GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 17, 2022

Sarah Novak
The Bells Assisted Living, LLC
401 Church St.
Almont, MI 48003

RE: License #: AL440397767
Investigation #: 2022A0582056
The Bells Assisted Living, LLC

Dear Ms. Novak:

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. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 643-7960.

Sincerely,

Derrick Britton, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 284-9721

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL440397767
Investigation #:	2022A0582056
Complaint Receipt Date:	09/01/2022
Investigation Initiation Date:	09/06/2022
Report Due Date:	10/31/2022
Licensee Name:	The Bells Assisted Living, LLC
Licensee Address:	401 Church St. Almont, MI 48003
Licensee Telephone #:	(989) 450-8323
Administrator:	Sarah Novak
Licensee Designee:	Sarah Novak
Name of Facility:	The Bells Assisted Living, LLC
Facility Address:	401 Church St. Almont, MI 48003
Facility Telephone #:	(989) 450-8323
Original Issuance Date:	07/25/2022
License Status:	TEMPORARY
Effective Date:	07/25/2022
Expiration Date:	01/24/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED

II. ALLEGATIONS

	Violation Established?
The facility staff failed to seek timely medical attention for a resident who became ill.	Yes
The director cleaned up fecal matter off the floor with no gloves.	No

III. METHODOLOGY

09/01/2022	Special Investigation Intake 2022A0582056
09/06/2022	Special Investigation Initiated - Telephone
09/06/2022	Inspection Completed On-site
10/04/2022	Contact - Telephone call received With Guardian A
10/10/2022	Contact - Telephone call made With Direct Care Worker Kathy Hayward
10/11/2022	Contact - Telephone call made With Resident A
10/11/2022	Exit Conference With Sarah Novak, Licensee Designee
10/12/2022	Inspection Completed On-site Face to face with Resident A, Director Sara Lesnesky, and Licensee Designee Sarah Novak
10/12/2022	Exit Conference With Sarah Novak, Licensee Designee
10/12/2022	APS Referral Referral made to APS.
10/13/2022	Contact – Document Received Email from Sarah Novak, Licensee Designee

ALLEGATION:

The facility staff failed to seek timely medical attention for a resident who became ill.

INVESTIGATION:

I received this complaint on 09/01/2022, and contacted Complainant on 09/06/2022. Complainant stated that on the morning of 08/27/2022, Resident A was acting very different than the previous night. Complainant stated that instead of calling 911, the director contacted the family of the resident to decide what to do. Complainant stated that by the time the relative decided to send the resident to the hospital, the resident became more ill.

On 09/06/2022, I conducted an unannounced, onsite inspection at the facility. I interviewed Sara Lesnesky, Director. Ms. Lesnesky stated that on the morning of 08/27/2022, Resident A woke up and was not herself. Ms. Lesnesky stated that Resident A seemed "out of it," not her usual self, and tired. Ms. Lesnesky stated that Resident A was not a "morning person," but she called Relative A to inform them of what she observed. Ms. Lesnesky stated that Guardian A lives across the street from the facility, and immediately came over. Ms. Lesnesky stated that Relative A did not want 911 to be contacted until she arrived. Ms. Lesnesky stated that Resident A's condition did not appear to be life threatening. Ms. Lesnesky stated that eventually Resident A was sent to the hospital and diagnosed with a urinary tract infection. Ms. Lesnesky stated that Resident A returned from the hospital on 08/31/2022. Resident A was not at the facility at the time of the onsite inspection.

On 10/04/2022, I contacted Relative A. Relative A stated that she has no concerns about the care of Resident A, and the facility had no fault in not calling 911 for Resident A during the incident in question. Relative A stated that she lives less than a mile from the facility and was informed immediately of the change in Resident A's condition. Relative A stated that she could not ask for a nicer place to provide care for Resident A.

I reviewed the Incident Report related to the complaint, which documented the following:

> **Person Involved:** Sara Lesnesky
> **Date of Incident**: 08/27/2022, **Time**: 11:00 AM
> **Explain What Happened**: Resident woke up not like her normal self, so I contacted family who was out with her the day before. They came right away and didn't want 911 called yet. Family stayed with her all morning until she had to go to the bathroom. I toileted her and she had a bowel movement on me and the floor. 911 was called after.
> **Action taken by staff:** Medications were taken person normal. Resident left to the hospital.

Corrective Measures: [Resident A] has been prescribed new medications since and now gets showers every other day to help with reoccurrence of a UTI.
Physician's Diagnosis: UTI and congestive heart failure

On 10/10/2022, I interviewed Direct Care Worker Kathy Hayward, she and other staff seek timely medical attention for residents that require the need.

On 10/11/2022, I interviewed Resident A, who stated that she has no complaints about the facility providing timely medical attention to her.

On 10/12/2022, I conducted an unannounced, onsite inspection at the facility. I interviewed and observed Resident A. Resident A was in her room watching television. Resident A was dressed appropriately. Resident A stated that she is receiving good care at the facility, and the workers treat her well. Resident A appeared to be receiving proper care and supervision.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Based on interviews with Ms. Lesnesky, Relative A, and Resident A, Ms. Lesnesky did not seek immediate medical attention when she identified Resident A's change in condition. Interviews and a review of the *Incident Report* show that Resident A was sent to the hospital later, and only after Relative A was contacted and came to the facility. Once Resident A was further observed by staff and Guardian A, she was then taken to the hospital and diagnosed with a urinary tract infection.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The director cleaned up fecal matter off the floor with no gloves.

INVESTIGATION:

I received this complaint on 09/01/2022, and contacted Complainant on 09/06/2022. Complainant stated that Sara Lesnesky, who is the Director at the facility, cleaned up fecal matter with no gloves on. Complainant stated that this was unsanitary and

could have caused a sickness. Complainant stated that there were no other staff around who witnessed Ms. Lesnesky cleaning the fecal matter with no gloves.

On 09/06/2022, I conducted an unannounced, onsite inspection at the facility. I interviewed Ms. Lesnesky, who stated that she was assisting Resident A with toileting. Ms. Lesnesky stated that before she could position Resident A on the toilet appropriately, Resident A had a bowel movement, which got on her leg and on the floor. Ms. Lesnesky stated that she finished assisting Resident A with toileting to ensure that she was safe, and then cleaned her up. Ms. Lesnesky stated that she did not initially have on gloves to assist Resident A to the toilet, but put them on later to clean the floor, Resident A, and herself. Ms. Lesnesky stated that she used "C. diff" (Clostridioides difficile) cleaner and Clorox disinfectant wipes to thoroughly clean Resident A's room once she left to be hospitalized.

I reviewed the Incident Report related to the complaint, as mentioned above, which documented that Ms. Lesnesky "toileted [Resident A] and she had a bowel movement on man and the floor. The bowel movement was cleaned up with C. diff cleaner and Clorox wipes after resident left to the hospital."

On 10/10/2022, I interviewed Direct Care Worker Kathy Hayward. Ms. Hayward stated that she was not present for the incident in question. Ms. Hayward stated that she has cleaned up fecal matter at the facility, and staff are instructed to use gloves and "C. diff" cleaner.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(g) Prevention and containment of communicable diseases.**
ANALYSIS:	Based on interviews with Ms. Lesnesky and a review of the Incident Report related to the allegation, there is no evidence to suggest that Ms. Lesnesky did not take precautions to clean up fecal matter in a sanitary and safe manner. While Ms. Lesnesky did not have on gloves to initially assist Resident A to the toilet, she stated that she did wear gloves to clean the fecal matter that was on her and the floor.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 10/12/2022, I conducted an Exit Conference with Sarah Novak, Licensee Designee. I informed Ms. Novak of the findings of the investigation. Ms. Novak stated that she discussed with Ms. Lesnesky that if another resident has a noticeable change in condition, she should immediately contact 911.

On 10/13/2022, I received an email from Sarah Novak, Licensee Designee. Ms. Novak stated that Resident A was feeling under the weather, refused us to ask for medical attention, so Relative A was contacted, who also refused medical attention for Resident A. Ms. Novak stated that Resident A has a right to refuse medical care. Ms. Novak stated that Resident A was not acting as her normal self, but it was not an emergent situation. Ms. Novak stated that the decision to send Resident A to the hospital was after she had a large bowel movement and had more of a change in behavior. I informed Ms. Novak that her staff are not medical professionals and a decision to refuse medical care should come from Resident A when a medical professional is asking. Additionally, when initially interviewed, Ms. Lesnesky stated that Resident A was "out of it" and "not her normal self," which is a change in her condition.

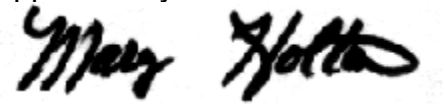
IV. RECOMMENDATION

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

10/13/2022

Derrick Britton — Date
Licensing Consultant

Approved By:



10/17/2022

Mary E. Holton — Date
Area Manager