GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 7, 2022

Gregory Richards
Parkside Estates LLC
2211 Parkside Street
Trenton, MI 48183

RE: License #: AS820313332
Investigation #: 2022A0116016
Parkside Estates

Dear Mr. Richards:

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 (313) 456-0380.

Sincerely,

Pandrea Robinson

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820313332
Investigation #:	2022A0116016
Complaint Receipt Date:	02/15/2022
Investigation Initiation Date:	02/15/2022
Report Due Date:	04/16/2022
Licensee Name:	Parkside Estates LLC
Licensee Address:	2211 Parkside Street Trenton, MI 48183
Licensee Telephone #:	(734) 692-0877
Administrator:	Gregory Richards
Licensee Designee:	Gregory Richards
Name of Facility:	Parkside Estates
Facility Address:	2211 Parkside Street Trenton, MI 48183
Facility Telephone #:	(734) 692-0877
Original Issuance Date:	07/12/2011
License Status:	REGULAR
Effective Date:	08/14/2020
Expiration Date:	08/13/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
During the week of 1/23/22 to 1/29/22 Resident E fell five times sustaining bruises and an abrasion. On 1/28/22, Resident E was finally taken to the hospital as the last fall caused cut to her arm that required stitches. There is concern regarding the care being provided.	No
Resident A was prescribed an oral antibiotic on 1/28/22 to treat an infection. The medication was not given as prescribed.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/15/2022	Special Investigation Intake 2022A0116016
02/15/2022	APS Referral-Received
02/15/2022	Special Investigation Initiated - Telephone Left a message for Relative (2) requesting a return call.
02/15/2022	Contact - Telephone call received Interviewed Relative (2).
02/16/2022	Inspection Completed-BCAL Sub. Non-Compliance Interviewed staff, Rena Kwek, and licensee designee, Gregory Richards. Reviewed Resident E's records.
02/17/2022	Contact - Telephone call made Spoke with Witness (2) from Waltz Manor.
02/22/2022	Contact - Telephone call made Spoke with Mr. Richards and scheduled onsite inspection for 03/01/22 at 10:30 a.m.
02/24/2022	Contact - Document Received Received pictures of Resident E's medication bottle, label and remaining capsules.
03/01/2022	Inspection Completed On-site

	Spoke with Mr. Richards and Mrs. Kwek.
03/01/2022	Contact-Telephone call made Spoke with Relative (2).
03/17/2022	Exit Conference With licensee designee, Gregory Richards.

ALLEGATION:

During the week of 1/23/22 to 1/29/22 Resident E fell five times sustaining bruises and an abrasion. On 1/28/22 Resident E was finally taken to the hospital as the last fall caused cut to her arm that required stitches. There is concern regarding the care being provided.

INVESTIGATION:

On 02/15/22, I interviewed Relative (2) and she reported that she visited Resident E on 01/25/22 and noticed that she had some bruises on her face and chin. Relative (2) reported that staff, Rena Kwek, informed her that Resident E fell a couple of times and that she appeared “out of it.” Relative (2) reported that she was aware that Resident E was prone to falls due to her lack of balance, unsteady gait and failure to utilize her walker or cane to ambulate. Relative (2) reported that prior to placing Resident E in an adult foster care (AFC) home, she lived in her own home with home health care services in place. Relative (2) reported that in September of 2020, Resident E fell and sustained a brain bleed and shortly after she moved Resident E into her home so that she could care for her. Relative (2) reported that due to Relative E’s physical aggression due to Dementia, and other health issues she moved her out of her home and eventually into Parkside Estates.

Relative (2) reported that on 01/28/22, she received a call from Mrs. Kwek informing her that Resident E had fallen and sustained a cut to her left forearm, and she was sending her to the hospital to be evaluated and treated. Relative (2) reported that Resident E was returned to the home the same day. Relative (2) reported that the cut required stiches and Resident E was prescribed an antibiotic to prevent infection. Relative (2) reported that on 02/04/22, Resident A fell again and was sent out to the hospital. Relative (2) reported that Resident E was diagnosed with a urinary tract infection (UTI) and remained in the hospital for about seven days. Relative (2) reported that upon discharge from the hospital she found a new home for Resident E and reported she is doing well. Relative (2) reported that although she is aware of Resident E’s balance issues and unsteady gait, she questions if the staff were being attentive and providing a safe environment for Resident E.

On 02/16/22, I conducted an unscheduled onsite inspection and interviewed Mrs. Kwek, Mr. Richards and reviewed Resident E’s records. Mrs. Kwek reported that Resident E is a fall risk and reported she has gotten worse since she was prescribed Depakote and Seroquel for her vascular dementia. Mrs. Kwek also reported that Resident E refuses to utilize her cane or walker when she gets up to ambulate. Mrs. Kwek reported that she has had several conversations with Resident E’s family about her declining health, her concerns that Resident E is being overmedicated, and the possibility of them needing to look for a different setting for Resident E. Mrs. Kwek reported she also spoke with Resident E’s psychiatric nurse about the negative impacts the medication was having on Resident E’s gait and overall health. Mrs. Kwek reported nothing changed.

Mrs. Kwek reported that Resident E did fall three times within a couple of weeks but denied that it was due to any failure on the part of the staff. Mrs. Kwek reported that on 01/28/22, Resident E fell and was sent to the hospital after sustaining a cut on her left forearm. Mrs. Kwek reported Resident E required stiches, returned home the same day, and prescribed an oral antibiotic to prevent infection in the cut. Mrs. Kwek reported that on 02/04/22, Resident E fell again and hit her head on her nightstand,

so she called 911. Mrs. Kwek reported that Resident E was not bleeding or anything, but as a precaution she thought it would be best for her to be evaluated. Mrs. Kwek reported that Resident E has not returned to the home, and she was informed on 02/14/22 that she would not be returning.

I interviewed Mr. Richards and he reported that Resident E was prone to falls and was very unsteady on her feet. Mr. Richards reported that he believes that some of the recent additions of medication was contributing to Resident E's increase in falls. Mr. Richards reported that Resident E would sleep for 16 hours at a time, was hard to wake, was having difficulty trying to eat and even talk. Mr. Richards reported that the staff provides good care and were trying to work with the family to do what was best for Resident E.

I reviewed Resident E's assessment plan dated 10/20/21. The assessment plan documents that Resident E's balance is not good and that she has a walker and cane but will not use them. The assessment does not outline a plan of action that the staff should take to assist Resident E with her balance issues, nor does it document the action staff will take to encourage Resident E to use her walker and cane to ambulate. The assessment plan is signed and agreed upon by all required parties.

On 03/17/22, I conducted the exit conference with Mr. Richards and informed him of the findings of the investigation. Mr. Richards agreed with the findings.

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:	Based on the findings of the investigation, which included interviews of Relative (2), Mrs. Kwek, Mr. Richards and review of Resident E's assessment plan, there is insufficient evidence to establish violation of this rule. On 02/15/22, Relative (2) admitted that Resident E was prone to falls, has balance issues and is unsteady on her feet. Relative (2) also reported that Resident E would not use her walker or cane. On 02/16/22, Mrs. Kwek reported that Resident E was unsteady on her feet, which caused her to fall at times and refused to utilize her walker or cane. Mrs. Kwek also believed that the recently prescribed medications were also contributing to Resident E's unsteady gait. On 02/16/22, Mr. Richards also reported his belief that the addition of new medications was contributing to the increase in falls and denied it had anything to do with the care the staff were providing. On 02/16/22, I reviewed Resident E's assessment plan. The plan documented that Resident E's balance was not good and that she has a walker and cane but would not use either. The assessment plan does not outline a plan of action that the staff should take to assist Resident E with her balance issues, nor does it document the action staff will take to encourage Resident E to use her walker and cane to ambulate. This violation is not established as Resident E's personal needs including protection and safety were attended to in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was prescribed an oral antibiotic on 01/28/22 to treat an infection. The medication was not given as prescribed.

INVESTIGATION:

On 02/15/22, I interviewed Relative (2) and she reported that Resident E was prescribed an oral antibiotic on 01/28/22 to prevent an infection in a cut she had sustained after falling. Relative (2) reported that the 500mg of Cefalexin antibiotic was to be given twice per day for five days. Relative (2) reported that when she went to the home on 02/14/22 to pick up Resident E's belongings she was given the prescription bottle and it still contained 5 capsules. Relative (2) reported that the medication course should have been completed on 02/03/22 or no later than 02/04/22.

On 02/16/22, I conducted an unscheduled onsite inspection and interviewed Mrs. Kwek. Mrs. Kwek reported that Resident E was prescribed Cefalexin to prevent/treat an infection for the cut she sustained after a fall on 01/28/22. Mrs. Kwek reported remembering administering most of the medication but was unable to recall how many capsules were left or provide a reason as to why the medication was not given as prescribed.

I reviewed Resident E's January and February 2022 medication administration records (MAR) and observed that the 500mg Cefalexin was not documented on the MAR. Mrs. Kwek reported that she forgot to document the medication on the MAR.

On 02/17/22, I interviewed Witness (2) from Waltz Manor, and she reported that Resident E was admitted into her adult foster care home on 02/14/22. Witness (2) reported when Relative (2) brought Resident E's medications with her to the home she came across a prescription for 500mg capsules of Cefalexin that was prescribed on 01/28/22 and filled on 01/29/22. Witness (2) reported that there were 5 remaining capsules in the bottle. Witness (2) reported that the label instructions were to give one capsule twice per day for five days and the quantity of pills listed on the bottle was 10. Witness (2) reported that according to the label instructions and the date the prescription was filled the medication course would have been completed on or about 02/02/22 or 02/03/22. I requested that Witness (2) take pictures of the pill bottle and remaining capsules and send to me.

On 02/24/22, I received pictures (copies in file) of Resident E's prescription bottle and the 5 remaining capsules.

On 03/01/22, I interviewed Mr. Richards and he reported that Resident E was sleeping a lot, some days up to 16 hours, and that it was difficult to administer her medications at times because she would not wake up. I asked Mr. Richards did he or the staff contact Resident E's physician to discuss their observations concerning Resident E's sleep patterns and the difficulty it caused relating to consumption of her medications. Mr. Richards did not provide a response.

On 03/17/22, I conducted the exit conference with Mr. Richards and informed him of the findings of the investigation. Mr. Richards did not agree with the findings and

reported that Resident E was over medicated and that he cannot help that she was sleeping 16 hours and unable to take her medication. Mr. Richards posed the question, “What should we have done? Forced her to take the medication while she was already in a comatose state, so she could choke on the medication?” Mr. Richards then added that it was on Resident E’s daughter to address medication concerns.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.

ANALYSIS:	Based on the findings of the investigation, which included interviews with Relative (2), Mrs. Kwek, Witness (2) and consultant observation, there is sufficient evidence to establish violation of this rule. On 02/15/22, Relative (2) reported that Resident E's 500mg capsules of Cefalexin was not given as prescribed. Relative (2) reported the 5-day course of medication should have been completed on 02/02/22 or 02/03/22 at the latest. Relative (2) reported that on 02/14/22 the medication bottle still contained 5 capsules. On 02/16/22, Mrs. Kwek admitted that all of medication was not given as prescribed. Mrs. Kwek was unable to provide a reason why. On 02/17/22, Witness (2) confirmed that on 02/14/22, when Resident E was admitted into her facility, she observed the medication bottle that still contained 5 capsules of 500mg of Cefalexin. Witness (2) confirmed that the medication was filled on 01/29/22 and was to be given twice per day for five days. On 02/24/22, I received and reviewed pictures of Resident E's medication bottle and the five remaining 500mg capsules of Cefalexin. This violation is established as Resident E's 500mg capsules of Cefalexin was not given as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**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:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.**

	(iv) Time to be administered. **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	Based on the findings of the investigation, which included an interview with Mrs. Kwek and consultant observation, there is sufficient evidence to establish violation of this rule. On 02/16/22, Mrs. Kwek reported that she administered most of Resident E's 500mg Cefalexin capsules and admitted that she forgot to record the medication on the MAR. On 02/16/22, I reviewed Resident E's January and February 2022 MARs and observed that they did contain any information regarding the 500mg Cefalexin medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 02/16/22, I conducted an unscheduled onsite inspection and reviewed Resident E's records. Resident E's record did not contain a completed health care appraisal.

I interviewed Mrs. Kwek and she reported that she did not know where the health care appraisal was and reported that I would need to speak to Mr. Richards.

I interviewed Mr. Richards and he reported the health care appraisal could be at his home office.

On 03/01/22, I conducted a scheduled onsite inspection and spoke with Mr. Richards. I asked to review Resident E's health care appraisal and Mr. Richards reported that the family must have taken it when they came to the home to pick up Resident E's belongings because he could not locate it.

On 03/01/22, I spoke with Relative (2). Relative (2) reported that she did not take Resident E's health care appraisal or any other paperwork from the home on 02/14/22. Relative (2) inquired as to how she would have access to the paperwork in

the first place. Relative (2) reported being unaware if a health care appraisal had even been completed for Resident E.

On 03/17/22, I conducted the exit conference with Mr. Richards and informed him of the findings of the investigation. Mr. Richards did not agree with the findings and reported that I could contact Resident E's doctor and obtain a copy. Mr. Richards reported that Resident E's daughter likely took the health care appraisal from the home.

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 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:	Based on the findings of the investigation, which included interviews of Mrs. Kwek, Mr. Richards and consultant observation, there is sufficient evidence to establish violation of this rule. On 02/16/22 and 03/01/22, I reviewed Resident E's records and observed it did not contain a written health care appraisal. Resident E was admitted into the home on 11/01/21. On 02/16/22, Mrs. Kwek reported not knowing where the health care appraisal was. On 02/16/22, Mr. Richards reported that the health care appraisal could be at his home office. On 03/01/22, Mr. Richards reported that Resident E's family may have taken it when they came to the home to retrieve her belongings. On 03/01/22, Relative (2) denied taking or receiving any paperwork when she went to the home on 02/14/22 to retrieve Resident E's belongings. This violation is established as the licensee designee failed to obtain a written health care appraisal within the 90-day period before Resident E's admission into the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 02/16/22, I conducted an unscheduled onsite inspection at reviewed Resident E's record. Resident E's record did not contain weights for December of 2021 and January of 2022. Further, no weight had been recorded to date for February of 2022.

I interviewed Mrs. Kwek and she reported being unaware of this requirement.

On 03/17/22, I conducted the exit conference with Mr. Richards and informed him of the findings of the investigation. Mr. Richards did not agree with the findings of the investigation.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.
ANALYSIS:	Based on the findings of the investigation, which included consultant observation and an interview of Mrs. Kwek, there is sufficient evidence to establish violation of this rule. On 02/16/22, I reviewed Resident E's record and observed that no weights were recorded for December of 2021 and January of 2022. Further, no weight had been recorded to date for February of 2022. This violation is established as the licensee designee, Gregory Richards, failed to record the weight of Resident E monthly as required.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED; LSR dated 02/10/20; CAP DATED 02/25/20.**

INVESTIGATION:

On 03/01/22, I conducted a scheduled onsite inspection, and reviewed Mrs. Kwek's employee record. Mrs. Kwek's record did not contain verification that she had been trained in the proper handling and administration of medication.

On 03/01/22, I interviewed Mrs. Kwek and she reported that she had completed medication training through a previous employer and was trying to obtain her training transcript.

On 03/01/22, I interviewed Mr. Richards and reported that Mrs. Kwek had informed him that she had completed all required trainings. Mr. Richards reported that Mrs. Kwek has requested her training verification and is awaiting them.

On 03/17/22, I conducted the exit conference with Mr. Richards and informed him of the findings of the investigation. Mr. Richards did not agree with the findings and reported that Mrs. Kwek is medication trained.

APPLICABLE RULE	
R 400.14312	**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: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	Based on the findings of the investigation, which included interviews with Mrs. Kwek, Mr. Richards and consultant observation, there is sufficient evidence to establish violation of this rule. On 03/01/22, I reviewed Mrs. Kwek's employee record and observed that it did not contain verification that she was trained in the proper handling and administration of medication. On 03/01/22, Mrs. Kwek reported that she has been trained, however, was unable to provide verification. On 03/01/22, Mr. Richards reported that according to Mrs. Kwek she has been medication trained and is awaiting the receipt of her training transcript. This violation is established as Mrs. Kwek administers medication to residents and to date, is unable to provide verification of that training.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend continuing the revocation recommendation for SIR# 2022A0116015.

03/24/22

Pandrea Robinson
Licensing Consultant

Date

Approved By:

03/25/22

_____

Ardra Hunter Date
Area Manager