GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 24, 2020

Sanjay Rattan
Dawns Res Care For Seniors Inc.
5701 Chicago Road
Warren, MI 48092

RE: License #: AL500007242
Investigation #: 2020A0990011
Dawns Center for Seniors

Dear Mr. Rattan:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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

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 #:	AL500007242
Investigation #:	2020A0990011
Complaint Receipt Date:	02/20/2020
Investigation Initiation Date:	02/26/2020
Report Due Date:	04/20/2020
Licensee Name:	Dawns Res Care For Seniors Inc
Licensee Address:	5701 Chicago Road Warren, MI 48092
Licensee Telephone #:	(586) 791-5800
Administrator:	Sanjay Rattan
Licensee Designee:	Sanjay Rattan
Name of Facility:	Dawns Center for Seniors
Facility Address:	22194 Thomson Clinton Township, MI 48035
Facility Telephone #:	(586) 791-5800
Original Issuance Date:	04/28/1992
License Status:	REGULAR
Effective Date:	10/23/2018
Expiration Date:	10/22/2020
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident C was not being transferred often enough causing bed sores. Due to the infection, Resident C required immediate guillotine amputation of the right foot.	No
Resident C was not regularly receiving pain medication as they did not have staff to disperse medications.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/20/2020	Special Investigation Intake 2020A0990011
02/26/2020	APS Referral Referral received from Adult Protective Services (APS)
02/26/2020	Special Investigation Initiated - Telephone Kristine Cilluffo initiated investigation. Left message for APS Worker, Cheryl Fisher. Requested Resident A's current location and police report information.
05/27/2020	Comment Special investigation re-assigned from Roeiah Epps to Kristine Cilluffo
05/29/2020	Contact - Document Sent Email to APS Worker, Cheryl Fisher
06/02/2020	Contact - Document Sent Email to Dawns Center for Seniors
06/02/2020	Contact - Document Sent Email to APS Worker, Sherie Posie
06/02/2020	Contact - Document Received Email from Sherie Posie. Sent return email. No known medical neglect when assigned case.
06/02/2020	Contact - Telephone call received Received message from Sanjay Rattan

06/03/2020	Contact - Telephone call made Left message for Sanjay Rattan.
06/03/2020	Contact - Telephone call received TC from Sanjay Rattan. Will resend documents that were emailed to Ms. Epps.
06/05/2020	Contact - Document Sent Email to APS Worker, Cheryl Fischer
06/05/2020	Contact - Document Sent Email to Sanjay Rattan. Follow up on record request.
06/09/2020	Contact- Document Received Received email from Sanjay Ratan with Resident A's medication logs, resident information record, resident care agreement, health care appraisal, assessment plan and contact numbers.
06/16/2020	Contact - Document Sent Email to Sanjay Rattan. Received return email.
06/16/2020	Contact- Telephone call made Left message for Relative 1
06/16/2020	Contact- Telephone call made TC to Dipa Begam, RN
06/17/2020	Email to Sanjay Rattan Sent another request for staff names and phone numbers. Received return email.
06/17/2020	Contact- Telephone call made Received message from Complainant. Returned call.
06/19/2020	Contact- Telephone call received Received message from Resident C. Returned call and Interviewed Resident C by phone.
06/19/2020	Contact- Telephone call made Left message for Nadia Kent, Nurse Practitioner
06/26/2020	Contact- Telephone call made Left message for Manager, Sonia Bhalla. No return call.

06/30/2020	Exit conference Completed exit conference with Licensee Designee, Sanjay Rattan.
07/01/2020	Contact- Telephone call received Returned call from Sanjay Rattan. Discussed findings and recommendation by phone.
07/10/2020	Contact- Document Sent Email to Sanjay Rattan. Requested staff schedules
07/16/2020	Contact- Telephone call received Received message from Sanjay Rattan
07/21/2020	Contact- Telephone call made TC to Sanjay Rattan. Informed him that staff schedules will be added to report.
07/21/2020	Contact- Document Received Email from Sanjay Rattan. Received copies of staff schedules from December 2019- July 2020
07/22/2020	Contact- Document Sent Email to Sanjay Rattan

ALLEGATION:

- **Resident C was not being transferred often enough causing bed sores. Due to infection Resident C required immediate guillotine amputation of the right foot.**
- **Resident C was not regularly receiving pain medication as they did not have staff to disperse medications**

INVESTIGATION:

A complaint was received regarding Dawn Center for Seniors on 02/20/2020. The complaint was referred to licensing by APS. It was alleged that Resident C is hard of hearing, disabled by way of recent medical amputation, arthritis causing weakness and frailty. Resident C was advised to be treated at Dawns Center for Seniors in December 2019. Resident C was not satisfied with his current conditions and treatment for knee replacement needing surgery but was unable have it done due to infection. Resident C attempted to have rehab conducted to make the knee better but was unsuccessful. While in his home Resident C lost muscle and had bone on bone contact due to arthritis and deemed unable to take care of himself in his home at that time and began being treated at Dawns Center for Seniors. While Resident C was being treated at Dawns

Center for Seniors, he was having legs rewrapped three times a week by staff. While in facility's care, due to improper staffing, Resident C was not regularly receiving pain medication as they did not have staff to disperse medications and Resident C also was not being transferred often enough causing bed sores. On Saturday, Resident C was found to have blood in his urine and staff did not have nurses on site to address the situation. Due to no nursing staff Resident C was sent to a hospital for evaluation and he was found to have level II sores from not being moved, gangrene infection of his feet and legs, pneumonia, urinary tract infection, required a bone scan due to knee and leg issues to see how deep the infection went and was found the infection was within the bone. Due to infection being within the bone Resident C required immediate guillotine amputation of the right foot to prevent infection from spreading throughout his body. Resident C will have the remainder of his lower right leg removed so he may get the opportunity to utilize a prosthetic. The left leg was not as bad but was infected as well and required several layers of dead flesh to be removed.

The complaint received also alleged that while Resident C was being treated John, Stephani, Christopher and Hazel were making withdrawals of his money, using his home as a drug residence, removing all belongings from the home, utilizing his van and utilizing his identification (ID) as if they are him. Christopher and John were observed via ATM cameras making withdrawals. John was utilizing Resident C's ID as he was pulled over in Resident C's van with Stephani in it prior to it being reported stolen. Hazel was utilizing a phone purchased in Resident C's name and from his account. Prior to vacating the residence all items were removed from the occupants. Unknown which occupants where using drugs within the home, but there is currently trash everywhere, drug residue everywhere and heroin spoons all over the home. On 06/16/2020, I interviewed Resident C's girlfriend (Relative 1) by phone. She confirmed that these allegations did not occur at Dawns Center for Seniors and that individuals involved were not staff at the facility. She stated that it was a personal matter that involved her daughter's boyfriend who has been charged criminally.

On 06/02/2020, I contacted APS Worker, Sherie Posie by email. Ms. Posie was the APS Worker assigned to Resident C's case while he resided at Meadows Assisted Living. Ms. Posie stated that she had (Resident C's) case when he left the Meadows and first moved to the Dawns Center for Seniors. He had two cases and one denied referral since then. The cases were investigated by Macomb County. The most recent specialist was Cheryl Fischer. Ms. Posie stated that there were no concerns regarding medical neglect at Dawns Center for Seniors when she had Resident C's case. Resident C was very demanding and spoke to people in degrading ways, however, he loved the staff at the Dawn Center for Seniors when she had the case.

On 06/03/2020, I interviewed Licensee Designee, Sanjay Rattan, by phone. He stated that Resident C was complaining of pain in legs. Resident C had a home health care nurse. Mr. Rattan stated that on 02/15/2020 or 02/16/2020, Resident C was sent to the hospital by EMS. About a week later, his son called and said he had gangrene and his foot was amputated. Mr. Rattan stated that Resident C did not return to the facility and

did not pay his rent that was due for two months. He does not know Resident C's current location.

On 06/16/2020, I interviewed Home Care Nurse, Dipa Begam by phone. She stated that Resident C had a lipedema and she would go to the facility to provide care to him on Mondays and Thursdays. She would clean, dry, and wrap his legs. She would clean his legs with soap and water. She would also put unna boots on his legs. Ms. Begam stated that Resident C also had an ointment prescribed for his legs. Ms. Begam always educated staff and Resident C on lifting his leg so he did not develop pressure ulcers. Ms. Begam noticed that Resident C had developed a small red sore and reported it to the physician assistant. Ms. Begam stated that she went on a vacation and when she returned, she heard that Resident C was hospitalized. She also learned that he had an amputation. Ms. Begam stated that Resident C was going to have issues with his legs for the rest of his life. He always reported his pain was an 8/10 or 10/10. She indicated that he received heavy pain medication every four to six hours for chronic pain. Ms. Begam stated that at times she would tell the administrator that it was time for Resident C's pain medication or Resident C would ask her to tell staff. She would make sure she told staff what Resident C needed before she left. Resident C also had a bell he rang to request staff. Ms. Begam stated that facility being short staffed caused delays. Resident C told her a few times that he did not receive his medication or received it late. She also stated that Resident C would ring bell when he needed staff to help him go to the bathroom. He had to sit in his brief once for an hour until they got help from the administrator. Ms. Begam stated that Resident C had to move every two hours and required a two to three-person transfer. Resident C is obese and could not be moved by one person. Ms. Begam stated that the facility was often understaffed but not every day. She stated that sometimes there was only one staff to care for about 15 residents, who also had to cook and clean.

I reviewed Resident C's resident information record. The record indicated that he was admitted to Dawns Center for Seniors on 12/06/2019. The record also identified Relative 1 as Resident C's next of kin/guardian/designated representative.

On 06/16/2020, I interviewed Resident C's girlfriend (Relative 1) by phone. She stated that Resident C was moved to a different facility after being discharged from the hospital. He did not want to return to Dawns Center for Seniors. She had many concerns regarding Dawns Center for Seniors. She visited the facility two to three times a week when Resident C was placed there. She stated that the facility is very run down and she does not believe it is up to code. It was always cold, snow was never shoveled, and she did not feel it was clean. Relative 1 stated that meals would be great at the beginning of month and would get worse towards end of month. She also stated that Resident C had a plug in his bedroom that was never fixed.

Relative 1 stated that the staffing at the facility seemed "iffy" and she is not sure if staff were qualified. Relative 1 stated that there were two staff scheduled at a time and one staff had to double as a cook. Two staff were scheduled at night. Relative 1 stated that Resident C could not use the bathroom by himself and he always had to wait for

assistance. One time he had to wait 30 minutes to an hour because staff were busy serving breakfast. Resident C would get irritated and sometimes would end up using the bathroom in his pants. Relative 1 stated that most facilities have a call button, but Dawns Center for Seniors did not have them. Staff brought Resident C a “school bell” to ring, however, the noise only went so far and staff could not hear it. Resident C eventually got a cow bell that was louder, however, staff did not like it. Staff would shut his door if they did not want to hear him. Sometimes he would have to wait one to one and a half hours if he rang the bell and sometimes no one would come. Relative 1 stated that Resident C was previously placed at Meadows Assisted Living where he had a hospital bed. His hospital bed was never brought to Dawns Center for Seniors. He had a regular bed, so he had to sleep in a reclining chair to keep his head up. It took two staff to transfer him from wheelchair to recliner and staff were not careful and threw him in the chair. Relative 1 stated that she is not sure what happened that Resident C had to get his leg amputated. She is not positive if it had to do with the care he received or not. Relative 1 did not know if staff were required to move his leg to prevent bed sores. She stated that he could move it himself a little bit. Relative 1 stated that medications were often given late and always given at different times. She stated that the medication administration was “all over the place”.

On 06/17/2020, I interviewed Complainant for Special Investigation # 2020A0604015 by phone. The Complainant had reported that there had not been hot water at the facility for three weeks. The Complainant also indicated that she believed the facility was short staffed. She stated that on about three to four occasions she had seen only one staff working at the facility. The Complainant also stated that on the day she found the hot water was out, there was only one staff working when she arrived, and another staff did not show up for about two hours and fifteen minutes.

I reviewed Resident C’s medication records for December 2019, January 2020 and February 2020. According to Resident C’s medication records, staff initials are missing to confirm administration of his medication for the following medications:

Calcium Carb 8:00 am - 12/6,12/7,12/8,12/14,12/21,12/22,12/26
Calcium Carb 8:00 pm - 12/13,12/14
Calmoseptine Ointment 8:00 am - 12/6,12/7,12/8
Calmoseptine Ointment 8:00 pm - 12/13,12/14,12/20
Doxazosin Mesylate 8:00 pm - 12/13,12/14,12/20,01/11,01/14
Finasteride 5 mg 8:00 am - 12/6,12/7,12/8,12/14,12/21,12/22,12/26,01/02
Furosemide 40 mg 8:00 am - 12/14,12/21,12/22
Gabapentin 300 mg 8:00 am - 12/6,12/7,12/8
Gabapentin 300 mg 8:00 pm - 12/13,12/14,12/20,01/06,01/11
Potassium Chloride 8:00 am - 12/6,12/7,12/8,12/14,12/26
Pravastatin Sodium 8:00 pm - 12/6,12/7,12/8,12/9,12/13,12/14,12/20,12/26,01/11
Lipedema Pumps 8:00 am - 12/21,12/22
Pumps to bilateral lower extremities 2 times daily for one hour 3:00 pm - 12/14
(No place on med log to initial for pumps a second time daily)
Metoprolol Tartrate 25 mg 8:00 am - 12/26

Metoprolol Tartrate 50 mg 8:00 pm - 12/20
Calcium 600 Vit D3 400 8:00 pm - 01/06,01/11,01/28
Trazadone 100 mg tab 8:00 pm - 01/11
Risamine 8:00 pm - 02/05
Oxycodeone Acetamino Phen 12:00 pm - 02/11
Oxycodeone Acetamino Phen 10:00 pm - 12/13

On 06/19/2020, I interviewed Resident C by phone. He stated that he is now residing at Comfort Care and is receiving good care. Resident C stated that while at Dawns Center for Seniors he was supposed to receive pain medication every six hours, however, sometimes he would not receive it at all. Staff would sometimes tell him that the pharmacy did not send it. He was prescribed Percocet. Resident C stated that there were a couple other medications he did not receive, however, mostly recalls pain pills because he would be in pain when he did not receive them. Resident C stated that medications were given at all different times and he never knew when he would be receiving them. Resident C stated that the facility was short staffed. He also stated that he never saw staff cleaning and the food would get worse towards the end of the month. There were usually two staff working. A couple of times there was only one staff working. Resident C stated that he had a hand bell to ring if he needed staff, however, sometimes they would come and sometimes they would not. Resident C stated that at times he would have to wait long periods of time for help going to the bathroom. He stated that one person could help him, but two people is better. He waited as long as an hour for help going to the bathroom. Resident C stated that he was able to move his legs around when pushing himself in a wheelchair. He stated that a nurse came to the facility to wrap and care for his legs. He indicated that he never wore shoes and he is not sure if this contributed to his leg issues. Resident C stated that he had lipedema and developed a spot on his heal. He ended up going to the hospital at the end of February and due to infection had his leg amputated up to his knee. He stated that the bandages were changed on his legs twice a week and he believe someone should have caught the issue sooner. He did not believe Dawns Center for Seniors provided good care and heard two residents died in February.

On 07/21/2020, I received copy of staff schedules from December 2019-July 2020 from Licensee Designee, Sanjay Rattan. Staff schedules indicate that two staff are scheduled per shift from 6-2, 2-10 and 10-6 (am/pm not listed on schedules). Changes to the schedule were made by crossing out staff name and adding the name of new staff covering shift.

APPLICABLE RULE	
R 400.15305	**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:	Resident C's personal needs were not met. Due to the facility being short staffed Resident C, Relative 1 and Nurse, Dipa Begam all indicated that Resident C waited up to an hour for assistance to use the bathroom. It was also reported that Resident C had a bell to call for assistance, however, he often had to wait for a long period of time for staff or sometimes staff would not come at all.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Special Investigation Report #2020A0986002 dated 12/12/2019**

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	There is not enough information at this time to determine that Resident C's infection and amputation were caused by not being transferred enough by staff. Nurse, Dipa Begam, provided care to Resident C twice a week to provide care for his legs. She noticed the sore and reported it to nurse practitioner. Resident C was hospitalized in February 2020. Ms. Begam always educated staff and Resident C on lifting his leg so he did not develop pressure ulcers. Resident C was able to move his leg on his own.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.

ANALYSIS:	According to Nurse Dipa Begam, Resident C had to move every two hours and required a two to three-person transfer. Resident C, Ms. Begam and Complainant 1 all stated that there were occasions when only one staff was working at the facility.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Special Investigation Report #2020A0986002 dated 12/12/2019**

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	According to Resident C and Relative 1, medications were given at multiple different times or not at all. Resident C also told Nurse, Dipa Begam that he did not receive his pain medication or received them late. In addition, Ms. Begam stated that there were times she reminded staff that it was time for Resident C's medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**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: (v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.
ANALYSIS:	Multiple staff initials are missing from December 2019, January 2020 and February 2020 medication logs to indicate whether Resident C received his medications.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Special Investigation Report #2020A0986002 dated 12/12/2019**

ADDITIONAL FINDINGS:

I reviewed Resident C's health care appraisal dated 05/10/2019. The health care appraisal indicates that Resident C is alert and orientated x3, memory intact and able to make needs known. His diagnoses are listed as osteoarthritis, fall, hyperlipidemia, HTN, constipation, vitamin deficiency and muscle weakness. Resident C's resident information record indicated that he was admitted to Dawns Center for Seniors on 12/06/2019. The health care appraisal was not completed within the 90-day period before Resident C's admission to Dawns Center for Seniors.

I completed the exit conference with licensee designee, Sanjay Rattan on 06/30/2020 by email. I informed him of the violations found and recommendation. I also informed him that he would be mailed report and a compliance conference would be scheduled. I also discussed the findings and recommendation with Sanjay Rattan by phone on 07/01/2020. On 07/21/2020, I spoke to Sanjay Rattan by phone and informed him that information from staff schedules would be added to special investigation report.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	Resident C was admitted to Dawns Center for Seniors on 12/06/2019. His health care appraisal was dated 05/10/2019, seven months before his admission while he was at another AFC facility and therefore, was not completed within the 90-day period before his admission to this facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

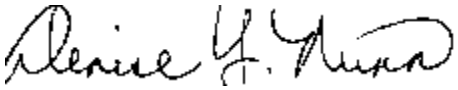
IV. RECOMMENDATION

I recommend revocation of the license.

07/22/2020

Kristine Cilluffo — Date
Licensing Consultant

Approved By:



07/22/2020

Denise Y. Nunn — Date
Area Manager