GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 5, 2023

Rebecca Eagle
Monark Grove Clarkston
7373 Sashabaw Rd.
Clarkston, MI 48348

RE: License #: AH630413772
Investigation #: 2023A1027044
Monark Grove Clarkston

Dear Ms. Eagle:

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 authorized representative 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) 241-1970.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630413772
Investigation #:	2023A1027044
Complaint Receipt Date:	02/21/2023
Investigation Initiation Date:	02/24/2023
Report Due Date:	04/23/2023
Licensee Name:	Clarkston Senior Living LLC
Licensee Address:	Ste 200 101 W. Big Beaver Road Troy, MI 48084
Licensee Telephone #:	(248) 680-7180
Administrator/ Authorized Representative:	Rebecca Eagle
Name of Facility:	Monark Grove Clarkston
Facility Address:	7373 Sashabaw Rd. Clarkston, MI 48348
Facility Telephone #:	(248) 954-1006
Original Issuance Date:	12/22/2022
License Status:	TEMPORARY
Effective Date:	12/22/2022
Expiration Date:	06/21/2023
Capacity:	83
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A had not received her medications as prescribed.	Yes
The narcotics were incorrect.	Yes
The call light response times were extended. There were no protocols for falls or emergencies.	No
Staff lacked Tuberculosis (TB) testing.	Yes
Staff lacked training prior to working the floor.	No
Additional Findings	Yes

The complaint alleged staff lacked fingerprinting prior to working the floor which was investigated in Special Investigation Report 2023A1027033.

III. METHODOLOGY

02/21/2023	Special Investigation Intake 2023A1027044
02/24/2023	Special Investigation Initiated - On Site
03/01/2023	Contact - Document Sent Email sent to Ms. Eagle inquiring about documentation/information requested at on-site inspection on 2/24/2023
03/02/2023	Contact - Document Received Email received from Ms. Eagle with requested information and documentation
03/03/2023	Inspection Completed-BCAL Sub. Compliance
03/03/2023	Contact – Document Sent Email sent to Ms. Eagle
03/06/2023	Contact – Document Received Additional information received by email from Ms. Eagle
03/09/2023	Exit Conference Conducted by voicemail with authorized representative Ms. Eagle

ALLEGATION:

Resident A had not received her medications as prescribed.

INVESTIGATION:

On 2/21/2023, the Department received a complaint through the online complaint system which alleged Resident A had not received her medications as prescribed.

On 2/24/2023, I conducted an on-site inspection at the facility. I interviewed Employee #1 who stated Resident A's medications were maintained in the second-floor medication cart after her death. I observed Resident A's medications in the medication cart and noted each medication.

I reviewed Resident A's January 2023 medication administration records which read consistent with each noted medication in the medication cart. The MARs read staff initialed Resident A's medications as administered or an abbreviation was utilized along with note as to why the medication was not administered. For example, Resident A's MARs read abbreviations of "*DNG"* which meant drug not given, "REF" which meant resident refused, and "DC" which meant discontinued order. Additionally, Resident A's MARs read some medication doses were not initialed nor was an abbreviation utilized and instead had a dash in that space. For example, the following medications for one or more doses on the following dates had a dash in the space for administration:

Cephalexin: 1/27/2023, 1/29/2023, 1/30/2023
Lactulose: 1/7/2023, 1/8/2023, 1/27/2023, 1/28/2023, 1/29/2023
Amlodipine: 1/28/2023
Cetirizine: 1/28/2023
Eliquis: 1/7/203, 1/8/2023, 1/27/2023
Famotidine: 1/28/2023
Furosemide: 1/27/2023, 1/28/2023
Levothyroxin: 1/28/2023
Lorazepam: 1/27/2023, 1/30/2023, 1/31/2023
Ondansetron: 1/24/2023, 1/25/2023, 1/29/2023, 1/30/2023, 1/31/2023
Potassium Chloride: 1/27/2023, 1/28/2023
Senna-S: 1/18/2023, 1/19/2023, 1/27/2023, 1/28/2023
Zolpidem: 1/20/2023, 1/27/2023, 1/29/2023

On 3/6/2023, email correspondence from Ms. Eagle read the dashes on the MAR meant those medications were not documented.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	Review of Resident A's medical records revealed the facility was responsible for administration of her medications. Review of Resident A's MARs revealed she had not always received her mediations as prescribed by her health care professionals; thus, a violation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The narcotics were incorrect.

INVESTIGATION:

On 2/21/2023, the Department received a complaint through the online complaint system which alleged the narcotics were "*messed up*."

On 2/24/2023, I conducted an on-site inspection at the facility. I interviewed Employee #1 who stated Resident A's narcotics were maintained in the medication after her death. Employee #1 and I counted each of Resident A's narcotic medications which corresponded accurately to the narcotic count sheets in the narcotic count book. It was observed Resident A had one syringe of morphine sulfate in which Employee #1 stated the rest of the syringes were in the director of nursing's office.

While on-site, Employee #1 and I conducted a narcotic count of the second-floor medication cart in which the total narcotic count for the medication blister packs/bottles was 12 but the shift-to-shift narcotic count sheet read 11. Employee #1 and I conducted a second count of the narcotics in which was consistent with a count of 12. The second-floor shift to shift narcotic count read Employee #1 and the previous employee on duty had signed off as completing the narcotic count, however the task was incomplete as the total number of medications was not written on it. Additionally, all previous staff had documented the narcotic count as 11.

While on-site, Employee #1 and I conducted a narcotic count of the first-floor medication cart. I observed Resident D's narcotic blister pack for Zolpidem had six pills while the narcotic count sheet read seven. I observed Resident E's narcotic blister pack for Clonazepam had 36 pills while the narcotic count sheet read 38. The

controlled medication sign-out sheet read there were 10 total narcotic medication blister packs/bottles maintained in the cart.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(5) A home shall take reasonable precautions to ensure or assure that prescription medication is not used by a person other than the resident for whom the medication is prescribed.
ANALYSIS:	Employee #1 stated each shift the narcotic medication blister packs/bottles were counted then each individual medication was counted. Employee #1 stated both counts were documented in the narcotic count book for each medication cart. Observations revealed the narcotic counts were incorrect for the total count as well as individual count of some medications. Based on this information, there was a violation substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The call light response times were extended. There were no protocols for falls or emergencies.

INVESTIGATION:

On 2/21/2023, the Department received a complaint through the online complaint system which alleged there were extended call light response times. The complaint alleged there were no protocols for falls or emergencies.

On 2/24/2023, I conducted an on-site inspection at the facility. I interviewed executive director Becky Howard who stated resident's pendants and pull cords were linked to the staff's iPhone and the computer at the concierge front desk. Ms. Howard stated staff were trained to respond to the call light system as soon as possible.

While on-site, I interviewed administrator Rebecca Eagle who statements were consistent with Ms. Howard. Ms. Eagle stated they did not have call light response reports nor a call light response policy. Ms. Howard provided the emergency binder for review in which staff were trained.

While on-site, I interviewed Employee #1 whose statements were consistent with Ms. Howard and Ms. Eagle.

While on-site, I reviewed the facility's emergency binder which read in part under *Emergency Policy*, all employees will be trained in emergency procedures upon hire and annually. The binder read in part under Medical Emergency, anytime a person hits their head due to falling or tripping, impact with an object or other serious head injury they must immediately receive medical treatment via responsible party or ambulance. The policy read in part staff were to provide the ambulance team with the resident's medical records and medication records. The policy read in part staff were to contact management and complete an incident report. The policy read in part management would contact the responsible parties and agencies, as well as report to the Department as applicable.

While on-site, I reviewed Employee #2, #3 and #4's files which read they had received training on safety and fire prevention as well as personal care protection.

While on-site, I interviewed Residents B and C, who both stated staff responded "pretty quickly" when their pendants were pushed.

While on-site, I observed staff had responded to call lights in a timely manner.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	Observations at the facility revealed assisted living residents were provided a pendant as well as had emergency pull cords located in their apartments in which summoned staff through iPhones and the call system at the concierge desk. Additionally, the emergency binder was maintained at the concierge desk for staff. Staff and resident attestations, along with observations and review of documentation revealed there was lack of evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff lacked Tuberculosis (TB) testing.

INVESTIGATION:

On 2/21/2023, the Department received a complaint through the online complaint system which alleged staff lacked TB testing.

On 2/24/2023, I conducted an on-site inspection at the facility and interviewed Ms. Eagle who stated some staff worked in the attached independent living prior to the licensed home for the aged (HFA). Ms. Eagle stated the employees HFA hire dates were not located in their file and would need to provide them.

While on-site, I reviewed three employee files:

Employee #2's file read he had received his TB test on 1/25/2023 and it was read on 1/28/2023, as well as second test on 2/3/2023 which was read on 2/7/2023.

Employee #3's file read she received her TB test on 10/7/2022 and it was read on 10/10/2022.

Employee #4's file read she received her TB test on 1/25/2023 and it was read on 1/27/2023.

On 3/2/2023 email correspondence with Ms. Eagle read each employee's date of hire within the licensed home for the aged (HFA): Employee #2 was 1/5/2023, Employee #3 was 1/1/2023, and Employee #4 was 1/2/2023.

I reviewed the January 2023 schedule read Employee #2 worked from 7:00 AM to 3:00 PM from 1/5/2023 through 1/8/2023, then 1/10/2023 through 1/13/2023. The schedule read Employee #3 trained on 1/1/2023, then worked 11:00 PM to 7:00 AM on 1/2/2023, 1/4/2023, and 1/6/2023, as well as 1/9/2023 through 1/11/2023. The schedule read Employee #4 worked from 7:00 AM to 3:00 PM on 1/2/2023 through 1/4/2023, 1/7/2023, 1/12/2023 and 1/13/2023.

APPLICABLE RULE	
R 325.1923	**Employee's health.**
	(2) A home shall provide initial tuberculosis screening at no cost for its employees. New employees shall be screened within 10 days of hire and before occupational exposure. The screening type and frequency of routine tuberculosis (TB) testing shall be determined by a risk assessment as described in the 2005 MMWR ?Guidelines for Preventing the Transmission of Mycobacterium

	tuberculosis in Health-Care Settings, 2005? (http://www.cdc.gov/mmwr/pdf/rr/rr5417.pdf), Appendices B and C, and any subsequent guidelines as published by the centers for disease control and prevention. Each home, and each location or venue of care, if a home provides care at multiple locations, shall complete a risk assessment annually. Homes that are low risk do not need to conduct annual TB testing for employees.
ANALYSIS:	Review of three employee files revealed TB screenings were completed. However, Employee #2 and #4's TB screenings were completed after their date of hire in which the January 2023 schedule, as well as their training records, revealed they had worked on the floor with residents. Employee #3's TB screening was not within 10 days of hire and prior to occupational exposure based on his HFA hire date of 1/1/2023. Thus, this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff lacked training prior to working the floor.

INVESTIGATION:

On 2/21/2023, the Department received a complaint through the online complaint system which alleged staff lacked training prior to working the floor.

On 2/24/2023, I conducted an on-site inspection and interviewed with Ms. Eagle who stated some staff worked in the attached independent living prior to the licensed home for the aged (HFA).

While on-site, I interviewed Employee #1 who stated the HFA was delayed in opening however she had received medication training prior to working the floor, as well as training through Michigan Assisted Living Association (MALA).

While on-site, I reviewed three employee files:

Employee #2's file read he received training on 1/2/2023 for safety and fire prevention training, resident rights, prevention and containment of communicable disease, reporting requirements, introduction to pain management, personal care protection and supervision. The file read he received medication administration training on 1/25/2023 and a medication skills checklist on 2/3/2023.

Employee #3's file read she received training on 10/25/2022 for dementia care skills and dementia care provision. The file read on 12/20/2022 she received training for safety and fire prevention training, resident rights, introduction to pain management, personal care protection and supervision. The file read she received medication administration training on 12/12/2022 and a medication skills checklist on 1/2/2023.

Employee #4's file read she received training on 11/21/2022 for safety and fire prevention, reporting requirements, resident rights, personal care, and introduction to pain management. The file read she received medication administration training on 12/12/2022 and a medication skills checklist on 1/27/2023.

On 3/2/2023 email correspondence with Ms. Eagle read each employee's date of hire within the licensed home for the aged (HFA): Employee #2 was 1/5/2023, Employee #3 was 1/1/2023, and Employee #4 was 1/2/2023.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following: **(a) Reporting requirements and documentation.** **(b) First aid and/or medication, if any.** **(c) Personal care.** **(d) Resident rights and responsibilities.** **(e) Safety and fire prevention.** **(f) Containment of infectious disease and standard precautions.** **(g) Medication administration, if applicable.**
ANALYSIS:	Review of employee files revealed training was completed prior to their working in the licensed HFA. Based on this information, this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of Resident A's face sheet revealed it lacked information in compliance with the rule including her emergency contact's address, licensed health professional

address and phone number, and date of discharge. Additionally, the face sheet read under resident status “moved out,” however Resident A had passed away at the facility on 1/30/2023.

APPLICABLE RULE	
R 325.1942	**Resident records.**
	(3) The resident record shall include at least all of the following: **(a) Identifying information, including name, marital status, date of birth, and gender.** **(b) Name, address, and telephone number of next of kin or authorized representative, if any.** **(c) Name, address, and telephone number of person or agency responsible for the resident's maintenance and care in the home.** **(d) Date of admission.** **(e) Date of discharge, reason for discharge, and place to which resident was discharged, if known.** **(f) Health information, as required by MCL 333.20175(1), and other health information needed to meet the resident's service plan.** **(g) Name, address, and telephone number of resident's licensed health care professional.** **(h) The resident's service plan.**
ANALYSIS:	Resident A’s face sheet was not in compliance with this rule; thus, a violation was established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective plan, I recommend the status of this license remain unchanged.

03/07/2023

Jessica Rogers Date
Licensing Staff

Approved By:

03/07/2023

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Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section