GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 16, 2022

Dominique Groenveld
MCAP Clare Opco, LLC
4386 14 Mile Rd
Rockford, MI 49341

RE: License #: AL180404678
Investigation #: 2022A1033007
Prestige Place II

Dear Ms. Groenveld:

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 (517) 284-9730.

Sincerely,

Jana Lipps, 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 #:	AL180404678
Investigation #:	2022A1033007
Complaint Receipt Date:	05/13/2022
Investigation Initiation Date:	05/16/2022
Report Due Date:	07/12/2022
Licensee Name:	MCAP Clare Opco, LLC
Licensee Address:	4386 14 Mile Rd Rockford, MI 49341
Licensee Telephone #:	(989) 386-7524
Administrator:	Chelsea Blain
Licensee Designee:	Dominique Groenveld
Name of Facility:	Prestige Place II
Facility Address:	690 Ann Arbor Trail Clare, MI 48617
Facility Telephone #:	(989) 386-7524
Original Issuance Date:	02/01/2021
License **Status:**	REGULAR
Effective Date:	08/01/2021
Expiration Date:	07/31/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 5/8/22, Resident A was picked up from the facility by someone who was not authorized to pick him up. He did not have his medications, a bed to sleep in or food.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/13/2022	Special Investigation Intake 2022A1033007
05/16/2022	Special Investigation Initiated - On Site Interviewed Administrator, Chelsea Blain, direct care staff, Ann David & Ervanna Brugger, Resident A. Initiated record review.
05/17/2022	Contact - Telephone call made Interview with direct care staff, Austyn Swansey, via telephone.
05/17/2022	Contact - Telephone call made Attempt to interview Guardian A1. Voicemail message left.
05/17/2022	Contact - Telephone call received Interview with Guardian A1 via telephone.
05/18/2022	Inspection Completed-BCAL Sub. Compliance
06/16/2022	Exit Conference with Licensee Designee, Dominique Groenveld.

ALLEGATION:

On 5/8/22, Resident A was picked up from the facility by someone who was not authorized to pick him up. He did not have his medications, a bed to sleep in or food.

INVESTIGATION:

On 5/16/22 I conducted an on-site investigation at the Prestige Place II facility and interviewed Administrator, Chelsea Blain. Administrator Blain reported Resident A is a current resident at this facility, and she had been in communications with his guardian about the potential for him to have a leave of absence (LOA) from the

facility with Citizen 1. She reported that these arrangements had not been finalized when Citizen 1 telephoned the facility on 5/5/22 and stated to Administrator Blain that she would be coming that day to pick up Resident A for an LOA. Administrator Blain reported that she did not confirm this with Guardian A1 or Resident A's PACE team before Citizen 1 arrived to pick up Resident A. Administrator Blain noted she was not present when Citizen 1 arrived to pick up Resident A. She reported direct care staff (DCS) Ann David, was working at this time. Administrator Blain reported that Citizen 1 explained to DCS David that she would be taking Resident A on 5/5/22 and returning him to the facility on 5/9/22. Administrator Blain reported that DCS David provided Resident A's medications to Citizen 1 at that time. Administrator Blain further reported that on 5/9/22 the facility received a telephone call from Citizen 1 stating she was going to be keeping Resident A for one additional night and would be returning him to the facility on 5/10/22. Administrator Blain reported DCS Austyn Swansey took this phone call from Citizen 1 and relayed the message to the other facility staff. Administrator Blain reported she is uncertain if it was discussed with Citizen 1 that she was not given enough medication to administer to Resident A for this extended time frame. She reported DCS David had only provided medications through the evening of 5/9/22. Administrator Blain reported that Citizen 1 returned Resident A to the facility on 5/10/22 around 3:15pm. Administrator Blain reported Resident A appeared clean, happy, and well cared for when he returned. She further reported that it was noted, by Citizen 1, that Resident A had not been given lunch yet that day and would need a meal prepared for him.

Administrator Blain reported that the facility has a policy for LOA's which includes having the responsible party sign the resident out on the *Americana's Seniors of Clare, Resident Sign Out Sheet.* This record was reviewed, and Citizen 1 failed to sign out Resident A prior to leaving the facility on 5/5/22. Administrator Blain also noted policy that when a resident is leaving for an LOA that the medications are reviewed with the responsible party and there is a form signed by the responsible party acknowledging acceptance of the resident's medications and instructions on how to administer the medications. Administrator Blain could not produce a signed copy of this form during this on-site investigation.

During on-site investigation on 5/16/22 I interviewed direct care staff, Ervanna Brugger. DCS Brugger is the nurse at Prestige Place II facility. DCS Brugger reported that she has been interpreting the *Assessment Plan for AFC Residents* form, section *I. Social/Behavioral Assessment,* subsection *A. Moves independently in Community* to refer to how the resident functions within the facility. I provided education related to this question and stated to DCS Brugger and Administrator Blain that this section pertains to how the resident can function in the local community, outside of the facility. DCS Brugger noted she had completed the form incorrectly and Resident A should not be allowed on his own outside the Prestige II facility as he would become afraid and not know what to do without supervision.

During on-site investigation I interviewed DCS David. DCS David reported she had been working on 5/5/22 when Citizen 1 picked up Resident A from the facility, but

she did not take the telephone call from Citizen 1 that day. DCS David reported DCS Allie Fausett, had spoken with Citizen 1 about the plans for Resident A's LOA. DCS David reported when Citizen 1 arrived to pick up Resident A, on 5/5/22, DCS David provided Citizen 1 with Resident A's medications. DCS David reported she took the medications from the original packaging and placed them in separate containers for morning medications and evening medications. She further reported that she wrote down instructions for how Citizen 1 should administer the medications for Resident A. DCS David reported she provided Citizen 1 with enough medication to get Resident A through his evening meds on 5/9/22. DCS David reported giving Resident A his evening medications on 5/5/22 before he left the facility with Citizen 1. DCS David reported that she instructed Citizen 1 to sign Resident A out on the "book" before they left the facility. DCS David was not present when Resident A returned to the facility on 5/10/22.

During on-site investigation on 5/16/22 I interviewed Resident A. Resident A reported that he had gone for an LOA with Citizen 1. Resident A reported that he went to Citizen 1's home. They watched television. He reported he had food to eat and a bed to sleep in at Citizen 1's home. He also reported that Citizen 1 administered his medications while he was away from the facility.

On 5/17/22 I interviewed DCS Swansey via telephone. DCS Swansey reported she had taken the telephone call from Citizen 1 on 5/9/22. She reported Citizen 1 had stated she was going to be keeping Resident A for one additional night and would be returning him to the facility on 5/10/22. DCS Swansey reported Citizen 1 did not ask for additional medications for Resident A and it was not discussed during this telephone conversation. DCS Swansey reported she informed her management of the phone call after it occurred. DCS Swansey could not recall which manager was working at this time. DCS Swansey reported she was present at the facility when Resident A returned on 5/10/22. She reported he appeared happy and clean. She reported she was concerned about the fact that he had not received his medications that morning. DCS Swansey also reported Citizen 1 did not return any unused medications when she brought Resident A back to the facility on 5/10/22.

On 5/17/22 I interviewed Guardian A1 via telephone. Guardian A1 noted she was extremely upset with the facility for allowing Resident A to go on a five-day LOA with an unapproved party. Guardian A1 reported Resident A has a history of abuse and neglect from direct family members. She further reported that she must approve any person who is attempting to take Resident A from the facility due to this potential for abuse. Guardian A1 reported she had been in conversations with Administrator Blain regarding a potential LOA for Resident A but had advised her that she needs to make a home visit to Citizen 1's home prior to this being approved. Guardian A1 reported she had explained to Administrator Blain that Citizen 1 had not been compliant with returning telephone calls to arrange for a home visit and had not been authorized to take Resident A on an LOA. Guardian A1 reported she was not informed by the facility that Resident A had gone with Citizen 1. She reported she was informed by the PACE team when they arrived at the facility for a regular visit

with Resident A and he was not there. Guardian A1 reported she immediately called Citizen 1 to check on Resident A as this had not been an approved LOA. She reported Citizen 1 stated Resident A had spent most of the time sitting in front of the television while he was away from the facility. Guardian A1 reported that the Prestige Place II facility has since sent her the following forms, *Assessment Plan for AFC Residents* & *AFC Resident Care Agreement,* to complete and sign for Resident A's care. She reported these are forms she has not been asked to sign before and she has been Resident A's guardian since September 2021. Guardian A1 was asked about Resident A's ability to be in the community on his own. Guardian A1 reported that Resident A needs supervision and would not be able to intellectually manage being out in the community on his own.

On 5/16/22 I reviewed Resident A's record including his *Assessment Plan for AFC Residents* form. This form dated 11/03/21 does not have a signature for Guardian A1. This form also dictates under Section *I. Social/Behavioral Assessment,* subsection *A. Moves independently in Community*, "Yes" this Resident moves independently within the community. Per conversation with DCS Brugger, she reported completing this section in error as Resident A does not move independently in the community.

On 5/16/22 I reviewed The *Health Care Appraisal* forms found in Resident A's record. The most recent copy of this form was dated *11/3/20.* I also reviewed the *AFC – Resident Care Agreement* form which was dated 11/13/19 and was signed by Resident A. An updated version of this form to include Guardian A1's signature was not available to view on this date.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on interviews with Administrator Blain, DCS Brugger, DCS David, DCS Swansey, & Guardian A1, the facility did not provide for Resident A's protection and safety by allowing him to leave the facility with an unauthorized party.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:
INVESTIGATION:

On 5/16/22 I reviewed The *Health Care Appraisal* forms found in Resident A's record. The most recent copy of this form was dated *11/3/20.*

APPLICABLE RULE	
R 400.15301	**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 review of Resident A's record, there was not a current *Health Care Appraisal* in the resident record at the time of this on-site investigation. The most recent record was dated 11/3/2020 and had not been updated annually as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 5/16/22 I reviewed Resident A's record. I reviewed his *Assessment Plan for AFC Residents* form. This form dated 11/03/21 does not have a signature for Guardian A1 nor any other form or letter demonstrating Guardian A1 participation in the completion of this form.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.

ANALYSIS:	Based on review of Resident A's record and interview with Guardian A1 the *Assessment Plan for AFC Residents* form in Resident A's record, dated 11/03/21, does not have a signature for Guardian A1 or any other documentation that collaboration in completing this form was established between the facility staff and Guardian A1.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 5/17/22 I interviewed Guardian A1 via telephone. Guardian A1 reported that the Prestige Place II facility had sent her the following forms, *Assessment Plan for AFC Residents* & *AFC Resident Care Agreement,* to complete and sign for Resident A's care, on 5/17/22. She reported these are forms she has not been asked to sign before and she has been Resident A's guardian since September 2021.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(9) A licensee shall review the written resident care agreement with the resident or the resident's designated representative and responsible agency, if applicable, at least annually or more often if necessary.
ANALYSIS:	Based on review of Resident A's record and interview with Guardian A1 the *AFC – Resident Care Agreement* form was dated 11/13/19 and was signed by Resident A. An updated version of this form to include Guardian A1's signature was not available to view on this date nor was the form updated annually as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During onsite investigation on 5/16/22 I interviewed Administrator Blain. Administrator Blain noted policy that when a resident is leaving for an LOA that the medications are reviewed with the responsible party and there is a form signed by the responsible party acknowledging acceptance of the resident's medications and instructions on how to administer the medications. Administrator Blain could not produce a signed copy of this form during this on-site investigation.

During onsite investigation on 5/16/22 in interviewed DCS David. DCS David reported that when Citizen 1 arrived to pick up Resident A, on 5/5/22, DCS David provided Citizen 1 with Resident A's medications. DCS David reported that she took the medications from the original packaging and placed them in separate containers for morning medications and evening medications. She further reported that she wrote down instructions for how Citizen 1 should administer the medications for Resident A. DCS David reported that she provided Citizen 1 with enough medication to get Resident A through his evening meds on 5/9/22.

APPLICABLE RULE	
R 400.15312	**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 interviews with Administrator Blain and DCS David, the facility removed Resident A's prescription medication from the original pharmacy supplied container when providing Citizen 1 Resident A's medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During onsite investigation on 5/16/22 I interviewed Administrator Blain. Administrator Blain reported that Citizen 1 explained to DCS David that she would be taking Resident A on 5/5/22 and returning him to the facility on 5/9/22. Administrator Blain reported that DCS David provided Resident A's medications to Citizen 1 at that time. Administrator Blain further reported that on 5/9/22 the facility received a telephone call from Citizen 1 stating she was going to be keeping Resident A for one additional night and would be returning him to the facility on 5/10/22. Administrator Blain reported that DCS Austyn Swansey took this phone call from Citizen 1 and relayed the message to the other facility staff. Administrator Blain reported that she is uncertain if it was discussed with Citizen 1 that she was not given enough medication to administer to Resident A for this extended time frame. She reported that DCS David had only provided medications through the evening of 5/9/22.

During onsite investigation on 5/16/22 I interviewed DCS David. DCS David reported she provided Citizen 1 with enough medication to get Resident A through his evening meds on 5/9/22.

On 5/17/22 I interviewed DCS Swansey via telephone. DCS Swansey reported she had taken the telephone call from Citizen 1 on 5/9/22. She reported Citizen 1 had stated she was going to be keeping Resident A for one additional night and would be returning him to the facility on 5/10/22. DCS Swansey reported Citizen 1 did not ask for additional medications for Resident A and it was not discussed during this telephone conversation. DCS Swansey reported she informed her management of the phone call after it occurred. DCS Swansey could not recall which manager was working at this time. DCS Swansey reported she was present at the facility when Resident A returned on 5/10/22. She reported he appeared happy and clean. She reported that she was concerned about the fact that he had not received his medications that morning. DCS Swansey also reported Citizen 1 did not return any unused medications when she brought Resident A back to the facility on 5/10/22.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(5) When a resident requires medication while out of the home, a licensee shall assure that the resident or, in the alternative, the person who assumes responsibility for the resident has all of the appropriate information, medication, and instructions.
ANALYSIS:	Based on interviews with Administrator Blain, DCS David, and DCS Swansey the facility had provided Citizen 1 with Resident A's medications through 5/9/22. Citizen 1 did not return Resident A to the facility until approximately 3:15pm on 5/10/22. Citizen 1 did not have adequate quantities of Resident A's medications to accommodate his plan of care.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an approved corrective action plan, no change to the license is recommended at this time.

06/16/2022

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Jana Lipps Date
Licensing Consultant

Approved By:

06/16/2022

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Dawn N. Timm Date
Area Manager