GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 17, 2022

Liz Kimberly Vidana
Prime Residential Care LLC
496 E Lovell Dr
Troy, MI 48085

RE: License #: AS630403736
Investigation #: 2023A0993002
Prime Residential Care

Dear Ms. Vidana:

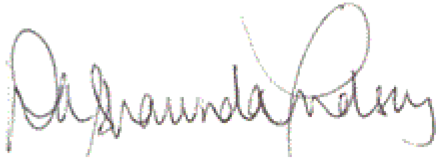
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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,



DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste. 9-100
Detroit, MI 48202
(248) 505-8036

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630403736
Investigation #:	2023A0993002
Complaint Receipt Date:	10/03/2022
Investigation Initiation Date:	10/04/2022
Report Due Date:	12/02/2022
Licensee Name:	Prime Residential Care LLC
Licensee Address:	496 E Lovell Dr Troy, MI 48085
Licensee Telephone #:	(248) 797-4536
Administrator:	Liz Kimberly Vidana
Licensee Designee:	Liz Kimberly Vidana
Name of Facility:	Prime Residential Care
Facility Address:	496 E Lovell Dr Troy, MI 48085
Facility Telephone #:	(248) 797-4536
Original Issuance Date:	10/26/2020
License Status:	REGULAR
Effective Date:	04/26/2021
Expiration Date:	04/25/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 10/1/2022, officers responded to a 911 call of a male with difficulty breathing. First Officer arrived and found Resident A with no pulse and not breathing. CPR was started. There was no paperwork at the facility for Resident A, and staff could not provide any medical history/information. Approximately, 45 minutes later, the owner showed up to the property with paperwork, stating it was in his wife's vehicle.	Yes

III. METHODOLOGY

10/03/2022	Special Investigation Intake 2023A0993002
10/03/2022	APS Referral Allegations received from adult protective services (APS). APS denied the intake.
10/04/2022	Special Investigation Initiated - Telephone Telephone call made to Troy police officer Timothy Nolan. Left a message.
10/04/2022	Contact - Telephone call received Telephone call received from Troy police officer Timothy Nolan
10/04/2022	Contact - Document Sent Requested a copy of Troy police report
10/04/2022	Contact - Document Received Received a copy of Troy police report
10/05/2022	Inspection Completed On-site Conducted an unannounced onsite investigation. There was no answer at the door.
10/05/2022	Contact - Telephone call made Called the facility. Left a message.
10/05/2022	Contact - Telephone call made Telephone call made to the program director's husband Jeff Cox. Left a message. Sent a text message.

10/05/2022	Contact - Telephone call received Telephone call received from the program director's husband Jeff Cox
10/05/2022	Contact - Telephone call made Telephone call made to program director Susana Cox
11/14/2022	Contact - Telephone call made Telephone call made to program director Susana Cox. Left a message.
11/15/2022	Contact - Telephone call made Telephone call made to program director Susana Cox. Left a message.
11/15/2022	Contact - Document Sent Emailed program director Susana Cox
11/15/2022	Contact - Telephone call received Telephone call received from program director Susana Cox
11/15/2022	Contact - Document Received Documentation received
11/16/2022	Exit Conference Attempted to hold exit conference with licensee designee Liz Kimberly Vidana. Left a message.
11/17/2022	Exit Conference Attempted to hold a second exit conference with licensee designee Liz Kimberly Vidana. Left a message.

ALLEGATION:

On 10/1/2022, officers responded to a 911 call of a male with difficulty breathing. First Officer arrived and found Resident A with no pulse and not breathing. CPR was started. There was no paperwork at the facility for Resident A, and staff could not provide any medical history/information. Approximately, 45 minutes later, the owner showed up to the property with paperwork, stating it was in his wife's vehicle.

INVESTIGATION:

On 10/03/2022, I received the allegations from adult protective services (APS). APS denied the intake.

On 10/04/2022, I conducted a telephone interview with Troy police officer Timothy Nolan. Mr. Nolan confirmed when officers arrived at the facility Resident A's record was not there. CPR was performed until the DNR was provided. CPR was stopped. Resident A was pronounced dead.

On 10/04/2022, I received a copy of the police report from Troy Police Department. Per the report, officers were dispatched to the facility on 10/01/2022 due to Resident A having trouble breathing. Resident A was observed in his bedroom unresponsive to verbal commands and sternum rubs. He had no pulse but was warm to the touch. Staff was unable to provide any medical information and was not sure if Resident A had a do not resuscitate (DNR) order. CPR was started at 12:22pm. About 30 minutes later, program director's husband Jeff Cox arrived at the facility with Resident A's paperwork and advised it was in his wife's car. Mr. Cox stated he did not see a DNR in the paperwork. Resident A's guardian arrived at the facility with the DNR. CPR was terminated. Resident A was pronounced dead at 13:09pm. There were no observed signs of foul play.

On 10/05/2022, I conducted a telephone interview with program director's husband Jeff Cox. Her confirmed when officers arrived at the facility Resident A's file was not there. He stated his wife and her partner were working on the residents' files. Otherwise, Resident A's file would have been in the facility. Mr. Cox suggested that I contact his wife for additional information.

On 10/05/2022, I conducted a telephone interview with program director Susana Cox. Ms. Cox confirmed when officers arrived at the facility Resident A's file was not there. She stated Resident A's file was in her car. She confirmed CPR was performed on Resident A due to the DNR not being in the facility. When the DNR was provided, CPR was terminated. Resident A died.

On 11/15/2022, I received a copy of Resident A's file. I observed the following documents:

- Information and Identification Record
- Assessment Plan signed and dated in February 2021
- Resident Care Agreement signed and dated in February 2021
- Health Care Chronological
- Incident Report dated 10/01/2022
- Health Care Appraisal signed and dated in February 2021

Per the incident report, on 10/01/2022, Resident A was vomiting in the morning. Ms. Cox was notified. Resident A was still conscious, but his breathing was not good. He had lunch and later took his last breath. 911 was called. His family and Ms. Cox was notified.

On 11/15/2022, I conducted a telephone interview with program director Susana Cox. When I asked for a copy of Resident A's weight chart, Ms. Cox stated Resident A had not been weighed since September 2022 due to his combativeness. A copy of the

weight chart was not provided. In addition, she stated she could not provide a copy of the medication administration record (MAR) as it was computerized. Ms. Cox stated they are planning to close the license as they are selling the facility.

On 11/16/2022 and 11/17/2022, I attempted to conduct an exit conference with licensee designee Liz Kimberly Vidana with no success. I left messages.

APPLICABLE RULE	
R 400.14301	**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:	Resident A's assessment plan was last completed in February 2021. The assessment plan was not present in the facility on 10/01/2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(9) A license shall review the written resident care agreement with the resident or resident's designated representative and responsible agency, if applicable, at least annually or more often if necessary.
ANALYSIS:	Resident A's resident care agreement was last completed in February 2021.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14301	**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 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 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:	Resident A's health care appraisal was last completed in February 2021.
CONCLUSION:	**VIOLATION ESTABLISHED**

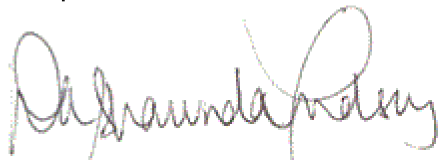
APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.
ANALYSIS:	Ms. Cox stated Resident A had not been weighed since September 2022 due to his combativeness. A copy of the weight chart was not provided.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident

	record shall include, at a minimum, all of the following information: **(a) Identifying information, including, at a minimum, all of the following:** **(i) Name.** **(ii) Social security number, date of birth, case number, and marital status.** **(iii) Former address.** **(iv) Name, address, and telephone number of the next of kin or the designated representative.** **(v) Name, address, and telephone number of the person and agency responsible for the resident's placement in the home.** **(vi) Name, address, and telephone number of the preferred physician and hospital.** **(vii) Medical insurance.** **(viii) Funeral provisions and preferences.** **(ix) Resident's religious preference information.** **(b) Date of admission.** **(c) Date of discharge and the place to which the resident was discharged.** **(d) Health care information, including all of the following:** **(i) Health care appraisals.** **(ii) Medication logs.** **(iii) Statements and instructions for supervising prescribed medication, including dietary supplements and individual special medical procedures.** **(iv) A record of physician contacts.** **(v) Instructions for emergency care and advanced medical directives.** **(e) Resident care agreement.** **(f) Assessment plan.** **(g) Weight record.** **(h) Incident reports and accident records.**
ANALYSIS:	Resident A’s information and identification form, health care appraisal, assessment plan, weight record, and assessment plan were not present in the facility on 10/01/2022. Resident A’s DNR was also not present. CPR was performed until the DNR was provided. CPR was terminated. Resident A was pronounced dead. There were no observed signs of foul play.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, issuance of a provisional license is recommended.



11/17/2022

DaShawnda Lindsey Date
Licensing Consultant

Approved By:

11/17/2022

Denise Y. Nunn Date
Area Manager