GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 10, 2021

Khurram Shahzad
New Hope Partners, L.L.C.
3785 North Center Road
Saginaw, MI 48603

RE: License #: AH730317973
Investigation #: 2021A1019032

Dear Mr. Shahzad:

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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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 authorized representative and a date.

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,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH730317973
Investigation #:	2021A1019032
Complaint Receipt Date:	05/10/2021
Investigation Initiation Date:	05/11/2021
Report Due Date:	07/09/2021
Licensee Name:	New Hope Partners, L.L.C.
Licensee Address:	3785 North Center Road Saginaw, MI 48603
Licensee Telephone #:	(989) 498-4000
Administrator:	Erriesha Dunnaway
Authorized Representative:	Khurram Shahzad
Name of Facility:	New Hope Valley
Facility Address:	3785 North Center Road Saginaw, MI 48603
Facility Telephone #:	(989) 498-4000
Original Issuance Date:	01/24/2013
License Status:	REGULAR
Effective Date:	11/05/2020
Expiration Date:	11/04/2021
Capacity:	93
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive her medications for several days.	No
Additional Findings	Yes

III. METHODOLOGY

05/10/2021	Special Investigation Intake 2021A1019032
05/11/2021	Comment Complaint was forwarded to LARA from APS. APS denied the referral and did not assign it for investigation.
05/11/2021	Special Investigation Initiated - Telephone Called complainant to conduct interview, left voicemail requesting return phone call.
05/11/2021	Contact - Document Sent Emailed administrator requesting information, correspondence ongoing.
06/02/2021	Inspection Completed On-site
06/02/2021	Inspection Completed BCAL Sub. Compliance
06/03/2021	Contact- Telephone call made Called complainant to conduct interview, voicemail left requesting return phone call.
06/09/2021	Exit Conference

ALLEGATION:

Resident A did not receive her medications for several days.

INVESTIGATION:

On 5/10/21, the department received a complaint regarding Resident A. The complaint read that Resident A was hospitalized (date not provided) and an unknown facility employee informed hospital staff that Resident A had not taken her medications in two weeks. The complainant was concerned that there could be fatal consequences if Resident A did not receive her medications.

On 6/2/21, I conducted an onsite inspection. I interviewed administrator Erriesha Dunnaway and executive director June Nadolny at the facility. Ms. Dunnaway stated that Resident A moved into the facility on 4/19/21. Ms. Dunnaway and Nadolny confirmed that Resident A was hospitalized on 4/27/21 for lethargy and mental status change and that Resident A was diagnosed with COVID-19 and returned to the facility the same day.

A "Resident/Visitor Incident Report" was completed on the 4/27/21 hospitalization which read:

> Per sons (POA) request, the resident was sent to Covenant Hospital via MMR. Residents BP: 143/75, P:70, O2: 96, T: 99.8. The resident is exhibiting increased confusion & lethargy. Resident is warm to the touch. UA results negative. Hospital called at 10:30pm with confirmed positive Covid case. Hospital sent the resident back to NHV at approximately 11:00pm.

Ms. Dunnaway and Ms. Nadolny stated that after she returned, Resident A experienced a noticeable decline in her level of functioning. Ms. Dunnaway and Ms. Nadolny stated that Resident A was hospitalized again on 5/7/21 and has not returned to the facility. Ms. Dunnaway stated that she is aware that Resident A had a habit of refusing her medication but denies that Resident A went two weeks without receiving any medication as the complaint alleged. Ms. Dunnaway stated that the facility nurse Geri Turner would be the best person to speak to about any medication issues Resident A may have had.

On 6/2/21, I interviewed Geri Turner at the facility. Ms. Turner confirmed that Resident A's health was waning after returning from the hospital with COVID and stated that she required increased assistance with personal care tasks. Ms. Turner stated that Resident A "Acted helpless and wouldn't do things that she could normally do." Ms. Turner stated that staff would offer Resident A her medications but there were times that she would refuse. Ms. Turner stated that she was not informed by any med passing staff that medications were not administered as the complaint alleged.

While onsite, I obtained Resident A's medication administration records (MAR) for the entire duration that she resided at the facility (4/19/21-5/7/21). I observed occasions of Resident A refusing her medication, however staff appropriately documented the refusals and any other explanation for not receiving medication (such as being out of the facility). Despite the refusals, the MAR documentation revealed that Resident A still received scheduled medication daily.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	Interviews with staff combined with review of MAR documentation and facility progress notes reveal that there were times that Resident A refused her medication, which is within her right to do so. I was unable to find any evidence that Resident A went two weeks without medication. Based on this information, the allegation is not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Attestations from Ms. Dunnaway, Ms. Nadolny and Ms. Turner describe Resident A as having experienced a decline to her baseline level of functioning after returning to the facility from the hospital on 4/27/21 and required increased assistance and attention from facility staff. Ms. Dunnaway described Resident A as "not thriving" and stated that she did not feel that the facility was the best environment for her. It was acknowledged that after her return to the facility on 4/27/21, she could not always feed herself. Ms. Turner stated "It seemed like she would pretend she couldn't do things. I'm not sure if it was mental or if she wanted attention or if she really couldn't do it." Home health care services were initiated and during Resident A's initial home care assessment on 4/29/21, the home health nurse documented "Unable to feed self and must be assisted or supervised throughout the meal/snack". Ms. Dunnaway and Ms. Nadolny stated that per the facility's admission contract, they do not provide feeding assistance in the level of care that Resident A resided in. Review of Resident A's admission contract did outline that a resident must be able to feed him/herself as part of their admission criteria. Ms. Nadolny, Ms. Dunnaway and Ms. Turner stated that a request was made to Resident A's family to obtain private duty

one on one care for her (in part due to her increased feeding needs), however that request was made seven days following home health care's determination that she could not complete feeding tasks independently. Ms. Dunnaway stated that while Resident A's family seemed agreeable to the additional help, they did not bring anyone in before she was hospitalized for dehydration on 5/7/21. Ms. Dunnaway stated that the facility was not staffed to be able to provide one on one care that she needed and reiterated that feeding assistance is not offered at Resident A's level of care but stated that staff helped out when they could. Facility charting notes were reviewed and while they identify times where Resident A refused food and/or fluid or consumed very little, the documentation does not identify that staff were assisting her with feeding as home health care identified.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(1) A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization, which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.
For Reference MCL 333.20201	**(2) (e) A patient or resident is entitled to receive adequate and appropriate care, and to receive, from the appropriate individual within the health facility or agency, information about his or her medical condition, proposed course of treatment, and prospects for recovery, in terms that the patient or resident can understand, unless medically contraindicated as documented by the attending physician in the medical record.**

ANALYSIS:	During a home care assessment on 4/29/21, it was determined that Resident A could not feed herself independently. Once this was identified, staff had the obligation to ensure the care was provided at the level she needed 100% of the time however it was not until 5/6/21 that facility staff requested that Resident A's family institute private duty care in part, to help with this task. One on one care was never implemented and facility staff could not ensure that they were always able to supplement this need. Furthermore, facility staff identify that needing feeding assistance disqualifies someone to reside in the level of care that Resident A was in. Based on this information, the facility did not comply with this statue.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	The facility lacked an organized program to ensure all Resident A's care needs were provided at the level she needed and did not issue a discharge notice when she no longer met criteria to reside in assisted living. While staff were aware of Resident A's decline and may have informed her family of their concerns, the facility could not produce evidence that these concerns were being addressed with her physician or home health care company to properly coordinate care. Based on this information, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

As mentioned above, Ms. Dunnaway, Ms. Nadolny and Ms. Turner reported a noticeable increase in Resident A's care needs after 4/27/21 and began receiving

home health care services on 4/29/21. Resident A's service plan dated 4/19/21 did not reflect her amplified care needs and also did not include the addition of home health care services.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	Resident A's service plan was not updated at the time her level of care changed or to include the receipt of home care services. Based on this information, the facility did not comply with his rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Resident A was transferred to the hospital via ambulance on 4/27/21 and was diagnosed with COVID-19. The facility completed an internal incident report for the hospitalization and COVID diagnosis but did not provide notification or submit it the report to the department. Additional review of Resident A's internal incident reports and facility progress notes reveal Resident A sustained two falls on 4/22/21 within roughly 60 minutes of each other and another two falls on 4/26/21 which were also not reported to licensing staff.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.
For Reference R 325.1901	**Definitions.**
	(17) "Reportable incident/accident" means an intentional or unintentional event in which a resident suffers harm or is at

	risk of more than minimal harm, such as, but not limited to, abuse, neglect, exploitation, or unnatural death.
ANALYSIS:	Staff documented that Resident A had repeated falls, a hospitalization and COVID-19 positive diagnosis that were not reported to the department. Based on this information, the facility did not comply with this rule.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [For reference, see special investigation report (SIR) 2020A0784051, SIR 2019A0784029 and 2018A1019025]**

On 6/9/21, I shared the findings of this report with authorized representative Khurram Shahzad. Mr. Shahzad verbalized understanding of the citations and reports that he will work with his team to correct the deficiencies.

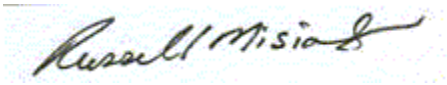
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

6/10/21

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:



6/10/21

Russell B. Misiak Date
Area Manager