GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 11, 2022

Achal Patel
Divine Life Assisted Living Center 2 LLC
2045 Birch Bluff Drive
Okemos, MI 48864

RE: License #: AL330404951
Investigation #: 2022A0466020
Divine Life Assisted Living Center 2 LLC

Dear Mr. Patel:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 (517) 284-9727.

Sincerely,

Julie Elkins

Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL330404951
Investigation #:	2022A0466020
Complaint Receipt Date:	01/13/2022
Investigation Initiation Date:	01/14/2022
Report Due Date:	03/14/2022
Licensee Name:	Divine Life Assisted Living Center 2 LLC
Licensee Address:	2045 Birch Bluff Drive Okemos, MI 48864
Licensee Telephone #:	(517) 339-3677
Administrator:	Achal Patel
Licensee Designee:	Achal Patel
Name of Facility:	Divine Life Assisted Living Center 2 LLC
Facility Address:	5905 Edson Street Haslett, MI 48840
Facility Telephone #:	(517) 339-3677
Original Issuance Date:	11/20/2020
License Status:	REGULAR
Effective Date:	05/20/2021
Expiration Date:	05/19/2023
Capacity:	16
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATIONS:

	Violation Established?
Resident A's mail is being opened prior to her receiving it.	No
Resident A is being administered the wrong doses of medications.	No

III. METHODOLOGY

01/13/2022	Special Investigation Intake- 2022A0466020.
01/14/2022	Special Investigation Initiated - On Site.
03/07/2022	Contact- Telephone call to Rhonda Tri-county Office, number disconnected.
03/07/2022	Contact- Telephone call to case manager Jessica, she is off on extended leave- please contact April Yager.
03/07/2022	Contact- Telephone call to CMH, April Yager, number disconnected.
03/07/2022	Contact- Telephone call to Relative A1, message left.
03/07/2022	Contact- Telephone call to Relative A2, message left.
03/07/2022	Contact- Telephone call to Resident A interviewed.
03/09/2022	Contact- Telephone from Relative A2, message left.
03/09/2022	Contact- Telephone call to Relative A2, interviewed.
03/09/2022	Contact- Telephone call to DCW Roger Lewis, phone number disconnected.
03/09/2022	Contact- Telephone call to DCW Shelly Melrose, interviewed.
03/09/2022	Contact- Documents received from licensee designee Achal Pate.
03/11/2022	Exit Conference with Achal Pate.

ALLEGATION: Resident A's mail is being opened prior to her receiving it.

INVESTIGATION:
On 01/13/2022, Complainant reported that Relative A1 sent Resident A a Christmas card on 12/20/2021 and Resident A received the Christmas card on 01/06/2022 but it was already open. Complainant reported Resident A has not received some mail from Christmas that friends reported was sent. Complainant reported that PACE sent a package to Resident A 10 days ago and Resident A still has not received it. Complainant reported that the facility is withholding Resident A's mail.

On 01/14/2022, I interviewed direct care worker (DCW) Tanashia Fletcher who reported that she was not aware of any mail that Resident A was anticipating that she did not receive. DCW Fletcher reported that she does not open any resident mail nor has she observed any other DCW opening resident mail. DCW Fletcher reported that Resident A was not at the facility at the time of the unannounced investigation and therefore Resident A was not available to be interviewed.

On 03/09/2021, I interviewed Resident A who reported that she is not getting her mail at the facility. Resident A reported that Program of All-inclusive Care for the Elderly (PACE) sent her a packet but Resident A believes facility direct care staff members received the packet and sent it back to PACE. Resident A reported when she "bugs" DCWs about her mail they find it for her and give it to her. Resident A reported she received an opened Christmas card from Relative A1 that was missing the check that Relative A1 told her would be in the card. Resident A reported she was unaware if the Christmas card was opened prior to the facility receiving it via US mail. Resident A reported she is not aware if the mail service is taking longer to receive. Resident A reported that she was unaware if other residents are also having issues with the mail at the facility. Resident A reported that she does not believe that other residents receive mail at the facility.

On 03/09/2022, I called Relative A1 and left a message for Relative A1 to return my telephone call and I left my telephone number. As of the writing of this report no return phone call has been received.

On 03/10/2022, I interviewed Relative A2, who is Resident A's durable power of attorney (DPOA), reported Resident A's legal mailing address is Relative A2's home address, not the facility address. Relative A2 reported that she was not aware of Relative A1 sending Resident A Christmas card with a check that she did not receive. Relative A2 is not aware of any PACE paperwork or package that Resident A did not receive. Relative A2 reported Resident A never told her about her mail being opened, a check missing or that she did not receive PACE paperwork/package. Relative A2 reported that Relative A1 never told her that he sent Resident A check nor that it was not received.

On 03/10/2022, I interviewed DCW Shelly Melrose who reported that Resident A never reported to her that she did not receive mail that she was expecting nor that

her mail was being opened. DCW Melrose reported that the facility does not open resident mail.

On 03/10/2022, I reviewed the facility's *Resident Rights* policy which documented that the residents have "the right to write, send and receive uncensored and unopened mail at their expense."

On 03/10/2022, I interviewed licensee designee and administrator Achal Patel who reported that neither he nor any other DCW at the facility opened any residents' mail. Licensee designee Patel reported that none of Resident A's mail has been opened by anyone at the facility.

APPLICABLE RULE	
R 400.15304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(d) The right to write, send, and receive uncensored and unopened mail at his or her own expense.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Although Complainant reported that Resident A's mail is being opened prior to her receiving there is no evidence to support this allegation. DCW Fletcher, DCW Melrose and licensee designee Patel all reported that no one at the facility opens resident mail. The facility's *Resident Rights* policy documented that the residents have "the right to write, send and receive uncensored and unopened mail at their expense." Resident A reported she was unaware if the Christmas card she received was opened prior to the facility receiving it via US mail therefore there is not enough evidence to establish an allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A is being administered the wrong doses of medications.

INVESTIGATION:
On 01/13/2022, Complainant reported that Resident A has to count medications every time the facility administers her prescribed medications as the DCWs give Resident A the wrong medications. Complainant reported Resident A has been

administered the wrong medications because the facility's computer messes up medications. Complainant reported on one occasion Resident A was administered double the number of Norco that she should have been administered and on another occasion Resident A was administered triple the amount of Norco that she was prescribed in a day. Complainant reported Resident A was sleepy all the time. Complainant reported DCW Melrose brought Resident A's medications in a cup and Resident A dumped them out and found one Norco pill was missing so Resident A called DCW Melrose. Complainant stated DCW Melrose brought back the bubble packs and showed Resident A that the medication had been administered. Complainant reported DCW Melrose was afraid Resident B would take Resident A's medication, so they didn't give it to Resident A nor did they replace it when it was missing. Complainant reported that DCW Melrose said the medication might have dropped or something, but it was not given to Resident A. Complainant reported that the facility is upset with Resident A and all of her medications are being administered in the medication room rather than DCWS bringing it to Resident A's room. Complainant reported Resident A has been writing down everything that has occurred this month.

On 01/14/2022, I interviewed DCW Fletcher who reported that she was not aware of any time Resident A was administered multiple doses of her medication. DCW Fletcher reported that she was not aware of anytime that the computer medication administration records (MAR)s listed the wrong medications for Resident A nor has the computer ever malfunctioned. DCW Fletcher reported that she was not aware of any time that Resident A was not administered her prescribed medications because DCWs were afraid that Resident B would take the medications. DCW Fletcher reported when medications are administered, the DCW watches the resident ingest the medication. DCW Fletcher reported Resident A was not at the facility at the time of the unannounced investigation and therefore Resident A was not available to be interviewed.

On 01/14/2022, I reviewed Resident A's record which documented that she was 73 years and admitted to the facility on 11/30/2021. I reviewed Resident A's *Assessment Plan for Adult Foster Care (AFC) Residents* which was dated 11/30/2021 and signed by Relative A2. Resident A's *Assessment Plan for AFC Residents* documented in the "taking medications" section of the report that "medications will be managed by staff."

On 01/14/2022, I reviewed Resident A's January 2022 MAR and compared the MAR to the prescribed medication which were in the original pharmacy prescribed containers. I found no evidence that Resident A had been administered more medication than she had been prescribed after comparing the medications to the MARs.

On 03/09/2021, I interviewed Resident A who reported that she could not remember the exact date but sometime between 01/01/2022 through 01/11/2022 she was offered more hydroco/apap (Norco) than she was prescribed. Resident A reported

that she is prescribed Norco at 12am, 6am, 12pm and 6pm. Resident A reported DCW Roger Lewis who works midnights offered her a Norco at 3:30am and again at 6am even though the medication is supposed to be administered every 6 hours. Resident A reported that the same day DCW Melrose offered her a Norco at 8:30am which she refused as that would have been an overdose of the medication. Resident A reported that she no longer lives at this facility.

On 03/09/2021, I reviewed Resident A's January 2022 MARs for a second time. Resident A's MAR documented that she was prescribed "hydroco/apap tab 7.5-325, take 1 tablet by mouth every 6 hours around the clock." Resident A's January 2022 MAR documented that she was administered the medication every day as prescribed without any refusals. DCW Lewis administered this medication to her on 01/01/2022 at 12am and 01/02/2022 at 12am. DCW Melrose administered this medication to Resident A on 01/01/2022, 01/07/2022 and 01/10/2022 at 6am, on 01/01/2022, 01/05/2022, 01/07/2022, 01/10/2022 and 01/11/2022 at 12pm and on 01/018/2022, 01/04/2022, 01/05/2022, 01/06/2022, 01/07/2022, 01/10/2022 and 01/11/2022 at 6pm. DCW Melrose never administered Resident A medication at 12am according to the MAR.

On 03/09/2022, I called DCW Lewis and his phone number was disconnected.

On 03/09/2022, I contacted licensee designee Patel who reported that DCW Lewis no longer works at the facility and that he does not have any additional phone numbers for him. Licensee designee Patel reported that he was not aware of anytime that Resident A was administered more medications than she was prescribed nor was there a time when their medication computer malfunctioned.

On 03/10/2022, I interviewed Relative A2, Resident A's durable power of attorney (DPOA), who reported Resident A did complain to her about the number of medications that she has been prescribed by her physician and that Resident A reported that she was being administered more Norco than she was prescribed. Relative A2 reported Resident A informed her she had refused the extra Norco medication that was offered and only took the medications at the prescribed dosage times. Relative A2 reported Resident A did not tell her which medication or which DCWs administered her more medication than she was prescribed. Relative A2 reported she was out of town at the time and could not recall the date but reported she did contact the facility about this concern. Relative A2 reported she spoke with Vivek Thakore who looked into the situation and assured Relative A2 that Resident A was not being administered more medication than she had been prescribed. Relative A2 reported Resident A had only been living at the facility since the beginning of December 2021, but she felt that the care was good. Relative A2 reported that Resident A does have a history or refusing medications.

On 03/10/2022, I interviewed DCW Shelly Melrose who reported that she was not aware of any time that Resident A has been administered multiple doses of her medication. DCW Melrose reported that she was not aware of anytime that the

computer had listed the wrong medications for Resident A nor has the computer ever malfunctioned. DCW Melrose reported that she is not aware of any time that Resident A was not administered her prescribed medications because DCWs were afraid that Resident B would take the medications. DCW Melrose reported when medications are administered, DCWs watch the resident ingest the medication. DCW Melrose reported Resident A's medications were administered to her in the medication room as there is a camera in the medication room and therefore there was record of the medications Resident A was administered in addition to the MAR in case Resident A questioned that she received all of her prescribed medications.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Although Complainant and Resident A believed that Resident A was administered the wrong dose of medications, there is no evidence to support this allegation. DCW Fletcher and DCW Melrose reported not being aware of any time Resident A was administered multiple doses of her medication, anytime that the computer listed the wrong medications or has the computer ever malfunctioned and advised the wrong medication dosages to be administered. Additionally, I reviewed Resident A's January 2022 MAR and compared the MAR to the prescribed medication which were in the original pharmacy prescribed containers and found no discrepancy. I found no evidence Resident A had been administered more medication than she had been prescribed after comparing the medications to the MARs therefore no violation has been established.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

I recommend no change in the current license status.

03/11/2022

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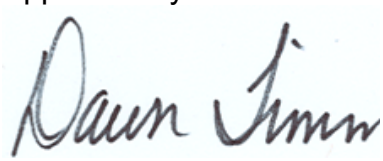
Julie Elkins Date
Licensing Consultant

Approved By:



03/11/2022

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Dawn N. Timm Date
Area Manager