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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 30, 2022

Leonardo Marino-Ochoa
Hearthstone Communities Macomb I, LLC
Unit 1712
2844 Livernois Road
Troy, MI 48099

RE: License #: AS500393440
Investigation #: 2022A0617022
Hearthstone Communities Macomb I

Dear Mr. Marino-Ochoa:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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,

Eric Johnson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500393440
Investigation #:	2022A0617022
Complaint Receipt Date:	07/08/2022
Investigation Initiation Date:	07/12/2022
Report Due Date:	09/06/2022
Licensee Name:	Hearthstone Communities Macomb I, LLC
Licensee Address:	Unit 1712 - 2844 Livernois Road Troy, MI 48099
Licensee Telephone #:	(248) 812-9410
Administrator:	Angelyth Marino-Ochoa
Licensee Designee:	Leonardo Marino-Ochoa
Name of Facility:	Hearthstone Communities Macomb I
Facility Address:	50036 Barrett Drive Macomb, MI 48044
Facility Telephone #:	(248) 812-9410
Original Issuance Date:	11/29/2018
License Status:	REGULAR
Effective Date:	05/29/2021
Expiration Date:	05/28/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A's medications were given incorrectly on several occasions due to language barriers with staff.	**No**
Additional Findings	**Yes**

III. METHODOLOGY

07/08/2022	Special Investigation Intake 2022A0617022
07/12/2022	Special Investigation Initiated - Telephone TC was placed to the LD Mr. Leo Mario
07/13/2022	Contact - Telephone call made TC placed to the Complainant
07/13/2022	Contact - Document Sent Email sent to the LD Mr. Marino
07/14/2022	Contact - Document Received Email received from the Complainant
07/15/2022	Contact - Document Received I received and reviewed the following documents: Resident A's assessment plan, Resident A's Identification record, staff list with phone numbers, staff schedule for June and July 2022, and Resident Registry.
07/20/2022	Inspection Completed On-site I conducted an unannounced onsite investigation at the Hearthstone Communities facility. I interviewed staff, Flaminia Nieto, Stefane Castellanos, Home manager Angelyth Marino, licensee designee Leo Marino, Resident B and Resident C.
08/10/2022	Contact - Telephone call made TC to Custom Home Health*Palliative*Hospice
08/10/2022	Exit Conference I held an exit conference with licensee designee Mr. Marino informing him the findings of the investigation.

ALLEGATION:

Resident A's medications were given incorrectly on several occasions due to language barriers with staff.

INVESTIGATION:

On 07/08/22, I received a complaint regarding the Hearthstone Communities facility. The complaint indicated that at the facility, there was a language barrier between the staff and the residents causing medications to be given incorrectly on several occasions. Medication instructions had to be translated into Spanish. When staff by the name of “grandmother” was questioned about some of the medications, she called Angie, the home manager. While talking to the grandmother, the two switched from Spanish to English so that the complainant could hear her. Angie told the grandmother to tell the complainant that she was too busy, and she had other things to do.

On 07/13/22, I completed a phone interview with the complainant. The complainant stated that Resident A passed away on 02/16/22. According to the complainant, there were several times in January 2022, when Resident A was provided with the same medications several times. The complainant stated that she saw a pill that looked like a pill Resident A had already received being given to him again. She questioned the staff member named “grandmother” who oversaw the medications, but grandmother speaks very limited English, and she was unable to communicate with the complainant. Grandmother then called the home manager Angie so that she could translate between the two. Angie told Grandmother that she was too busy to speak at that time and she would follow up with the complainant at a later time. The complainant stated that Angie never contacted her to address her concerns with regards to the medications. According to the complainant, on 02/10/22, the facility gave Resident A’s family a box containing his medications to take home as the facility said they were only going to give Resident A, the medications that Hospice provided. The hospice nurse contacted the complainant stating that Resident A’s medications that were still needed, were missing. The family had to go through the box of medications and found that the box of medications accidentally included medications that Resident A was still in need of. The family had to return the necessary medications back to the facility. Resident A went without his medications from 02/10-02/15/22. Resident A passed away on 02/16/22. The complainant also reported that Resident A’s family provided the facility with a hospital bed for Resident A. The complainant stated that the bed’s plug was damaged at the facility. The complainant took the hospital bed home in February 2022.

On 07/15/22, I received and reviewed the following documents sent by Mrs. Marino: Resident A’s assessment plan, Resident A’s identification record, staff list with phone numbers, staff schedule for June and July 2022, and Resident Registry. I reviewed the staff schedule for the month of June and July 2022. There were enough staff scheduled to care for the needs of the residents, as there were two staff listed per day for less than six residents in the home. However, per the facility staff schedules, there are no shift

times that the staff works each day. The schedule is a calendar that lists two staff members working each day. According to Resident A's Medication Administration Records (MARS), all of his medications were initialed for the months of January and February 2022.

On 07/20/22, I conducted an unannounced onsite investigation at the Hearthstone Communities facility. I interviewed staff, Flaminia Nieto, Stefane Castellanos, Home manager Angelyth Marino, licensee designee Leo Marino, Resident B and Resident C.

When I entered the home, I was greeted by Ms. Flaminia Nieto. Ms. Nieto spoke very limited English and was not able to communicate with me. She was not able to tell me her name or answer any of my questions. Ms. Nieto then went and got Ms. Castellanos who also spoke very limited English. Ms. Nieto then called Ms. Marino who is the home manager of the facility to translate and communicate for her. Mrs. Marino stated that Ms. Castellanos is only a volunteer and not an employee. According to Mrs. Marino, Ms. Nieto is never left alone at the facility and there is usually another worker there with her. Mr. Marino who is the licensee designee, was supposed to be at the home but he went out to get groceries. I was at the home for approximately 20 to 30 minutes before Mr. and Mrs. Marino arrived at the facility.

During the onsite investigation, I interviewed Resident B. According to Resident B, she has no issues living in the home and she is well cared for. Resident B stated that there is a little bit of a language barrier between her and Ms. Nieto who is also referred to as "grandmother". Resident B stated that she uses google translate to communicate with Ms. Nieto. Ms. Nieto is the primary medication passer, but Resident B has not had any issues with regards to her medications.

During the onsite investigation, I interviewed Resident C. According to Resident C, she has no issues living in the home and she is well cared for. Resident C reported no issues with communicating with staff.

During the onsite investigation, I interviewed Mr. Marino. According to Mr. Marino, Ms. Nieto is normally not working alone. Either Mr. Marino or his wife are there with Ms. Nieto, but he stepped out to get groceries. Ms. Castellanos is a volunteer, but she has no training, file, or fingerprint clearances.

During the onsite investigation, I interviewed Mrs. Marino. According to Mrs. Marino, Resident A's family, complained about medications that the family provided and were not prescribed by Resident A's doctor. Ms. Marino stated that she told Ms. Nieto not to speak with the family regarding the medications because she wanted to communicate with them directly. Ms. Marino communicates with Resident A's family almost daily with regards to his medications. Ms. Marino stated that she gave Resident A's family back the medications that were not prescribed. Mr. Marino stated that he personally went

through the medications and the box only contained medications that were not prescribed. According to Mr. and Mrs. Marino, the hospital bed that was provided by Resident A's family was old but still worked while at the facility. When Resident A was placed in Hospice, Hospice provided a new hospital bed that better suited his needs. Mr. and Mrs. Marino denied that the hospital bed provided by Resident A's family was damaged or broken at the facility.

During the onsite investigation, I completed an interview with Ms. Nieto. Due to Ms. Nieto's limited English, Mr. and Mrs. Marino had to translate my questions and Ms. Nieto's answers. According to Mr. and Mrs. Marino, Ms. Nieto stated that she provided Resident A's medications as prescribed. Ms. Nieto conducted a medication simulation where she demonstrated the ability to properly administer medications.

On 08/10/22, I interviewed Resident A's Hospice nurse Laura Terlecki. Ms. Terlecki stated that she was the Hospice nurse and case manager for Resident A. According to Ms. Terlecki, the facility followed her instructions and orders with regard to the care of Resident A, including his medication administration. Ms. Terlecki stated that she did not have any concerns about the staff's ability to administer Resident A's medication. Staff's primary language is Spanish and Ms. Terlecki would use an app to translate information to staff when needed. Ms. Terlecki does not believe there were any misunderstandings with respect to Resident A's medication.

On 08/10/22, I held an exit conference with licensee designee Mr. Marino informing him the findings of the investigation. Mr. Marino understood the findings of the investigations and stated that he would provide a corrective action plan once the report is received.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the information gathered through my interviews and documentation reviews, there is no evidence to support that Resident A's medication was not given, taken or applied pursuant to label instructions. According to Resident A's Medication Administration Records (MARS), all of his medications were initialed for the months of January and February 2022.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on the information gathered through my interviews and documentation reviews, there is sufficient information to conclude that the facility violated this rule. During my onsite investigation, Ms. Nieto and Ms. Castellanos were the only staff in the home. Both Ms. Nieto and Ms. Castellanos spoke very limited English and was not able to communicate with me. Neither was able to tell me their names or answer any of my questions. Ms. Nieto then called Mrs. Marino who is the home manager of the facility to translate and communicate for her. According to Mr. Marino, Ms. Nieto is normally not working alone. Ms. Nieto lacks the verbal and written communication skills to appropriately care for the residents alone. In the event of an emergency, there should always be staff on shift who can effectively and efficiently communicate in the English language.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14207	**Required personnel policies.**
	(2) The written policies and procedures identified in subrule (1) of this rule shall be given to employees and volunteers at the time of appointment. A verification of receipt of the policies and procedures shall be maintained in the personnel records.
ANALYSIS:	Based on the information gathered through my interviews and documentation reviews, there is sufficient information to conclude that the facility violated this rule. During my onsite investigation, I observed Ms. Castellanos working at the facility by assisting residents and cleaning around the home. According to Mr. Marino, Ms. Castellanos is a volunteer, but she has no training, file, or fingerprint clearances.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.** **(b) Job titles.** **(c) Hours or shifts worked.** **(d) Date of schedule.** **(e) Any scheduling changes.**
ANALYSIS:	Based on the information gathered through my interviews and documentation reviews, there is sufficient information to conclude that the facility violated this rule. I reviewed the staff schedule for the month of June and July 2022. There were enough staff scheduled to care for the needs of the residents, as there were two staff listed per day for less than six residents in the home. However, per the facility staff schedules, there are no shift times that the staff works each day. The schedule is a calendar that lists two staff members working each day.
CONCLUSION:	**VIOLATION ESTABLISHED**

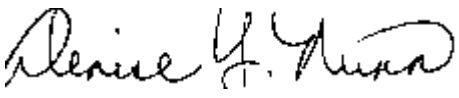
IV. RECOMMENDATION

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

08/10/22

Eric Johnson Date
Licensing Consultant

Approved By:



08/30/2022

Denise Y. Nunn Date
Area Manager