GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 25, 2019

Mary Black
Scotland Manor Enterprises, LLC
1357 N. River Road
St. Clair, MI 48079

RE: License #: AS740282833
Investigation #: 2019A0604022
River's Edge Assisted Living

Dear Mrs. Black:

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,

Kristine Cilluffo, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 285-1703

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS740282833
Investigation #:	2019A0604022
Complaint Receipt Date:	06/05/2019
Investigation Initiation Date:	06/05/2019
Report Due Date:	08/04/2019
Licensee Name:	Scotland Manor Enterprises, LLC
Licensee Address:	1357 N. River Road St. Clair, MI 48079
Licensee Telephone #:	(810) 329-1112
Administrator:	Mary Black
Licensee Designee:	Mary Black
Name of Facility:	River's Edge Assisted Living
Facility Address:	1427 Oakland St. Clair, MI 48079
Facility Telephone #:	(810) 329-1112
Original Issuance Date:	10/26/2006
License Status:	REGULAR
Effective Date:	11/04/2018
Expiration Date:	11/03/2020
Capacity:	6
Program Type:	MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Licensee lies to families and steals medications.	No
Resident A is receiving expired insulin and documents are forged to cover it up.	Yes
Kitchen water does not get hot and toilets get plugged due to addition that was put onto facility.	Yes
Bathrooms are not wheelchair assessible	No

III. METHODOLOGY

06/05/2019	Special Investigation Intake 2019A0604022
06/05/2019	APS Referral Complaint made to Adult Protective Services (APS)
06/05/2019	Special Investigation Initiated - Telephone Returned call from Adult Protective Services (APS) Worker, Marnie DeBell.
06/07/2019	Inspection Completed On-site Completed unannounced onsite investigation with APS Worker, Marnie DeBell. Interviewed Mary Black, staff and POA.
06/07/2019	Contact - Document Received Email from Marnie DeBell
06/07/2019	Contact - Document Received Email to and from Mary Black
06/10/2019	Contact - Document Sent Email to Mary Black
06/10/2019	Contact - Document Received Email from Mary Black
06/17/2019	Contact - Document Received Received medication logs from Mary Black by email

06/18/2019	Contact - Document Sent Email to Mary Black
06/18/2019	Contact - Document Received Received medication logs from Mary Black by email
06/19/2019	Contact - Document Sent Email to and from Mary Black
06/20/2019	Contact - Document Received Received insulin notes from Mary Black by email
06/21/2019	Contact - Document Sent Emails to Marnie DeBell
08/01/2019	Contact - Document Sent Email to APS Worker, Marnie DeBell.
08/02/2019	Contact - Document Received Email from APS Worker Marnie DeBell. Sent return email. APS will not be substantiating.
08/02/2019	Contact- Document Sent Email to Mary Black
08/06/2019	Contact- Document Received Email to and from Mary Black. Received pictures of exits at River's Edge.
08/07/2019	Contact- Document Sent Email to Mary Black
09/23/2019	Contact- Document Sent Email to Mary Black requesting documents. Email from Mary Black
10/07/2019	Contact- Document Received Resident assessment plans and resident care agreements mailed to Pontiac office
10/18/2019	Contact- Document Received Email from Mary Black. Sent return email.
10/22/2019	Contact- Document Sent Email to Mary Black

10/23/2019	Contact- Document Received Email from Mary Black
10/24/2019	Contact- Document Received Received health care appraisals from Mary Black by email
10/24/2019	Contact- Document Sent Text messages to and from Mary Black.
28283310/24/2019	Exit Conference Completed exit conference with Mary Black. Text to and from Mary Black and email.

ALLEGATION:

Licensee lies to families and steals medications.

INVESTIGATION:

I received a complaint regarding River's Edge Assisted Living on 06/05/2019. A referral was made to APS on 06/05/2019 and I was notified by APS Worker, Marnie DeBell. The Complainant alleged that Resident A has been given expired insulin for the past two years. It is believed that Mary Black did not know this was occurring, but once it was discovered, Ms. Black was going to forge documents to cover up the mistake. Mary Black has been known to steal medications from residents and take them herself. The bathrooms are not wheelchair accessible and the kitchen's water does not heat up to a hot temperature because when they added an addition to the facility, it was done incorrectly. It has also caused the toilets to be plugged all the time. Mary will lie to the families of the residents at the facility. Residents have left the facility due to the poor care they receive.

I completed an unannounced onsite investigation with APS Worker Marnie DeBell on 06/07/2019. I interviewed Staff, Samantha Tetreau, Mary Black and Resident A's Power of Attorney.

I interviewed Staff Samantha Tetreau. She stated that that she is new to the home and has only worked a few days. She was not aware of any missing medication at the home.

During the onsite investigation, I reviewed resident medication logs and medications in the home. I did not identify any missing medications.

APPLICABLE RULE	
R 400.14201	**Qualifications of administrator, direct care staff, licensee, and members of the household; provision of names of employee, volunteer, or member of the household on parole or probation or convicted of felony; food service staff.**
	(9) A licensee and the administrator shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, social, and intellectual needs of each resident.** **(b) Be capable of appropriately handling emergency situations.**
ANALYSIS:	There is not enough information to determine that licensee designee, Mary Black, is stealing resident medications. I did not identify any missing medications during the onsite investigation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A is receiving expired insulin and documents are forged to cover it up.

INVESTIGATION:

I interviewed Staff, Samantha Tetreau at River's Edge Assisted Living on 06/07/2019. Ms. Tetreau stated that Resident A does not take any insulin. Resident A does have insulin that is kept in the refrigerator. She stated that Resident A has her blood sugar checked before breakfast. I reviewed Resident A's current medication log and insulin was not listed.

During the onsite investigation, I observed Resident A's insulin that was in a lock box in refrigerator. The insulin was Humalog 100 Units/ML and date on box was 01/20/2017. Resident A moved into the home on 01/16/2017. The box said "No refills".

I interviewed Licensee Designee, Mary Black. She stated that Resident A's doctor discontinued her insulin. However, Ms. Black was unable to locate the order. She stated that Resident A came to the home with a lot of medications and brought several bottles of insulin. Ms. Black stated that the bottles are good for two years if unopened. Ms. Black stated that her staff opened-up the last bottle and called the doctor for a new prescription. The secretary asked where they kept insulin and became upset when staff said it was stored in a "whatcha ma call it".

On 06/07/2019, I interviewed Resident A's Power of Attorney. She stated that she is generally happy with the care that Resident A receives. She tries to get to know the

workers at the home. She stated that Resident A was admitted to the home on 01/16/2017 and has dementia. She stated that Resident A previously took Metformin. She stated that about 1½ years ago Resident A was in the hospital and they stated giving her insulin. She stated that she was contacted by River's Edge staff, Sarah and told they needed to refill insulin. She was never asked for refill before and thought the prescription was being filled at Neimans Pharmacy. Resident A's doctor has now said not to give her insulin anymore. She stated that she is not sure if Resident A came to the home with insulin or not. She stated that according to Mary Black insulin is still good if not opened. She stated that Resident A's health was managed well and doctor never had any concerns about numbers that would indicate that insulin was not being given appropriately.

I received Resident A's medication logs from Mary Black by email on 06/17/2019 and 06/18/2019. I reviewed Resident A's medication logs for 2017, 2018 and 2019. The logs states that Resident A was prescribed Humalog 100 units and to inject per scale before breakfast and after dinner. Staff were to initial whether Resident A received 2 units, 4 units, 6 units or 8 units. The sliding scale for number of units is also located on medication logs. The logs indicate that Resident A did not receive Humalog on a daily basis. The Humalog is not listed on Resident A's medication log for September 2017. Resident A's April 2019 medication log indicates that the medication is discontinued per doctor and that Resident A was last given Humalog on 04/30/2019.

Ms. Black provided her notes by email on 06/20/2019 which were reported to be the Humalog count upon Resident A moving into the home. The note indicates that Resident A's medications were given to them by family along with the Humalog and scripts for refills. The note states that the last bottle was opened on 04/23 and they called in for script. The note also indicates the following bottles were received:

01/16/2017- 6 vials from Marwood- sent to River's Edge with her exp July 2019
01/21/2017- 6 vials from Neimans- exp. July 2019
01/24/2017- 7 unused unopened vials from (Resident A's) home - vials 12/15 ex
12/2017- 9 unused unopened vials from (Resident A's) home - vials 2016 exp 2018

I received an email from APS Worker Marnie DeBell on 08/02/2019. Ms. Debell stated that she did not substantiate, as the doctor had no concerns regarding neglect, said that her A1C was always okay and she is no longer prescribed insulin.

Mary Black stated on 10/24/2019 that Resident A is no longer placed in the home and was moved closer to her power of attorney.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician

	or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	There is not enough information to determine that Resident A was not given her Humalog as prescribed. APS Worker, Marnie Debell did not substantiate allegations, as Resident A's doctor had no concerns regarding neglect and Resident A's A1C was always okay and she is no longer prescribed insulin.
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: **(b) Complete aan individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(ii) 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.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	I reviewed Resident A's medication logs for 2017, 2018 and 2019. Resident A's Humalog was not on the August 2017 medication log. Medication logs indicate that Resident A's Humalog was not discontinued until April 2019. Licensee did not have a copy of an order discontinuing Humalog.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	During the onsite inspection, I observed Resident A's Humalog in the home. According to licensee and medication log, the medication was discontinued by doctor in April 2019. The medication should have been disposed of if Resident A is no longer prescribed insulin.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Kitchen water does not get hot and toilets get plugged due to addition that was put onto facility.

INVESTIGATION:

I interviewed Staff, Samantha Tetreau at River's Edge Assisted Living on 06/07/2019. Staff, Samantha Tetreau, stated that the water in kitchen does not get very hot. She stated that there is still an issue with the water temperature even when the washer is not running.

During the onsite investigation, I measured the water temperature with a digital thermometer. The water in the kitchen measured 89.1 degrees Fahrenheit. The water in the bathroom measured 141.6 degrees Fahrenheit.

I interviewed staff Samantha Tetreau and Licensee Designee, Mary Black at River's Edge Assisted Living on 06/07/2019. Samantha Tetreau and Mary Black did not state that there were any issues with toilets getting plugged at the facility. The toilets appeared to be in working order at the time of my investigation.

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(2) Hot and cold running water that is under pressure shall be provided. A licensee shall maintain the hot water temperature for a resident's use at a range of 105 degrees Fahrenheit to 120 degrees Fahrenheit at the faucet.

ANALYSIS:	During the onsite investigation, I measured the water temperature with a digital thermometer. The water in the kitchen measured 89.1 degrees Fahrenheit. The water in the bathroom measured 141.6 degrees Fahrenheit.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(6) All plumbing fixtures and water and waste pipes shall be properly installed and maintained in good working condition. Each water heater shall be equipped with a thermostatic temperature control and a pressure relief value, both of which shall be in good working condition.
ANALYSIS:	During the onsite investigation, I observed that the toilets appeared to be in good working order.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Bathrooms are not wheelchair assessible

INVESTIGATION:

During the onsite inspection, I observed the bathrooms in the home. The bathrooms appeared to be large enough to fit a standard size wheelchair. Mary Black stated that there is no issue with wheelchairs fitting into bathroom with shower.

I reviewed the Original Licensing Inspection Report for River's Edge dated 08/18/2010. The report indicates that the home is not wheelchair assessible.

I received pictures of the home's exit from Mary Black by email on 08/06/2019. The exits are not wheelchair assessible. The home does not have ramps. Mary Black stated in her email dated 08/06/2019, "We have not accepted any wheelchair bound residents. Residents use walkers - we do however have wheelchairs that are the residents own personal property. The chairs in accordance with our rules...are used for their outings with family or to be used if resident is having physical therapy and or too weak afterwards. There are no long term wheelchair bound residents at Rivers Edge".

Ms. Black provided health care appraisals for current residents, Resident B, Resident C and Resident D on 10/24/2018. Resident A has moved and Resident E passed away.

The health care appraisals indicate that Resident B is fully ambulatory and that Resident C and Resident D use walkers.

I reviewed Resident B's assessment plan dated 07/27/2019. No assistive devices are listed. I reviewed Resident C's assessment plan dated 08/13/2019. Use of walker is listed. I reviewed Resident C's assessment plan dated 05/04/2019. The plan states that Resident C uses a walker and wheelchair on occasion- when refuses walker and on outings.

I completed an exit conference with Mary Black on 10/24/2019 by email and text. I informed her of the violations found. I also informed her that a copy of the special investigation report would be mailed once approved and that a corrective action plan would be requested.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	There are currently no residents in the home that require regular use of a wheelchair or a wheelchair assessible shower.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14509	**(1) Small group homes that accommodates residents who regularly use wheelchairs shall be equipped with ramps that are located at 2 approved means of egress from the first floor.**
ANALYSIS:	There are currently no residents in the home that require regular use of a wheelchair.
CONCLUSION:	VIOLATION NOT ESTABLISHED

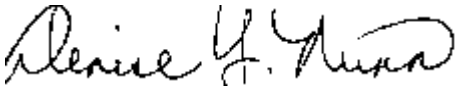
IV. RECOMMENDATION

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

10/24/2019

Kristine Cilluffo — Date
Licensing Consultant

Approved By:



10/25/2019

Denise Y. Nunn — Date
Area Manager