GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 10, 2019

Derek Robbins
Heartfelt Residential Care, LLC
STE 392
37637 Five Mile Rd
Livonia, MI 48154

RE: License #: AS630387131
Investigation #: 2019A0605030
Heartfelt Hawthorne Home

Dear Mr. Robbins:

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:

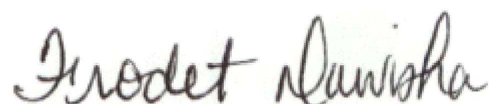
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance 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 (248) 975-5053.

Please note that violations of any licensing rules are also violations of the MSA and your contract.

Sincerely,



Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630387131
Investigation #:	2019A0605030
Complaint Receipt Date:	05/22/2019
Investigation Initiation Date:	05/22/2019
Report Due Date:	07/21/2019
Licensee Name:	Heartfelt Residential Care, LLC
Licensee Address:	STE 392 37637 Five Mile Rd Livonia, MI 48154
Licensee Telephone #:	(800) 379-3860
Licensee Designee/ Administrator:	Derek Robbins
Name of Facility:	Heartfelt Hawthorne Home
Facility Address:	22430 Hawthorne St Farmington, MI 48336
Facility Telephone #:	(800) 379-3860
Original Issuance Date:	08/22/2017
License Status:	REGULAR
Effective Date:	02/22/2018
Expiration Date:	02/21/2020
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED/MENTALLY ILL AGED/TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A is not getting enough nutritious food.	No
Resident A’s blood sugar is not being checked before each meal to determine how much insulin he should receive per physician’s orders.	Yes

III. METHODOLOGY

05/22/2019	Special Investigation Intake 2019A0605030
05/22/2019	Special Investigation Initiated - Telephone Left message for Adult Protective Services (APS) worker, Candid Jamerson.
05/22/2019	APS Referral Complaint was made by Adult Protective Services (APS)
05/28/2019	Contact - Telephone call made I interviewed APS worker, Ms. Candid Jamerson via telephone.
05/29/2019	Inspection Completed On-site I conducted an unannounced on-site investigation. I interviewed staff member, Lonea Moorehead, Resident's B, C and D and reviewed medication logs. I also interviewed the administrator, Tracy Shannon-Woelfel via telephone.
05/29/2019	Inspection Completed On-site I conducted an unannounced on-site investigation. I interviewed staff member Lonea Moorehead and Resident's B, C and D. I also reviewed Resident A's medication logs, physician orders, daily staff documentation forms and medications.
06/11/2019	Contact - Telephone call received APS worker, Ms. Jamerson left message requesting a return call.
06/19/2019	Contact - Telephone call made Telephone call made with APS worker, Ms. Jamerson.

06/19/2019	Contact - Telephone call made Telephone call made with administrator, Tracey Shannon-Woelfel and Resident A's DPOA.
06/19/2019	Contact - Telephone call received Telephone call received from Resident A's friend.
06/19/2019	Exit Conference A telephone call was made with licensee designee, Derek Robbins regarding my findings.

ALLEGATIONS:

- **Resident A is not getting enough nutritious food.**
- **Resident A's blood sugar is not being checked before each meal to determine how much insulin he should receive per physician's orders.**

INVESTIGATION:

On 05/22/19, intake #164638 was received from Adult Protective Services (APR) regarding this home not knowing how much insulin to give to Resident A and not checking his blood sugar levels. There are concerns of Resident A not getting enough nutritional rich food. I conducted an onsite investigation on 05/29/19. I interviewed staff member, Lonea Moorehead and Residents B, C and D who were present. I reviewed Resident A's medication logs and doctor's orders regarding Resident A's insulin.
On 05/28/19, I contacted via telephone APS worker, Candid Jamerson. Ms. Jamerson contacted this home. Resident A was at the Veteran Affairs (VA) Hospital; therefore, she was unable to interview Resident A. Ms. Jamerson reviewed Resident A's medication chart and blood sugar log. There are certain times when Resident A's blood sugar is high, and this results in Resident A's hospitalizations. Resident A's sister is the durable power of attorney (DPOA). Ms. Jamerson does not have the sister's contact information.

On 05/29/19, I conducted an unannounced on-site investigation. I interviewed staff member, Lonia Moorehead. Resident A was still at the VA Hospital and will be picked up tomorrow by the administrator, Tracy Shannon-Woelfel. Ms. Moorehead reported that APS worker, Ms. Jamerson came to this home and reviewed Resident A's medication records and looked at the food and Resident A's insulin. Resident A has been in the hospital since 05/07/19. Ms. Moorehead contacted Ms. Woelfel while I was present. I spoke with Ms. Woelfel briefly on the telephone. Ms. Woelfel stated that Resident A's friend, Marsha (last name unknown) takes Resident A to and from the VA Hospital for all appointments. Marsha was provided with specific instructions by the VA during the last appointment in April 2019, but never provided these instructions to this home. Ms. Woelfel will be personally picking Resident A up from the VA Hospital to ensure the home understands all instructions regarding Resident A's insulin. In addition,

the VA Hospital is willing to instruct staff on the administration of Resident A's insulin. I advised Ms. Woelfel I will be in contact with her should I have any further questions.

Ms. Moorehead stated that Resident A was at the VA Hospital from 02/11/19-April 2019. When Resident A was discharged in April, Marsha picked him up with specific instructions and a glucometer she was supposed to give to this home, but never did. The VA Hospital called the beginning of May asking about the sliding scale and why they were not receiving the blood sugar readings for Resident A. Ms. Moorehead advised the VA Hospital she was unaware of a glucometer as they never received anything from Marsha. Ms. Moorehead called Marsha who told her the glucometer was in her car and she forgot to give it to the home in April. The glucometer should have been used to take Resident A's blood sugar as the results are sent directly to the VA Hospital, which this was not completed because they never received the supplies from Marsha. Ms. Moorehead was instructed by the VA Hospital to take Resident A to the hospital, which they did on 05/07/19. Ms. Moorehead stated that based on the physician's instructions, they must check Resident A's blood sugar prior to each meal and document the reading on their daily staff documentation form and based on that reading is how much insulin Resident A receives.

I reviewed Resident A's insulin orders which states that Resident A receives Prandial/Mealtime insulin: eight units with breakfast, twelve units with lunch, and twelve units with dinner. If pre-prandial BG less than 100, please give half Aspart for meal rather than no insulin. In addition, Aspart during mealtime is given on a sliding scale as well as bedtime. I reviewed Resident A's insulin sheet that indicates that Resident A's blood sugar must be checked before breakfast, snack, lunch, snack, dinner and bedtime. I then reviewed Resident A's daily staff documentation logs for 05/01/19, 05/03/19, 05/04/19 and 05/06/19. Resident A did not have a daily staff documentation log for 05/02/19 and 05/05/19 even though the medication log had staff member initials for 05/02/19 and 05/05/19 for Resident A's insulins, Novolog and Solo Star. On 05/01/19, staff only checked and/or documented Resident A's blood sugar at 8:30PM; on 05/03/19, staff only checked and/or documented Resident A's blood sugar at 7:00PM and 8:20PM; on 05/04/19, staff only checked/documented Resident A's blood sugar at 8:37PM; and on 05/06/19, staff checked/documented Resident A's blood sugar at 7:50 (unsure AM or PM as it was not noted). Based on these logs, staff were not completing blood sugar checks for Resident A as required. I observed nutritional food in the home for Resident A.

I interviewed Resident B who indicated her daughter was her DPOA. Resident B moved in December 2018. Resident A is alert and oriented. She knows what medications she is supposed to be on, and states staff gives her medications on time. She takes medication in the morning and afternoon only. Resident A gets nutritional foods such as fruits and vegetables. Staff is pretty good here with her and the other residents. She knows Resident A is diabetic and receives insulin. She has observed staff checking Resident A's blood sugar before each meal. She also saw staff give Resident A insulin. She has no concerns to report.

I interviewed Resident C who indicated her daughter is her DPOA. She loves living here and stated, “staff are wonderful.” She receives her medications on time and gets enough food that’s nutritional to eat. She gets her medications on time and does not know much about Resident A. She too reported no concerns.
I interviewed Resident D and her nephew who was present in her bedroom. Resident D likes living here and stated, “They are nice people.” She too is aware of all her medications and when she’s supposed to receive them. She has a caregiver who comes to the home and provides services to her in addition to the staff here helping her. She too reported no concerns.

On 06/19/19, APS worker, Ms. Jamerson advised her case was still pending and she wanted to know about the records I reviewed for this home. I advised Ms. Jamerson that it appears the staff were not checking/documenting Resident A’s blood sugar before every meal based on the daily staff documentation log. Ms. Jamerson does not know what the outcome of her APS case is currently as she is still investigating the allegations.

On 06/19/19, I contacted via telephone Ms. Woelfel. She stated Resident A was discharged on 05/30/19. She took Resident A to his follow-up appointment along with four other staff members as the VA hospital conducted an in-service training on insulin administration. Instructions were provided by the VA and the staff is following all instructions. Ms. Woelfel stated since Resident A has been home, they have implemented a blood sugar log that she will send so I can review it. I advised her that I reviewed the daily staff documentation forms that were being utilized for Resident A’s blood sugar checks and it seemed that staff were either not checking or documenting Resident A’s blood sugar before each meal. Ms. Woelfel stated that Resident A’s blood sugar is being documented before each meal and the reading is being provided to the VA hospital.

On 06/19/19, I contacted Resident A’s DPOA. The DPOA likes this home as it’s very clean and Resident A is near his friends. This is the best place she’s ever found, but the staff members are uneducated or well trained. Resident A is brittle diabetic. His diabetes is uncontrollable. He also has celiac disease so whenever he has gluten, he explodes. Resident A’s friend was visiting and saw Resident A eating pizza. It’s unclear if the pizza was gluten free. Resident A was discharged from the VA hospital with a Wi-Fi glucometer. Marsha, Resident A’s friend gave the home the new medicine and the glucometer that sends the reading to the VA, but the home was not using it. I advised the DPOA that the home reported that Marsha never gave them the instructions or the Wi-Fi glucometer after Resident A was discharged from the VA in April. The DPOA stated, “I don’t know the logistics or when the home received the glucometer, but I believe it’s all straightened out now.” The DPOA has no concerns with Resident A residing at this home.

On 06/19/19, I interviewed Resident A’s friend via telephone. The friend was responsible for taking Resident A to and from their doctor appointments at the VA Hospital. The friend cannot recall forgetting to give the Wi-Fi glucometer to this home

but stated that the concerns have now been addressed. Resident A’s blood sugar is being checked before each meal and documented and this information is being provided to the VA Hospital. The friend stated there are no concerns.

On 06/19/19, Ms. Woelfel sent the blood sugar chart staff was logging/documenting Resident A’s blood sugar; however, there are no dates anywhere on the sheet to determine the month and/or days when staff checked Resident A’s blood sugar. Ms. Woelfel also sent June 2019 daily staff documentation forms showing the implementation of staff documenting each blood sugar check completed before Resident A’s meals.

On 06/19/19, I conducted an exit conference with licensee designee Derek Robbins. Mr. Robbins indicated staff were documenting Resident A’s blood sugar on a log sheet in addition to the daily staff documentation form. He stated it was being completed and that he will submit all documents to me to reflect that staff were following the physician’s instructions.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(2) Meals shall meet the nutritional allowances recommended pursuant to the provisions of "Appendix I: Recommended Dietary Allowances, Revised 1980" contained in the publication entitled "Basic Nutrition Facts: A Nutrition Reference," Michigan Department of Public Health publication no. H-808, 1/89. This publication may be obtained at cost from The Division of Research and Development, Michigan Department of Public Health, P.O. Box 30195, Lansing, Michigan 48909.
ANALYSIS:	During the on-site investigation on 105/29/19, I observed plenty of nutritious and gluten free food in this home for Resident A as did APS worker, Candid Jamerson.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(a) Medications.**

ANALYSIS:	Based on my investigation, Resident A's physician with the VA Hospital requested that staff check Resident A's blood sugar before each meal to determine how much insulin Resident A needs. According to the daily documentation forms I reviewed, staff was not checking and/or documenting Resident A's blood sugar levels before each meal. I reviewed the daily staff documentation forms from 05/1/19-05/06/19 and staff had only documented Resident A's blood sugar once per those days. In addition, the daily staff documentation forms were missing for 05/2/09 and 05/05/19. I also reviewed the blood sugar chart log sheet; however, there was no dates on the chart log to determine when these blood sugars were checked/documented.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend that this special investigation be closed and no change to the status of the license.

Frodet Dawisha 06/25/19

Frodet Dawisha Date
Licensing Consultant

Approved By:

Denise Y. Nunn 07/10/2019

Denise Y. Nunn Date
Area Manager