GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 9, 2024

Priscilla Espinosa
Angels Retirement Home, Corp.
108 Spruce Ave
Holland, MI 49423

RE: License #: AS230407136
Investigation #: 2024A1033058
Angels Retirement Home, Corp.

Dear Ms. Espinosa:

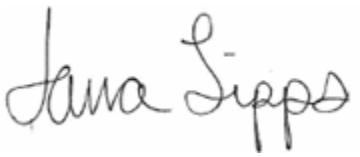
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AS230407136
Investigation #:	2024A1033058
Complaint Receipt Date:	09/11/2024
Investigation Initiation Date:	09/11/2024
Report Due Date:	11/10/2024
Licensee Name:	Angels Retirement Home, Corp.
Licensee Address:	108 Spruce Ave Holland, MI 49423
Licensee Telephone #:	(616) 546-5567
Administrator:	Jose Espinosa
Licensee Designee:	Priscilla Espinosa
Name of Facility:	Angels Retirement Home, Corp.
Facility Address:	10216 Royston Rd. Grand Ledge, MI 48837
Facility Telephone #:	(616) 546-6556
Original Issuance Date:	03/09/2022
License Status:	REGULAR
Effective Date:	09/09/2024
Expiration Date:	09/08/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED AGED

II. ALLEGATION(S)

	Violation Established?
Resident A went into cardiac arrest on 9/4/24 and direct care staff, Tapanga Bernal, did not perform cardiopulmonary resuscitation prior to emergency medical services arriving on-site.	Yes

III. METHODOLOGY

09/11/2024	Special Investigation Intake 2024A1033058
09/11/2024	APS Referral- Resident A is deceased. No referral required.
09/11/2024	Special Investigation Initiated - Letter Email correspondence sent to Complainant.
09/18/2024	Inspection Completed On-site Interviews conducted with Resident B and direct care staff, Tapanga Bernal.
09/18/2024	Contact - Document Sent Email correspondence sent to licensee designee, Priscilla Espinosa, requesting Resident A resident documents.
09/18/2024	Contact - Telephone call received Interview conducted with licensee designee, Priscilla Espinosa, via telephone.
09/19/2024	Contact - Telephone call made Interview with Guardian A1, via telephone.
09/19/2024	Contact - Document Sent Email correspondence sent to Guardian A1.
09/19/2024	Exit Conference- Conducted via telephone with licensee designee, Priscilla Espinosa.
10/04/2024	Contact - Document Sent FOIA request sent to Eaton County Sheriff's office for police report #2024-4462.
10/04/2024	Contact - Telephone call made

	Attempt to interview Harmony Cares medical provider, Jessica Bates. Message left, awaiting a returned call.
10/04/2024	Contact – Document Sent Email sent to licensee designee, Priscilla Espinosa, requesting employee file documents.
10/07/2024	Contact – Telephone Call Received Returned call received from Jessica Bates, Nurse Practitioner, with Harmony Cares Medical Group.

ALLEGATION: Resident A went into cardiac arrest on 9/4/24 and direct care staff, Tapanga Bernal, did not perform cardiopulmonary resuscitation prior to emergency medical services arriving on-site.

INVESTIGATION:

On 9/11/24 I received an online complaint regarding the Angels Retirement Home, adult foster care facility (the facility). The complaint alleged that on 9/4/24 Resident A experienced cardiac arrest and direct care staff, Tapanga Bernal, did not perform cardiopulmonary resuscitation (CPR) prior to emergency medical services arriving on-site. The complaint further alleged that Resident A did not have a Do Not Resuscitate (DNR) order in place at the time of the cardiac arrest. On 9/11/24 I emailed Complainant regarding the allegations. I received a returned correspondence from Complainant on 9/13/24, who identified that there was a police report filed for this incident and the police report number was 2024-4462. On 9/16/24 I sent a FOIA request to the Eaton County Sherrif's Office requesting a copy of the police report. I received a follow up response noting that the police report had not been completed and to wait two to three additional weeks before resubmitting this request.

On 9/11/24 I received the document, *AFC Licensing Division – Incident/Accident Report*, for Resident A, dated 9/4/24, via email from Ms. Espinosa. This document was completed by Ms. Bernal. Under the section, *Explain What Happened/Describe Injury*, it reads, "[Resident A] was not doing good the whole day. Licensee Priscilla called her doctor and stated that [Resident A] was not eating or drinking and wanted to put her on hospice as they discuss at her last appointment. The doctor and hospice were going to come out the next day to see [Resident A]. As I was doing my rounds around 10:50pm on the residents I noticed [Resident A] was unresponsive. I checked for a pulse and heartbeat. I did not feel or hear one. Went to call 911 right away and open the door for EMT to come in and then they took over her care." Under the section, *Corrective Measures Taken to Remedy and/or Prevent Recurrence*, it reads, "Resident was going to be on hospice the next day before she

passed away." Under the section, *Physician's Diagnosis of Injury, Illness or Cause of Death*, if known, it reads, "Dementia with behaviors, T2DM, Vitamin D Deficiency."

On 9/18/24 I conducted an unannounced, on-site investigation at the facility. I interviewed Ms. Bernal on this date. Ms. Bernal reported that she is the live-in direct care staff member at the facility. She reported that on the date of 9/4/24 she was at the facility, providing care and noted that the licensee designee, Priscilla Espinosa, had been away on vacation. Ms. Bernal reported that several days prior to 9/4/24 Resident A had been demonstrating signs of a physical decline. She reported she spoke with Ms. Espinosa daily and informed her of the decline. She described the decline as Resident A was not eating and drinking well. She reported that she would attempt to get Resident A to drink liquids, and the liquids would just dribble out of the sides of her mouth because she was not swallowing. Ms. Bernal reported that Resident A was not swallowing her food either. Ms. Bernal reported that during one of her telephone conversations with Ms. Espinosa it was discussed that due to Resident A's dementia and continued physical decline that hospice may be an appropriate next step for Resident A. Ms. Bernal reported that Ms. Espinosa was planning to have this conversation with the medical provider for Resident A. Ms. Bernal reported that she was rounding on Resident A every one to two hours because of the decline she had been exhibiting. She reported that she received a call from Resident B's call button around 10:30pm on 9/4/24. Ms. Bernal reported that she went to the bedroom to check on Resident B and Resident B advised that she felt Resident A had stopped breathing. Ms. Bernal reported that she checked Resident A for a pulse with her fingers and a stethoscope and then called 911 for assistance. She reported that after she called 911, she then called Ms. Espinosa to update her to the situation. Ms. Bernal reported that shortly after calling 911 the emergency medical technicians (EMT) arrived and began CPR. She reported that they told her she should have started CPR as Resident A did not have a signed DNR order at the facility. She reported that shortly after the EMTs began CPR, it was ended, and Resident A was pronounced deceased. Ms. Bernal reported that until this incident transpired, she was unaware whether Resident A was considered a "full code" or a DNR. She reported that since hospice care had been discussed for Resident A, CPR was not expected. Ms. Bernal reported that the Medical Examiner (name not known) did contact her to discuss the circumstances surrounding Resident A's death. She reported she answered these questions to the best of her abilities.

During the on-site investigation I attempted to interview Resident B. Resident B has a barrier in communicating verbally due to her current medical condition. It was very difficult to understand her speech on this date. I attempted to communicate with her by using a communication board and Resident B did not engage with this activity.

On 9/18/24 I interviewed Ms. Espinosa, via telephone, regarding the allegations. Ms. Espinosa reported that Resident A had been physically and cognitively declining for at least a week. She reported that Resident A was not eating and drinking as well as she normally did and they had communication with the Harmony Cares medical

provider, Jessica Bates, regarding this concern. Ms. Espinosa reported that Ms. Bates is a nurse practitioner who makes home visits to Resident A at the facility. Ms. Espinosa reported on 9/3/24 she made a telephone call to the Harmony Cares office to report that Resident A was not doing well. She reported that the individual she spoke with noted a medical provider would make a visit to the facility on 9/4/24 and discuss a transition to hospice care for Resident A. Ms. Espinosa reported that she received information from Harmony Cares that manager, Jim Knepp, had been in contact with Guardian A1's office regarding signing Resident A up for hospice services and signing a DNR order on 9/3/24, but Resident A died on 9/4/24 before this service could be arranged. Ms. Espinosa reported that Resident A was still a "full code" resuscitation status at the time of the cardiac arrest on 9/4/24. She reported that Ms. Bernal did not realize that Resident A was a full code and did not perform CPR when she observed Resident A to be without a pulse. Ms. Espinosa reported that she has made modifications to the resident paperwork to make it easily identifiable whether a resident is a full code or a DNR. Ms. Espinosa reported that she received a call from Ms. Bernal on 9/4/24 informing her that she found Resident A unresponsive and with no pulse. Ms. Espinosa reported that she advised Ms. Bernal to contact 911 for emergency assistance. Ms. Espinosa reported that Ms. Bernal communicated to her that she had checked Resident A for a pulse with her fingers and a stethoscope. She reported that Ms. Bernal stated that when she checked Resident A for a pulse her body was already stiff as though she had been deceased for a longer period of time. Ms. Espinosa reported that after Resident A was pronounced deceased, she called Guardian A1 to inform her of the death. She reported she left two voicemail messages for Guardian A1 regarding the death.

On 9/19/24 I interviewed Guardian A1, via telephone, regarding the allegations. Guardian A1 reported that Resident A had been experiencing a physical and cognitive decline. She reported that Ms. Espinosa had made telephone calls to her identifying that Resident A was experiencing psychotic behaviors and the direct care staff were struggling to manage her care due to these behaviors. Guardian A1 had little information to provide during this telephone conversation as she noted she was not near her computer or her files to check Resident A's case. She was not certain whether Resident A was a full code or a DNR. Guardian A1 reported that each of her wards remains a full code unless two physicians provide documentation to determine that an individual should be ordered a DNR. Guardian A1 reported that she would like this licensing consultant to email her any additional questions, and she would follow up via email when she can review her notes.

On 9/19/24 I emailed Guardian A1 requesting additional information regarding Resident A. On 9/24/24 I received a response to this email correspondence. Guardian A1 reported that Resident A had been a full code resuscitation status. She reported that someone from the Harmony Cares Hospice group had reached out to her office on 9/4/24 and requested a DNR order for Resident A. She reported that Ms. Espinosa and the Harmony Cares team did attempt to speak with the Guardian's office on 9/4/24 regarding Resident A's continued decline.

On 9/20/24 I received the following documents from Ms. Espinosa, via email:

- Visiting Physicians Association, *Advance Directive*, for Resident A, dated 4/28/22. This document identifies Guardian A1 as the emergency contact for Resident A. It further is marked that Resident A should receive CPR in the event of cardiac arrest and is signed by Guardian A1.
- *Health Care Appraisal*, for Resident A, dated 6/7/24. This document is completed by Ms. Bates. Under the section, *7. Diagnoses*, it reads, "Dementia with behaviors, T2DM, Vit D. Deficiency." Under section, *10. General Appearance*, it reads, "anxious, nonverbal, well groomed."

On 10/4/24 I submitted another FOIA request for police report #2024-4462. On 10/4/24 I received a copy of this document. I reviewed this document on 10/7/24. On page two, the report identified that on 9/4/24 at 10:58pm the Eaton County Sherrif's Department, Deputy A. Kerrigan and Deputy Maring were dispatched to the facility due to a 911 call reporting Resident A was not breathing and did not have a pulse. EMTs arrived on the scene and it was reported at this time, by Ms. Bernal, that Resident A was not on hospice services and did not have a DNR order. The report further identifies that Resident A was pronounced deceased by "Dr. Deluca" at Sparrow Hospital on 9/4/24 at 11:45pm. The report states that no signs of abuse or neglect were observed when examining Resident A's body. On page 3 of this report under the section, *Charges requested*, it reads, "None". Under the section, *Follow up*, it reads, "None".

On 10/7/24 I received documentation, via email, from Ms. Espinosa, of Ms. Bernal's CPR certification. This certificate identifies that Ms. Bernal has successfully completed CPR/AED/First Aid for adults, child, infant. The course is marked as completed on 7/30/24.

On 10/7/24 I interviewed Ms. Bates, via telephone, regarding the allegation. Ms. Bates reported that Resident A had been a patient of hers for the past year. She reported that she has multiple residents she provides care for at the facility. Ms. Bates reported that she noted Resident A was experiencing a physical and cognitive decline a couple of months ago and cited a visit note dated 8/14/24 where she documented having concerns about Resident A's continued behavioral and physical decline and discussed hospice with Ms. Espinosa. She reported that Ms. Espinosa was planning to address the need for hospice with Guardian A1. Ms. Bates reported that she had concerns about Resident A's weight loss, behaviors, lack of interest in food and overall decline. She reported that on 9/4/24 Ms. Espinosa had called Harmony Cares and was requesting hospice services due to Resident A's continued decline. She reported that Jim Knepp with Harmony Cares Hospice reached out to Guardian A1 and was met with resistance to signing the hospice admission paperwork for Resident A. She reported that Mr. Knepp expressed that Guardian A1 wanted two physicians to agree that Resident A required hospice services. Ms. Bates reported that the authorization for hospice services did not come through prior to Resident A experiencing cardiac arrest at the facility. She reported that Resident A was a full code and did not have a current DNR order on file. Ms. Bates reported,

"I don't feel like life sustaining measures would have changed [Resident A's] outcome." She reported that she had assessed Resident A had been declining for at least one to two months and was trying to advocate for hospice services this entire time, but Guardian A1 met these recommendations with resistance.

APPLICABLE RULE	
R 400.14310	**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 conducted with Ms. Bernal, Ms. Espinosa, Guardian A1, and Ms. Bates, it can be determined that Resident A experienced cardiac arrest on 9/4/24 and despite her code status being a "full code", Ms. Bernal did not perform CPR when she identified that Resident A was not breathing and did not have a heartbeat. Although, Ms. Espinosa, Ms. Bernal, & Ms. Bates, agree that Resident A had been experiencing a physical and cognitive decline prior to the cardiac arrest, it was also identified that Resident A's code status had not yet been changed to a DNR. As a result, a violation has been established as Ms. Bernal had an obligation to perform CPR on Resident A until the EMTs arrived to assume Resident A's care.
CONCLUSION:	**VIOLATION ESTABLISHED**

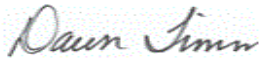
IV. RECOMMENDATION

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


10/8/24

Jana Lipps Date
Licensing Consultant

Approved By:


10/09/2024

Dawn N. Timm Date
Area Manager