GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 18, 2022

Ellen Byrne
MCAP East Paris Opco, LLC
Suite 115
21800 Haggerty Rd.
Northville, MI 48167

RE: License #:	AL410404575
Investigation #:	2023A0356002
	Commonwealth Senior Living at East Paris #6

Dear Ms. Byrne:

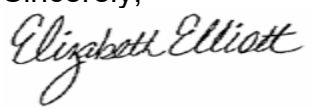
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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 (616) 356-0100.

Sincerely,



Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410404575
Investigation #:	2023A0356002
Complaint Receipt Date:	09/28/2022
Investigation Initiation Date:	09/29/2022
Report Due Date:	11/27/2022
Licensee Name:	MCAP East Paris Opco, LLC
Licensee Address:	21800 Haggerty Rd. Suite 115 Northville, MI 48167
Licensee Telephone #:	(248) 773-4600
Administrator:	Mackenzie Ferguson
Licensee Designee:	Ellen Byrne
Name of Facility:	Commonwealth Senior Living at East Paris #6
Facility Address:	3980 Whispering Way, SE Grand Rapids, MI 49546
Facility Telephone #:	(616) 949-9500
Original Issuance Date:	11/05/2020
License Status:	REGULAR
Effective Date:	05/02/2021
Expiration Date:	05/01/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED, AGED DEVELOPMENTALLY DISABLED, MENTALLY ILL ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A ingested a medication that was not prescribed to her.	Yes
Resident A had an unwitnessed fall at the facility and care was not sought immediately.	No
Additional Findings	Yes

III. METHODOLOGY

09/28/2022	Special Investigation Intake 2023A0356002
09/29/2022	Special Investigation Initiated - Telephone Relative #1.
10/05/2022	Contact - Telephone call made Michelle Gingrich, Careline Healthcare partners re: Resident A and medications.
10/05/2022	Contact - Telephone call received Careline physician services (Michelle Gingrich's office) direct screening information.
10/06/2022	Contact - Telephone call made Sarah Scheel, facility nurse.
10/06/2022	Contact - Document Received Drug screen for Resident A from Careline physician services.
10/10/2022	Contact - Document Sent Sarah Scheel facility nurse.
10/14/2022	Inspection Completed On-site
10/14/2022	Contact - Face to Face Sarah Scheel, facility nurse & Resident A.
10/14/2022	APS Referral
10/14/2022	Contact - Document Received Facility documents.
10/19/2022	Contact - Telephone call made

	Relative #1.
10/20/2022	Contact - Document Received Medical information and pictures from Relative #1.
11/03/2022	Contact - Telephone call made DCW's Miatta Bushman, Markila Pruitt, Shannon Padilla, Karyah Elliott.
11/07/2022	Contact - Telephone call made DCW Halida Causivic, Dexter Burress, Shannon Padilla.
11/17/2022	Contact-Telephone call made Shannon Padilla, staff. Pete DeGrieger Reliance Social Worker.
11/18/2022	Exit Conference-Mackenzie Ferguson, Administrator (in Licensee Designee, Ellen Byrne's absence).

ALLEGATION: Resident A ingested a medication that was not prescribed to her.

INVESTIGATION: On 09/28/2022, I received a BCAL (Bureau of Children and Adult Licensing) online complaint. The complainant reported that Resident A was given Clozaril medication when Resident A is not prescribed that medication. Resident A reacted negatively to the medication and was taken to ER (emergency room), a drug screen was completed, and they found the medication in the drug screen. The complainant reported Resident A was unresponsive after four Narcan (a prescription medication to treat a known or suspected opioid overdose) treatments and staff at the facility told the ambulance driver that Resident A must have taken too much of her Norco medication when Resident A does not have access to Norco.

On 09/29/2022 and 10/19/2022, I interviewed Relative #1 via telephone. Relative #1 confirmed the information in the complaint is accurate. Relative #1 stated an unknown staff told the EMS driver that Resident A must have gotten ahold of her Norco medication and overdosed on that, which, Relative #1 stated is not true. Relative #1 stated Resident A's Norco is locked in the medication cart, and it was Clozaril that she was not prescribed that showed up in her blood test. Relative #1 stated Resident A received four doses of Narcan in the hospital and he was told at the hospital that Resident A probably received two doses of Clozaril.

On 09/29/2022, I reviewed the IR (incident report) for this incident. The first IR is dated 07/14/2022 at 1:00p.m., staff on duty, Tianna Townsend, IR signed by Sarah Scheel, LPN and Mechelle Genigeski, administrator. The IR documented the following information, '*When resident was brought her lunch staff noticed that the resident was not at her normal mental baseline. Upon assessment vitals within*

normal limits. Resident lethargic and unable to communicate per her usual baseline. Resident sent to ER for eval. Assessed, called 911 and transported to ER via EMS.'

The second IR submitted was dated 07/21/2022 and signed by Jeannine Hayes, RN and Ms. Genigeski. The IR documented the following information, *'Resident sent to hospital due to lethargy and mental status changes. Hospital called facility on 07/15/2022 and reported that a drug screen completed on resident identified Clozapine in her drug screen. Review of medication policy, medication pass, scanning of bar codes with med techs, med tech observation of medication pass.'*

On 10/05/2022, I interviewed Michelle Gingrich, NP (nurse practitioner) with Careline Physician services. Ms. Gingrich stated Clozapine was detected in Resident A's drug screen when she went to the hospital. Ms. Gingrich stated Clozapine is an anti-psychotic medication that Resident A is not prescribed.

On 10/06/2022, I received and reviewed the Spectrum Health Blodgett Campus Laboratory Report dated 07/14/2022, ordered by Ellen Junewick, comprehensive blood drug screen, basic drug extraction detected, *'caffeine, diphenhydramine, citalopram, hydrocodone, spironolactone metabolite, clozapine. No other drugs detected.'*

On 10/14/2022, I conducted an announced inspection at the facility and interviewed facility nurse, Sarah Scheel. Ms. Scheel stated when this incident occurred in July 2022, she was new to the facility and the former facility nurse, Jeannine Hayes investigated the incident. Ms. Scheel stated on 07/15/2022, she discovered a bag of old medications in Resident A's room, the medications were 10 years old and included fentanyl patches, coricidin HBP, antidiarrheal and acetaminophen. Ms. Scheel stated those medications were confiscated and destroyed. Ms. Scheel stated Resident A does not take clozapine, however, Resident B takes clozapine, and his room is down the hall from Resident A's room, Ms. Scheel stated she is not sure if they interact or know one another. Ms. Scheel stated staff told her (Ms. Scheel) they noticed Resident A was lethargic and was not acting like herself so Resident A was sent to the hospital for observation and treatment where Narcan was administered to Resident A.

On 10/14/2022, I interviewed Resident A in her room at the facility. Resident A confirmed that she got the wrong medication, became ill and required hospitalization. Resident A stated staff administer her medications in a small cup accompanied by a small cup of water. Resident A stated some staff, "stay and watch me take my pills and others do not stay and watch me take my meds." Resident A stated she pours her cup of pills out into her hand and takes the big pills first and then the small pills. Resident A stated on the day she went to the hospital, she does not remember anything different about her pills, she stated she took her pills as usual; she got sick and was in an ambulance. Resident A stated she does not know Resident B, she does not visit with him, they do not share pills and she is alone or with staff when she takes her medications. Resident A stated she has no access to

her Norco medication as that is locked up in the med cart so there is no way she could take that without staff knowing as reported in the complaint.

On 10/14/2022, I received and reviewed information from the internal investigation Ms. Hayes conducted. Ms. Hayes documented on 07/15/2022 a review of the medications in the med cart revealed no Clozapine blister pack within the medications for Resident A. Resident B had 2 blister packs of 28 pills of Clozapine identified with his medications. Ms. Hayes documented on 07/13/2022, the pharmacy refilled this prescription. Ms. Hayes documented on 07/15/2022, staff conducted a room sweep of Resident A's room and checked it for medications, staff found 7 fentanyl patches, date of fill was 05/10/2012, Coriciden HBP, Antidiarrheal caps and Acetaminophen, 2 large bottles (500 tabs) and 1 small bottle (150 tabs). All medications were removed from the room.

On 10/14/2022, I received and reviewed the MAR (medication administration record) for the month of July 2022 for Resident A. Clozapine is not a medication documented on Resident A's MAR as a prescribed medication.

On 10/14/2022, I received and reviewed the Spectrum Health encounter information dated 07/14/2022, admission diagnosis, '*altered mental status*,' admitting physician, Garrett Kerndt, MD.

On 10/14/2022, I received and reviewed the Careline Physician Services report dated 07/20/2022. Ms. Gingrich documented, '*Patient was hospitalized 07/14/2022-07/16/2022. She presented to the ED with chief complaint somnolence and altered mental status. She was diagnosed with acute toxic metabolic encephalopathy. Drug screen was positive for Clozapine. She is not prescribed this medication and she does not know how this got in her system.'*

On 11/18/2022, I conducted an exit conference with Mackenzie Ferguson, Administrator via telephone. Ms. Ferguson stated an acceptable corrective action plan will be submitted.

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:	The complainant reported that Resident A was given Clozaril medication when Resident A is not prescribed that medication. Relative #1 confirmed Resident A is not prescribed Clozaril but a drug screen at the hospital confirmed the medication was in her system. Two IRs documented Resident A was not at her normal baseline and was lethargic. Resident A was sent to the hospital where Clozapine was identified in a drug screen. Ms. Gingrich stated Clozapine was detected in Resident A's drug screen and Resident A is not prescribed Clozapine medication. The Spectrum Health Blodgett Campus Laboratory Report detected Clozapine in Resident A's drug screen. Ms. Scheel and Resident A reported that Clozaril is not a medication Resident A is prescribed but she ingested the medication. Ms. Hayes documented on 07/15/2022 a review of the medications in the med cart revealed no Clozapine blister pack within the medications for Resident A. Ms. Hayes documented on 07/15/2022, staff found old medications in Resident A's room that were not prescribed to her at this time. A review of Resident A's MAR shows that Clozapine is not a medication prescribed to Resident A. Spectrum Health admitted Resident A on 07/14/2022, with an altered mental status. Based on investigative findings, there is a preponderance of evidence to show that on or about 07/14/2022, Resident A ingested Clozaril which is a medication that is not prescribed to her, and due to the ingestion of this medication, Resident A had to be hospitalized for two days. A violation of this applicable rule is established.

CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: Resident A had an unwitnessed fall at the facility and care was not sought immediately.

INVESTIGATION: On 09/28/2022, I received a BCAL (Bureau of Children and Adult Licensing) online complaint. The complainant reported Resident A fell in her room at the facility, hit her head and was left on the floor on her bathroom. The complainant reported Resident A pulled emergency cords and pressed the emergency button she wore around her neck, and no one responded for 5 ½ hours while she laid on the floor all night in her bathroom.

On 09/29/2022 and on 10/19/2022, I interviewed Relative #1 via telephone. Relative #1 confirmed the information in the complaint is accurate. Relative #1 stated the date of this incident was 08/29/2022 and that he received a telephone call from an unknown staff at the facility who asked him if Resident A should be sent to the ER and Relative #1 told staff to send her. Relative #1 stated Resident A told him she fell in the bathroom in her room during the middle of the night, she pulled the cord and pushed the emergency call button for assistance, and no one came all night long. Relative #1 stated Resident A is supposed to be checked on every two hours but it is apparent that did not occur. Relative #1 stated he contacted and spoke to a supervisor, Dee Orr who told him the emergency cords are not connected to the system yet as it is a newer system. Relative #1 stated since that contact with Ms. Orr, he has not been able to reach her for further information and follow-up.

On 10/05/2022, I interviewed Michelle Gingrich, NP (nurse practitioner) with Careline Physician services. Ms. Gingrich stated she was not aware that Resident A fell in her room at the facility and laid on the floor for 5 ½ hours. Ms. Gingrich asked if the emergency call light was utilized and if so, does the call light log indicate staff did not respond for that amount of time.

On 10/14/2022, I conducted an announced inspection at the facility and interviewed Ms. Scheel. Ms. Scheel stated staff conduct 2-hour checks on residents and all residents have pull cords and emergency buttons to carry with them, but she is not aware of any incidents or hospitalizations since Resident A went to the hospital in July 2022. Ms. Scheel reported there are no incident reports filed for the date of 08/29/2022 or around that date documenting Resident A's fall or hospitalization.

On 10/14/2022, I interviewed Resident A in her room at the facility. Resident A stated she got up in the middle of the night on an unknown date, around 12:30 a.m. to use the bathroom. Resident A stated she fell asleep while on the toilet and fell off the toilet onto the floor. Resident A stated she had an emergency call button around her neck which she pushed as well as the pull cord on the wall of the bathroom with no response until approximately 6:00a.m. when staff entered the adjoining room to provide care to Resident C and that is when she was able to get the attention of staff to assist her. Resident A stated she was sent to the emergency room.

On 10/20/2022, I received and reviewed the emergency room discharge information and viewed pictures of Resident A's injury sent from Relative #1. The Spectrum Butterworth ER discharge information is dated 08/29/2022 at 10:00a.m. and documented the following information, '*History of present illness: Patient is an 82-year-old female with past medical history significant for atrial fibrillation on Coumadin, CHF coronary artery disease dementia, hypertension dyslipidemia presenting to emergency department today for evaluation after a fall. Patient reports that she was sitting on her toilet seat left mid when she fell asleep in the middle the night. She reports that while asleep, she fell off from the toilet and hit her face on the floor. She reports that she did not get up until this morning when she was able to have someone help her. She normally walks with a walker. She does take Coumadin for blood thinner. She did hit her face, she thought on the right side, however, she does have a little bit of bruising and ecchymoses in the left periorbital area. She denies any eye or face pain. No head pain. No neck pain. She does have a little bit of lower back pain. She denies any chest wall pain, abdominal pain, hip pain or lower extremity pain. She otherwise reports that she has been feeling well. Denies any fevers, chills, cough or cold symptoms, shortness of breath or difficulties breathing. She does state when asked specifically that she feels as though she is having a little bit a hard time focusing with her eyes but cannot distinguish if 1 is necessarily worse than the other.'* The pictures of Resident A's face show a significant black and blue left eye, the bruising surrounds the entire eye and the white of Resident A's eye is blood red.

On 10/21/2022, I received and reviewed the CISCOR One Source alarm history. The documents showed Resident A used the bedroom call station alarm on 08/28/2022 at 6:55a.m. and the staff response time was 19 minutes 52 seconds. That is the only call light alarm documented for the month of August 2022

On 11/07/2022, I interviewed staff Dexter Burress via telephone. Mr. Burress stated he started working at the facility in August 2022 and confirmed he worked in the same building that Resident A resided in on 08/29/2022. Mr. Burress stated he worked with Shannon Padilla and that Ms. Padilla was there and knows about Resident A's fall. Mr. Burress stated he did not conduct 2-hour checks on Resident A during the night shift even though they try to take turns, but that Ms. Padilla did conduct those checks. Mr. Burress stated the call lights have been a problem, they do not come on when residents use them, but that Resident A did not use the calls lights often and is very independent.

On 11/17/2022, I interviewed staff Shannon Padilla via telephone. Ms. Padilla confirmed that she and Mr. Burress worked on the evening of 08/28/2022-08/29/2022 when Resident A fell. Ms. Padilla stated she went into Resident C's room to check on her at approximately 5:00a.m. when she noticed Resident A on the floor in the shared bathroom. Ms. Padilla stated she had checked Resident A at 3:00a.m. and she was asleep in her chair, Resident A is checked on every 2 hours so the longest she could have been laying on the floor in the bathroom is from 3:00 a.m-5:00 a.m., in between the two-hour checks. Ms. Padilla stated there is "no way"

Resident A was on the floor from midnight until 5:00a.m. Ms. Padilla stated the emergency cords and buttons “work one minute and the next they don’t work,” and are unreliable. Ms. Padilla stated Resident A never showed on the call register as requesting help via the emergency pull cord or button on the morning of 08/28/2022. Ms. Padilla stated she is the one who called and sent Resident A to the hospital.

On 11/18/2022, I conducted an exit conference with Mackenzie Ferguson via telephone. Ms. Ferguson stated she agrees with the information, analysis and conclusion of this applicable rule.

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:	The complainant reported Resident A fell in her room at the facility, hit her head and was left on the floor on her bathroom for 5 ½ hours. Relative #1 stated Resident A told him she fell in the bathroom in her room during the middle of the night, she pulled the cord and pushed the emergency call button for assistance, and no one came all night long. Ms. Gingrich stated she was not aware that Resident A fell in her room at the facility and laid on the floor for 5 ½ hours. Ms. Scheel stated staff conduct 2-hour checks on residents and she is not aware of any incidents or hospitalizations with Resident A due to a fall. Resident A stated she got up in the middle of the night, fell on the floor in the bathroom where she laid all night with no staff assistance. The Spectrum Butterworth ER discharge information dated 08/29/2022 confirmed Resident A’s fall, hitting her face. The CISCOR One Source alarm history does not show Resident A’s alarm calls on 08/29/2022 when she fell in the bathroom.

	Mr. Burress acknowledged he did not conduct 2-hour checks of Resident A but Ms. Padilla did. Mr. Burress stated he and Ms. Padilla found Resident A on the floor in her bathroom. Ms. Padilla stated she called and sent Resident A to the hospital immediately after discovering her on the floor after an unwitnessed fall. Ms. Padilla said the fall had to have occurred between 3:00a.m. and 5:00a.m. in between the two hour checks she conducted. Staff reported checking on Resident A at 3:00a.m. on 08/29/2022 found her asleep in her chair and upon checks made at 5:00a.m., found Resident A on the floor and called EMS for transport to the hospital. Based on the investigative findings, there is not a preponderance of evidence to show that on the evening of 08/28/2022-08/29/2022, when Resident A fell, that she laid on the floor from midnight until 5:00a.m. without care and therefore, a violation of this applicable rule is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING

INVESTIGATION: Upon receipt of this complaint on 09/28/2022, I did not have an IR (incident report) documenting Resident A's fall and hospitalization.

On 10/14/2022, Ms. Scheel reported there are no incident reports filed for the date of 08/29/2022 or around that date documenting Resident A's fall or hospitalization. Ms. Scheel stated Resident A's Reliance case manager, Pete DeGriener would have contacted her for more information had Resident A had a fall with hospitalization.

On 10/05/2022, I interviewed Ms. Gingrich via telephone. Ms. Gingrich stated she had no knowledge of an incident where Resident A fell and went to the hospital.

On 11/17/2022, I interviewed Pete DeGriener, Reliance Social Worker. Mr. DeGriener stated he did not receive an IR from the facility regarding a fall and visit to the ER on 08/29/2022.

On 11/17/2022, Ms. Padilla stated she does not recall filling out an IR or notifying anyone other than Relative #1. Ms. Padilla stated she discovered Resident A in the morning when they were getting everyone up and ready for the day, she called EMS to get Resident A to the hospital and got busy, failing to fill out the IR.

On 11/18/2022, I conducted an exit conference with Ms. Ferguson via telephone. Ms. Ferguson stated an acceptable corrective action plan will be submitted.

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: (b) Any accident or illness that requires hospitalization.
ANALYSIS:	Ms. Scheel, Ms. Gingrich and Mr. DeGriener stated they did not receive an IR nor were they notified of Resident A's fall and hospitalization. Licensing did not receive an IR documenting Resident A's fall and hospitalization. Ms. Padilla stated she did not complete an IR or notify anyone other than Relative #1.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

Elizabeth Elliott

11/18/2022

Elizabeth Elliott, Licensing Consultant Date

Approved By:

Jerry Hendrick

11/18/2022

Jerry Hendrick, Area Manager Date