GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 20, 2022

Megan Fry
MCAP Holt Opco, LLC
Suite 115
21800 Haggerty Road
Northville, MI 48167

RE: License #: AL330404596
Investigation #: 2023A1033005
Prestige Way #1 (Cedar Cottage)

Dear Ms. Fry:

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 #:	AL330404596
Investigation #:	2023A1033005
Complaint Receipt Date:	10/26/2022
Investigation Initiation Date:	10/31/2022
Report Due Date:	12/25/2022
Licensee Name:	MCAP Holt Opco, LLC
Licensee Address:	Suite 115 21800 Haggerty Road Northville, MI 48167
Licensee Telephone #:	(517) 694-2020
Administrator:	Megan Fry
Licensee Designee:	Megan Fry
Name of Facility:	Prestige Way #1 (Cedar Cottage)
Facility Address:	4300 Keller Road Holt, MI 48842
Facility Telephone #:	(517) 694-2020
Original Issuance Date:	11/02/2020
License **Status:**	REGULAR
Effective Date:	05/02/2021
Expiration Date:	05/01/2023
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Direct care staff LaCher Greenwood treats residents poorly and uses threats and intimidation with residents.	Yes
Direct care staff LaCher Greenwood refused to administer anti-diarrhea medication to Resident A.	No

III. METHODOLOGY

10/26/2022	Special Investigation Intake 2023A1033005
10/31/2022	Special Investigation Initiated – Telephone call- Interview with Licensing Consultant, Julie Elkins.
11/02/2022	Inspection Completed On-site- Interviews with direct care staff, Victoria Ramirez, direct care staff, Makiya Jackson, Resident A, B, & C, Facility Nurse, Julie Jones. Review of Resident A record initiated. Resident A medication reconciliation completed.
11/03/2022	Contact - Telephone call made- Interview with direct care staff, Dallas Reynolds.
12/01/2022	Contact - Telephone call made- Interview with direct care staff, Darlene Gonzalez, via telephone.
12/08/2022	Contact – Document Received- Received email from Marcia Curtiss containing employee file documents for Lacher Greenwood.
12/20/2022	Exit Conference Exit Conference conducted via telephone with Licensee Designee, Megan Fry.

ALLEGATION:

Direct care staff, LaCher Greenwood, treats residents poorly and uses threats and intimidation with residents.

INVESTIGATION:

On 10/27/22 I received an online complaint regarding Prestige Way #1 (Cedar Cottage) adult foster care facility (the facility). The complaint alleged direct care staff

member LaCher Greenwood treats residents poorly and uses verbal threats and intimidation with residents. On 11/2/22, I completed an on-site investigation at the facility. I interviewed direct care worker Victoria Ramirez who reported she recently started working at the facility about one month ago. Ms. Ramirez reported that on 10/24/22 she directly observed Ms. Greenwood in a verbal altercation with Resident A. Ms. Ramirez reported Resident A had asked for an antidiarrhea medication and Ms. Greenwood refused to administer the medication. Ms. Ramirez reported Ms. Greenwood became "hostile" with Resident A during this altercation. Ms. Ramirez reported Resident A stated, "I'm being treated like a 10-year-old." Ms. Ramirez reported that after the altercation, on 10/24, during this same shift she spoke with Resident A. Ms. Ramirez reported Resident A confided in her that she is "afraid" of Ms. Greenwood. Ms. Ramirez reported Ms. Greenwood consistently acts in this manner toward other residents, referring to Ms. Greenwood making threats and using intimidation with residents.

On 11/2/22, during on-site investigation, I interviewed Resident A. Resident A reported, "LaCher is strict." She further explained Ms. Greenwood follows the rules in a strict manner and will not administer a medication until it is time for that medication to be administered. Resident A reported others may have trouble getting along with Ms. Greenwood due to her "strict personality." Resident A reported she is not afraid of Ms. Greenwood and has not felt threatened or intimated by her. Resident A reported she feels "safe" at the facility.

On 11/2/22, during on-site investigation, I interviewed direct care staff, Makiya Jackson. Ms. Jackson reported that she works afternoon shifts at the facility. Ms. Jackson reported she has worked with Ms. Greenwood at the facility in a limited capacity as they work opposite shifts. Ms. Jackson reported she has never witnessed Ms. Greenwood use threatening or intimidating language or actions with the residents, but she has heard rumors from other direct care staff reporting they have observed these behaviors. Ms. Jackson reported she has not observed any staff members, at the facility, acting in this manner.

On 11/2/22, during on-site investigation, I interviewed Resident B. Resident B reported that she has resided at the facility for about 1.5 years. Resident B reported that she has never witnessed the staff yelling at the residents or speaking to residents in a derogatory manner. Resident B further reported that she feels "safe" in the facility and "all staff are good."

On 11/2/22, during on-site investigation, I interviewed Resident C. Resident C reported that she has lived at the facility for about one month. Resident C reported that she has not experienced any issues with the staff speaking in a derogatory manner or using threats or intimidation with the residents. Resident C had no concerns at this time.

On 11/2/22, during on-site investigation, I interviewed direct care staff, Julie Jones. Ms. Jones reported that she is the nurse for the facility. Ms. Jones reported that she

works with Ms. Greenwood on a regular basis. Ms. Jones reported that she has not observed Ms. Greenwood, or any of the direct care staff, speaking with residents in a derogatory manner or using threats and/or intimidation with the residents. Ms. Jones reported that she has not received any complaints from residents noting feeling threatened or intimidated by Ms. Greenwood.

On 11/3/22 I interviewed direct care staff, Dallas Reynolds, via telephone. Ms. Reynolds reported that she has worked for the facility for about three months. Ms. Reynolds reported that she feels she is building rapport with the residents, and they are beginning to confide in her. Ms. Reynolds reported that Resident A had confided in her that she feels Ms. Greenwood talks down to her and treats her like a child. Ms. Reynolds reported Resident A has reported to her she is "afraid" of Ms. Greenwood. Ms. Reynolds did not have any direct accounts of Ms. Greenwood threatening or intimidating residents during this interview.

On 12/1/22 I interviewed direct care staff, Darlene Gonzalez, via telephone. Ms. Gonzalez reported she has been employed by the facility for about 18 months. Ms. Gonzalez reported that since my on-site visit to the facility Ms. Greenwood, Ms. Jones, and facility Administrator, Amanda Dunlap's, employment have been terminated. Ms. Gonzalez did not provide specific reasonings for the terminations as she is not responsible for hiring and firing practices at the facility. Ms. Gonzalez reported that she had witnessed Ms. Greenwood express to a resident, "I'm gonna put you out in the rain." She reported this threat was reported to facility management. Ms. Gonzalez reported that during her time, employed by the facility, Ms. Greenwood has treated many residents with threats and intimidation. Ms. Gonzalez reported that there had been multiple reports to management at the facility and to Licensing and Regulatory Affairs (LARA) Complaint Hotline and there was never any action taken to remedy Ms. Greenwood's behaviors.

On 12/8/22 I received an email from Marcia Curtiss, Vice President of Operations, for the facility. The email contained requested documents from Ms. Greenwoods employee file. I reviewed a *Performance Improvement Plan* dated for 12/6/21 and signed by Ms. Greenwood, Ms. Jones, and Ms. Dunlap. The performance improvement plan noted, "This memorandum is written as a 30-Day Performance Improvement Plan designed to focus your attention on substantially improving your performance in several key areas listed below.

Communicating with the residents in a manner that is profession. Communicating with staff in a manner that is professional. Not sharing personal numbers with resident's family members. Communicating with hospice, therapy and other outside vendors in a manner that is professional." The performance improvement plan highlighted the following areas that should be brought up to "minimal acceptable standards."

1. "Treat each resident with respect and dignity. Avoid saying you can't do this or you can't have that.

2. Communicate with residents in a way that is professional and caring. We are here to make their lives easier.
3. Family members should not have care staff's personal numbers. If there is a question from the family they should be directed to myself or Julie.
4. Communicate with family members, hospice groups, or outside therapy services in a polite and professional manner.
5. Communicate with staff members in a way that is professional and polite. Staff is an added resource to help and should be treated in a manner that creates a team."

Along with this performance improvement plan was a *Notes From First Follow Up* form. This form was dated 2/7/22 and signed by Ms. Greenwood and Ms. Dunlap. The note reported, "Not personally calling family members has gotten a lot better. There has been one hospice nurse that has voiced that she wasn't happy with Lacher. Lacher is trying to be more polite and treat everyone with respect. There has been improvement, hope to see more!"

On 12/12/22 I reviewed the Special Investigation Report (2022A0790020) written by Licensing Consultant, Rodney Gill, and dated 7/19/22. The allegations investigated in this report were reported as, "Direct care staff member LaCher Greenwood woke up Resident A by pushing her and telling her she needed to get up. Resident A's arm was cut due to Ms. Greenwood being so rough with her while assisting her with getting into her wheelchair." There were no violations cited in this report.

On 12/12/22 I reviewed the Special Investigation Report (2022A0577040) written by Licensing Consultant, Bridget Vermeesch, and dated 7/8/22. The allegations investigated in this report were reported as, "LaCher Greenwood yelled and threatened Resident A. LaCher Greenwood hit Resident A's head on the bed rail while rotating resident A." There were no violations cited in this report and the analysis reported the following, "It has been determined Staff 1 has a straightforward, matter-of-fact tone which is not always easily interpreted by all residents. However, there was no evidence presented of Staff 1 yelling obscenities, name calling, or otherwise treated residents harshly. There was also no evidence of Staff 1 physically mistreating Resident A while repositioning her."

APPLICABLE RULE	
R 400.15304	**Resident rights; licensee responsibilities.**
	Rule 304. (1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights:

	(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy. **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Based upon interviews with Ms. Ramirez, Ms. Gonzalez, Ms. Reynolds, Ms. Jackson, Residents A, B, and C, review of Ms. Greenwood's employee file, review of previous Special Investigation Reports, completed by Mr. Gill and Ms. Vermeesch, the facility was aware of Ms. Greenwood's history of not treating residents with dignity and respect, based on the Performance Improvement Plan that was included with her employee file and dated 12/6/21. There was no further record, beyond the note from 2/7/22, indicating that further follow up consultation or trainings were completed to ensure that Ms. Greenwood's behaviors had been modified. Three additional complaints related to Ms. Greenwood's behaviors resulted in three additional special investigations since the date of her initial employee discipline, 12/6/21. Although, Mr. Gill's and Ms. Vermeesch's investigations resulted in a finding of "Violation Not Established" and Residents A, B, and C reported feeling "safe" at the facility, there have been direct reports from Ms. Ramirez, Ms. Gonzalez, and Ms. Reynolds that there are several residents who are "afraid" of Ms. Greenwood and frightened to make statements due to fear of retaliation. In addition, Ms. Jones reported that she had no knowledge of Ms. Greenwood acting in an intimidating or threatening manner toward residents, however, there was signed documentation (Performance Improvement Plan), in Ms. Greenwood's employee file indicating Ms. Jones had prior knowledge of these behaviors.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Direct care staff, LaCher Greenwood, refused to administer anti-diarrhea medication to Resident A.

INVESTIGATION:

On 10/27/22 I received an online complaint alleging that Ms. Greenwood refused to administer an antidiarrhea medication to Resident A. On 11/2/22 I completed an on-site investigation. I interviewed Ms. Ramirez who reported that on 10/24/22 she had been working with Ms. Greenwood. Ms. Ramirez reported she was giving Resident A a shower that morning around 9am and Resident A was experiencing active diarrhea while she was in the shower. Ms. Ramirez reported she instructed Resident

A to inform Ms. Greenwood if the issue persisted as Ms. Greenwood was working as a Medication Technician on that date. Ms. Ramirez reported that she witnessed Resident A request an antidiarrhea medication from Ms. Greenwood at 11:30am on 10/24/22. Ms. Ramirez reported she observed Ms. Greenwood state to Resident A that she would give her some “Pepto Bismol”, but she would not administer the ordered, as needed, antidiarrhea medication Resident A had requested. Ms. Ramirez reported she then went to Ms. Greenwood and reported that Resident A had been experiencing active diarrhea since her shower around 9am and noted Ms. Greenwood ignored her statement. Ms. Ramirez reported there were not any other direct care staff present to observe these interactions between Resident A, Ms. Ramirez, and Ms. Greenwood.

On 11/2/22, during on-site investigation, I interviewed Resident A. Resident A reported that she has no recollection of being denied an antidiarrhea medication on 10/24/22. Resident A reported that Ms. Greenwood is very “strict” when it comes to giving medications in a timely manner and does not stray from the schedule. Resident A reported that she does not recall asking Ms. Greenwood for a medication that Ms. Greenwood refused to administer.

On 11/2/22, during on-site investigation, I interviewed Ms. Jackson. Ms. Jackson reported that she has not observed Ms. Greenwood refusing to administer medications to any residents at the facility.

On 11/2/22, during on-site investigation, I interviewed Resident B. Resident B reported that she has not been denied medication administration by Ms. Greenwood and feels her medications are well managed at the facility.

On 11/2/22, during on-site investigation, I interviewed Resident C. Resident C reported that she feels her medications are managed well and has not had any staff members refuse to administer requested medications.

On 11/2/22, during on-site investigation, I interviewed Ms. Jones. Ms. Jones reported that she has not observed Ms. Greenwood refuse to administer requested medications to Resident A or any other residents.

On 12/1/22 I interviewed Ms. Gonzalez, via telephone. Ms. Gonzalez reported that it was reported to her, by Ms. Ramirez, that Ms. Greenwood refused to administer Resident A’s antidiarrhea medication on 10/24/22. Ms. Gonzalez reported that a week prior to the 10/24/22 incident, she had witnessed Ms. Greenwood state to Resident A that she could not have her antidiarrhea medication on that day as Ms. Jones had noted it was not time to administer the medication yet. Ms. Gonzalez did not have a specific date noted for this second alleged incident.

On 11/2/22, during on-site investigation, I reconciled Resident A’s medications to her *Medication Administration Record* (MAR) for the month of October 2022. I noted that Resident A is ordered the following antidiarrhea medication:

- Loperamide Cap 2mg: Take 1 capsule by mouth four times daily, as needed.

This medication was found with Resident A's medications in a locked medication cabinet. The Loperamide was documented on the October 2022 MAR as being administered on the following dates and times:

- 10/2/22, 4:01pm & 7:57pm
- 10/10/22, 11:23am
- 10/23/22, 12:05pm

On 11/2/22, during on-site investigation, I reviewed the *Assessment Plan for AFC Residents* form (dated 4/19/23) and the *Health Care Appraisal* form (dated 4/2/23) for Resident A. Neither of these forms indicated a history of Dementia or other cognitive impairment.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based upon interviews with Ms. Ramirez, Ms. Gonzalez, Ms. Jackson, Residents A, B, and C, and Ms. Jones as well as review of Resident A's resident file, there is not adequate evidence available to determine Resident A was denied administration of her Loperamide medication by Ms. Greenwood on 10/24/22. Although, Ms. Ramirez and Ms. Gonzalez, both report they had observed these occurrences, Resident A denies knowledge or a memory of Ms. Greenwood refusing to administer her Loperamide.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the status of the current license recommended at this time.

12/20/2022

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Jana Lipps Date
Licensing Consultant

Approved By:

12/20/2022

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Dawn N. Timm Date
Area Manager