lansing, MI 48917
Facility Telephone #:	(517) 708-8745
Original Issuance Date:	11/20/2020
License **Status:**	REGULAR
Effective Date:	05/20/2023
Expiration Date:	05/19/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Direct care staff are not providing for the supervision, personal care, and protection of Resident A.	Yes
Resident A had a fall and sustained injury the week of 8/12/24 and was not sent for medical attention. Resident A's family was also not notified of the fall.	No
Resident A is being administered Lorazepam and Morphine medication without the consent of the Durable Power of Attorney or a physician's order. Resident A is allergic to Morphine and should not be administered this medication.	No
Residents at the facility are being overmedicated by direct care staff.	No
The facility is not clean and has been found with feces on the floor of the bathrooms and smeared on the toilets.	No
Additional Findings	Yes

III. METHODOLOGY

08/20/2024	Special Investigation Intake- 2024A1033056
08/20/2024	APS Referral- Denied APS referral.
08/20/2024	Special Investigation Initiated – Telephone call made. Interview conducted with Relative A1, via telephone.
08/21/2024	Inspection Completed On-site- Interviews conducted with direct care staff, Chelsie Butler & Michelle Engel, in person. Interview with direct care staff/home manager, Samantha Gardner, via telephone. Review of Resident A's resident record, initiated, facility walkthrough conducted.
08/22/2024	Contact - Document Sent- Email correspondence sent to direct care staff/home manager, Samantha Gardner, requesting further documentation for investigation.
08/23/2024	Contact - Documents received via email from Ms. Gardner.
09/09/2024	Contact - Telephone call made- Joint interview conducted with licensing consultant, Julie Elkins, of Relative A2, via telephone.

09/10/2024	Contact – Document Sent- Email correspondence sent to Ms. Gardner requesting additional documentation.
09/10/2024	Contact – Telephone Call Made Interview conducted with direct care staff, Arica Williams, via telephone.
09/10/2024	Contact – Telephone Call Made Interview conducted with direct care staff, Alyssa Valasek, via telephone.
09/11/2024	Contact – Telephone Call Made Interview conducted with direct care staff, Rebekah Isreal, via telephone.
09/18/2024	Contact – Document Sent Email correspondence sent to co-licensee designees, Achal Patel, Vivek Thakore, and Chief Operating Officer, Cheri Lynn Weaver.
09/20/2024	Exit Conference Conducted via telephone with Chief Operating Officer, Cheri Lynn Weaver, at direction of licensee designees.

ALLEGATION:

- **Direct care staff are not providing for the supervision, personal care, and protection of Resident A.**
- **Resident A had a fall and sustained injury the week of 8/12/24 and was not sent for medical attention. Resident A's family was also not notified of the fall.**

INVESTIGATION:

On 8/20/24 I received an online complaint regarding the Divine Life Assisted Living Center 5 LLC, adult foster care facility (the facility). The complaint alleged that Resident A was observed with a black eye by Relative A1. The direct care staff reported to Relative A1 that Resident A had a fall from her walker and that possibly another male resident had tried to hit Resident A on 8/16/24. The complaint further alleged that Resident A does not use a walker, and that Resident A was found lying on the ground in the facility and in soiled incontinence briefs and no one could provide a timeframe for how long Resident A had been on the ground. On 8/20/24 I interviewed Relative A1 via telephone. Relative A1 reported that she is a relative of Resident A and resides in Canada. She reported that she had traveled to see Resident A on 8/17/24 and made an unannounced visit to Resident A at the facility.

She reported that she was greeted by a direct care staff member who reported to her that she needed to prepare Relative A1 for Resident A's current condition. Relative A1 reported that she was then informed that Resident A had a fall, from her walker, on 8/16/24, and sustained injury to her face and head. Relative A1 reported that she found Resident A with a black eye, in a completely saturated incontinence brief that weighed about "20lbs" and was full of "pee and poop." Relative A1 reported that about one month prior to this date, Resident A was able to visit Relative A1 in Canada and was ambulatory enough to get in and out of her Jeep. Relative A1 reported that Resident A was fully continent of bowel and bladder one month ago and did not require an incontinence brief. Relative A1 reported that she spoke with direct care staff, Chelsie Butler, who reported that Resident A had been left sleeping on the floor in the dining room all night long, the previous night. Relative A1 was also told by another direct care staff (name she could not recall) that Resident A and another resident (name unknown) had an altercation at the facility on 8/16/24. Relative A1 reported that Relative A2 is the Durable Power of Attorney for Resident A's medical needs, and was not informed of Resident A's fall, causing injury, on 8/16/24.

On 8/20/24 I received text messages from Relative A1, containing eight photographs of Resident A that she noted she had taken on 8/17/24 at the facility. The photographs showed dark purple bruising to Resident A's left eye and left temple. They also showed blackish/gray bruising above Resident A's right eye on her forehead. In two of the images Resident A is seen sleeping in a wheelchair.

On 8/21/24 I conducted an unannounced, on-site investigation at the facility. I observed Resident A to be sleeping, soundly in a chair in the living room area. Resident A could not be roused at this time. I observed Resident A to have fading bruising to her face to her left eye, and over both eyebrows. The bruising was consistent with the images that Relative A1 provided to this Consultant on 8/20/24, via text. I conducted a walkthrough of Resident A's resident bedroom and noted an oxygen concentrator in the bedroom. I asked Ms. Butler and direct care staff, Michelle Engle, about the oxygen concentrator and they noted it arrived with Resident A, but she rarely uses it as she does not like to keep it on her face.

During the on-site investigation on 8/21/24, I interviewed Ms. Butler. Ms. Butler reported that she has worked at the facility for about 4-5 months. Ms. Butler reported that she could not recall the exact date that Resident A experienced the fall, but she was working on this date. She reported that she had been in the restroom, assisting another resident when the fall occurred. She reported that her co-worker (name she could not recall), was in the main living room area setting up for medication pass and had her back to Resident A. Ms. Butler reported that Resident A had been sitting on her seated walker and the brakes on the walker were not set. She reported that from what they determined, Resident A tried to stand-up from the seated walker, put her hands on the handles to push up and the walker moved backwards, away from Resident A, causing Resident A to fall face first on the floor. Ms. Butler reported that she made a telephone call to Resident A's medical provider, the Senior CommUnity

Care of Michigan PACE program to report the fall. She reported that she felt Resident A should be sent out to the hospital for evaluation, but she was told by the representative (name unknown) from PACE that Resident A was an “end of life” resident and there was no need to send her to the emergency department. Ms. Butler reported that she did not feel comfortable with this directive and gave the telephone to her supervisor (name unknown), to discuss further. Ms. Butler reported that it was agreed to keep Resident A at the facility and observe at this time. Ms. Butler reported that she did not contact Resident A’s family members as she was under the impression that the direct care staff on the following shift made this communication to the family. Ms. Butler reported that she did not complete an incident report for this incident because she could not find a printed incident report form in the office at the facility. She reported that to her knowledge an incident report was not completed for this incident. Ms. Butler reported that she is not sure where an order for the walker for Resident A would be located. She reported that the direct care staff have been using Resident B’s wheelchair for Resident A due to Resident A’s rapid physical decline since admission. Ms. Butler reported that she is not aware of any resident trying to assault Resident A. She reported that to her knowledge this has not occurred. Ms. Butler reported that Resident A is listed to receive incontinence brief changes every two hours by direct care staff members. Ms. Butler reported that she could not recall the exact date but a day the week of 8/12/24 she did come to work in the morning and found Resident A lying on the floor in the dining room. She reported that Resident A was sleeping on the floor. Ms. Butler reported that direct care staff, Michelle Engle was also working that morning and assisted Ms. Butler in lifting Resident A off the floor. Ms. Butler reported that Resident A was found sleeping on the floor in front of the medication room with no assistive devices around her. She reported that she spoke with the direct care staff, Rebekah Isreal, who had been working the overnight shift on this date and was told that Resident A was throwing herself out of her wheelchair all throughout this shift and that she could not get Resident A to stay in her wheelchair.

On 8/21/24, during the on-site investigation, I interviewed Ms. Engle. Ms. Engle reported that she has worked at the facility for about two months. She reported that she was not working on the date of Resident A’s fall from her walker. Ms. Engle reported that she was not aware what date this fall occurred, but it was one day during the week of 8/12/24. Ms. Engle reported that there is a group chat text message chain among the direct care staff members, and she noted conversation about Resident A’s fall to be reported in the group chat on 8/14/24. Ms. Engle reported that Resident A is now using the wheelchair more often than the walker since the fall from her walker. Ms. Engle reported that she is unsure whether there is an order for Resident A to have a wheelchair or walker at the facility. She reported she does not know where this documentation would be located. Ms. Engle reported Resident A can alert direct care staff to when she needs to use the restroom by either verbally announcing this or attempting to stand and walk to the restroom. Ms. Engle further reported that Resident A is on a two-hour incontinence brief schedule where direct care staff check on her to make sure she is clean and dry. Ms. Engle reported that she has not yet found Resident A in a saturated incontinence brief that

was not changed. She reported that she has found Resident A to be in the same clothes that she had worn the previous day, but she was not unclean. Ms. Engle reported that Resident A requires a two-person assist with mobility, transfers, and personal care. She reported that she has never observed or heard of another resident having a physical altercation with Resident A. Ms. Engle advised that on the morning of 8/17/24 she arrived for her scheduled shift and found Resident A lying on the floor in the dining room. Ms. Engle reported that she is unsure how long Resident A had been left on the floor, but she and Ms. Butler had to get Resident A off from the floor. Ms. Engle reported that she does not recall if Resident A was injured or incontinent when she and Ms. Butler assisted her off from the floor. She did report that she does not recall seeing any assistive devices near Resident A on this date. Ms. Engle reported that the previous shift direct care staff (name unknown) had stated that Resident A had been throwing herself out of her wheelchair all night.

On 8/21/24, during the on-site investigation, I interviewed direct care staff/Home Manager, Samantha Gardner, via telephone. Ms. Gardner reported that she has been promoted to the home manager at the facility and has been in this role for the past month. She reported that Resident A admitted to the facility on 8/13/24 and fell, either on 8/14/24 or 8/15/24, from her walker. Ms. Gardner reported that she was not working on the date of Resident A's fall from her walker. She reported that Ms. Butler had reported to her that she and direct care staff, Arica Williams, were working on the date of the fall. Ms. Gardner reported that Ms. Williams is no longer employed at the facility. Ms. Gardner reported that she could not recall the exact details of the date of the fall as an incident report was not completed. She reported that Ms. Butler stated they did not have any printed incident report forms that she could document the fall. Ms. Gardner reported that she has no knowledge of another resident assaulting Resident A and that the current bruising to Resident A's face is a result of falling from her walker. Ms. Gardner reported that she did not currently have a physician's order for Resident A's walker and wheelchair, but they were ordered by the PACE care team. She reported that normally assistive devices are listed on a Resident Care Plan, but these documents are not signed by a physician. Ms. Gardner further reported that she was not present on the date Resident A was found sleeping on the floor in the dining room. She reported that it was conveyed to her by direct care staff (name not known) that Resident A was experiencing high levels of agitation the evening before and kept throwing herself onto the ground, despite being redirected by direct care staff.

On 8/21/24, during the on-site investigation, I reviewed the following documents:

- *MDHHS-5836 Michigan Physician Orders For Scope of Treatment (MI-POST)*, for Resident A, dated 5/14/24. On page one, under section, *Part 2 – Medical Orders*, subsection, *Section A – Cardiopulmonary Resuscitation (CPR)*, the box is checked noting this directive, "DO NOT attempt Resuscitation/CPR (No CPR, allow Natural Death). Under subsection, *Section B – Medical Interventions*, the box is checked noting the following directive, "Selective Treatment. Primary goal of treating medical conditions while avoiding burdensome measures. May include IV fluids, cardiac

monitoring including cardioversion, and non-invasive airway support." On page two this document is signed by, Leslie Miles, NP-C, Relative A2, and Bailey Whitcomb, RN.

- *Memorial Healthcare, Determination of Resident's Inabilty to Make Health Care, Custody of Medical Treatment Decisions, For Purpose of Activating a "Durable Power of Attorney for Health Care".* This document was written regarding the decision-making capabilities of Resident A. The document was signed by Lynn Larson, DO, on 2/6/24, and Cara Leahy, DO, on 2/27/24. The document reads, "Patient does not appear to understand consequences of medical decisions due to advancing dementia" and "[Resident A] is under my care for a diagnosis of moderate dementia. Due to her dementia she is unable to make her own medical decisions."
- *Patient Advocate Designation,* for Resident A, dated and signed by Resident A on 9/25/23. On page one of this document, it is noted Resident A designated Relative A2 to be her "Health Care Patient Advocate". On page 9 of this document, section, *Medical Directions and End-of-Life Decisions*, subsection, *1. If I have an incurable and irreversible (terminal) condition that will result in my death within a relatively short time, I direct that:*, Resident A has initialed the choices, "I be removed from any artificial life support or any additional life-prolonging treatment" and "I not be artificially administered food and water, realizing this may hasten my death."
- *Assessment Plan for AFC Residents,* for Resident A, dated 7/16/24. On page one, under section, *I. Social/Behavioral Assessment*, subsection, D. *Alert to Surroundings*, it reads, "May be confused at times and staff is to provide redirection." Under subsection, *I. Controls Aggressive Behavior*, the document is marked, "yes". On page two, under section, *II. Self Care Skill Assessment*, it is identified in subsections, *B. Toileting, C. Bathing, D. Grooming, E. Dressing, F. Personal Hygiene, and G. Walking/Mobility*, that Resident A is a "1 person assist with cueing and prep." Under subsection, *J. Use of Assistive Devices*, the document is marked, "yes", with the narrative, "walker." Under section, *III. Health Care Assessment*, subsection, *D. Special Equipment Used (Wheel chair, walker, cane, etc.)*, the document is marked, "yes", with the narrative, "Walker for distances".
- *Health Care Appraisal,* for Resident A, dated 7/9/24. This document lists Resident A's current medical Diagnoses as, Chronic Obstructive Pulmonary Disease, Hypertension, Chronic Kidney Disease, and Coronary Artery Disease. Under the section, *Mobility/Ambulatory Status*, the box is checked for, "Fully Ambulatory". There are no assistive devices listed on this document.
- *PCP Comp Assessment,* for Resident A, dated 5/14/24. This document is noted as the initial assessment for Resident A's PACE services and the Responsible Party noted on the first page, is, Leslie Miles, AGNP. Page 5 of this document identifies the "primary source of information" to be the "participant" or Resident A. The document asks, "How reliable is the primary source?" and is answered, "Good". Per this document it is noted that Resident A indicated that she does not use oxygen, does feel short of breath more than

once per day, is continent of bowel and bladder, and has experienced falls within the past year.

On 8/22/24 I had email correspondence with Ms. Gardner. I requested a copy of the physician orders for Resident A's walker and wheelchair. Ms. Gardner responded to this correspondence on 8/23/24 noting that Resident A's PACE care team "should" have the scripts for the assistive devices. I clarified with Ms. Gardner that she was confirming the physician orders for the assistive devices for Resident A were not in the facility resident record. Ms. Gardner responded on 8/26/24 reporting that Resident A did not have a walker or a wheelchair when she moved into the facility. She further reported that Resident A's decline has been rapid, and she has not yet received the physician's order for Resident A's walker. She reported that she would reach out to the PACE care team and request this order and fax it to this licensing consultant.

On 9/9/24 adult foster care licensing consultant, Julie Elkins, and I interviewed Relative A2 via telephone. Relative A2 reported that she is the Durable Power of Attorney for Healthcare for Resident A. She reported that Resident A was residing in her own home in the month of June 2024 and physically active on a regular basis. She reported that Resident A's home is on the same street as Relative A2 and about 1/8 of a mile from Relative A2's home. She reported that Resident A was walking to see Relative A2 multiple times per day, every day. She reported that a decision was made to have Resident A placed in an adult foster care facility because she was having increased agitation and behavioral outbursts with Relative A2 and her spouse, Relative A3. Relative A2 reported that Resident A was moved from the first adult foster care placement to the facility the week of 8/12/24. She reported that she had been told by Relative A2's PACE care team that Resident A was having increased behavioral issues and required increased supervision and potential medication management for these behaviors. Relative A2 reported that Resident A began to use a seated walker at the previous adult foster care placement. Relative A2 reported that she had not been notified of the fall from the walker that Resident A sustained the week of 8/12/24 at the facility. She reported that she learned of this fall from Relative A1, who had made an unannounced visit to the facility and discovered the injury. Relative A2 reported that Relative A1 took photographs of Resident A's face and sent them to Relative A3, who in turn sent them to Relative A2. She reported that she made a telephone call to the PACE care team to discuss the fall. She reported hat she did not recall who she spoke with, but she was told that the PACE team did not think Resident A's injuries would require medical attention and the PACE team advised Relative A2 to not pursue medical treatment for Resident A's injuries. Relative A2 reported that to this date no direct care staff from the facility have contacted her to discuss Resident A's injuries caused by the fall from her walker.

On 9/10/24 I had email correspondence with Ms. Gardner. I inquired whether she had received physician orders for Resident A's walker and wheelchair. Ms. Gardner responded that she has requested these physician orders from the PACE care team,

and she does not yet have them at the facility. I also requested the most current version of Resident A's *Assessment Plan for AFC Residents* document. Ms. Gardner supplied me the same version I had previously reviewed during the on-site investigation. This assessment plan was dated 7/16/24. Ms. Gardner did supply a document titled, *Resident Care Plan*, for Resident A. This document notes that it was prepared by licensee designee, Achal Patel, but there is no date listed on this document. Under the section, *Mobility/DME*, the boxes are checked for "Assist" and "wheelchair".

On 9/10/24 I interviewed direct care staff, Arica Williams, via telephone. Ms. Williams reported that she had worked at the facility for about 3-4 weeks, but she is no longer employed at the facility. Ms. Williams reported that she did work during the timeframe when Resident A was admitted and that her last date of employment at the facility was 8/16/24. Ms. Williams reported that Resident A required assistance with ambulation, personal care, and toileting. She reported that Resident A could not hold herself up very well and she only had a seated walker for mobility purposes. Ms. Williams reported that to transport Resident A around the facility she would have her sit on the seated walker, and she would push her on this device. She reported that she had expressed concerns to Ms. Gardner that this was not an ideal situation, and that Resident A needed a wheelchair. Ms. Williams reported direct care staff started using Resident B's wheelchair for Resident A as they knew she needed this level of care. Ms. Williams reported that she had been working on the date that Resident A fell from the seated walker. She reported that she had been administering medications and had her back to Resident A, who had been sitting on the seated walker. She reported that Ms. Butler came into the dining room area and yelled out that Resident A had fallen onto the floor. Ms. Williams reported that she did not see the event and is unsure how Resident A fell. She reported that Resident A did have difficulty sitting up on the seated walker previously and did tend to lean forward. Ms. Williams reported that she then assisted Ms. Butler in getting Resident A up and then either Ms. Butler or Ms. Gardner contacted Resident A's PACE care team and updated them to the fall. Ms. Williams reported that they were instructed by the PACE care team not to send Resident A to the hospital as she was under end-of-life care and that the PACE team would come to the facility to check over Resident A's injuries. Ms. Williams reported that she has never observed Resident A being left on the floor of the facility by another direct care staff member. She reported that she heard about this being an incident through the group text message chat she participated in, but she did not directly observe this incident or have any information about this incident. Ms. Williams reported that she had come into the facility for her scheduled shift at 6am on one or two occasions and found Resident A in a saturated incontinence brief that appeared to have not been changed in multiple hours by the overnight direct care staff members.

On 9/10/24 I interviewed direct care staff, Alyssa Valasek, via telephone. Ms. Valasek reported that she has worked at the facility, on the overnight shift, for about six months. Ms. Valasek reported that she has held some concerns about Resident A's personal care not being attended to by other direct care staff members. Ms.

Valasek reported that she can recall on at least one occasion when she arrived for her shift and Resident A was found in an incontinence brief that appeared as though it had not been changed all day. She reported that she could tell Resident A had not been changed because the brief “turned to sand” when she took it off Resident A. Ms. Valasek reported that the incontinence brief was disintegrating due to the amount of urine that was in the brief and she had to take Resident A to the shower to clean her at this time. Ms. Valasek reported that she has heard complaints from residents that the second shift direct care staff are not treating residents with dignity and respect by speaking to them in a rude manner and not providing personal care when required. Ms. Valasek reported that she worked on 9/9/24 and found Resident C in his bed and he had been left in a soiled incontinence brief that was saturated with feces. She reported that Resident C stated that the previous shift had left him in his own feces and had refused to change his brief. Ms. Valasek further reported that the week of 9/2/24, Resident D had called the local police for assistance because direct care staff, Latatyana Tatum and Taquelea Watkins, had taken Resident D’s cell phone charger and given it to another resident for use. Ms. Valasek reported that when Resident D requested his cell phone charger back Ms. Tatum And Ms. Watkins teased him with it by withholding it from him and then threw it on the ground in front of him instead of handing the cell phone charger back to Resident D. Ms. Valasek reported that she believes the exact date of this occurrence was 9/5/24.

Ms. Valasek reported Resident A admitted to the facility without a walker or a wheelchair. She reported Resident A was not able to ambulate and required assistance from two direct care staff with mobility. She reported that Resident A’s family did bring her a seated walker after admission. She reported direct care staff started using Resident B’s wheelchair to assist Resident A as they did not have a wheelchair for Resident A to use. Ms. Valasek reported that Resident A is now bedbound and rapidly declining, but prior to this they would have her sit in the living room either on her seated walker or in a wheelchair and she would slide out of these devices onto the floor. She further reported direct care staff have a group text message chat and she recalled reading in this chat a directive to not allow Resident A to sleep on the floor, even if she does throw herself onto the ground.

On 9/11/24 I interviewed direct care staff, Rebekah Isreal, via telephone. Ms. Isreal reported that she has worked at the facility for about one month and works on the overnight shift. She reported that this shift is scheduled from 10pm to 6am. Ms. Isreal reported that when Resident A admitted to the facility she could not stand and did not have a walker or a wheelchair. She reported that Resident A could not stand up straight and could not hold herself up in a chair. Ms. Isreal reported that a walker was located, and they attempted to use this walker with Resident A but she could not maneuver the device. Ms. Isreal reported direct care staff would try to transport Resident A on the seated walker, but she could not hold herself up on this device. She reported direct care staff then started using Resident B’s wheelchair to transport Resident A as she did not have her own wheelchair at this point. Ms. Isreal reported that Resident A would lower herself out of the wheelchair and crawl on the floor. Ms. Isreal reported that Resident A would frequently slide herself out of the wheelchair

and end up on the floor as well. She reported that she would get Resident A back into the chair and she would repeat the same activity. She reported that Resident A was lying on the ground in the dining room at the end of one of her shifts and the first shift staff who arrived at 6am picked Resident A up off from the ground and got her back to her chair. Ms. Isreal reported that after the other direct care staff members picked Resident A up off from the floor, Resident A slide herself back onto the floor again. Ms. Isreal reported that she has observed on occasion where Resident A was left in a completely saturated incontinence brief when she has arrived for her shifts. Ms. Isreal reported that she is not sure whether Resident A was not changed by the previous direct care staff, or not as "[Resident A] is a heavy wetter."

On 9/18/24 I reviewed the following document, *Eaton County 911 Event Report*, dated 9/5/24. Under the section, Notes, it reads, "Male stating help. Female in Background stating let me talk to 911. Sounds like fighting over the phone. Female telling male to go to his room. Male keeps stating help help help. TX HX w/[Resident D]. Staff on TX states high behavior pt, calls 911 a lot. Pt is [Resident D] room 113 per staff. Staff member is Shaquayla."

On 9/18/24 I sent an email correspondence to co-licensee designees, Achal Patel & Vivek Thakore, as well as direct care staff/Chief Operating Officer, Cheri Lynn Weaver, requesting assistance in identifying whether there is documentation of orders for assistive devices for Resident A's walker and wheelchair that have been noted to be used at the facility. I received a voicemail message from Ms. Weaver on 9/19/24 which acknowledged receipt of the email correspondence sent. Ms. Weaver stated that she is still trying to obtain these orders from the PACE care team and will send them to this Consultant once they are received.

APPLICABLE RULE	
R 400.15305	**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 upon interviews with Relative A1, Ms. Butler, Ms. Engle, Ms. Gardner, Relative A2, Ms. Williams, Ms. Valasek, & Ms. Isreal, as well as review of Resident A's resident record, there is a preponderance of evidence to suggest that the direct care staff have not been providing for Resident A's personal care needs, protection, and safety, at the facility. It was reported by each direct care staff member interviewed that Resident A admitted to the facility in a weakened condition, without a walker or a wheelchair for her use. That a walker was brought by family members, but that Resident A was not physically capable of using the walker due to her weakened condition. The direct care staff chose to have Resident A, sit unsupervised on this seated walker in this condition, resulting in Resident A attempting to stand up from the walker and falling on the ground. The direct care staff further reported that they then chose to utilize Resident B's wheelchair for Resident A to keep Resident A safer in the facility. Ms. Williams, Ms. Valasek, Ms. Isreal, and Relative A1 all reported on separate occasions, finding Resident A completely saturated in either urine and/or feces. Relative A1 reported that the incontinence brief she found Resident A wearing was so completely saturated that she felt as though it "weighed 20lbs". Ms. Valasek described finding Resident A in an incontinence brief that was so saturated it was disintegrating when she went to remove it from Resident A's body. Additionally, Ms. Valasek reported an incident concerning Resident C being found in soiled incontinence briefs. As a result of the above findings, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15306	**Use of assistive devices.**
	(2) An assistive device shall be specified in a resident's written assessment plan and agreed upon by the resident or the resident's designated representative and the licensee.

ANALYSIS:	Based upon interviews with Relative A1, Ms. Butler, Ms. Engle, Ms. Gardner, Relative A2, Ms. Williams, Ms. Valasek, & Ms. Isreal, as well as review of Resident A's resident record, it can be determined that the direct care staff did not have a wheelchair listed on the *Assessment Plan for AFC Residents* form for Resident A, despite reporting the use of Resident B's wheelchair for Resident A's safety. The *Resident Care Plan* document does list a wheelchair, but this document is not dated, making it difficult to determine when this document was prepared. Therefore, a violation has been established as all assistive devices being used for Resident A's care were not listed on the current assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15306	**Use of assistive devices.**
	(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization.
ANALYSIS:	During the on-site investigation on 8/21/24 I requested to view the physician's orders for Resident A's walker, wheelchair, and oxygen and Ms. Butler, Ms. Engle, and Ms. Gardner, were not able to provide this documentation. I emailed Ms. Gardner on 8/22/24 and 9/10/24 requesting she provide documentation of the physician's orders for Resident A's wheelchair, walker, and oxygen. Ms. Gardner responded with an order for Resident A's oxygen that was dated 9/6/24 but reported that she had been unable to obtain the orders for the walker and wheelchair to date. I emailed Mr. Patel, Mr. Thakore, and Ms. Weaver, requesting information on whether they had physician's orders for Resident A's walker and wheelchair on 9/18/24. Ms. Weaver responded, via voicemail message, on 9/19/24 noting she was still attempting to obtain these orders from the PACE care team. A violation has been established as the direct care staff were not able to present a valid physician's order for Resident A's walker and wheelchair despite noting using both assistive devices for Resident A's safety, and having the walker listed on Resident A's *Assessment Plan for AFC Resident's*, form, dated 7/16/24, and the wheelchair listed on Resident A's *Resident Care Plan* document, undated.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 upon interviews with Relative A1, Ms. Butler, Ms. Engle, Ms. Gardner, Relative A2, Ms. Williams, Ms. Valasek, & Ms. Isreal, as well as review of Resident A's resident record it can be determined that the direct care staff did seek medical attention for Resident A after she sustained a fall at the facility the week of 8/12/24. Ms. Williams, Ms. Butler, and Ms. Gardner reported that the PACE medical provider was contacted via telephone for Resident A on this date. They further reported that they were instructed to keep Resident A at the facility as she was receiving comfort care and not to send Resident A to the emergency department. As a result, the direct care staff followed the appropriate steps to contact the primary medical care team and followed the instructions provided to them. Therefore, a violation will not be established at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

- **Resident A is being administered Lorazepam and Morphine medication without the consent of the Durable Power of Attorney or a physician's order. Resident A is allergic to Morphine and should not be administered this medication.**
- **Residents at the facility are being overmedicated by direct care staff.**

INVESTIGATION:

On 8/20/24 I received an online complaint regarding the facility. The complaint alleged that Resident A is being administered morphine when she is allergic to this medication and that she is being administered Lorazepam medication without consent. The complaint further alleged residents at the facility appear to be overmedicated as evidence by them sleeping heavily after the noon meal each day. On 8/20/24 I interviewed Relative A1. Relative A1 reported that she made an unannounced visit to Resident A at the facility and discovered that Resident A has been administered morphine and Lorazepam medications. She reported that she spoke with Ms. Butler who confirmed these medications were being administered. Relative A1 reported that Resident A has a morphine allergy and should not be

administered morphine. She further reported that Resident A was never ordered Lorazepam prior to admission to this facility, and she feels as though many of the residents appeared “drugged” when she was visiting. Relative A1 reported concerns that these residents are being administered too much medication, causing lethargy.

On 8/21/24 I conducted an unannounced, on-site, investigation at the facility. I interviewed Ms. Butler. Ms. Butler reported that she had recently been made aware, by Relative A1, that Resident A has a morphine allergy. I inquired when she was made aware and she reported that while this licensing consultant was reviewing Resident A’s resident record today, Ms. Butler received a telephone call from Relative A1 stating not to continue administering the morphine to Resident A as Resident A has an allergy to this medication. Ms. Butler reported that the morphine will be discontinued as of 8/21/24.

On 8/21/24, during the on-site investigation, I interviewed Ms. Engle. Ms. Engle reported that she was unaware if Resident A had any medication allergies. I inquired how Ms. Engle would determine if a resident had a medication allergy. She reported that this information could be found in the computer under the resident’s *Medication Administration Record* (MAR). I asked Ms. Engle to check Resident A’s MAR. She logged onto the computer and reported that the MAR indicates Resident A is allergic to morphine. Ms. Engle reported being surprised by this as she was not aware of this, and the direct care staff have been administering morphine to Resident A since she was admitted to the facility.

On 8/21/24, during the on-site investigation, I interviewed Ms. Gardner, via telephone. Ms. Gardner reported that she is aware Resident A is allergic to morphine and noted this information on her admission paperwork when she admitted to the facility on 8/13/24. Ms. Gardner reported that she reached out to the PACE medical care team for Resident A and expressed her concerns regarding the morphine allergy and the fact that morphine was ordered for Resident A’s use. Ms. Gardner reported that she cannot recall the name of the individual she spoke with at PACE, but she was told that Resident A’s allergy to morphine, is not really an “allergy” but more of an “intolerance.” She reported that she was told by this provider that the morphine, at most, may cause Resident A to have an upset stomach but no detrimental side effects. Ms. Gardner reported that she has been holding Resident A’s morphine since 8/19/24 as Relative A1 expressed concerns about the medication. I inquired how this is communicated with the direct care staff. Ms. Gardner reported that she initiated a message in the direct care staff group text chat indicating to hold Resident A’s morphine. She reported that she does not have an order from Resident A’s PACE care team to hold this medication. She further reported that the PACE care team have not decided whether they are going to discontinue the medication or continue with the morphine.

During the on-site investigation on 8/21/24 I reviewed the following documents:

- *MAR* for Resident A for the month of August 2024. Some of the medications listed on this document included:

- Lorazepam CON 2mg/ml, “Take 0.5ml between the gum and cheek every 4 hours for anxiety/restlessness”. This medication was prescribed by Leslie Miles on 7/31/24. This medication is marked as being administered at the facility from 8/13/24 at 12pm through 8/21/24 at 8am, with the following exceptions; 8/13/24 12am, 4am, 8am, 8/17/24 12am, 4am, 8am, 12pm, 4pm. The following reasons are documented as reasons why this mediation was not administered as prescribed:
  - “Did not have proper orders this morning to give mediations”
  - “Third shift did not pass”
  - “Resident’s daughter, [Relative A1] did not want us to give resident med due to extreme drowsiness and is having concerns”
  - “I wasn’t here till 6am”
  - “Family did not want this medication given”
- Morphine Sul Sol 100/5ML, “Take 0.25ml between the gum and cheek every 4 hours as needed for pain & shortness of breath”. This medication was prescribed by Ms. Miles on 7/25/24. This medication is marked as being administered on 8/14/24, 8/15/24, 8/18/24, 8/19/24. The following reasons are documented as reasons why this medication was administered:
  - “Resident says her body hurts all over.”
  - “Medication was given earlier, forgot to mark”
  - “Pain”
- Haloperidol CON 2mg/ml, “Take 0.5ML (1mg) by mouth every 6 hours as needed”. This medication was prescribed by Ms. Miles on 7/25/24. This medication is marked as being administered on 8/14/24, 8/15/24, 8/18/24, 8/19/24. The following reasons are documented as reasons why this medication was administered:
  - “Anxious”
  - “Agitation”

- *Physician’s Orders for Resident A*, dated 8/11/24. This document notes PACE Senior Community Care of Michigan as the primary care provider for Resident A, morphine is listed as an allergy for Resident A, and identifies that Ms. Miles prescribed, Morphine, Lorazepam, Haloperidol, as written on the August 2024 MAR.
- *Medication Profile,* for Resident A, dated 8/13/24. On page two of this document under the section, *Allergy*, it reads, “morphine”. Under the subsection, *Reaction*, it reads, “Drug allergy”. Under the subsection, *Description*, it reads, “Drug allergy”. Under the subsection, *Onset*, it reads, “03/27/2024”.
- *Lansing Senior CommUnity Care Michigan – Participant Medications,* for Resident A, dated 8/13/24. Under the section, *Allergies*, it reads, “Morphine”. Under the section, *Current Medications*, is listed:
  - *Acetaminophen*
  - *Atropine*

    - *Haloperidol Lactate*
    - *Lorazepam*
    - *Morphine Sulfate*
    - *Ondansetron*
    - *Prochlorperazine*
    - Quetiapine Fumarate
- *Divine Nest Assisted Living – Resident Face Sheet*, for Resident A. This document lists that Resident A is a "DNR" (Do Not Resuscitate) and involved with the PACE program. Under the section, *Allergies*, "morphine" is listed.
- *Health Care Appraisal*, for Resident A, dated 7/9/24, signed by Bailey Whitcomb, RN. Under section, *Allergies*, it reads, "Morphine".
- *PCP Comp Assessment,* for Resident A, dated 5/14/24, and completed by Ms. Miles. On page one, under section, *Allergy*, it reads, "Morphine", under section, *Date Identified*, it reads, "3/27/2024 Age: 79 years".

On 8/23/24 I received, via email, from Ms. Gardner, a copy of all resident *MARs* for the month of August 2024. I reviewed each of these *MARs*. I did not find any indications of overmedication with antipsychotic medications, pain medications, or anti-anxiety medications. The *MARs* demonstrated all resident routine medications and medications ordered on an as needed basis, administered as prescribed. The "as needed medications" did not appear to be used in a frequent, consistent manner in any way indicating the need for consultation with the medical provider.

On 9/9/24 Ms. Elkins and I interviewed Relative A2, via telephone. Relative A2 reported that she is the designated Durable Power of Attorney for medical decision making for Resident A. Relative A2 reported that prior to residing at the facility, Resident A had been a resident at another adult foster care facility. She reported that while at this previous placement Relative A2 received communication from Resident A's PACE care team, noting Resident A was experiencing behaviors at the facility where she was acting in an aggressive manner and trying to climb out of the windows to escape. She reported that she was told by this PACE team member (name she could not recall), that they needed to "medicate the behaviors." Relative A2 reported that it was not uncommon for Resident A to act in this manner as when she lived alone Resident A would become physically aggressive with Relative A2 and Relative A3. Relative A2 reported that the PACE care team discussed adding some medications for Resident A's comfort, such as an anti-anxiety medication and possibly morphine. Relative A2 reported that it was not clear to her that Resident A was going to be started on the morphine right away and she was not aware Resident A had been administered morphine until a direct care staff from the previous adult foster care facility sent her a text message on her cell phone indicating that Resident A was being administered morphine and noting Resident A's chart listed a morphine allergy. Relative A2 reported that she spoke with the PACE care team regarding the morphine allergy and was told that because Resident A was receiving comfort care that morphine would be the medication used. Relative A2 was asked if Resident A had a morphine allergy. Relative A2 reported that she was not sure Resident A did, in fact, have a morphine allergy. She reported that there was speculation that

Resident A had stated to a physician that she was allergic because she did not want to take morphine, and then this was placed on her resident record going forward. When asked if she felt Resident A was being "overmedicated", Relative A2 reported, "I think she was totally being overmedicated." She reported that she expressed this concern to the PACE care team and to the direct care staff at the facility. Relative A2 reported that it appeared the PACE care team changed when Resident A moved from her prior adult foster care placement to the facility. Relative A2 reported that she did not instruct the PACE care team to remove morphine from Resident A's medications and that she was aware Resident A was being administered morphine. She reported that she was aware Resident A was ordered Lorazepam for anxiety, but thought this medication was being administered one time per day, not every four hours.

On 9/10/24 I requested, via email, for Ms. Gardner to send Resident A's completed MAR for the month of August 2024 and the current MAR for September 2024. I reviewed these documents and noted the following findings:

- MAR, August 2024, Resident A:
    - Lorazepam, "take 0.5ml between the gum and cheek every 4 hours for anxiety/restlessness. **Resident out of facility 23 Aug 2024 to 26 Aug 2024: Went with daughter to Canada**." This medication was administered as prescribed with the exception for the time period she was away from the facility with her family, 8/27/24 (4pm, 8pm), 8/28/24 (12am, 4am, 8am, 12pm), 8/29/24 (4pm). Reasons noted on the MAR for these missed doses included, "Waiting for pharmacy to fill", "Resident did not need", "asleep".
    - Morphine Sul, "Take 0.25ml between the gum and cheek every 4 hours as needed for pain and shortness of breath." This medication was administered on 8/14/24, 8/15/24, 8/18/24, 8/19/24, 8/22/24, 8/27/24, 8/28/24. Reasons noted on the MAR for administered doses, "resident says her body hurst all over", "medication was given earlier, forgot to mark", Resident says her chest and legs are in pain", "pain", "pain/anxious", "restless/agitation/pain".
    - Haloperidol, "Take 0.5ml (1mg) by mouth every 6 hours as needed". This medication was administered on 8/14/24, 8/15/24, 8/18/24, 8/19/24, 8/22/24, 8/26/24, 8/27/24, 8/28/24, 8/29/24, 8/30/24. Reasons noted on the MAR for administered doses, "anxious", "agitation", "agitation/restless", "agitation132", "agitation/hitting", "restless".
- MAR, September 2024, Resident A:
    - Lorazepam medication is marked as being administered as ordered except on dates, 9/3/24 (12am, 4am, 8am), 8/8/24 (12am, 4am). Reasons noted for missed doses include, "resident refused", "resident did not need", "was asleep".
    - Haloperidol medication is marked as being administered on 9/2/24 & 9/8/24. Reasons noted for administered doses include, "Restless, agitated, sitting self on floor", "agitation", "restless".

- Morphine medication is marked as being administered on 9/5/24, 9/7/24, 9/8/24, 9/9/24. Reasons noted for administered doses include, “pain”, “doctors orders”, “restless”, “shortness of breath/pain”

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Based upon the interviews conducted with Relative A1, Relative A2, Ms. Butler, Ms. Engle & Ms. Gardner, as well as review of Resident A’s resident record and the MARs for the month of August 2024 for each resident in the facility, it can be determined that the direct care staff have been administering medications as prescribed by licensed physicians. There was no evidence found of resident medications being administered in a manner in which they were not prescribed. Although, Resident A's file notes in multiple places that she has an allergy to morphine, the direct care staff did discuss this concern with the medical provider who ordered Resident A the morphine and were told to continue to administer the medication. Relative A2 reported that she was made aware the morphine had been ordered for Resident A’s use and reported that she did not direct the provider or the direct care staff to discontinue the administration of the morphine.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility is not clean and has been found with feces on the floor of the bathrooms and smeared on the toilets.

INVESTIGATION:

On 8/20/24 I received an online complaint regarding the facility. The complaint alleged that the facility is not clean and has been found with feces on the floor of the

bathrooms and smeared on the toilets. On 8/20/24 I interviewed Relative A1 regarding the allegations. Relative A1 reported that she made an unannounced visit to the facility on 8/17/24 and observed food debris and dirt on the floors in the main dining room/living room area, and feces on the toilets. She reported that she took Resident A to the restroom and had to request a direct care staff member to clean the bathroom so that she could toilet Resident A.

On 8/21/24 I made an unannounced, on-site investigation, to the facility. I walked through the facility. I observed Ms. Butler mopping the main dining room/living room area, when I arrived. This area was free from food debris and dirt on the floor and other surfaces. I observed the restrooms to be clean and with no visible feces on the toilet or in the shower areas.

On 9/10/24 I interviewed Ms. Williams, via telephone. Ms. Williams reported that she is a previous direct care staff member and worked at the facility for about 3-4 weeks. She reported that she did not have concerns about the cleanliness of the facility. She reported that the direct care staff were constantly cleaning after meals and ensuring a sanitary environment.

On 9/10/24 I interviewed Ms. Valasek, via telephone. Ms. Valasek reported that she has not experienced the facility to be unclean when she is working. She reported that she works the midnight shift and the direct care staff on this shift do deep cleaning while the residents are sleeping.

On 9/11/24 I interviewed Ms. Isreal, via telephone. Ms. Isreal reported that she feels the facility is being kept clean by the direct care staff. She reported no concerns regarding this issue and advised that the overnight direct care staff members clean when the residents are sleeping.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	Based upon interviews with Relative A1, Ms. Williams, Ms. Valasek, & Ms. Isreal, as well as observations made during the unannounced, on-site investigation on 8/21/24, there is not a preponderance of evidence to suggest that the facility is not being kept clean, comfortable, and orderly, by the direct care staff. Therefore, a violation will not be established at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

During the on-site investigation on 8/21/24 I reviewed Resident A's resident record. I reviewed the document:

- *Assessment Plan for AFC Residents*, form dated 7/16/24. This document was completed prior to Resident A's admission to the facility on 8/13/24.

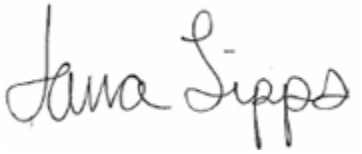
On 9/10/24 I sent email correspondence to Ms. Gardner, requesting the current assessment plan for Resident A. Ms. Gardner responded to this email on 9/10/24 and provided the same copy of the *Assessment Plan for AFC Residents* form, dated 7/16/24, that I had previously reviewed on 8/21/24. This document indicates that Resident A only uses a "walker" as an assistive device.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.

ANALYSIS:	Based upon interviews conducted with direct care staff members and review of Resident A's resident record, it can be determined that Resident A was admitted to the facility on 8/13/24 and her *Assessment Plan for AFC Residents* form was dated 7/16/24. It was identified that Resident A was transferred to the facility from another adult foster care facility and the assessment plan reviewed appears to be the assessment plan that was written at the previous facility. Ms. Gardner was asked to produce the current assessment plan for Resident A on 9/10/24 and provided the same assessment plan dated 7/16/24. Therefore, Resident A's assessment plan was not completed at the time of admission to the facility, and it was not updated with accurate information regarding the assistive devices being used for Resident A's care, as every direct care staff member interviewed agreed that Resident A required the use of a wheelchair and was being transported in the facility with Resident B's wheelchair.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



9/20/24

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Jana Lipps Date
Licensing Consultant

Approved By:

09/23/2024

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Dawn N. Timm Date
Area Manager