GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 21, 2022

Anthony Parker
New Hope Assisted Living, LLC
702 E. Remus Road
Mt. Pleasant, MI 48858

RE: License #: AM370304806
Investigation #: 2023A1029003
New Hope Assisted Living, LLC

Dear Mr. Parker:

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 (231) 922-5309.

Sincerely,

Jennifer Browning

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
Browningj1@michigan.gov - (989) 444-9614

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM370304806
Investigation #:	2023A1029003
Complaint Receipt Date:	10/26/2022
Investigation Initiation Date:	10/27/2022
Report Due Date:	12/25/2022
Licensee Name:	New Hope Assisted Living, LLC
Licensee Address:	702 E. Remus Road Mt. Pleasant, MI 48858
Licensee Telephone #:	(989) 621-2677
Administrator:	Anthony Parker
Licensee Designee:	Anthony Parker
Name of Facility:	New Hope Assisted Living, LLC
Facility Address:	702 E. Remus Road Mt. Pleasant, MI 48858
Facility Telephone #:	(989) 779-1477
Original Issuance Date:	04/03/2012
License Status:	REGULAR
Effective Date:	09/24/2022
Expiration Date:	09/23/2024
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive adequate care at New Hope Assisted Living before he passed away on October 10, 2022.	No
Additional Findings	Yes

III. METHODOLOGY

10/26/2022	Special Investigation Intake 2023A1029003
10/26/2022	APS Referral not required as this was a denied APS referral
10/27/2022	Special Investigation Initiated – Telephone to Relative A1
10/27/2022	Contact - Telephone call received from Guardian A1
11/04/2022	Contact - Telephone call made to Careline Health Group
11/04/2022	Inspection Completed On-site – face to face with direct care staff members Destiny Lake, Abby Parker, Jenny Sehl, Laura Lynn Bellinger and spoke with licensee designee Anthony Parker on the phone.
11/16/2022	Contact - Telephone call made Patty Rohn, Regional Clinical Manager
11/17/2022	Contact - Telephone call made to Stacey Smith, RN administrator Careline Hospice
12/01/2022	Contact - Telephone call made to Detective Sergeant Fall from the Isabella County Sheriff's Office and reviewed police report.
12/15/2022	Contact – Email to Mr. Parker requesting clarification
12/16/2022	Contact – Email from Mr. Parker
12/16/2022	Exit conference with Licensee designee Mr. Parker.

ALLEGATION:

Resident A did not receive adequate care at New Hope Assisted Living before he passed away on October 10, 2022.

INVESTIGATION:

On October 26, 2022, a complaint was received from a denied adult protective services referral from Centralized Intake. The complaint alleged Resident A was not given an antiviral treatment which was ordered, had a fall, and a bed sore all leading to him passing away on October 10, 2022, at New Hope Assisted Living. These were the reasons given for Resident A not receiving adequate care while living at the facility.

On October 27, 2022, I interviewed Guardian A1 who stated she asked licensee designee Anthony Parker for Resident A to have an antiviral medication because he was diagnosed with COVID-19. Guardian A1 stated Mr. Parker called her the day the COVID-19 outbreak started and told her Resident A would receive the antiviral medication. Guardian A1 stated Resident A was residing at New Hope Assisted Living because he had vascular dementia. Guardian A1 stated on September 28, 2022, the COVID-19 restrictions were lifted at New Hope Assisted Living and shortly after an unknown nurse from hospice let her know Resident A was not rallying and his condition had worsened. Guardian A1 stated she spoke with Mackenzie McMann, RN from Careline Hospice, who she said Resident A did not get the antiviral medication. Guardian A1 also stated Resident A also had a terrible fall on an unknown date. Guardian A1 stated she went to visit the facility on October 5, 2022 and she was surprised by the decline in Resident A's health. Guardian A1 stated she noticed when she was at New Hope Assisted Living Resident A was wincing in pain even though he was not one to complain of pain. Guardian A1 also noticed Resident A was sitting in his brief for several hours and the smell was so bad that she had to open the window in his room. Guardian A1 stated Resident A did not receive the oxygen he should have had because he had COVID-19 but he did receive morphine starting on October 5, 2022, which was prescribed by hospice.

On November 4, 2022, I completed an unannounced investigation at New Hope Assisted Living and interviewed direct care staff member, Destiny Lake. While at the facility, I reviewed Resident A's resident record. According to Resident A's *Assessment Plan for AFC Residents* from Resident A's 2018 admission, Resident A needed assistance with the following tasks: eating and feeding, toileting, bathing, grooming, dressing, administering medications, and has some physical limitations. This was the most recent *Assessment Plan for AFC Residents* in the resident record.

Ms. Lake stated Resident A did not receive the antiviral medication. Ms. Lake stated Resident A would have received this medication if it was prescribed from Careline Hospice as a faxed physicians order. I also reviewed orders from Medline who provided supplies to Resident A. I also reviewed the medication listing which confirmed that

Resident A did have Oxygen O2 – Nasal Cannula available to him as a PRN. I did not observe any order from Careline Hospice for any antiviral treatment while Resident A had COVID-19. The only order regarding an open sore was from August 3, 2022, regarding how to provide care to an open sore on his great toe where Resident A had bloody drainage and to cleanse with wound cleanser and wrap with Kerlix daily.

Ms. Lake stated Resident A was diagnosed with COVID-19 but was testing negative before he passed away. Ms. Lake stated Resident A's health was declining for a period of time before he passed but especially the last few weeks when he was noticeably weaker Ms. Lake stated Resident A did have a fall a few weeks before he passed away. Ms. Lake stated Resident A was found on his stomach on the floor. Ms. Lake stated Careline Hospice was contacted and that is when they ordered the lift. Ms. Lake stated Resident A never went under his bed from any fall because his bed was not high enough for him to go under. Ms. Lake stated Careline Hospice evaluated Resident A after his fall and assisted Ms. Lake to get him off the floor. Ms. Lake stated Careline Hospice found that Resident A incurred any severe injuries from the fall and did not have any concerns. I reviewed a communication log from October 3, 2022, which provided the same details from this incident.

Ms. Lake stated direct care staff members provided medications, blood sugar checks, distributed morphine, changed his briefs and checked him every two hours. Ms. Lake stated the direct care staff members used to take Resident A into the bathroom but toward the end of his life, Resident A was toileted in his bed due to his increased need for assistance and increased number of bowel movements. Ms. Lake stated she did not recall a time where Resident A went several hours without personal care provided or that she noticed a window needed to be opened due to smells in his room.

On November 4, 2022 I interviewed direct care staff member Jenny Sehl at New Hope Assisted Living. Ms. Sehl stated the direct care staff members were responsible for changing Resident A's briefs, administering comfort medications, repositioning him, changing his bed, and giving him Ensure shakes. Ms. Sehl stated the direct care staff members were very concerned because they knew they would lose him soon and hospice services were started through Careline Hospice. Ms. Sehl stated there was an off and on decline for a few months before he passed away. Ms. Sehl stated Resident A tested positive for COVID-19 and had it for a few weeks but he was not doing well before contracting COVID-19. Ms. Sehl confirmed Careline Hospice was already involved in his care due to his health declining before Resident A contracted COVID-19. Ms. Sehl stated she did not know if he was on a schedule for changing his briefs because he could be "stubborn and combative." Ms. Sehl stated he was also not willing to take a shower and protested about this personal task until the end of his life. Ms. Sehl stated before he passed away sometimes the room had a smell because Resident A refused a brief change or to take a shower. Ms. Sehl also stated if Resident A wanted to, he could have changed his own brief but he also refused to do so.

While at the facility, licensee designee Anthony Parker called the facility, so I was able to interview him at that time. I spoke with Mr. Parker who stated Sergeant Douglas Fall

from the Isabella County Sheriff's Department was at the facility asking about Resident A's passing so he was not surprised I was also there. Mr. Parker stated he showed Detective Sergeant Fall copies of Resident A's medication administration record (MAR) to verify Resident A did not receive any antiviral treatment for COVID-19 because Careline Hospice did not order it. Mr. Parker further stated Careline Hospice decided it would not benefit Resident A because he did not have a lot of symptoms. Mr. Parker stated two weeks before Resident A passed away, he tested negative for COVID-19. Mr. Parker stated he started hospice services about two months before he contracted COVID-19 and his health was declining. Mr. Parker said Resident A was showing more agitation and Resident A was prescribed Ativan to lessen these behaviors.

Mr. Parker stated Resident A did not receive a breathing treatment or anti-viral medication because he did not receive a physician's order from Careline Hospice. Mr. Parker stated Resident A did have an oxygen concentrator in his room, but he would not use it, said he did not want it, and then eventually yanked it off his face. Mr. Parker stated Careline Hospice was there every day with Resident A the last few days of his life.

On November 16, 2022, I interviewed Careline - Regional Clinical Manager Patty Rohn. Ms. Rohn stated Resident A was not testing positive at the time he passed away. Ms. Rohn stated COVID was on the death certificate because he had it for thirty days prior to him passing. Ms. Rohn stated his primary RN was Mackenzie McCann who was at the facility often and never expressed concerns regarding Resident A's care. Ms. Rohn stated Resident A was already toward the end of life and him receiving the anti-viral medication would not have improved his condition. Ms. Rohn stated she has been to the facility and Mr. Parker is "hands on and there were no concerns." Ms. Rohn stated she was not aware of Resident A having an anti-viral treatment and was not aware of any issues regarding the direct care staff members not providing necessary personal care to Resident A.

On November 17, 2022, I contacted Careline Hospice administrator, Stacey Smith, RN. RN Smith stated Resident A had no signs or symptoms of respiratory distress so a nebulizer would not be ordered. RN Smith stated oxygen was available for Resident A to use but he often refused it and took it off. The oxygen was delivered to the facility at the start of care and was prescribed as a PRN. RN Smith stated Resident A started care with Careline Hospice on March 25, 2022, due to being diagnosed with hypertension and vascular dementia and originally Resident A was started on Hospice for extra services until it was determined Resident A had a terminal diagnosis of six months or less. RN Smith stated there was no antiviral treatment ordered or provided through Careline Hospice. RN Smith stated she was not aware of any bed sores on Resident A. RN Smith stated there were no concerns regarding the care in the facility and Resident A had some agitation and there were repeated attempts to provide personal care as they could. RN Smith stated she spoke with RN McCann during the time Careline Hospice provided care and RN McCann did not have any concerns regarding the care provided to Resident A before he passed.

On December 1, 2022, I interviewed Detective Sergeant Fall from the Isabella County Sheriff's Office. Detective Sergeant Fall stated Central Dispatch received a referral from adult protective services regarding Resident A not receiving proper care at New Hope Assisted Living. Detective Sergeant Fall stated he went to New Hope Assisted Living and talked with licensee designee Mr. Parker regarding Resident A. Detective Sergeant Fall stated he did not find any concerns regarding the care provided to Resident A prior to his death and stated Mr. Parker had a lengthy file regarding Resident A for him to review. Mr. Parker was able to provide detailed accounts regarding Resident A's care. I reviewed the police report for Incident 22-002640 and there was no call history for New Hope Assisted Living for a death investigation or medical examiner on October 10, 2022. According to the report, Mr. Parker told Detective Sergeant Fall Resident A's health was declining, he contracted COVID-19 in September 2022, and he remained in his room while receiving care. According to the police report I reviewed, Resident A deteriorated further and was not getting out of bed or eating often. Detective Sergeant Fall reviewed the medication administration record and Resident A was refusing to take his routine medications and mid-September Careline Hospice decided to discontinue these medications and continue with only comfort medications. According to the police report and information gathered by Detective Sergeant Fall, he did not receive any antiviral treatment because Careline Hospice was no longer providing routine medication to him at this time other than comfort medications. Detective Sergeant Fall noted no further concerns and closed his case.

APPLICABLE RULE	
R 400.14303	**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:	There was no indication Resident A was not provided supervision, protection, and personal care according to the *Assessment Plan for AFC Residents* prior to his death. According to interviews with Careline Hospice providers, RN Smith and Ms. Rohn, there were no concerns with the quality of care provided by New Hope Assisted Living direct care staff members. Both providers confirmed Resident A's health was declining which led to him passing. Resident A did not receive the antiviral treatment while at New Hope Assisted Living as it was not ordered by a physician however Ms. Rohn stated Resident A was already toward the end of life and him receiving the anti-viral medication would not have improved his condition. Resident A received care for one open sore on his toe in August 2022, but hospice providers noted no concerns regarding this care nor after the fall Resident A experienced in early October 2022.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On November 4, 2022, I completed an unannounced onsite investigation at New Hope Assisted Living. Ms. Parker stated she was not sure if an Incident Report was submitted to the licensing division when Resident A passed away. Upon review of Resident A's resident record, there was not a copy of the *Incident / Accident Report* to show one was completed.

Based on the information obtained during the investigation, reviewing the facility file, and from my own observations an *Incident / Accident Report* was not submitted to the division within the required 48 hours. Mr. Parker was able to provide an *Incident / Accident Report* for review which was completed by direct care staff member, Emily Grimlich, on October 10, 2022, however this was not forwarded to the division for review. Mr. Parker stated he did not send the *Incident / Accident Report* to the licensing division because he thought Careline Hospice would notify licensing.

APPLICABLE RULE	
R 400.14311	**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: **(a) The death of a resident.**
ANALYSIS:	Based on the information obtained during the investigation, reviewing the facility file, and from my own observations an *Incident / Accident Report* was not submitted to the division within the required 48 hours. Mr. Parker stated he did not send the *Incident / Accident Report* because he thought Careline Hospice would send the notification of Resident A's passing.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On November 4, 2022, I completed an unannounced onsite investigation at New Hope Assisted Living. Ms. Parker stated she was not sure if there was an updated *Assessment Plan for AFC Residents* for Resident A but thought it may have been filed away after he passed. Upon review of Resident A's resident record, there was not a copy of the *Assessment Plan for AFC Residents* to show one was completed in 2021 or 2022. The most recent *Assessment Plan for AFC Residents* provided for Resident A was from 2018.

APPLICABLE RULE	
R 400.14301	**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:	Based on the information obtained during the investigation, reviewing the facility file, and from my own observations licensee designee Mr. Parker was not able to provide documentation of Resident A's *Assessment Plan for AFC Residents* for 2020 or 2021.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change in the license status.

Jennifer Browning _____12/19/2022_____

Jennifer Browning
Licensing Consultant

Date

Approved By:

Dawn Timm 12/21/2022

_____

Dawn N. Timm
Area Manager

Date