GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 18, 2025

Kory Feetham
Big Rapids Fields Assisted Living LLC
4180 Tittabawassee Rd
Saginaw, MI 48604

RE: License #: AL540415024
Investigation #: 2025A0622021
Big Rapids Fields II Assisted Living

Dear Mr. Feetham:

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) 284-9727.

Sincerely,

Amanda Blasius, 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 #:	AL540415024
Investigation #:	2025A0622021
Complaint Receipt Date:	01/06/2025
Investigation Initiation Date:	01/07/2025
Report Due Date:	03/07/2025
Licensee Name:	Big Rapids Fields Assisted Living LLC
Licensee Address:	18900 16 Mile Road Big Rapids, MI 49703
Licensee Telephone #:	(989) 450-8323
Administrator:	Kenda Gilbert, Administrator
Licensee Designee:	Kory Feetham, Designee
Name of Facility:	Big Rapids Fields II Assisted Living
Facility Address:	18880 16 Mile Rd Big Rapids, MI 49307
Facility Telephone #:	(231) 426-2521
Original Issuance Date:	08/08/2023
License Status:	REGULAR
Effective Date:	01/25/2024
Expiration Date:	01/24/2026
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
In the last 45 days the Resident A has said that she is hungry. Resident B reports she has limited options and limited quantities of food available.	No
The facility is not following Resident A's diet.	Yes
Facility is supposed to assist Resident B with putting cream on her back and nails due to her psoriasis. Staff at the facility are documenting that they are doing this, but Resident B has personally disputed this.	No

III. METHODOLOGY

01/06/2025	Special Investigation Intake 2025A0622021
01/07/2025	Special Investigation Initiated – Telephone call to complainant.
01/24/2025	APS Referral- Additional allegations came in through APS denial
01/24/2025	Inspection Completed-BCAL Sub. Compliance
02/10/2025	Contact - Telephone call made to Resident A
02/11/2025	Contact - Telephone call made to DCW, Resident B and LD
02/13/2025	Contact- Telephone call made to direct care worker
02/18/2025	Exit conference with administrator Kenda Gilbert.

ALLEGATION: In the last 45 days, Resident A has said that she is hungry. Resident B reports she has limited options and limited quantities of food available.

INVESTIGATION:
On 01/06/2025, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, Resident A moved into the facility in October 2024 and over the past 45 days, Resident A has been reporting she is hungry. The complaint stated that Resident A is not being fed enough. On 01/24/2025, additional allegations were received. The additional complaint reported that Resident B reports that there are limited food options and

limited quantities of food at the AFC home. Resident B does not appear to be emaciated or malnourished at this time according to the complaint.

On 01/07/2025, I interviewed Complainant via phone. Complainant reported that Resident A reports that she is hungry, and she complains daily. She stated that they don't always feed Resident A dinner or provide peanut butter and jelly sandwiches. Complainant stated that the AFC has a lack of food, has ran out of juice and has had to borrow coffee from Resident A one morning. Complainant reported that she has provided snacks for Resident A to keep in her room.

On 01/24/2025, I completed an unannounced onsite investigation to Big Rapids Fields II Assisted Living. During the investigation, I viewed the kitchen and interviewed Resident A. While walking through the kitchen, I viewed multiple refrigerators and freezers full of food and a pantry full of food. I also viewed a snack area that is kept in the dining room, that offered snacks and fresh fruit. On a white board within the kitchen was alternative options for residents who did not want the meals served. The options available are a deli sandwich, peanut butter and jelly sandwich, soup or leftovers. Also listed on the white board was drinks available at meals. For breakfast, residents have the option of water, milk, coffee, tea, juice or cocoa. For lunch and dinner residents have the option of water, tea, coffee, lemonade or milk. On the white board was also listed the times for each meal. Breakfast is offered at 8am, lunch at 12pm and dinner at 4:45pm. During the investigation, I arrived during lunch time and observed the residents to be eating a full plate of food, which matched the meal listed on the menu. The residents were having meatballs, egg noodles, peas and muffins.

On 01/24/2025, I interviewed Resident A in person. Resident A reported no concerns that she is hungry. She stated that she can ask for seconds if she needs additional food. Resident A stated that they have had many changes with kitchen staff, but over the last two weeks the food has been better. Resident A did report that the eggs can be cold sometimes and the toast is not always toasted. Resident A stated that snacks are available at the home and her daughter in law also brings in snacks that she can keep in her room. Resident A stated that last month, staff had to borrow coffee from her, as they had run out in the kitchen. Resident A reported that she volunteered to share her coffee with the kitchen.

On 01/24/2025, I interviewed Resident C in person. Resident C reported that the home offers a lot of food, and she has no concerns about the portions available. Resident C stated that her favorite meal is spaghetti and fruit, and vegetables are offered for each meal.

On 02/11/2025, I interviewed Resident B via phone. Resident B was asked if she is getting enough food at meals, and she reported that she gets enough food, and the home is going "to serve what they serve." Resident B reported that she had no complaints she wanted to share about the food served at the home.

APPLICAB/LE RULE	
R 400.15313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	During the investigation, I interviewed three current residents, and no concerns were reported regarding the amount of food available within the home. During the investigation, I observed a meal being served that was appropriate in portion size and nutritional value, along with an appropriate amount of food available within the kitchen for meals and current snacks available to residents in the dining room.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The facility is not following Resident A's diet.

INVESTIGATION:
On 01/06/2025, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, Big Rapids Fields II Assisted Living is not following Resident A's diet.

On 01/07/2025 I interviewed Complainant via phone. Complainant reported that Resident A is prescribed a healthy heart diet from her doctor and the AFC facility is not following or providing this diet to her. Complainant explained that they have visited Resident A during meals times and have observed chips being served during dinner meals.

On 01/24/2025, I completed an unannounced onsite investigation to Big Rapids Fields II Assisted Living. During the unannounced onsite investigation, I viewed Resident A's file. I viewed Resident A's *Health Appraisal*, which was completed on 10/3/24 and stated in box number 14 under special dietary instructions, healthy heart diet- general consistency and thin liquids. I also viewed Resident A's *Assessment Plan for AFC Residents,* which was dated 10/10/2024. Under special diets, it listed healthy heart diet and small amounts of salt.

On 01/24/2025, I interviewed Resident A in person. She reported that she is on a healthy heart diet and would like to try and follow it. Resident A stated that she does not feel that her diet is being followed, as she is able to eat everything that is listed on the menu. Resident A reported that when she was in rehab, the food she was allowed to eat looked much different and healthier options for her heart healthy diet were provided.

On 01/24/2025, I interviewed Kenda Gilbert, administrator in person. I asked to view menus for the AFC home, along with special diet menus. Administrator, Ms. Gilbert reported that the home only has one menu for all residents and their menu made up of healthy foods for all the residents. I asked administrator, Ms. Gilbert how a healthy heart diet was accommodated for, and she reported that the kitchen does not use any salt and only uses Mrs. Dash on the food. She was asked if any other accommodations were made for a healthy heart diet and she reported no. Administrator, Ms. Gilbert stated that on 12/01/2024, her main kitchen staff member quit without notice, therefore, there was a few days they needed to scramble to cover the kitchen and re-supply the kitchen with food as the food order was not placed.

On 01/24/2025, I interviewed direct care worker (DCW), Heather Helsel who was covering in the kitchen for the past week. She reported that she mainly works in activities, but in the past, she was the kitchen manager for one year, therefore she was helping until staff were hired. DCW Helsel reported that the kitchen staff personally prepares each resident's plate according to any special diets, allergies or food preferences, which is listed on the white board in the kitchen. DCW Helsel stated that for a healthy heart diet, they use Mrs. Dash, which is a salt free seasoning, and no regular salt is used. On 02/11/2025, I interviewed DCW Helsel via phone to ask additional follow up questions. DCW Helsel reported that the home uses a variety of canned, frozen and fresh vegetables. She stated that they attempt to buy low sodium canned items. I asked DCW Helsel how she would know that Resident A had a healthy heart diet, and she explained that it would be in a book they had in the kitchen and then that information is transferred to the white board and under each residents identified number. DCW Helsel stated that she would then adjust Resident A's plate if needed to follow her healthy heart diet. I read out the items listed under Resident A's number to DCW Helsel, which were no rice, no corn, no fish, no poppy seeds. DCW Helsel asked if Resident A's doctor prescribed her a healthy heart diet and if it was listed on her health appraisal, as she was unsure why her healthy heart diet was not listed on the white board. On the white board in the kitchen, staff had diabetic diets, allergies and small portions listed next to other resident's numbers.

On 01/24/2025, I viewed the cupboard where the seasonings were kept. I viewed Mrs. Dash seasoning that is salt free. Next to Mrs. Dash seasoning, was a saltshaker full of regular salt and the container was almost empty. On the bottom shelf of the seasoning cabinet was a large box of Morton coarse Kosher Salt.

On 01/24/2025, I viewed January's menus for breakfast, lunch and dinner. Administrator Ms. Gilber and DCW Helsel reported that only one menu is used for the entire facility and the kitchen staff personally make changes to resident's plates based on the information listed on the white board.

The following items were found on the January menus that could cause concerns for Resident A's healthy heart diet.

Lunch Menu

- 1/4/25: French fries
- 1/8/25: fried potatoes
- 1/9/25: Onion rings
- 1/11/25: Chips
- 1/15/25: Fried potatoes
- 1/16/25: Fried chicken

Dinner Menu

- 1/3/25: Pizza
- 1/4/25: Chips
- 1/7/25: Chips
- 1/15/25: Tater tot casserole
- 1/21/25: KFC bowls
- 1/25/25: Chips
- 1/31/25: Pizza

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet.
ANALYSIS:	After interviewing administrator, Ms. Gilbert and DCW Helsel it was determined that Big Rapids Fields II Assisted living is not following Resident A's healthy heart diet that is prescribed from her doctor and listed in her *Health Appraisal* and *Assessment Plan for AFC Residents.* After reviewing the homes January menu, it was determined that additional food substitutions need to be made to support Resident A's healthy heart diet. Just adjusting the salt used within the facility is not effective to support a prescribed healthy heart diet. In addition, the staff report they do not use regular salt on the food, although it was observed to be in the cupboard and almost empty. The white board located within the kitchen, which details all residents' special diets, allergies or need for portion control did not list that Resident A had a healthy heart diet, therefore staff were not informed while preparing Resident A's plate that special diet substitutions would need to be made.
	VIOLATION ESTABLISHED

ALLEGATION: Facility is supposed to assist Resident B with putting cream on her back and nails due to her psoriasis. Staff at the facility are documenting that they are doing this, but Resident B has personally disputed this.

INVESTIGATION:
On 01/27/2025, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint direct care workers are supposed to assist Resident B with putting cream on her back and nails due to her psoriasis. Staff at the facility are documenting that they are doing this, but Resident B has personally disputed this.

On 02/06/2025 I received medication administration records for Resident B for the month of January and February. According to the record, Resident B was either out of the facility or refused her ointment for her back and fingers on the following dates:

- 01/01/2025
- 01/06/2025
- 01/08/2025 8 am
- 01/08/2025 7:30pm
- 01/10/2025
- 01/13/2025
- 01/16/2025
- 01/27/2025
- 01/30/2025
- 02/03/2025

Based on Resident B's medication administration record, no missed doses of her ointment were documented, nor were any direct care worker medication errors.

On 02/11/2025, I interviewed Resident B via phone. She reported that sometimes staff get busy during the morning shift and forget to help her put on her creams for her fingers and back. Resident B was unable to identify any specific dates or direct care workers names. Resident B reported that she is also supposed to be having creams put on her toes, but staff do not complete this.

On 02/11/2025, I compared Resident B's *Medication Administration Record* to her statement about the cream needing to be put on her toes. According to the *Medication Administration Record* it states the following:

Clobetasol OIN 0.05%; Apply Topically to scalp, hands and hands twice daily, three times weekly (MWF)

On 02/11/2025, I spoke with administrator, Kenda Gilbert via phone. She confirmed that the pharmacy enters the prescriptions into the electronic Quick Mar system that the facility uses. I explained to administrator that Resident B is reporting that the Clobetasol ointment should also be applied to her toes also and that there could be a potential error in the electronic Quick Mar system, since it states "hands" twice. Administrator, Ms. Gilbert was able to find the original prescription and confirmed that the electronic Quick

Mar should state toes, instead of hands twice. Administrator, Ms. Gilbert reported that she was going to contact the pharmacy ASAP and get this changed in the system.

On 02/11/2025, I interviewed direct care worker, Bettie Hubbard via phone. DCW Hubbard reported that she works first shift during the week and was able to confirm that Resident B has ointment that goes on her back and fingers. She also stated that gloves are used after her ointment for her fingers to assist with the effectiveness of the ointment. DCW Hubbard stated that Resident B can refuse her medications and ointment a few times a week, but she was unaware of direct care workers not applying it on Resident B. DCW Hubbard reported that she has not forgotten to apply her ointment for Resident B.

On 02/11/2025, I interviewed direct care worker, Jaycee Schuberg via phone. DCW Schuberg was able to explain that Resident B receives ointment on her fingers three times a week and receives an ointment for her back for pain. DCW Schuberg reported that Resident B has complained that her back pain is getting worse, and her ointment is not helping. She stated that she directed Resident B to talk with her provider at her PACE program to discuss the back pain. DCW Schuberg stated that she has not missed giving Resident B her prescribed ointments.

On 02/12/2025, I interviewed direct care worker, Jade Smith via phone. DCW Smith stated that she works first shift. She was able to confirm that Resident B gets ointment on her hands and back. DCW Smith stated that Resident B has not refused the ointment for her. DCW Smith denied forgetting to put ointment on Resident B during the morning shifts. DCW Smith reported that she applies the ointment at 8am before Resident B leaves for the PACE program.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on interviews with Resident B and direct care workers, there was not enough evidence to determine if Resident B's ointment is not being applied as it is documented by direct care workers. Resident B was unable to identify names or dates of when the ointment was not applied to her back or fingers. A typing error was found on the electronic Quick Mar so it did not match the original prescription. This error was corrected after administrator, Kenda Gilbert contacted the pharmacy who inputs the data into the Quick Mar system for Big Rapids Fields Assisted Living.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend that the status of the license remains the same.

02/18/2025

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Amanda Blasius Date
Licensing Consultant

Approved By:

02/18/2025

_____

Dawn N. Timm Date
Area Manager