GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 30, 2022

Meaghan Rinaldi
Emmaus Corp.
2447 N Williamston Rd
Williamston, MI 48895

RE: License #: AL330093906
Investigation #: 2022A1033017
Haven Of Rest

Dear Ms. Rinaldi:

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 #:	AL330093906
Investigation #:	2022A1033017
Complaint Receipt Date:	07/05/2022
Investigation Initiation Date:	07/05/2022
Report Due Date:	09/03/2022
Licensee Name:	Emmaus Corp.
Licensee Address:	2447 N Williamston Rd Williamston, MI 48895
Licensee Telephone #:	(517) 655-8953
Administrator:	Meaghan Rinaldi
Licensee Designee:	Meaghan Rinaldi
Name of Facility:	Haven Of Rest
Facility Address:	2447 N Williamston Williamston, MI 48895
Facility Telephone #:	(517) 655-8953
Original Issuance Date:	03/13/2001
License **Status:**	REGULAR
Effective Date:	02/18/2022
Expiration Date:	02/17/2024
Capacity:	18
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
There is a 14-year-old individual assisting with direct care of residents.	Yes
Complaint alleges Resident A was left in direct sunlight for multiple hours resulting in sunburn.	Yes
Medications are not locked, and residents have easy access to medications.	Yes
Medication doses are being missed by direct care staff.	Yes
Direct Care Staff are not properly trained to administer medications.	No
Additional Findings	Yes

III. METHODOLOGY

07/05/2022	Special Investigation Intake 2022A1033017
07/05/2022	Special Investigation Initiated - Telephone Interview with complainant.
07/05/2022	Contact - Telephone call made Interview with APS complainant.
07/06/2022	Inspection Completed On-site Interview with Licensee Designee, Meaghan Rinaldi, direct care staff, Jody McCartney, and housekeeping staff, Karen Jones. Facility walkthrough, including medication storage observations and resident record review initiated.
07/07/2022	Contact - Telephone call made Interview with direct care staff, Harmony Daniels, via telephone.
08/05/2022	Contact - Telephone call made Interview with direct care staff, Autumn Powell, via telephone.
08/05/2022	Contact - Document Sent Requested MARs for the months of June 2022 and July 2022, also requested all staff training documentation.
08/05/2022	Inspection Completed-BCAL Sub. Compliance
08/25/2022	Contact – Face to Face

	Interview with Licensee Designee, Meaghan Rinaldi at the facility. Reviewed all resident MARS for June and July 2022. Reviewed all staff medication trainings.
08/25/2022	Exit Conference completed on-site with Licensee Designee, Meaghan Rinaldi.

ALLEGATION:

There is a 14-year-old individual assisting with direct care of residents.

INVESTIGATION:

On 7/5/22 I received an online complaint alleging that the Haven of Rest adult foster care facility (the facility), is utilizing a 14-year-old to assist with direct care of residents. On 7/6/22 I completed an on-site investigation at the facility and interviewed Licensee Designee, Meaghan Rinaldi. Ms. Rinaldi reported she does have a 15-year-old Minor Employee working in the facility. Ms. Rinaldi reported Minor Employee does such tasks as passes plates to residents at meals times, assists with feeding residents and completes cleaning tasks in the facility. Ms. Rinaldi reported Minor Employee is never counted in the ratio for direct care staff scheduling. Ms. Rinaldi reported Minor Employee is not expected to assist in an emergency. Ms. Rinaldi reported Minor Employee does not provide personal care and does not pass medications.

On 7/6/22, during on-site investigation, I interviewed direct care staff, Jody McCartney. Ms. McCartney reported the Minor Employee does work in the facility. Ms. McCartney reported that Minor Employee does not provide direct care to residents. Ms. McCartney reported Minor Employee may feed residents, with supervision of direct care staff. Ms. McCartney reported Minor Employee does not provide personal care, pass medications, or assist with resident transfers. Ms. McCartney reported Minor Employee never replaces a regular staff member in the ratio for direct care staff to resident staffing guidelines.

On 7/7/22 I received an email from Ms. Rinaldi that included a copy of the staff schedule for the month of June. I did not see Minor Employee's name on the schedule on any of the dates listed.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(1) Direct care staff shall not be less than 18 years of age and shall be able to complete required reports and follow

	written and oral instructions that are related to the care and supervision of residents.
ANALYSIS:	Based upon interviews with Ms. Rinaldi and Ms. McCartney it can be established that Minor Employee has been providing direct care to residents as it was documented by licensee designee Rinaldi and she has been helping feed residents during mealtimes. Feeding a resident requires supervision of a resident and proper training by direct care staff who are over 18 years old.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Complaint alleges Resident A was left in direct sunlight for multiple hours resulting in sunburn.

INVESTIGATION:

On 7/5/22 I received an online complaint alleging that Resident A was left on the porch, in direct sunlight, which resulted in a sunburn. On 7/5/22 I interviewed Complainant via telephone. Complainant reported Resident A was left outside for around a three-hour period by direct care staff, Autumn Powell, on 6/20/22, resulting in a sunburn to the right side of Resident A's neck and shoulders.

On 7/6/22 I completed an on-site investigation at the facility. I interviewed Ms. Rinaldi regarding the allegation. Ms. Rinaldi reported she was not working on 6/20/22 but was alerted to the incident with Resident A by direct care staff, Jessica Clark. Ms. Rinaldi reported that she sent a group text message to all direct care staff members reminding them that when residents are outside, they need to be in the shade, with sunscreen on, and checked frequently. Ms. Rinaldi reported that the date of 6/20/22 Ms. Powell and Ms. McCartney were working the day shift from 7am to 3pm. Ms. Rinaldi reported that Ms. Powell had taken Resident A outside. Ms. Rinaldi reported at 3pm direct care staff, Harmony Daniels reported to work. Ms. Rinaldi reported housekeeping staff, Karen Jones, was on-site on 6/20/22. Ms. Rinaldi reported that Ms. Jones had texted Ms. Powell to ask her how long Resident A had been outside, and Ms. Jones received a response from Ms. Powell indicating Resident A had been outside for around 3 hours and she had placed her in the shade with sunscreen on. Ms. Rinaldi reported she made a visit to the facility on 6/21/22 to observe Resident A's sunburn. Ms. Rinaldi reported Resident A's skin was red, with no blisters. Ms. Rinaldi reported it was painful for Resident A when direct care staff members changed her clothing due to the sunburn on her neck and shoulders. Ms. Rinaldi reported Resident A's physician was not contacted. Ms. Rinaldi reported Resident A's husband made a visit to the facility on 6/21/22. Ms. Rinaldi reported Resident A's spouse was verbally told of the sunburn, and he noted

no concerns at that time. Ms. Rinaldi reported that it took three to four days for Resident A's skin to fully heal but there was never any blistering or skin peeling observed during this time frame.

On 7/6/22, during on-site investigation, I interviewed Ms. Jones. Ms. Jones reported that she was present at the facility on 6/20/22 as she was working this date. Ms. Jones reported that she arrived this date around 5:30am and was still present around 3:30pm when Ms. Daniels reported to her that Resident A was found outside on the porch sitting in full sunlight on the swing. Ms. Jones reported she assisted Ms. Daniels with transferring Resident A to a wheelchair and taking her into the facility. Ms. Jones reported Resident A's skin was red around her neck and right shoulder area. Ms. Jones reported she sent a text to Ms. Powell to ask how long Resident A had been outside and Ms. Powell's response was that she had put sunscreen on Resident A when she set Resident A outside just after lunch. Ms. Jones reported Ms. Rinaldi did send a text message to the direct care staff reminding them to have residents placed in the shade when they go outside and to check them frequently.

On 7/6/22, during on-site investigation, I interviewed Ms. McCartney. Ms. McCartney reported she had worked on 6/20/22 from 6am to 3pm. Ms. McCartney reported she last recalled observing Resident A when Ms. Powell wheeled her outside after lunch. Ms. McCartney reported Resident A is usually last to leave the table, and this is generally between 1:30p and 2pm. Ms. McCartney reported she asked Ms. Powell if she had sat Resident A in the shade when she took her outside. Ms. McCartney reported Ms. Powell verbalized she had sat Resident A in the shade and put sunscreen on her. Ms. McCartney reported direct care staff usually take residents outside under the covered porch but on 6/20/22 Ms. Powell took Resident A out on the side porch of the facility. Ms. McCartney reported the procedure when there is shift change is that the incoming shift receive an update from the outgoing staff and then the incoming staff will conduct a house check to ensure all residents are accounted for.

On 7/7/22 I interviewed Ms. Daniels via telephone. Ms. Daniels reported she arrived for her scheduled shift on 6/20/22 and was not told Resident A was on the side porch. Ms. Daniels reported she was doing her house check and found Resident A, sitting in a swing, on the side porch. Ms. Daniels reported, "it looked like she had some pretty bad sunburn" when referring to Resident A's appearance. Ms. Daniels reported she and Ms. Jones took Resident A inside and put aloe on the affected areas of her skin. She reported Resident A then drank some water and took a nap. Ms. Daniels reported Ms. Jones did send a text to Ms. Powell regarding Resident A being outside in the sun and Ms. Powell's reply was that she had left her outside for about three hours. Ms. Daniels reported Ms. Jones reported this incident to management and Resident A did not have any other issues, resulting from this sunburn, the rest of her shift that evening, from 3pm – 11pm.

On 7/7/22 I interviewed Ms. Powell, via telephone. Ms. Powell reported she had worked 6am – 3pm on 6/20/22. Ms. Powell reported she had taken Resident A outside about 1 ½ hours prior to the end of her shift at 3pm on 06/20/2022. Ms. Powell reported that she had put sunscreen on Resident A and had sat her on the side porch in the swing. Ms. Powell reported it was a cloudy at the time she sat Resident A outside. Ms. Powell reported Resident A being on the side porch to the incoming staff at 3pm before she left the facility for the day.

During on-site investigation, on 7/6/22, I reviewed the employee logbook, where the direct care staff make notations about events that occurred with the residents each day. On 6/20/22 there was an entry from Ms. Daniels that read, "[Resident A] – found her at beginning of my shift, outside in direct sunlight w/pretty bad sunburn, wasn't told about it but I put some aloe on to help." There was an additional notation, on this date, that stated, "[Resident A] – very careful giving her a shower because of her sunburn. Ate well, got her high-back wheelchair today."

During on-site investigation, on 7/6/22, I reviewed Resident A's *Assessment Plan for AFC Residents* form. This form noted that Resident A requires assistance with walking and mobility and uses a wheelchair as an assistive device.

During on-site investigation, on 7/6/22, I observed Resident A. Resident A appeared comfortable and her skin appeared to be healed and no further evidence of sun exposure. Resident A was not able to verbally communicate to be interviewed today.

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 upon interviews with Ms. Rinaldi, Ms. Jones, Ms. Daniels, Ms. Powell, Ms. McCartney, and Complainant, in addition to my review of Resident A's *Assessment Plan for AFC Residents* and the direct care staff logbook, direct care staff did not provide adequate supervision to ensure Resident A was not at risk for harm due to sun exposure. She was placed on an uncovered porch, in a swing from which she could not independently transfer without the assistance of direct care staff members. She would not have been able to verbalize her needs or seek assistance due to being placed on the side porch where there is limited foot traffic from direct care staff or visitors to the facility. Given Resident A would not have been able to seek shelter from the sun without the assistance of a direct care staff member, her personal care needs were not met per her written assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Medications are not locked, and residents have easy access to medications.

INVESTIGATION:

On 7/5/22 I received an online complaint alleging resident medications at the facility are not kept in a locked medication cart and that residents have access to the medications. On 7/5/22 I interviewed Complainant via telephone. Complainant reported the resident medication cart is never locked. Complainant reported that there is Fentanyl in the medication cart and the cart is never locked. Complainant also reported resident medications are being kept in a small refrigerator in the kitchen and that this refrigerator is never locked.

On 7/6/22 I completed an on-site investigation at the facility. I interviewed Ms. Rinaldi during this investigation. Ms. Rinaldi reported resident medications are always locked at the facility. She demonstrated how to unlock the medication cart and the small refrigerators used for resident medications located just off from the kitchen, in the dining room.

On 7/6/22, during on-site investigation, I interviewed Ms. McCartney. Ms. McCartney reported every direct care staff member has access to the medication cart. Ms. McCartney reported that the medication cart is not always locked. Ms. McCartney reported that at times the cart is left unlocked because there is "usually someone in the kitchen area observing the cart." Ms. McCartney reported that the facility keeps medications that need to be refrigerated in the small refrigerator just off

from the kitchen. Ms. McCartney reported that she has never had to unlock this refrigerator to access the medications inside.

On 7/7/22 I interviewed Ms. Daniels via telephone. Ms. Daniels reported that the medication cart at the facility does not require a key for entry. Ms. Daniels reported that she has never had to use a key to access the medications in the medication cart. Ms. Daniels reported that the staff had received a message on 7/6/22 that "the med cart will be locked, going forward." Ms. Daniels reported she was not aware of any medications being stored in the refrigerators at the facility at this time.

On 7/7/22 I interviewed Ms. Powell via telephone. Ms. Powell reported that there is a key to open the medication cart and she has had to use the key to access medications in the medication cart. Ms. Powell reported that the small refrigerator in the dining room has medications and has not been unlocked.

During on-site investigation on 7/6/22 I observed Ms. Rinaldi open the medication cart with a key. I was at the facility for about a two-hour period. When I left the facility, I checked the medication cart again and the medication cart was left unlocked and unattended. All direct care staff were providing care and not within eyesight of this unlocked medication cart.

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 upon interviews with Ms. Rinaldi, Ms. Daniels, Ms. Powell, Ms. McCartney, and Complainant, in addition to observations made by this consultant during my facility walkthrough, resident medications were not kept in a locked cabinet, drawer or refrigerator, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Medication doses are being missed by direct care staff.

INVESTIGATION:

On 7/9/22 I received an email from Complainant. The email reported medication administrations are being missed by direct care staff and not signed for on the medication administration records (MARs). On 8/5/22 I sent an email to Ms. Rinaldi requesting she send copies of resident MARs for the months of June 2022 and July 2022. On 8/8/22 Ms. Rinaldi reported that she had faxed these documents. These documents did not arrive via fax. On 8/25/22 I completed a follow-up on-site investigation to the facility. I met with Ms. Rinaldi and completed a review of all resident MARs for the months of June 2022 and July 2022. Resident D is prescribed, Pravastatin 10mg, 1 tab nightly (cardiovascular disease). On the July 2022 MAR, on 7/5/22 this medication was marked as "out." The medication was continued to be marked as "out" from 7/5/22 through 8/11/22.

On 8/25/22, during on-site investigation, I interviewed Ms. Rinaldi. Ms. Rinaldi reported there had been issues with Resident D's insurance and the pharmacy noted no longer being able to fill this medication due to non-payment from insurance. Ms. Rinaldi reported that she was instructed, by the pharmacy, to get this medication filled via mail order pharmacy as this is how the insurance wants to fill this medication. Ms. Rinaldi reported she updated Resident D's physician, Dr. Kristin Gaumer, and requested she send the refill to a mail order pharmacy. Ms. Rinaldi reported this was done but it was sent to the wrong mail order pharmacy and had to be corrected to be sent to the CVS mail order pharmacy. Ms. Rinaldi reported the issue was finally resolved, and Resident D was able to obtain his medication refill on 8/12/22. Ms. Rinaldi was asked if she maintained any documentation of this issue throughout this process. Ms. Rinaldi reported that she did not keep track of these communications in a written format.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based upon review of Resident MARs and interview with Ms. Rinaldi, Resident D went without his Pravastatin medication, for heart disease, for 38 days. Resident D's Pravastatin medication was not given as prescribed from 07/05/2022 through 08/11/2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Direct Care Staff are not properly trained to administer medications.

INVESTIGATION:

On 7/9/22 I received an email message from Complainant. This email message reported an allegation that the staff at the facility are not properly trained to pass medications. On 8/5/22 I sent an email to Ms. Rinaldi requesting she provide the training records for all current staff members. Ms. Rinaldi reported she had faxed the training records on 8/8/22. These records did not arrive via fax. I completed a follow-up on-site investigation to the facility on 8/25/22 to review the training records. I met with Ms. Rinaldi on this date. I reviewed all training records for current staff. All staff direct care staff had documentation of medication administration training in their employee files.

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: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	Current direct care staff records show documentation of medication training completed by all direct care staff. Based upon this review there is no evidence that staff were not trained prior to providing medication administration at the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During on-site investigation completed on 7/6/22 I walked through the facility and observed medication management. There is a small refrigerator that is being stored in the dining room, just off from the kitchen. This refrigerator contained two medications for residents who have since been deceased.

- Lorazepam, 0.5mg, dated 10/12/21. Expiration date 4/12/22. Prescribed to former Resident B. Resident B expired on 10/18/21.
- Morphine Sulfate Oral Solution, 100mg per 5mL, dated 4/6/22. Expiration date 10/5/22. Prescribed to former Resident C. Resident C expired on 6/14/22.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(7) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a physician or a pharmacist.
ANALYSIS:	Based on the findings of my on-site investigation, medications belonging to two deceased former residents remained at the facility and were not disposed of as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the on-site investigation on 7/6/22 I interviewed Ms. Rinaldi. Ms. Rinaldi reported that Minor Employee is currently working at the facility passing plates to residents at mealtimes, assists with feeding residents, and completes cleaning tasks in the facility. Ms. Rinaldi reported that Minor Employee has not completed a TB test prior to assuming these responsibilities.

APPLICABLE RULE	
R 400.15205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(5) A licensee shall obtain written evidence, which shall be available for department review, that each direct care staff, other employees and members of the household have been tested for communicable tuberculosis and that if the disease is present, appropriate precautions shall be taken as required by state law. Current testing shall be obtained before an individual's employment, assumption of duties,

	or occupancy in the home. The results of subsequent testing shall be verified every 3 years thereafter or more frequently if necessary.
ANALYSIS:	Based upon the interview with Ms. Rinaldi it was identified that Minor Employee is working in the facility and has not received a TB test.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

08/30/2022

_____

Jana Lipps Date
Licensing Consultant

Approved By:

08/30/2022

_____

Dawn N. Timm Date
Area Manager