GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 17, 2019

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

RE: License #: AS630387131
Investigation #: 2020A0611001
Heartfelt Hawthorne Home

Dear Mr. Robbins:

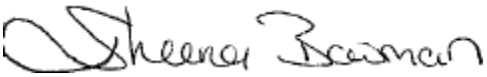
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.

Sincerely,



Sheena Bowman, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630387131
Investigation #:	2020A0611001
Complaint Receipt Date:	10/02/2019
Investigation Initiation Date:	10/04/2019
Report Due Date:	12/01/2019
Licensee Name:	Heartfelt Residential Care, LLC
Licensee Address:	STE 392 37637 Five Mile Rd Livonia, MI 48154
Licensee Telephone #:	(800) 379-3860
Administrator:	Derek Robbins
Licensee Designee:	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, ALZHEIMERS AGED, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident W passed away about two weeks after being admitted to the facility. It is believed the resident may have been over medicated.	No
Additional Findings	Yes

III. METHODOLOGY

10/02/2019	Special Investigation Intake 2020A0611001
10/04/2019	Special Investigation Initiated - On Site I conducted an unannounced onsite investigation. I interviewed staff member Santorria Porter, and the house manager Tracey Woelfel. I received copies of Resident W's assessment plan, health care appraisal, and medication administration records.
10/07/2019	Contact - Document Received I received video screenshots from the licensee designee, Derek Robbins via email.
10/08/2019	Contact - Telephone call made I made a telephone call to Derek Robbins. The allegations were discussed.
10/08/2019	Contact - Telephone call made I left a message for the hospice nurse, Alicia Gibbons requesting a call back.
10/08/2019	Contact - Telephone call received I received a telephone call from Alicia Gibbons. Ms. Gibbons stated she only saw Resident W once at the time of his admission into the AFC group home. Ms. Gibbons advised that Teresa Vlk was the assigned nurse to Resident W.
10/09/2019	Contact - Telephone call made I left a message for Teresa Vlk requesting a call back.
10/09/2019	Contact - Telephone call made I made a telephone call to Resident W's Son #1. The allegations were discussed.

10/10/2019	Contact - Telephone call received I received a telephone call from hospice nurse, Teresa Vlk. The allegations were discussed.
10/10/2019	Contact - Document Received I received video footage of the AFC group home from 09/11/19 via email from Derek Robbins.
10/16/2019	Contact - Telephone call made I made a telephone call to Resident W's wife. However, Resident W's wife was not available as she was receiving chemo treatment. I spoke with Resident W's stepdaughter regarding the allegations.
10/16/2019	Exit Conference I conducted an exit conference with the licensee designee, Derek Robbins.

ALLEGATION:

Resident W passed away about two weeks after being admitted to the facility. It is believed the resident may have been over medicated.

INVESTIGATION:

On 10/04/19, I conducted an unannounced onsite investigation. I interviewed staff member Santorria Porter, and the house manager Tracey Woelfel. I received copies of Resident W's assessment plan, health care appraisal and medication administration records.

On 10/04/19, I interviewed staff member Santorria Porter. Ms. Porter has worked for the AFC group home for two years. Regarding the allegations, Ms. Porter stated Resident W was in hospice. Resident W passed away a few weeks ago in his bedroom. Resident W's wife and stepdaughter visited Resident W between 11:00 am-12:00 pm the day he passed away. Ms. Porter stated the day Resident W passed away he was having trouble breathing as he was actively dying. Ms. Porter stated after Resident W's wife and stepdaughter left the AFC group home, she and staff member Hannah Orow went into his bedroom to change his diaper. Ms. Porter noticed that Resident W was taking deep breathes. Ms. Porter covered Resident W up and cleaned up his bedroom. Ms. Orow left the AFC group home between 2:00 pm-3:00pm. Ms. Porter stated after Ms. Orow left, she checked on Resident W around 4:00 pm. Ms. Porter checked on Resident W again around 6:00 pm.

Ms. Porter stated while she was cleaning the bathroom around 6:10pm, she looked in Resident W's bedroom and noticed he didn't look like he was breathing. At this time, Ms. Porter stated Resident W's sons had arrived at the AFC group home. Ms. Porter stated she answered the door and asked Resident W's sons to give her a second because something didn't look right. Resident W's sons waited at the door while Ms. Porter went into Resident W's bedroom. Ms. Porter checked Resident W's pulse and he wasn't breathing. Ms. Porter stated she informed Resident W's sons that Resident W was not breathing. Ms. Porter contacted the house manager, Tracey Woelfel, Resident W's wife, and the hospice nurse. Ms. Porter stated someone from the funeral home arrived at the AFC group home around 9:30pm. The hospice nurse called the police. Ms. Porter stated Resident W's wife and stepdaughter did not want to enter the AFC group home while Resident W's sons were inside the home. Resident W's wife and stepdaughter wanted the sons to leave however; they refused to do so. Resident W's wife and stepdaughter entered the AFC group home with the police. The police asked Resident W's wife and stepdaughter what the cause of death was. The police also looked at Resident W's medication log and activity book.

Ms. Porter stated the Sunday (09/08/19) before Resident W passed away, he was looking comatose. Ms. Porter stated during this day, Resident W's granddaughter visited him. After Resident W's granddaughter left, Resident W's son, and daughter in-law visited him. Ms. Porter stated Resident W's son was talking to Resident W on the couch. Ms. Porter stated Resident W was talking back to his son and he was able to lift his head.

Ms. Porter stated when Resident W was admitted into the AFC group home, he only ate small amounts of food. Resident W stopped eating the last five days before he passed away however; he would drink Ensure. Ms. Porter stated the day before (09/11/19) Resident W passed away she thought he had a slight stroke because when she tried to put him in bed he started shaking, and his eyes rolled back in his head. Ms. Porter stated she called the police and the police came and checked his vitals. Resident W's vitals were not good. Ms. Porter contacted the hospice nurse. When the hospice nurse came to the AFC group home, she stated Resident W did not have a stroke, but he was in an active stage of dying. Ms. Porter stated Resident W was prescribed medication for diabetes. Ms. Porter was not sure if Resident W had a pacemaker.

On 10/04/19, I interviewed the house manager, Tracey Woelfel. Ms. Woelfel arrived to the AFC group home after I spoke to her and advised her that I needed to review Resident W's file. Ms. Woelfel agreed to come to the AFC group home to unlock the cabinet that contained Resident W's file. Regarding the allegations, Ms. Woelfel stated she was not present in the AFC group home the day Resident W passed away. Resident W was admitted in the AFC group home on 08/29/19 with hospice in place and; he passed away on 09/12/19. Resident W was considered a respite client and not a resident. Ms. Woelfel stated she does not have any concerns regarding Resident W being overly medicated. Ms. Woelfel stated staff only administered Resident W's medications as it was prescribed on his medication administration records (MAR). Ms.

Woelfel stated when Resident W choking started to increase while he was eating the staff started giving him protein shakes. The hospice nurse visited Resident W on 08/29/19, 09/10/19, 09/11/19, and 09/12/19. Ms. Woelfel stated the hospice nurse documented her notes in the daily binder.

On 10/04/19, I observed Resident W's medications. Ms. Woelfel and Ms. Porter were informed that Resident W's medications should have been properly disposed of when he passed away. Ms. Woelfel indicated that she understood and will return the medications to the pharmacy. Ms. Woelfel agreed to email me a copy of the camera footage of the first day (09/01/19) Resident W's son visited him at the AFC group home to confirm whether or not Resident W appeared overly medicated and/or comatose. I took a picture of the AFC group home's sign in sheet and confirmed Resident W's son signed in on 09/01/19.

On 10/04/19, I received a copy of Resident W's MAR's for the month of August 2019 and September 2019. There were no medications errors observed for the month of August 2019. According to the MAR for the month of September 2019, Resident W was administered Tylenol and Hydrocod/APAP as a PRN however; there was no documentation indicating the reason Resident W was administered a PRN. Resident W is prescribed Gabapentin three times a day. Resident W was not administered Gabapentin on 09/05/19 at 1:00 pm or 5:00 pm. Resident W is prescribed Glipizide twice a day however; he was not administered this medication on 09/04/19 or 09/05/19. According to Ms. Woelfel, Resident W passed away on 09/12/19 however; his MAR indicates he was administered medications on 09/13/19.

On 10/04/19, I received a copy of Resident W's health care appraisal dated 08/29/19. The health care appraisal indicates that Resident W was diagnosed with late onset dementia, pacemaker, CHF, and vascular disease. According to the health care appraisal, Resident W had lack of appetite.

On 10/04/19, I received a copy of Resident W's assessment plan. Resident W's assessment plan indicated that he was in hospice, uses a walker and wheelchair, and he has a decreased appetite.

On 10/07/19, I received video screenshots from the licensee designee, Derek Robbins. The following dates are the dates of the screenshots:

- 09/01/19-Resident W was sitting in the living room
- 09/01/19- Resident W was sitting in the living room while another male was showing him something
- 09/01/19- Resident W was sitting at the dinner table with a bottle of ensure in front of him
- 09/02/19-Resident W was sitting at the dinner table drinking
- 09/02/19-Resident W was sitting in the living room next to his wife and stepdaughter

- 09/02/19-Resident W was sitting at the dinner table being fed by a staff member
- 09/02/19-Resident W was sitting at the dinner table drinking with the assistance of a staff member
- 09/02/19-A staff member was transporting Resident W from the chair in the living room to his wheelchair
- 09/11/19-Resident W was sitting at the dinner table
- 09/11/19-There were two screenshot of Resident W's wife and stepdaughter arriving and leaving the AFC group home
- 09/11/19-Resident W was being checked out by EMS.

On 10/08/19, I made a telephone call to the licensee designee, Derek Robbins. Regarding the allegations, Mr. Robbins stated that he has never met Resident W's sons. Ms. Woelfel handles all communications with family members as she is a RN. Mr. Robbins stated the day before Resident W passed away, he spoke with someone over the phone who identified themselves as Resident W's son. Mr. Robbins stated he notified Resident W's son that due to HIPPA laws he cannot discuss a resident with someone he doesn't know. Mr. Robbins stated he referred Resident W's son to speak to Ms. Woelfel. Mr. Robbins stated he does not believe Resident W was hospitalized and; he believes he passed away at the AFC group home.

On 10/09/19, I made a telephone call to Son #1. Son #1 stated he was not aware that Resident W was in hospice until he was admitted into the AFC group home. Son #1 stated he later found out from his stepmother that Resident W had been in hospice since October 2018. Son #1 stated Resident W did not know he was being taken to an AFC group home nor did he want to reside in one. Resident W was admitted into an AFC group home because Resident W's wife could not take care of him anymore because she was being treated for Cancer. Regarding the allegations, Son #1 stated on 09/12/19, he received a phone call from the hospice nurse stating Resident W was dying. Son #1 was also informed that on 09/11/19, while Resident W was sitting in a chair his head lifted back and his eyes rolled back in his head. Son #1 stated Resident W became unconscious and all the staff did was put him in the bed and; he stayed in the bed from 5:00 pm until 5:00 pm the next day when he passed away. On 09/12/19, Son #1 spoke with Mr. Robbins. Son #1 stated Mr. Robbins knew Resident W was dying and he did not tell him. Son #1 understands HIPPA laws, but he doesn't understand why Mr. Robbins couldn't have at least told him that Resident W was dying.

On 10/10/19, I received a telephone call from hospice nurse Teresa Vlk. Ms. Vlk stated prior to Resident W admission into the AFC group home, he was placed in hospice through the branch in Lansing, MI as he lived in Pinckney, MI. Ms. Vlk does not know how long Resident W was in hospice prior to living at the AFC group home. Regarding the allegations, Ms. Vlk stated Resident W's cause of death was congested heart failure. Resident W was also diagnosed with coronary heart disease and he was oxygen dependent. Ms. Vlk stated she did not make any medication changes nor did she discontinue any of Resident W's medications. Resident W was not eating well prior to living at the AFC group home nor was he eating well when he was placed at the AFC

group home. Ms. Vlk stated it is common for someone to stop eating when their health is declining.

Ms. Vlk stated as far as she knows there were no instructions for staff to check Resident W's blood sugar. Resident W was non-insulin dependent as he was only prescribed Glipizide 5mg for his blood sugar. Ms. Vlk stated she was not aware that Resident W had a pacemaker. Ms. Vlk stated it was not possible for staff to check Resident W's pacemaker as that must be done at a doctor's office. Ms. Vlk stated she did not have any abuse and/or neglect concerns regarding how Resident W was being cared for at the AFC group home. Ms. Vlk also denied any concerns regarding staff overly medicating Resident W. Ms. Vlk stated there was nothing strange about how Resident W's health decline as it was "absolutely normal". Ms. Vlk stated she did not observe anything out of the ordinary regarding staff caring for Resident W. Ms. Vlk stated Resident W was very comfortable and at peace when he passed away. Resident W's health was declining before he was admitted into the AFC group home. Ms. Vlk stated according to the hospice branch in Lansing, MI, Resident W was on comfort medications because he was choosing not to eat.

Ms. Vlk stated she was aware there were some family issues as Resident W's children were against Resident W's wife. Ms. Vlk stated she had ongoing contact with Resident W's wife and stepdaughter. Ms. Vlk stated when Resident W passed away the wife were speaking to the police and; the police examined Resident W's body as if someone did something wrong to him. Ms. Vlk stated per Resident W's wife request, on 09/12/19, she contacted Resident W's son to inform him that Resident W was actively dying. Ms. Vlk stated on 09/10/19, she received a phone call from staff stating Resident W's health was declining. As a result, Ms. Vlk ordered a non-scheduled visit to see Resident W. Ms. Vlk stated when she saw Resident W at 10:35 am it was evident that his health had declined. Ms. Vlk stated Resident W would wake up, but he was unable to communicate. Ms. Vlk stated later that night she was informed by staff that Resident W's health had continued to decline. Ms. Vlk stated another nurse visited Resident W on 09/11/19 and; ordered a "by your side level 2" which means a nurse will visit Resident W twice a day.

Regarding Resident W's medications, Ms. Vlk was informed that according to Resident W's MAR, he was not administered Gabapentin on 09/05/19 at 1:00 pm or 5:00 pm, nor was he administered Glipizide on 09/04/19 or 09/05/19. Ms. Vlk stated Resident W would not have experienced an adverse effect for not receiving his Glipizide because he was not eating. However, if Resident W was given his Glipizide it could have caused his blood sugar to go down as a result of not eating. Ms. Vlk stated Glipizide does not have to be taken with food however; it a person is not eating the pills will sit in their stomach and cause their blood sugar to drop. Ms. Vlk stated Resident W would not have experienced an adverse effect for not receiving his Gabapentin as this medication is a neuropathic pain medicine. Ms. Vlk also stated Resident W had trouble swallowing at times.

On 10/10/19, I received video footage of Resident W in the AFC group home from the licensee designee, Derek Robbins. The video is dated for 09/11/19 at 3:26 pm. The video shows staff member Hannah Orow standing next to Resident W while he was in his wheelchair in the living room. Ms. Porter was also in the living room sitting on the couch. There were two other residents sitting at the dinner table. Ms. Orow noticed that something was wrong and called Ms. Porter over to look at Resident W. Resident W was observed hunch over to the side in his wheelchair. Ms. Porter rushed into the kitchen to call someone. At this time, a male staff member entered the living room with another resident. The male staff walked over to Resident W to observe what was going on. While Ms. Porter was on the telephone, she walked over to Resident W next to the other staff members to observe him again. The video ended shortly after.

On 10/16/19, I made a telephone call to Resident W's wife. However, Resident W's wife was not available as she was receiving chemo treatment. I spoke with Resident W's stepdaughter. The stepdaughter stated prior to Resident W's admission into the AFC group home, she was threatened by one of Resident W's sons that she would be charged with murder if she put Resident W in a group home. The stepdaughter stated Resident W had been in hospice since June 2018 and; he was placed at the AFC group home because his wife couldn't take care of him anymore due to starting chemo treatment. Resident W had stopped eating about two weeks prior to living at the AFC group home. The stepdaughter stated she felt like Resident W was going to pass away before he was admitted into the AFC group home.

The stepdaughter stated she has no concerns regarding the AFC group home or hospice as they did an awesome job caring for Resident W. The stepdaughter stated the staff at the AFC group home did a good job with making sure that Resident W ate as they fed him smoothies with kale in it. The stepdaughter stated the AFC group home went above and beyond to care for Resident W. On 09/10/19, the stepdaughter was contacted by the AFC group home regarding Resident W being unresponsive. The stepdaughter stated when she and Resident W's wife arrived at the home, Resident W was not eating, and his eyes were close. However, Resident W did recognize his wife's voice and told her "don't let me go". Resident W's wife and stepdaughter saw Resident W on 09/11/19 and 09/12/19. The stepdaughter stated on both days Resident W was actively dying. On 09/11/19, the stepdaughter was told by the hospice nurse that Resident W was being given comfort medications.

On 10/16/19, I conducted an exit conference with the licensee designee, Derek Robbins. The findings and recommendations were discussed. Mr. Robbins was informed that a corrective action plan will be required.

APPLICABLE RULE	
R 400.14305	**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 on my findings, there is no information that supports the AFC group home did not meet Resident W's personal needs or failed to protect him. The staff at the AFC group home provided immediate medical assistance when it was necessary; as well as contacting his legal guardian and the hospice nurse.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.**
ANALYSIS:	Based on my findings, there is no evidence that supports the staff adjusting or modifying Resident W's medications. The hospice nurse confirms she did not make any changes to Resident W's medications.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

Resident W is prescribed Gabapentin three times a day. Resident W was not administered Gabapentin on 09/05/19 at 1:00 pm or 5:00 pm. Resident W is prescribed Glipizide twice a day however; he was not administered this medication on 09/04/19 or 09/05/19.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	The staff did not administer Resident W's Gabapentin as prescribed on 09/05/19. The staff also did not administer Resident W's Glipizide as prescribed on 09/04/19 or 09/05/19.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

According to Ms. Woelfel, Resident W passed away on 09/12/19 however; his MAR indicates he was administered medications on 09/13/19. Resident W's stepdaughter also confirmed that Resident W passed away on 09/12/19.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	According to Resident W's MAR, he was administered medications on 09/13/19; which is the day after he passed away.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 10/04/19, I received a copy of Resident W's MAR's for the month of August 2019 and September 2019. There were no medications errors observed for the month of August 2019. According to the MAR for the month of September 2019, Resident W was administered Tylenol and Hydrocod/APAP as a PRN however; there was no documentation indicating the reason Resident W was administered a PRN.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(c) Record the reason for each administration of medication that is prescribed on an as needed basis.**
ANALYSIS:	During the month of September 2019, the staff did not document the reasons why Resident W was administered PRN's.
CONCLUSION:	**VIOLATION ESTABLISHED**

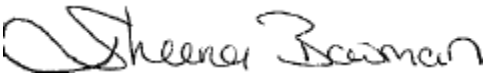
INVESTIGATION:

On 10/04/19, I observed Resident W's medications. Ms. Woelfel and Ms. Porter were informed that Resident W's medications should have been properly disposed of when he passed away. Ms. Woelfel indicated that she understood and that she will return the medications to the pharmacy.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(7) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a physician or a pharmacist.
ANALYSIS:	Resident W passed away on 09/12/19. However, on 10/04/19, Resident W's medications were still present in the AFC group home as the staff had not properly disposed of the medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

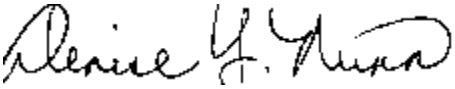
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



10/16/19

Sheena Bowman — Date
Licensing Consultant

Approved By:



10/17/2019

Denise Y. Nunn — Date
Area Manager