GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 17, 2020

Rene Goupayou
12921 Oak Park Blvd
Oak Park, MI 48237

RE: License #: AS630399856
Investigation #: 2021A0993004
Diamond Care

Dear Rene Goupayou:

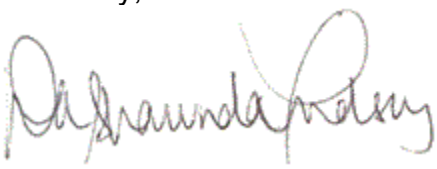
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 505-8036

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630399856
Investigation #:	2021A0993004
Complaint Receipt Date:	10/28/2020
Investigation Initiation Date:	10/28/2020
Report Due Date:	12/27/2020
Licensee Name:	Rene Goupayou
Licensee Address:	23200 Gardner St Oak Park, MI 48237
Licensee Telephone #:	(734) 444-6192
Administrator:	Cesaire Ekane-Lee
Licensee Designee:	N/A
Name of Facility:	Diamond Care
Facility Address:	12921 Oak Park Boulevard Oak Park, MI 48237
Facility Telephone #:	(734) 444-6192
Original Issuance Date:	05/14/2020
License Status:	TEMPORARY
Effective Date:	05/14/2020
Expiration Date:	11/13/2020
Capacity:	4
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident B died unexpectantly in the facility. She was not on hospice and she was not sick.	Yes

III. METHODOLOGY

10/28/2020	Special Investigation Intake 2021A0993004
10/28/2020	Contact - Document Received Received an incident report (IR)
10/28/2020	Special Investigation Initiated - Telephone Telephone call made to licensee Rene Goupayou
10/28/2020	Contact - Document Sent Requested documentation
10/30/2020	Contact - Document Received Received documentation
11/05/2020	Contact - Telephone call made Telephone call made to licensee Rene Goupayou
11/06/2020	Contact - Telephone call made Telephone call made to staff Pricilia Chi
11/06/2020	Contact - Telephone call made Telephone call made to licensee Rene Goupayou
11/06/2020	Contact - Telephone call made Telephone call made to Resident B's sister. The number was busy. Sent a text message.
11/06/2020	Contact - Telephone call made Telephone call made to Resident B's guardian. She was unavailable. Suggested to contact the guardian's case manager
11/06/2020	Contact - Document Sent Emailed Resident B's guardian's case manager
11/06/2020	Contact - Telephone call received Telephone call received from Resident B's guardian's case manager

11/09/2020	Contact - Document Received Received an email from licensee Rene Goupayou requesting to cancel onsite investigation. One of the residents tested positive for COVID-19
11/13/2020	Inspection Completed On-site Virtual inspection conducted due to a COVID-19 positive resident
11/16/2020	Contact - Telephone call made Telephone call made to Resident B's sister
11/16/2020	Contact - Document Received Received a copy of Resident's B death certificate
11/16/2020	Exit Conference Attempted to conduct an exit conference with licensee designee Rene Goupayou. Left a message.

ALLEGATION:

Resident B died unexpectantly in the facility. She was not on hospice and she was not sick.

INVESTIGATION:

On 10/28/2020, I received an incident report. Per the incident report, at 7am on 10/27/2020, Resident B ate 100% of her breakfast. Staff administered her medications to her at 8am. Resident B went out to smoke a cigarette, and then went into her bedroom. Staff checked on her in an hour. She was okay. Staff checked on her again at noon and she was unresponsive. 911 came to the facility and pronounced Resident B dead.

On 10/28/2020, I conducted a telephone interview with licensee Rene Goupayou. Mr. Goupayou confirmed Resident B died unexpectantly in the facility on 10/27/2020. Resident B was not receiving hospice or palliative care. Resident B also was not sick. Mr. Goupayou did not know the cause of Resident B’s death.

On 10/30/2020, I received a copy of Resident B’s assessment plan, weight chart and health care chronological. Per the assessment plan, dated and signed by Resident B, Resident B’s guardian as well as licensee Rene Goupayou, Resident B could move independently in the community. Resident B did not need help with toileting, grooming, dressing and personal hygiene. Resident B walked with a cane. No health concerns were documented in the plan.

I reviewed Resident B’s weight chart from July 2020 to October 2020. I did not observe any weight loss concerns.

Per Resident B's health care chronological, Resident B was admitted into the facility on 07/30/2020. She had a e-visit with nurse practioner Lacretia Fisher on 10/08/2020. Resident B had annual examination scheduled with Dr. Naila Ahmad at 10am on 10/28/2020.

On 11/05/2020, I conducted a telephone interview with Mr. Goupayou. He stated him and staff Pricilia Chi are the only staff working in the facility. He was not working when Resident B died. According to Mr. Goupayou, Resident B was not sick. She did not exhibit any abnormal behaviors prior to her death. She took her medications as prescribed and consumed an adequate amount of food and fluids. Mr. Goupayou acknowledged a health care appraisal was not received when Resident B moved into the facility. He has been in contact with Resident B's family. Per her family, Resident B had health issues that he was not aware of.

On 11/06/2020, I conducted a telephone interview with staff Pricilia Chi. She verified she worked in the facility on 10/27/2020. She was scheduled to work from 8pm on 10/26/2020 to 8am on 10/27/2020, but she worked a longer. Ms. Chi stated Resident B did not appear sick. She ate well. She was compliant with her medications. She did not show any sign of illness. During the morning of 10/27/2020, Resident B ate all her breakfast and took all her medications. She went outside to smoke and then came back in and went into her bedroom. Ms. Chi described Resident B as the type of person who was always around. If you did not see her, something was wrong. Ms. Chi stated she checked on Resident B around 10:30am. Resident B was unresponsive. Ms. Chi tried to wake her by shaking her. Ms. Chi could not find a pulse. She called 911 and performed CPR until they arrived. Resident B was pronounced death in the facility.

On 11/06/2020, I conducted a follow up telephone interview with Mr. Goupayou. He stated Resident B's sister talked to Resident B's physician. Per the physician, Resident B's cause of death was chronic obstructive pulmonary disease (COPD).

On 11/06/2020, I conducted a telephone interview with Resident B's guardian's case manager. She confirmed Resident B moved into the facility towards the end of July 2020. Resident B had a history of heavy drug use. Resident B did not do any drugs while living in the facility and appeared to have been doing well. Resident B's guardian's case manager stated she did not have any concerns about the care staff provided Resident B. Staff took well care of her. Per Resident B's guardian's case manager, she was informed Resident B's cause of death was hypoxia. Dr. Naila Ahmad signed the death certificate.

On 11/13/2020, I conducted a virtual inspection of the facility. Mr. Goupayou was present. Mr. Goupayou stated all Resident B's medications were sent back to the pharmacy. I observed Resident B's medication administration record (MAR) for September and October 2020. I did not observe any medication administration concerns.

On 11/16/2020, I conducted a telephone interview with Resident B's sister. She stated Resident B was "happy, productive and herself" while living in the facility, "that was the first time she had been that way in a million years." Resident B's sister stated Resident B was compliant with her medications and staff took well care of her. Resident B had a history of COPD. Resident D died from acute chronic COPD with hypoxia.

On 11/16/2020, I received a copy of Resident B's death certificate. The primary cause of death was "acute on chronic" COPD with hypoxia.

On 11/16/2020, I attempted to conduct an exit conference with licensee designee Rene Goupayou. I left a message.

APPLICABLE RULE	
R 400.14301	**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 license 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.
N ANALYSIS:	Mr. Goupayou did not obtain a health care appraisal for Resident B at the time of admission in July 2020. Resident B was scheduled to have a physical examination on 10:00am on 10/28/2020.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Resident B died on 10/27/2020. The primary cause of death was “acute on chronic” COPD with hypoxia. Per Mr. Goupayou and Ms. Chi, Resident B was not sick. She did not exhibit and signs of illness. Resident B’s sister and Resident B’s guardian’s case manager did not have concerns with the care Resident B received in the facility. They stated staff took well care of her.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14310	**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:	On 10/27/2020, when Ms. Chi checked on Resident B, Resident B was unresponsive. Ms. Chi tried to wake her by shaking her. Ms. Chi could not find a pulse. She called 911 and performed CPR until they arrived. Resident B was pronounced death in the facility.
CONCLUSION:	VIOLATION NOT ESTABLISHED

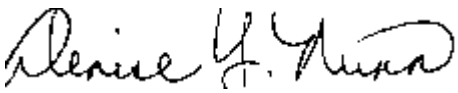
IV. RECOMMENDATION

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

11/17/2020

DaShawnda Lindsey — Date
Licensing Consultant

Approved By:



11/17/2020

Denise Y. Nunn — Date
Area Manager