GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 22, 2023

Shawn Brown
Domel Inc
Suite 112
39293 Plymouth Road
Livonia, MI 48150

RE: License #: AS820069350
Investigation #: 2023A0992014
Domel Belton II

Dear Mr. Brown:

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 (313) 456-0380.

Sincerely,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 300-9922

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820069350
Investigation #:	2023A0992014
Complaint Receipt Date:	01/30/2023
Investigation Initiation Date:	01/31/2023
Report Due Date:	03/31/2023
Licensee Name:	Domel Inc
Licensee Address:	Suite 112 39293 Plymouth Road Livonia, MI 48150
Licensee Telephone #:	(734) 632-0125
Administrator:	Shawn Brown
Licensee Designee:	Shawn Brown
Name of Facility:	Domel Belton II
Facility Address:	18499 Grimm Livonia, MI 48152
Facility Telephone #:	(248) 478-7918
Original Issuance Date:	02/22/1996
License Status:	REGULAR
Effective Date:	08/25/2022
Expiration Date:	08/24/2024
Capacity:	4
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A experienced a significant change in mental status and was transported to the hospital. It is suspected that he had a seizure. There is concern the staff failed to notice or address the change in Resident A's mental status.	No
Additional Findings	Yes

III. METHODOLOGY

01/30/2023	Special Investigation Intake 2023A0992014
01/30/2023	APS Referral Denied
01/31/2023	Special Investigation Initiated - Telephone Madelyn Board, Resident A's Supports Coordinator with Community Living Services (CLS)
01/31/2023	Contact - Telephone call made Machelle Clark, home manager
01/31/2023	Contact - Telephone call made Guardian A
02/01/2023	Contact - Telephone call received Voicemail received from Guardian A
02/03/2023	Contact - Telephone call made Ms. Clark
02/03/2023	Contact - Telephone call made Guardian A
02/09/2023	Inspection Completed On-site Kara Kenney, direct care staff (DCS); Berrnice Marchwinski, DCS and Resident A.
02/10/2023	Contact - Telephone call made Ms. Clark

02/10/2023	Contact - Telephone call made Shawn Brown, licensee designee was not available. Message left.
02/10/2023	Contact - Telephone call received Mr. Brown
02/10/2023	Contact - Telephone call made Marsha Cain, DCS
02/22/2023	Contact - Telephone call received Guardian A
03/09/2023	Contact - Telephone call made Normita Vicencio, MD, Resident A's primary care physician. Not available. Only work Mon-Tues. No message left.
03/13/2023	Contact - Telephone call made Message left for Dr. Vicencio
03/13/2023	Contact - Document Sent Medical record request sent to MRO Beaumont Hospital Farmington Hills
03/13/2023	Contact - Telephone call received Normita Vicencio
03/13/2023	Contact - Telephone call made Guardian B
03/15/2023	Referral - Recipient Rights
03/15/2023	Exit Conference Mr. Brown was not available. Message left.
03/15/2023	Contact - Telephone call received Mr. Brown

ALLEGATION: Resident A experienced a significant change in mental status and was transported to the hospital. It is suspected that he had a seizure. There is concern the staff failed to notice or address the change in Resident A's mental status.

INVESTIGATION: On 01/31/2023, I contacted Madelyn Board, Resident A's Supports Coordinator with Community Living Services (CLS) regarding the reported

allegations. Ms. Board said she was contacted by Resident A's guardian and made aware he was hospitalized due to a sudden change in his mental status. Ms. Board said Resident A was hospitalized and discharged on 01/30/2023 with in-home health care. She said Resident A's guardians are concerned that the staff on shift failed to notice or address the sudden change in Resident A's mental status. Ms. Board said she last visited with Resident A on 01/04/2023. She said he is semi-independent as it pertains to his activities of daily living (ADL) and has limited verbal skills.

On 01/31/2023, I contacted Machelle Clark, home manager, and interviewed her regarding the allegations. Prior to addressing the allegations, Ms. Clark provided some insight regarding Resident A's needs and behaviors. She said Resident A is semi-independent as it pertains to his ADLs and requires very little redirection. She said during wake hours he toilets himself but throughout the night, he requires reminders and verbal prompting. Ms. Clark said sometimes Resident A has incontinence issues despite being reminded nightly. She said this has been his ongoing routine since he was admitted into the home in 11/2022. As it pertains to the allegations, Ms. Clark said she was not present at the time the incident occurred, but has since spoken with Marsha Cain, direct care staff that was on shift. She said Ms. Cain administered Resident A's p.m. medications and he went to bed as normal. She said Guardian B arrived for visitation and although Resident A was asleep, he decided to wake him up. Ms. Clark said according to Ms. Cain, Guardian B said something was not right and that there was a significant change in Resident A's mental status; she said Guardian B called Guardian A. Ms. Clark said Ms. Cain stated both guardians insisted Resident A be transported to the hospital, so Ms. Cain called 911. Ms. Clark said Resident A was kept for observation and discharged back to the home on 01/30/2023.

On 01/31/2023, I contacted Guardian A, Resident A's guardian and interviewed her regarding the allegations. Guardian A confirmed the allegations and made me aware she was just leaving Resident A's follow-up doctors appointment. Guardian A said Resident A possibly experienced a seizure, but the medical professionals are unable to pinpoint what caused the sudden change in his mental status. Guardian A made me aware that Resident A was currently with her, and she would prefer to call me back to further address the allegations.

On 02/03/2023, I made follow-up contact with Ms. Clark regarding Resident A. Ms. Clark made me aware that Resident A had a follow-up doctor's appointment with his primary care physician, and he was accompanied by Guardian A. She said Guardian A transports him to all medical appointments. Ms. Clark said based on the consultation form, it is not definitive that Resident A had a seizure. She said there were some changes made to his medications. She said blood pressure medications were discontinued, and he was prescribed medication for his cholesterol. She said the doctor did not authorize in-home health care. Ms. Clark said Resident A has been doing well since he returned to the home.

On 02/03/2023, I contacted Guardian A and interviewed her regarding the allegations. Guardian A expressed concerns regarding the level of care Resident A is receiving at the home. She further explained that Guardian B was visiting with Resident A and stated he was exhibiting abnormal behaviors and was incoherent. She said Guardian B contacted her and made her aware of Resident A's condition, so she stayed on the telephone while in route to the home. Guardian A said when she arrived Resident A's mouth was crooked, and he was in and out of consciousness. She said she insisted the staff call 911 and the emergency medical services (EMS) arrived. She said the emergency medical technicians (EMTs) assessed him and they did not appear to be moving with a sense of urgency. Guardian A said Resident A was transported to Beaumont Hospital Farmington Hills and examined. Guardian A said the physicians were unable to determine the underlying issue and Resident A was referred to a heart specialist, which she doesn't agree with doctors' medical opinion. She said she believes Resident A needs occupational therapy and physical therapy, as well as in-home health care but the doctors did not authorize the requested services. Guardian A is adamant Resident A experienced a stroke or similar because his mouth appeared to be crooked. I explained the investigation process to Guardian A and agreed to update her upon completion of the investigation.

On 02/09/2023, I completed an unannounced onsite inspection and interviewed Kara Kenney, direct care staff (DCS); Berrnice Marchwinski, DCS and observed Resident A. Ms. Kenney said she was not on shift when the incident occurred, but she is aware, Resident A was transported to the hospital due to abnormal behavior when his guardian arrived. Ms. Kenney said she typically works midnights, and she has not observed Resident A demonstrating any abnormal behaviors. She said she prompt him to go to the bathroom during the night and even though she reminds him, he still soils himself. Ms. Kenney said it could be contributed to deep sleep, but it happens regularly. I requested to review Resident A's hospital discharge documents and follow-up consultation. According to the hospital discharge documents, Resident A was treated for "toxic metabolic encephalopathy" (TME) a condition of acute global cerebral dysfunction manifested by altered consciousness, behavior changes, and/or seizures in the absence of primary structural brain disease or direct central nervous system; sinus bradycardia with first-degree atrioventricular block condition delay; elevated serum creatinine; lymphopenia; hypokalemia and D-dimer, elevated. It also indicated Resident A's medications were changed; his Clonidine (Catapres) was discontinued and he was prescribed Atorvastatin (Lipitor). As it pertains to after care instructions, Resident A was instructed to pick up medications from the identified pharmacy and follow-up with his primary care physician. I attempted to review Resident A's consultation form from his follow-up doctor's appointment on 01/31/2023 with Dr. Normita Vicencio but it was not legible.

Berrnice Marchwinski, DCS said she was not on shift when the incident occurred, but she is aware, Resident A was transported to the hospital. Ms. Marchwinski said she is typically on shift during the afternoon, she denied Resident A has ever demonstrated any sudden change in mental status to her knowledge.

I observed Resident A, he appeared to be clean and adequately dressed. He has limited verbal skills and was not interviewed. I observed him eating lunch, gesturing to the DCS to communicate, and watching television. Resident A did not show any obvious signs of distress, he appeared to be doing well.

On 02/10/2023, I received a call from Shawn Brown, licensee designee. Mr. Brown made me aware that he was previously made aware of the allegations by Marsha Cain, DCS. He said from his understanding the guardians arrived and insisted Resident A be transported to the hospital because he appeared to be incoherent. He said Ms. Cain notified Ms. Clark and called 911. He said from his understanding, the EMT did not feel as though Resident A required additional medical treatment, but Guardians A and B insisted. I made Mr. Brown aware that I will follow-up with him upon completion of the investigation to conduct an exit conference. Mr. Brown denied having any questions at this time.

On 02/10/2023, I contacted Marsha Cain, DCS and interviewed her regarding the allegations. Ms. Cain said she administered Resident A's two oral medications at 7:00 p.m. and he started getting ready for bed around 7:30 p.m. Ms. Cain said she checked on him around 7:45 p.m. and he was resting. Ms. Cain said at approximately 8:00 p.m. Guardian B arrived and wanted to visit with Resident A. She said she made him aware that Resident A was sleeping but he said he would wake him up and he proceeded to do so. Ms. Cain said Guardian B said something was noticeably wrong with Resident A because he was not responding. Ms. Cain said Guardian B became upset and started using foul language towards her and he called Guardian A. Ms. Cain said Guardian A arrived and she demanded Resident A be transported to the hospital to be examined. Ms. Cain said she called 911 and Resident A was transported to the hospital. She said in her opinion, Resident A appeared to be groggy because he was awakened out of his sleep.

On 03/13/2023, I received a telephone call from Normita Vicencio, MD, Resident A's primary care physician. I explained the nature of the investigation and referenced Resident A's visit to the emergency department, follow-up doctor's appointment and consultation form she completed on 01/31/2023. Dr. Vicencio confirmed Resident A did attend a follow-up appointment with her on 01/31/2023 once he was discharged from the hospital. I asked if she could explain her findings, diagnosis and recommendation written on the consultation form. Dr. Vicencio stated Resident A was examined in the emergency department because he appeared to be dazed and lethargic. She said several tests were completed at the hospital, all of which were negative and unable to confirm he had a seizure. Dr. Vicencio said Resident A has a history of seizure many many years ago, so it is possible he experienced a seizure, but it is not definitive. Dr. Vicencio said as a preventative he was given a low dose of

anti-seizure medication and referred to the urologist. Dr. Vicencio said Resident A did follow-up with the urologist and the urologist did not indicate Resident A suffered a seizure.

On 03/13/2023, I contacted Guardian B and interviewed him regarding the allegations. Guardian B said he arrived to visit Resident B and Ms. Cain made him aware that Resident A was asleep. Guardian B said he decided to wake him up. Guardian B said when he entered his room, he tried to wake Resident A up, but he did not respond. Guardian B said Resident A's body was limp. Guardian B said he immediately notified the staff and asked her if she noticed Resident A's condition. Guardian B said Ms. Cain said she administered Resident A's evening medications, and he went to bed. She said when she checked on him, he was resting. Guardian B said Resident A's physical state was not normal, he said it seemed like he had been drugged. Guardian B said Resident A could not make it to the bathroom by himself, which is abnormal, so he had to assist him. He said Resident A is independent in that sense. Guardian B said he immediately called Guardian A and when she arrived, she agreed something was wrong. He said Ms. Cain and Guardian A discussed Resident A's medications, but it did not make sense why he appeared so helpless and confused. Guardian B said he and Guardian A agreed Resident A needed to go to the hospital and requested Ms. Cain call 911. He said EMS arrived and transported Resident A to the hospital.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.** **(b) Be capable of appropriately handling emergency situations.**

ANALYSIS:	During this investigation, all involved parties were interviewed except for Resident A; Resident A has limited verbal skills. I observed Resident A's hospital discharge documents, follow-up consultation form, and spoke with Dr. Normita Vicencio, who stated she cannot definitively confirm Resident A had a seizure. Based on my investigation and information gathered, I am unable to determine direct care staff Marsha Cain does not possess the qualification including meeting the needs of the resident and/or appropriately handling emergency situations. The allegation is unsubstantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 02/09/2023, I completed an unannounced onsite inspection and reviewed Resident A's medication administration records (MARs). At the time, Resident A's 7: 00 a.m. medications did not contain the initials of the person who administered his medications. I asked Kara Kenney, direct care staff, if Resident A received his a.m. medications and she said yes. She said it was a very busy morning and she failed to initial. Ms. Kenney further explained that right after she administered Resident A's medication, she heard Resident B waking up and she requires full assistance, so she went to assist her and forgot to initial.

The following medications were not initialed on 02/08/2023:

- Oyster Shell 500 VIT D3 200: take one capsule by mouth every morning was not initialed at 7:00 a.m.

The following medications were not initialed on 02/09/2023:

- Amlodipine 10 MG Tablets, take 1 tablet by mouth every morning was not initialed at 7:00 a.m.

- Aspirin Low Dose 81MG EC TBEC; take 1 tablet by mouth every morning was not initialed at 7:00 a.m.

- Chlorhexidine 0.12%Rinse; rinse mouth every morning as directed as needed was not initialed at 7:00 a.m.

- Clotrimazole 1% CREA; apply sparingly to the affected area twice a day morning and at bedtime and the toenails at bedtime was not initialed at 7:00 a.m.

- Fluticasone 50MCG Nasal SPR; place two sprays into each nostril twice daily in the morning and at bedtime was not initialed at 7:00 a.m.

- Genteal Tears Moderate PF 0; instill 1 drop into both eye in the morning, supper, and at bedtime was not initialed at 7:00 a.m.

- Tamsulosin HCL 0.4 MG CAPS; take one capsule by mouth every morning was not initialed at 7:00 a.m.

- Vitamin D# 2,000 Unit Soft; take one capsule by mouth every morning was not initialed at 7:00 a.m.

- Zonisamide 100 MG CAP; take one capsule by mouth every morning was not initialed at 7:00 a.m.

- Zonisamide 50 MG CAP; take one capsule by mouth every morning was not initialed at 7:00 a.m.

- HCTZ 12.5MG Tablets: Zonisamide 100 MG CAP; take one capsule by mouth every morning was not initialed at 7:00 a.m.

- Losartan 100MG Tablets; take one tablet by mouth every morning was not initialed at 7:00 a.m.

- Multi-Vitamin TABS; take one tablet by mouth every morning was not initialed at 7:00 a.m.

- Omeprazole 40MG CPDR (do not crush or chew); take one capsule by mouth every morning was not initialed at 7:00 a.m.

- Oyster Shell 500 VIT D3 200: take one capsule by mouth every morning was not initialed at 7:00 a.m.

- Potassium 20MEQ; take one tablet by mouth every morning was not initialed at 7:00 a.m.

- Sucralfate 1GM/10ML SUSP; take two teaspoonfuls by mouth morning and bedtime.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions:

	(b) Complete an individual medication log that contains all of the following information: **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	At the time of inspection, the direct care staff who administered Resident A's 7:00 a.m. medications on 02/08/2023 and 02/09/2023, did not initial at the time medications were given.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 02/09/2023, I completed an unannounced onsite inspection and interviewed Kara Kenney, direct care staff (DCS) and review Resident A's hospital discharge documents and MARs. According to the hospital discharge documents, Resident A's Clondinine HCL 0.1 MG (Catapres) was discontinued as of 01/30/2023 and he was prescribed Atrovastatin (Lipitor) upon discharge from the hospital. The Atrovastatin (Lipitor) was later discontinued as of 02/06/2023. However, the Atrovastatin was not documented on Resident A's MARs 01/31/2023 through 02/06/2023. Although the Clondinine HCL 0.1 MG (Catapres) was discontinued as of 01/30/2023, the medication was February 2023 and was initialed on 02/02/2023, 02/03/2023 at 7:00 a.m. and 02/01/2023, 02/02/2023 and 02/03/2023 at 7:00 p.m. I brought this issue to Ms. Kenney's attention and she said she is uncertain why the staff initialed for the mediation because it was discontinued.

On 02/10/2023, I spoke with Ms. Clark and made her aware of the medication error. Ms. Clark confirmed Resident A was prescribed Atrovastatin (Lipitor) upon discharge from the hospital. She said she wrote it down but failed to document it on his MARs.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	At the time of inspection, the direct care staff failed to administer Resident A's medication pursuant to label instructions.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 02/09/2023, I completed an unannounced onsite inspection and reviewed Resident A's medication administration records (MARs). At the time, I observed GenTeal Tears medication in Resident A's medication bin without a label. Kara Kenney, direct care staff (DCS) stated that Guardian A buys medication over the counter, and she gives it to him. I explained to Ms. Kenney that all medication given, taken, or applied to the resident must be prescribed by a licensed physician or dentist. Ms. Kenney said she is aware, and this has been addressed with Guardian A, but she insists on buying the medication and administering it. Ms. Kenney said Resident A is prescribed a form of artificial tears but there is a specific brand that Guardian A prefers to give him. Ms. Kenney provided a copy of the prescription and said the medication does not have a label because it was purchased by Guardian A. I asked if Resident A has a standing medication order (SMO) sheet, and she said no. I explained that a SMO is completed by the residents' treating physician, and it outlines medications that can be purchased over the counter to treat specific medical issues. Ms. Kenney agreed to discuss the SMO with Ms. Clark.

On 02/10/2023, I spoke with Ms. Clark and made her aware that all medication administered to the residents must be prescribed by a licensed physician or dentist. I further stated that Resident A's medication bin contained GenTeal Tears medication in it without a label. Ms. Clark said she is aware, and this has been addressed with Guardian A. She said Guardian A continues to buy Resident A medications and bring it to the home including eye drops and cough syrup. I suggested Ms. Clark speak with Resident A about obtaining a SMO and further described the purpose of a SMO. Ms. Clark agreed to discuss the SMO with Guardian A.

On 02/22/2023, I received a call from Guardian A. She said the direct care staff at the home told her she is not allowed to provide Resident A's eye drops. She said he has used several eyedrops in the past and they would irritate his eyes. Guardian A was adamant that she is going to continue providing his eye drops. I explained to Guardian A that all medication given to Resident A must be prescribed by a licensed physician or dentist; she said he has a prescription. I further explained that it is my responsibility to make sure the resident is receiving the medication he was prescribed and the eyedrops in his medication bin did not contain a label because it was purchased over the counter. I further explained the SMO and suggested she speak with his physician, so that she can purchase the eyedrops that works for him, if the physician agrees.

On 03/15/2023, I conducted an exit conference with Mr. Brown. I made him aware that based on the investigative findings, there is insufficient evidence to support the reported allegation. However, I made him aware of the additional findings including direct care staff failure to initial at the time Resident A's medications were given, to administer Resident A's medication pursuant to label instructions and the over-the-counter medication that was found in Resident A's medication bin. Mr. Brown said he has made Guardian A aware that she cannot purchase over-the-counter medications for Resident A and it has been an ongoing issue. Mr. Brown said he understands and will complete the corrective action plan as required.

APPLICABLE RULE	
R 400.14312	**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:	At the time of inspection, Resident A's medication bin contained over-the-counter medication without a label specified for the resident.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend that the status of the license remains the same.

03/15/2023

Denasha Walker Date
Licensing Consultant

Approved By:

03/22/2023

_____

Ardra Hunter Date
Area Manager