GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 12, 2024

Ellen Byrne
Commonwealth Senior Living at East Paris
3956 Whispering Way, SE
Grand Rapids, MI 49546

RE: License #: AH410407276
Investigation #: 2025A1021013
Commonwealth Senior Living at East Paris

Dear Ellen Byrne:

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 authorized representative 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,

Kimberly Horst

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410407276
Investigation #:	2025A1021013
Complaint Receipt Date:	10/31/2024
Investigation Initiation Date:	10/31/2024
Report Due Date:	12/30/2024
Licensee Name:	MCAP East Paris Opco, LLC
Licensee Address:	Suite 301 915 E. High Street Charlottesville, VA 22902
Licensee Telephone #:	(434) 963-2421
Administrator:	Ellen Byrne
Authorized Representative:	Ellen Byrne
Name of Facility:	Commonwealth Senior Living at East Paris
Facility Address:	3956 Whispering Way, SE Grand Rapids, MI 49546
Facility Telephone #:	(616) 949-9500
Original Issuance Date:	08/16/2023
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	90
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was administered insulin incorrectly.	Yes
Additional Findings	No

III. METHODOLOGY

10/31/2024	Special Investigation Intake 2025A1021013
10/31/2024	Special Investigation Initiated - Telephone left message with administrator
11/07/2024	Contact - Telephone call made interviewed SP1
11/17/2024	Contact - Document Received received Residen A's docuements
11/12/2024	Exit Conference

ALLEGATION:

Resident A was administered insulin incorrectly.

INVESTIGATION:

On 10/31/2024, the licensing department received a complaint with allegations on 07/20/2024, Resident A received insulin incorrectly. The complainant alleged Resident A’s blood glucose was low, and insulin should not have been administered. The complainant alleged the staff person that administered insulin was already under investigation for past behavior.

On 11/07/2024, I interviewed staff person 1 (SP1) by telephone. SP1 reported on 07/22/2024, she was notified by Relative A1 that Resident A was administered incorrect insulin. SP1 reported she immediately placed SP2 on suspension and completed an investigation. SP1 reported the investigation revealed that second shift came on duty, checked Resident A’s blood glucose level, which was at 38, and provided cake and juice to Resident A. SP1 reported Resident A’s blood glucose did not rise after 15 minutes, and Resident A was transferred to the emergency room for evaluation. SP1 reported it was learned that SP2 did administer insulin incorrectly and SP2 was terminated.

On 11/08/2024, I received Resident A's medication administration record (MAR) for July 2024. The MAR revealed Resident A was ordered Novolog Inj flexpen with instructions to inject 4 units three times daily with meals in addition to sliding scale <70=call MD. The MAR revealed on 07/20/2024 at 12:00pm, Resident A's blood glucose was 61 and Resident A was administered 4 units. The MAR revealed at 5:00pm, Resident A's blood glucose was 38 and insulin was not administered.

I reviewed SP2 employee record. SP2 was hired on 09/01/2022. SP2 completed *Medication Administration Competency* on 12/16/2022. The employee record revealed the following:

Counseling/Disciplinary Notice: Date of Notice: 12/22/2022
On 12/20/2022 associate was the scheduled med tech in building 6. Associate failed to sign out several narcotics from the log book resulting in the narcotic count being off.
Corrective Action: Associate will be removed from med tech and only be scheduled as a caregiver until further training can be obtained by ARCD or RCD. Along with Relias training scheduled. Further violations to CSL handbook will result in further disciplinary action up to termination.
Review of SP2 record revealed this training never occurred.

Counseling/Disciplinary Notice: Date of Notice: 04/11/2023
(SP2) was witnessed clocking in for another associate on 4/11/2023. This is against CSL policy.
Corrective Action: Employee will not falsify time punches and will not punch in anyone else beside herself. Further infractions of that handbook will lead to disciplinary action up to termination.

Counseling/Disciplinary Notice: Date of Notice: 05/14/2024
The above employee called RCD and reported that she had mistakenly given the member the wrong medication.
Corrective Action: Due to nature of the offense disciplinary action currently is a Final written warning currently and re-education on Commonwealth Policies for the above violations. The employee must complete training in Relias and will be removed from the med cart until training has been completed. If the behavior persists it will lead to further disciplinary actions up to and including termination of employment at CSL-EP.
Review of SP2 training revealed Relias training "A Review of Medical Error Prevention" was completed on 06/08/2024 and Medication Technician Test was administered on 05/04/2023.

Counseling/Disciplinary Notice: Date of Notice: 06/23/2024
It was reported that the employee was overheard dropping the "F" word while performing care for member and telling the member that she thought she was independent with cares, and "Don't you know how to move your leg."

Corrective Action: Final Written Warming due to nature of offense at this time, the employee persists with behavior it will lead to further actions up to termination.

Counseling/Disciplinary Notice: Date of Notice: 07/08/2024
The employee had call light times greater than 10 minutes.
Corrective action: Due to nature of the offense disciplinary action currently is a Final written warning currently and re-education on Commonwealth Policies for the above violations. If the behavior persist it will lead to further disciplinary actions up to and including termination of employment at CSL-EP.
Review of SP2 training revealed SP2 completed re-education on 07/08/2024.

Counseling/Disciplinary Notice: Date of Notice: 07/22/2024:
It was found through documentation in QuickMar that member was administered Novolog 4 units at 12:38pm with a BS less than 70 (61). The members order was called to inject 4 units three times daily with meals in addition to SS. Call MD if MS <70. Physician was not notified for lunch time BS readings. After reviewing Quick Mar and speaking with care staff it was documented that the member received insulin at 12:38pm with a blood sugar of 61. Per physicians orders physician should be notified if blood sugar is <70. There was no documentation that the RMA spoke with the physician nor any documentation that the lunch insulin was not given.
Correction Action: Termination.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
For Reference: R 325.1901	**Definitions.**
	(p) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	Review of SP2 employee record revealed SP2 had six disciplinary notices, and three offenses were medication issues. On 12/22/2022, SP2 was to complete re-training on medication

	administration, and review of SP2 employee record revealed this training was not completed. The facility did not ensure the safety and protection of Resident A by continuing to allow SP2 to administer medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

11/08/2024

Kimberly Horst — Date
Licensing Staff

Approved By:

11/12/2024

Andrea L. Moore, Manager — Date
Long-Term-Care State Licensing Section