GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 30, 2022

Marilyn Jenkins
Lakeside Manor Inc
8790 Arlington
White Lake, MI 48386

RE: License #: AL630086778
Investigation #: 2022A0612002
Lakeside Manor Inc

Dear Ms. Jenkins:

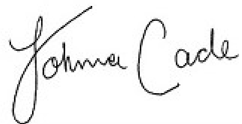
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Johnna Cade, Licensing Consultant
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
Phone: 248-302-2409

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630086778
Investigation #:	2022A0612002
Complaint Receipt Date:	06/01/2022
Investigation Initiation Date:	06/01/2022
Report Due Date:	07/31/2022
Licensee Name:	Lakeside Manor Inc
Licensee Address:	8790 Arlington White Lake, MI 48386
Licensee Telephone #:	(248) 666-9010
Licensee Designee:	Marilyn Jenkins
Name of Facility:	Lakeside Manor Inc
Facility Address:	8790 Arlington White Lake, MI 48386
Facility Telephone #:	(248) 666-9010
Original Issuance Date:	11/13/2000
License Status:	REGULAR
Effective Date:	07/07/2021
Expiration Date:	07/06/2023
Capacity:	20
Program Type:	MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A called 911, complaining that he was hungry. Direct care worker, Tad Ragatz was found asleep in another room in the home.	No
Additional Findings	Yes

III. METHODOLOGY

06/01/2022	Special Investigation Intake 2022A0612002
06/01/2022	APS Referral Received referral from Adult Protective Services (APS)
06/01/2022	Special Investigation Initiated - Telephone Call made to Jonathan Johnson, APS worker to initiate the investigation
06/15/2022	Inspection Completed On-site I interviewed Vice President, Nancy Newman and Resident B, Resident C, Resident D, and Resident E
06/16/2022	Contact - Telephone call made Interview completed with home manager, Nancy Huntington
06/16/2022	Contact - Telephone call made Interview completed with direct care worker, Tad Ragatz
06/16/2022	Contact - Telephone call made Interview completed with Resident A's guardian
06/17/2022	Contact - Document Received Home manager, Nancy Huntington emailed me Resident A's 2022 weight records, record of physician contacts, and hospital discharge paperwork
06/23/2022	Contact - Face to Face I conducted an unannounced onsite inspection at the Lakeside Manor home. I interviewed Resident A

06/29/2022	Exit Conference Completed with licensee designee, Marilyn Jenkins

ALLEGATION:

Resident A called 911, complaining that he was hungry. Direct care worker, Tad Ragatz was found asleep in another room in the home.

INVESTIGATION:

On 06/01/22, I received a complaint from Adult Protective Services (APS was received indicating on 05/28/22, at 3:30 am, Resident A called 911 and law enforcement (LE) responded. Resident A was outside of the home by himself complaining he was hungry. The direct care worker, Tad Ragatz, was asleep in another room in the home. LE woke Mr. Ragatz up. LE had to mitigate between Mr. Ragatz and Resident A to get Resident A more food. While speaking with Resident A, Mr. Ragatz called him "retarded" to his face.

I initiated my investigation on 06/01/22, by coordinating with the Adult Protective Service (APS) worker, Johnathan Johnson, via telephone. Mr. Johnson stated this complaint came into APS over the weekend. As such, Resident A was interviewed by his co-worker. Mr. Johnson stated per the notes, Resident A was manic, his speech was mumbled, and he was difficult to understand. Resident A was hospitalized for psychiatric reasons for 30 days in May 2022. On 05/28/22, Resident A called law enforcement and said he was afraid of Mr. Ragatz. Mr. Johnson is still conducting his investigation.

On 06/15/22, I conducted an unannounced onsite inspection at the Lakeside Manor home where I interviewed the vice president, Donna Newman, and Resident B, Resident C, Resident D, and Resident E. Ms. Newman has worked for this company since 1994. She stated that Resident A receives food via peg tube. He has had a peg tube for approximately three years. Resident A is prescribed five cans of Jevity daily with water and pleasure feeding in between. For pleasure food, Resident A receives mashed potatoes, yogurt, Jell-o, and/or pudding. Resident A receives his Jevity at 8:00 am, 12:00 pm, and 6:00 pm. Ms. Newman was unable to produce a medication administration record that shows staff are signing off when they administer Resident A's Jevity.

Ms. Newman stated in May 2022, Resident A was hospitalized for psychiatric care at the Ann Arbor Veterans Affairs (VA). He was discharged and returned home (exact date unknown.) On 06/02/22, Resident A was admitted back into the Ann Arbor VA after he became physically aggressive with staff and two residents. Resident A remains in the hospital at this time. Ms. Newman stated there is only one staff on the midnight shift. Staff are not permitted to sleep on shift. Ms. Newman reported no concerns regarding Mr. Ragatz and stated she has never heard him speaking disrespectfully to any of the residents and/or refusing to feed Resident A. Ms. Newman explained that after Resident

A receives his Jevity at 6:00 pm, there would be no reason for staff on the midnight shift to feed him. Ms. Newman further stated, Resident A has a “potty mouth” and calls people names, but she has never heard Mr. Ragatz call Resident A “retarded.”

On 06/15/22, I interviewed Resident B. Resident B stated he and his housemates get three meals a day. Resident A is fed through his stomach, and he also eats applesauce, yogurt, and mashed potatoes because he cannot swallow good. Resident B stated he has no issues with Mr. Ragatz. Mr. Ragatz speaks to him respectfully and he is a good cook.

On 06/15/22, I interviewed Resident C. Resident C stated he gets fed daily. The food has its “ups and downs, but he is satisfied.” Resident C stated Mr. Ragatz is not rude or disrespectful to him or any other residents. Resident C stated Mr. Ragatz sleeps during the midnight shift at the desk.

On 06/15/22, I interviewed Resident D. Resident D stated he and his housemates get enough to eat at his home.

On 06/15/22, I interviewed E. Resident E stated she and her housemates are fed three meals a day. Resident E stated Mr. Ragatz is “pretty cool” and she has never heard him call Resident A “retarded.” Resident E stated some of the staff “get after (Resident A) when he acts out.”

On 06/15/22, I reviewed a case of Resident A’s Jevity. The directions indicate, “give 5 cans by feeding tube as directed. Give 2 cans in the morning, 1 can at lunch, and 2 cans for dinner. Give water between feeding 300 ML every 6 hours. Check residuals prior to water push, if greater than 200 ML hold tube feeding.”

On 06/16/22, I conducted a telephone interview with home manager, Nancy Huntington. Ms. Huntington stated Resident A is severely mentally ill and currently not at baseline. Resident A is hospitalized at the Ann Arbor VA and is scheduled for discharge on 06/17/22. Ms. Huntington stated Resident A has a peg tube, and he does not like it. When he is manic, he ravages for food and water. Ms. Huntington explained, Resident A is at risk of choking. As such, when Resident A is manic, he must be reminded to slow down when consuming food and water. Resident A receives pleasure food in addition to his prescribed Jevity. Resident A’s pleasure foods include mashed potatoes, cottage cheese, Jell-o, and yogurt. Resident A receives Jevity via his peg tube at 8:00 am, 12:00pm, and 5:00 pm. He has pleasure food in between meals. Ms. Huntington stated Resident A’s Jevity is not being signed for on the Medication Administration Record because she “did not consider Jevity a medication.” Ms. Huntington confirmed the Jevity is prescribed by Resident A’s doctor and is filled by a pharmacy.

Ms. Huntington stated Tad Ragatz worked the midnight shift on 05/28/22 when Resident A called 911. Ms. Huntington stated Resident A is attention seeking and has a long history of calling 911. Despite Mr. Ragatz’s history of long-term employment with the company, he is new to working the midnight shift and 05/28/22 was his second midnight

shift. Ms. Huntington stated Mr. Ragatz told her he was in the bathroom in the staff office when the police arrived at the home. The staff office has a bathroom and a futon. If the office door is closed, you cannot see inside. Ms. Huntington has never known Mr. Ragatz to sleep on shift and further indicated it would be more likely that he was watching TV or playing video games in the staff office. Ms. Huntington has never heard Mr. Ragatz call Resident A "retarded." Ms. Huntington stated it is her understanding that Resident A called himself "retarded" and Mr. Ragatz told him he was not "retarded."

On 06/16/22, I conducted a telephone interview direct care worker, Tad Ragatz. Mr. Ragatz stated he worked a double shift starting Friday, 05/27/22 at 3:00 pm until Saturday, 05/28/22 at 7:00 am. From 9:00 pm on Friday, 05/27/22 until 7:00 am on Saturday, 05/28/22, Mr. Ragatz was on shift alone. Mr. Ragatz stated at approximately 3:00 am he completed bed checks, all residents were asleep in their beds, including Resident A who fell asleep around 9:00 pm. Mr. Ragatz then went into the basement to do laundry. After completing the laundry, he used the bathroom in the staff office which is in the basement. The door to the office was closed. Mr. Ragatz stated he was in the bathroom for a while, and he had the bathroom fan on which reduced is ability to hear what was occurring upstairs.

Mr. Ragatz stated when he finished in the bathroom, he heard knocking at the door, and it was the police. They stated a resident called, but the person was difficult to understand so they came out to the home. Mr. Ragatz went in the day room and Resident A was standing there, with his shoes on, wanting to leave. Resident A said he wanted to go to the hospital because they were starving him. Mr. Ragatz explained he fed Resident A dinner that evening between 6:00 pm – 6:30 pm. After dinner, Resident A had ice cream at 8:30 pm. Mr. Ragatz stated Resident A did not ask him for food before calling 911 saying he was being starved. Mr. Ragatz stated it is common for Resident A to call the police especially when he is manic. When Resident A is manic, he feels hungrier, and he eats and drinks water quickly. Resident A is at risk of choking so he must be redirected to slow down.

Mr. Ragatz stated Resident A "puts on a show" for medical personnel. As such, the police exited the home but remained outside. Mr. Ragatz stated, Resident A "put up a fight" because he wanted to go to the hospital. Mr. Ragatz explained he talked to Resident A and assured him that he was safe. When Resident A is manic it is difficult to redirect him and get him to focus. Mr. Ragatz remarked, "he goes somewhere else in his mind." Resident A began yelling saying he was stupid and "retarded." Mr. Ragatz remarked, he got frustrated and told Resident A he was "not retarded" and because he was frustrated, he said this louder than he should have. Mr. Ragatz said if the police were listening from outside, it is possible that they heard him. Mr. Ragatz denied calling Resident A "retarded" and stated he only told Resident A he was not "retarded."

Mr. Ragatz stated eventually, he got Resident A to go into his bedroom and sit in his recliner chair. He gave Resident A chocolate Ensure in his sippy cup and Resident A fell asleep. Mr. Ragatz denied sleeping on shift at any time. Mr. Ragatz denied refusing to feed Resident A.

On 06/16/22, I conducted a telephone interview with Resident A's guardian, Resident A's guardian stated she has no concerns about the care Resident A is receiving at the Lakeside Manor home. Resident A's guardian stated Resident A is severely mentally ill and has been since the age of 19. Currently, Resident A is not at baseline, and he is hospitalized at the Ann Arbor VA where they are working to find him a proper medication regime. Resident A's guardian stated that Resident A makes comments that are not true. Resident A has a feeding tube, and he does not like it. Resident A would prefer to eat hot dogs, bratwursts, and coney island. The home is feeding him what he is allowed to have per his doctor's recommendation. Resident A has lived in this home for four years, which is the longest time he has ever lived at any home. Resident A's guardian stated that they care about Resident A, she likes the home a lot, and has no concerns.

On 06/21/22, I reviewed Resident A's record of physician contacts. In 2022, Resident A was hospitalized for a psychiatric admission at the Ann Arbor VA from 03/24/22 – 05/04/22, 05/18/22 – 05/25/22, and 06/02/22 – 06/17/22.

On 06/21/22, I reviewed Resident A's Ann Arbor VA hospital discharge paperwork for his admission on 06/02/22 – 06/17/22. Relevant portions of the paperwork state the following:

> "Diet: tube feeding continue Jevity tube feedings."
> "Small volume (<4 oz) PO puree/ MT for pleasure, spaced between peg TF."
> "Continue taking these medications at your normal dosage:
> Jevity 1.5 Cal Liquid - Give 5 cans by feeding tube as directed give 2 cans in the morning, 1 can at lunch, and 2 cans for dinner. Give water between feeding 300 ml every 6 hours…"

On 06/21/22, I reviewed Resident A's 2022 weight records. Resident A was weighed on the following dates: 01/01/22 – 121 lbs., 02/01/22 – 123 lbs., 03/01/22 – 124 lbs., 04/01/22 – Resident A was in the hospital on this date, no weight was taken, 05/01/22 – 131 lbs., 06/01/22 122.6 lbs., 06/17/22 128.2 lbs.

On 6/23/22, I conducted an unannounced onsite inspection at the Lakeside Manor home. I interviewed Resident A. Resident A was dressed and well groomed. Resident A made eye contact; however, his speech was mumbled, and he was unable to be understood. Resident A said hello and stated he was feeling well, but he was unable to answer any questions related to this investigation.

On 06/29/2022, I conducted an exit conference via telephone with licensee designee, Marilyn Jenkins. I informed Ms. Jenkins of the investigative findings and recommendations documented in this report. Ms. Jenkins stated Resident A is receiving nutrients via his peg tube and comfort foods as prescribed. Ms. Jenkins stated she was unaware that the administration of Jevity needed to be documented on a medication administration record (MAR) but states this will be put into effect.

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:	Based on the information gathered through my investigation, there is insufficient information to conclude that staff are not treating Resident A with dignity and/or are failing to attend to Resident A's protection and safety at all times. Mr. Ragatz denied calling Resident A "retarded" and further denied sleeping on shift. Mr. Ragatz explained that he was in the basement bathroom when law enforcement arrived at the home on 05/28/22. Prior to going into the basement, Resident A was observed sleeping in bed. Resident A was interviewed however, due to mumbled speech he was unable to effectively answer interview questions. Resident A's guardian expressed no concerns about the care Resident A is receiving. The staff and residents who were interviewed consistently denied ever hearing Mr. Ragatz use derogatory language or call Resident A "retarded" on any occasion. They further denied witnessing Mr. Ragatz sleeping on shift.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that Resident A is not provided with a minimum of three regular, nutritious meals daily. Resident A has a peg tube and is prescribed five cans of Jevity daily with pleasure foods in between. The staff who were interviewed and Resident A's guardian consistently reported that Resident A receives Jevity three times daily and pleasure foods in between meals. The residents interviewed reported that they

	are satisfied with the meals provided to them and stated that they regularly receive enough food to eat. On 05/28/22, Mr. Ragatz fed Resident A dinner between 6:00 pm – 6:30 pm. Then, Resident A had ice cream at 8:30 pm. Prior to calling 911 on 05/28/22 and saying he was hungry, Resident A did not ask for additional food or communicate with staff that he wanted to eat.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.15312	**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.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the home was not maintaining an individual medication log that included Resident A’s Jevity. Resident A is prescribed 5 cans of Jevity daily. During the onsite inspection on 06/15/22, the home was unable to produce an individual medication log that contained the medication name, dosage, label instructions, time the medication is to be administered, and the initials of the person administering the medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

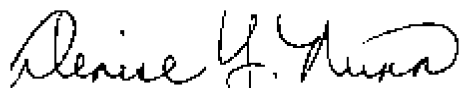
IV. RECOMMENDATION

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

06/29/2022

Johnna Cade Date
Licensing Consultant

Approved By:



06/30/2022

Denise Y. Nunn Date
Area Manager