STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

December 6, 2021

Sister Maureen Comer
Lourdes Alz Special Care Ctr Inc
2400 Watkins Lake Rd
Waterford, MI 48328

RE: License #: AL630007360
Investigation #: 2022A0993002
Clausen Manor

Dear Sister Comer:

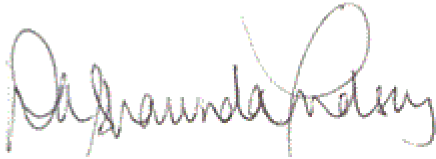
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AL630007360
Investigation #:	2022A0993002
Complaint Receipt Date:	10/22/2021
Investigation Initiation Date:	10/26/2021
Report Due Date:	12/21/2021
Licensee Name:	Lourdes Alz Special Care Ctr Inc
Licensee Address:	2400 Watkins Lake Rd Waterford, MI 48328
Licensee Telephone #:	(248) 674-4732
Administrator:	Robin McClintock
Licensee Designee:	Maureen Comer
Name of Facility:	Clausen Manor
Facility Address:	2400 Watkins Lake Road Waterford, MI 48328
Facility Telephone #:	(248) 674-4732
Original Issuance Date:	01/13/1995
License Status:	REGULAR
Effective Date:	02/01/2020
Expiration Date:	01/31/2022
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility is short staffed.	Yes
Staff Gigi (last name unknown) does not know how to verbally redirect the residents. She is always yelling at and combative with them. Management is aware of this and are not disciplining her for this inappropriate behavior. On 10/10/2021, Gigi was in an altercation with a resident. On 10/8/2021, Gigi and staff Jason (last name unknown) physically forced a resident into her room and then held the door closed.	Yes
The residents are not administered their medications as prescribed.	Yes

III. METHODOLOGY

10/22/2021	Special Investigation Intake 2022A0993002
10/22/2021	APS Referral Received allegations from adult protective services (APS). APS denied the intake.
10/26/2021	Special Investigation Initiated - Telephone Telephone call made to the reporting source
10/28/2021	Inspection Completed On-site Conducted an unannounced onsite investigation
10/29/2021	Contact - Document Received Received documentation
11/16/2021	Contact - Telephone call made Telephone call made to staff Tabitha Cruz
11/16/2021	Contact - Telephone call made Telephone call made to administrator Robin McClintock. Left a message.
11/16/2021	Contact - Telephone call received Telephone call received from administrator Robin McClintock

11/16/2021	Exit Conference Held with licensee designee Maureen Comer

ALLEGATION:

The facility is short staffed.

INVESTIGATION:

On 10/22/2021, I received the allegations from adult protective services (APS). APS denied the intake.

On 10/26/2021, I conducted a telephone interview with the reporting source, who is a former staff at the facility. She stated the facility is short staffed. There are about 16 residents in the facility and three to four staff work per shift.

On 10/28/2021, I conducted an unannounced onsite investigation. I interviewed administrator Robin McClintock, assistant director Megan Singleton, registered nurse Janet Burns, and resident service coordinator LaQuitta Jones. They denied that the facility is short staffed. From Monday to Friday, there are four staff on 1st shift and three staff on 2nd and 3rd shift. On the weekends, there are four staff on 1st shift, three staff on 2nd shift, and two staff on 3rd shift.

During the onsite investigation, I reviewed the staff schedule from 0 7/25/2021 until 10/16/2021. During this period, there was at least three to four staff working on 1st shift, two to three staff working during 2nd shift, and two to three staff working during 3rd shift. However, on 08/12/2021, per the schedule, there was only one staff working during 3rd shift due to a call-in.

I also reviewed Resident A's, Resident B's, Resident C's, Resident D's, Resident E's, Resident F's, Resident G's, Resident H's, Resident I's, Resident J's, Resident K's, Resident L's, Resident M's, Resident N's, and Resident O's assessment plan. I observed the following:

- Resident G requires "one/two person assist with hygiene, toilet transfer, incontinent, briefs worn". The other residents do not require two staff to meet any of their care needs. He walks short distances with therapy/walker. He can propel wheelchair.
- Resident H "requires staff to toilet/assist with hygiene, incontinent bowel/bladder, wear briefs". She is "total assist with shower, redressing assist, preparing the shower". She walks unassisted with rolling walker.
- Resident J is "total assist with shower/redressing". She is non-ambulatory but can propel wheelchair. She is a "1-2 assist with transfers".
- Resident K is total assist with bathing, grooming, dressing, and personal hygiene. She usually does not ambulate. Staff to assist with transfers and steps. She uses a high back wheelchair.

- Resident O is non-ambulatory. Staff propels her wheelchair.
- The other residents may require assistance or prompting with hygiene needs, but they are not total assist. In addition, they do not require assistance with mobility.

APPLICABLE RULE	
R 400.15206	**Staffing requirements**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 15 residents and children who are under the age of 12 years.
ANALYSIS:	During the onsite, I reviewed the staff schedule from 7/25/2021 until 10/16/2021. During this period, there was at least three to four staff working on 1st shift, two to three staff working during 2nd shift, and two to three staff working during 3rd shift. However, on 08/12/2021, per the schedule, there was only one staff working during 3rd shift due to a call-in. Due to the residents' needs, there should have been at least two staff working on the midnight shift on 08/12/2021.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff Gigi (last name unknown) does not know how to verbally redirect the residents. She is always yelling at and combative with them. Management is aware of this and are not disciplining her for this inappropriate behavior. On 10/10/2021, Gigi was in an altercation with a resident. On 10/8/2021, Gigi and staff Jason (last name unknown) physically forced a resident into her room and then held the door closed.

INVESTIGATION:

On 10/26/2021, I conducted a telephone interview with the reporting source. The reporting source stated staff Gigi (last name unknown) and staff Jayson Domingo do not have patience with the residents, and they yell at the residents. Resident A has Dementia. On 10/09/2021, Gigi and Mr. Domingo forced Resident A into her bedroom and held the door closed, preventing her from exiting her bedroom. Staff Tabitha (last name unknown) was also working that day. She assisted Gigi and Mr. Domingo with confining Resident A in her bedroom. On 10/10/2021, the reporting source stated Gigi was yelling at Resident B.

On 10/28/2021, I conducted an unannounced onsite investigation. I interviewed administrator Robin McClintock, assistant director Megan Singleton, registered nurse

Janet Burns, resident service coordinator LaQuitta Jones, staff Gerlyn Alonzo (who was referred to as staff Gigi earlier in this report), and staff Jayson Domingo with translating assistance from his wife and staff Arlene Domingo. I also interviewed Ms. Domingo. Ms. McClintock, Ms. Singleton, Ms. Burns, and Ms. Jones stated they were not working at the time of the alleged incidents. They denied observing Ms. Alonzo, Mr. Domingo or any other staff yelling at or mistreating any of the residents. The staff who were working the days of the alleged incident were Lashanda Houston (who terminated her employment with the facility), Tabitha Cruz, Ms. Alonzo, and Mr. Domingo. They verified management was informed Ms. Alonzo, Mr. Domingo, and Ms. Cruz confined Resident A into her bedroom while she was having behaviors. Management was also informed Ms. Alonzo yells at Resident A and Resident B. Ms. Alonzo, Mr. Domingo, and Ms. Cruz were either disciplined or suspended because of these incidents.

Ms. Alonzo verified she worked in the facility on or around 10/08/2021. Resident A was having behaviors. She was hitting the door with a wheelchair and going into other resident's bedrooms. Ms. Alonzo tried to redirect her with no success. Ms. Alonzo stated she asked Mr. Domingo and Ms. Cruz for help with trying to redirect Resident A and getting her into her bedroom. They talked to Resident A and she went into her bedroom. Resident A's behaviors continued. Ms. Alonzo confirmed she held the doorknob on Resident A's bedroom, preventing Resident A from exiting her bedroom. Ms. Alonzo had trouble with keeping the door closed so Mr. Domingo came over to assist her. They held the doorknob together, further preventing Resident A from exiting her bedroom. Ms. Alonzo stated, at one point, Ms. Cruz also assisted them with holding the doorknob, preventing Resident A from exiting her bedroom. Ms. Alonzo stated she told Resident A if she calmed down, she would be allowed to exit her bedroom. A few minutes later, Resident A calmed down and exited her bedroom. Regarding yelling or screaming at the residents, Ms. Alonzo denied ever yelling or screaming at Resident A, Resident B, or any of the other residents. She denied witnessing Mr. Domingo yelling or screaming at Resident A, Resident B, or any of the other residents.

With translation assistance from Ms. Domingo, Mr. Domingo verified he was working with Ms. Alonzo and Ms. Cruz when Resident A was having behaviors. Mr. Domingo stated Resident A was agitated and keep kicking on other residents' doors. In addition, she was grabbing the footrest on wheelchairs and pulling on the exit doors. Ms. Alonzo tried to calm her down with no success. Mr. Domingo stated he went into Resident A's bedroom and she followed him in there. He left out and Ms. Alonzo held the doorknob. Ms. Alonzo tried to calm Resident A's down with no success. Ms. Alonzo became tired from holding the doorknob. Mr. Domingo helped her with holding the doorknob. At some point, Ms. Cruz also assisted them with holding the doorknob, preventing Resident A from exiting her bedroom. Resident A eventually calmed down and exited her bedroom.

Regarding yelling or screaming at the residents, Mr. Domingo denied ever witnessing Ms. Alonzo yelling or screaming at Resident A, Resident B, or any of the other residents. He also denied that he has yelled or screamed at any of the residents.

Ms. Domingo stated she was not working the day of the alleged incidents. She denied ever witnessing Ms. Alonzo yelling or screaming at Resident A, Resident B, or any of the other residents. She also denied yelling or screaming at any of the residents.

During the onsite investigation, I attempted to interview Resident A and Resident B with no success due to their limited cognitive abilities.

I also reviewed the performance discipline form for Ms. Alonzo, Mr. Domingo, and Ms. Cruz. Ms. Alonzo was given a 1-day suspension. Mr. Domingo was given a 2-day suspension without pay. Ms. Cruz was given a 1st written warning. These disciplines were given due to the staff's participating in restraining a resident to her bedroom when her behaviors escalated. In addition, per the discipline form, the staff will be educated on proper ways to deescalate a resident's behaviors.

On 11/16/2021, I conducted at telephone interview with staff Tabitha Cruz. She verified she was working with Ms. Alonzo and Mr. Domingo when Resident A was having behaviors. Ms. Cruz stated Resident A was being combative. She was trying to break into other residents' bedrooms. Ms. Alonzo and Mr. Domingo were trying to calm her down, but they were struggling with it. Resident A went into her bedroom. While in her bedroom, Resident A tried to choke and push Ms. Alonzo. Ms. Alonzo and Mr. Domingo left out of Resident A's bedroom, and they held the doorknob. Ms. Cruz confirmed that at some point she held the doorknob as well. Eventually Resident A calmed down and exited her bedroom. Regarding yelling and screaming at the residents, Ms. Cruz stated there are a couple of residents that Ms. Alonzo yells at. She stated Ms. Alonzo is not trying to be mean. Instead, she is telling the residents "stopping doing that" or "it hurts". According to Ms. Cruz, all staff say that to the residents.

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:	On or around 10/08/2021, Resident A was having behaviors. Ms. Alonzo, Mr. Domingo, and Ms. Cruz held the doorknob, preventing her from exiting her bedroom until she calmed down. Regarding yelling or screaming at the residents, the reporting source and Ms. Cruz stated Ms. Alonzo and/or Mr. Domingo yells at the residents. Other staff interviewed denied witnessing Ms. Alonzo or Mr. Domingo yelling or screaming at the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(a) Use any form of punishment.** **(d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.** **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.**
ANALYSIS:	On or around 10/08/2021, Resident A was having behaviors. Ms. Alonzo, Mr. Domingo, and Ms. Cruz held the doorknob, preventing her from exiting her bedroom until she calmed down. Ms. Alonzo, Mr. Domingo, and Ms. Cruz received discipline due to their participation in restraining a resident to her bedroom when her behaviors escalated. In addition, per the discipline form, the staff will be educated on proper ways to deescalate a resident's behaviors. Regarding yelling or screaming at the residents, the reporting source and Ms. Cruz stated Ms. Alonzo and/or Mr. Domingo yells at the residents. Other staff interviewed denied witnessing Ms. Alonzo or Mr. Domingo yelling or screaming at the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The residents are not administered their medications as prescribed.

INVESTIGATION:

On 10/26/2021, I conducted a telephone interview with the reporting source. The reporting source stated the "medications are screwed up" at the facility. Staff pop out the medications and sit them on the counter for the residents. Staff do not administer medications as prescribed. Night medications are scheduled for 9pm, but staff give the night medications to the residents at 7pm. In addition, the medications are not locked up. The reporting source stated experienced staff train new staff on how to properly

administer medications; however, she does not feel that the experienced staff are properly trained to do so.

On 10/28/2021, I conducted an unannounced onsite investigation. I interviewed administrator Robin McClintock, assistant director Megan Singleton, registered nurse Janet Burns, resident service coordinator LaQuitta Jones, staff Gerlyn, and staff Jayson Domingo with translating assistance from his wife and staff Arlene Domingo. I also interviewed Ms. Domingo and staff Leslee Badenhoop. They stated all staff who administer medications have been trained to do so. To their knowledge, staff administer medications to one resident at a time and as prescribed. Medications are not set on the counter for the residents. Medications are administered no earlier than one hour prior or one later than the scheduled time. In addition, the medication cart is always locked.

During the onsite investigation, Ms. Badenhoop completed a medication administration simulation. She adequately demonstrated how to administer medications. When I arrived at the facility, I observed pharmacy staff conducting an audit of the medication carts. Therefore, the carts were unlocked. I reviewed eight out of 15 residents' medications and medication administration records. I observed the following medication errors:

- Staff did not document the time or reason PRN Lorazepam was administered to Resident C on 10/02/2021.
- Staff did not initial Resident D's MAR to show administration of Diclofenac Sodium 1% gel at 9am on10/18/2021.
- Staff did not initial Resident E's MAR to show administration of General Tears 0.1%-0.2% at 6am on 10/16/2021 and 10/17/2021, at 6pm on 10/10/2021, or at 12am from 10/23/2021 to 10/25/2021. Staff also did not initial the MAR to show administration of Norco 51325mg at 5pm on 10/11/2021.
- Staff did not initial Resident F's MAR to show administration of Lomotil 2.5-0.25mg at 5pm on 10/08/2021 and 10/09/2021.

On 10/29/2021, I reviewed verification that staff Aneke Akande, staff Natalia Barkley, staff Shanquise Betty, staff Clara Davis, staff Michelle Doucette, staff Kimberly Erickson-Cox, staff Candice Gall, staff Akilah Halliburton, staff Ashley McIntosh, Biancia Mojica, staff Marichu Pruyt, staff Maria Santiago, staff Lavida Shelmonsen-Bey, staff LaQuitta Jones as well as Ms. Alonzo, Ms. Badenloop, Ms. Cruz, Ms. Domingo, Mr. Domingo, and Ms. Houston completed medication administration training.

On 11/16/2021, I conducted a telephone interview with staff Tabitha Cruz. She stated all staff who administer medications have been trained to do so. To their knowledge, staff administer medications to one resident at a time and as prescribed. Medications are not set on the counter for the residents. Medications are administered no earlier than one hour prior or one later than the scheduled time.

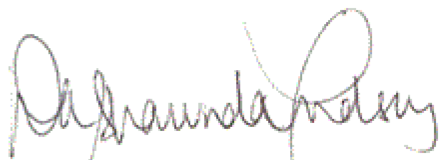
On 11/16/2021, I conducted an exit conference with licensee designee Maureen Comer. I informed her of the findings. She agreed to submit a corrective action plan.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of a 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:	During an unannounced onsite investigation, I observed that Staff did not initial Resident D's MAR to show administration of Diclofenac Sodium 1% gel at 9am on10/18/2021. Staff did not initial Resident E's MAR to show administration of General Tears 0.1%-0.2% at 6am on 10/16/2021 and 10/17/2021, at 6pm on 10/10/2021, or at 12am from 10/23/2021 to 10/25/2021. Staff also did not initial the MAR to show administration of Norco 51325mg at 5pm on 10/11/2021. Staff did not initial Resident F's MAR to show administration of Lomotil 2.5-0.25mg at 5pm on 10/08/2021 and 10/09/2021. I verified that staff have been trained to pass medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of a 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:	Staff did not document the time or reason PRN Lorazepam was administered to Resident C on 10/02/2021.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



12/06/2021

DaShawnda Lindsey — Date
Licensing Consultant

Approved By:

12/06/2021

Denise Y. Nunn — Date
Area Manager