



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 20, 2023

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

RE: License #: AL330404596
Investigation #: 2023A1029021
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 (231) 922-5309.

Sincerely,

A handwritten signature in black ink that reads "Jennifer Browning". The script is cursive and fluid.

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 #:	AL330404596
Investigation #:	2023A1029021
Complaint Receipt Date:	02/07/2023
Investigation Initiation Date:	02/07/2023
Report Due Date:	04/08/2023
Licensee Name:	MCAP Holt Opco, LLC
Licensee Address:	21800 Haggerty Road, Suite 115 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?
Prestige Way #1 (Cottage) did not issue a written discharge notice to Resident A or his guardian but did not allow him to return to the facility after he was discharged from rehabilitation.	Yes

III. METHODOLOGY

02/07/2023	Special Investigation Intake 2023A1029021
02/07/2023	Special Investigation Initiated – Telephone to complainant.
02/07/2023	APS Referral sent to Centralized Intake
02/24/2023	Contact - Telephone call made to Relative A1
02/24/2023	Inspection completed on-site - Face to Face with Executive Director, Zackary Fisher. Regional director, Sarah Henry, RN Janine Hayes
03/17/2023	Contact - Telephone call made to Zackary Fisher
03/17/2023	Exit Conference with licensee designee, Megan Fry

ALLEGATION:

Prestige Way #1 (Cottage) did not issue a written discharge notice to Resident A or his guardian but did not allow him to return to the facility after he was discharged from rehabilitation.

INVESTIGATION:

On February 7, 2023, a complaint was received via the online Bureau of Community and Health Systems complaint system alleging Resident A was not able to return to Prestige Way #1 (Cottage) after he was discharged from rehabilitation on February 6, 2023, however his family never received a discharge notice from Prestige Way #1 (Cottage).

On February 7, 2023, I interviewed Complainant who confirmed Resident A was still at the rehabilitation facility, but he was scheduled to return to Prestige Way #1 (Cedar

Cottage) on February 6, 2023, but she found out on the afternoon of February 3, 2023, he could not return to Prestige Way #1 (Cedar Cottage). Complainant stated Resident A will likely move to a different facility by the end of the week. Complainant stated Relative A1 informed her since he already paid for the month of February 2023 and he did not receive a discharge notice from anyone at Prestige Way #1 (Cottage), he assumed Resident A would be returning there.

Complainant stated Resident A has resided at the rehabilitation center since January 10, 2023 and has received intravenous antibiotics for his wound. Complainant stated she has spoken with Prestige Way Executive Director, Zackary Fisher and Registered Nurse (RN) Janine Hayes at Prestige Way #1 and both informed her they were unable to take Resident A back, but they did not issue a 30-day discharge notice informing Resident A of this. Complainant stated she was informed he could not return to the facility because he had a wound vacuum assisted closure (VAC) now and Prestige Way #1 (Cottage) did not accept residents needing care for wound VAC. Complainant stated she arranged for education at Prestige Way #1 through the health care agency and the only requirement for Resident A would be a dressing change every three days which was also arranged through a home health care company so AFC direct care staff member would not have to change the wound VAC dressings.

On February 24, 2023, I interviewed Relative A1 who stated he was informed on February 3, 2023, he would need to find another place to live for Resident A because he had a wound VAC. Relative A1 stated when he was informed of this on February 3, 2023, Resident A was going to be discharged on a February 6, 2023, leaving Relative A1 only three days to find new placement. Resident A did not have the wound vac when he resided at Prestige Way #1 (Cedar Cottage) previously but did now due to a surgery and a three-week rehabilitation stay. Relative A1 stated Resident A was going to be released on February 6, 2023, however that is when Prestige Way #1 (Cedar Cottage) informed him they could not handle taking care of the wound VAC even though there were aids assigned from a home health agency to take care of the wound vac twice a week. Mr. Burkitt stated he did not receive a written discharge notice from the administration at Prestige Way #1 (Cedar Cottage). Relative A1 stated he only had two/three days to find a new residence for Resident A. Relative A1 stated he learned from the staff at the rehabilitation center that Resident A could not return to the facility.

On February 24, 2023, I completed an unannounced onsite investigation at Prestige Way #1 (Cedar Cottage) and interviewed Prestige Way Executive Director, Zackary Fisher. Prestige Way Regional director, Sarah Henry was also present at the time of this investigation. Mr. Fisher provided me a copy with the discharge notice Prestige Way uses when a resident is discharged from the facility which states:

A. 30 Day Discharge:

Prestige Way may discharge the resident, with or without cause, with a 30 day written notice of discharge to the Resident, the Resident's Designated Representative, and a copy if applicable to the Resident's responsible agency. The discharge notice shall state the reasons for the discharge

and the effective date of the discharge. In the event of a discharge, the Resident is liable for the payment of any and all fees through the expiration of the 30 day notice period as well as any other unpaid fees through that date.

B. Emergency discharge:

As a licensed AFC home, Prestige Way must routinely assess the appropriateness of the Residents placement. If as part of the assessment or due to the conduct of the resident, Prestige Way determines and documents that any of the following exists the resident may be discharged on not less than 24 hours written notice:

- a. There is a substantial risk to the resident due to the inability of the home to meet the residents needs or assure the safety and well-being of other residents in the home.*
- b. There is a substantial risk or an occurrence of self-destructive behavior.*
- c. There is a substantial risk or an occurrence of serious physical assault or*
- d. There is a substantial risk or an occurrence of the destruction of property.*

During the onsite investigation I also reviewed Resident A's resident record. There was no record of a 30-day or 24 hour written discharge notice in Resident A's resident record.

Mr. Fisher stated the rehabilitation facility staff tried to discharge Resident A back to the Prestige Way #1 (Cedar Cottage) with the wound VAC, but Prestige Way #1 (Cedar Cottage) does not have the capacity to handle a wound VAC. Mr. Fisher did not recall what day he was informed Resident A now had wound VAC that would need care, but it was either the same day or the day before he was scheduled to be discharged from the rehabilitation center.

Mr. Fisher stated Prestige Way's regional nurse Janine Hayes informed him an order for a resident to have a wound vac they would need to have 24-hour RN availability in case of an emergency, which Prestige Way does not have. Mr. Fisher stated direct care staff members are not trained to handle a wound in this condition. Mr. Fisher stated he informed the rehabilitation center staff and Relative A1 they would reassess if the wound vac was no longer required. Mr. Fisher stated he did not give a written 24-hour discharge notice because he offered to Relative A1 to hold a room for Resident A. Mr. Fisher stated he did not follow up with a written notice after Relative A1 moved Resident A's personal items out of Prestige Way #1 (Cedar Cottage) for Resident A, but they did process a refund for Relative A1. Mr. Fisher stated the rehabilitation center did not call them soon enough to inform them of the discharge for Resident A or notify facility administration Resident A had a wound VAC.

On February 24, 2023, I interviewed registered nurse (RN) Janine Hayes. RN Hayes stated she explained to the rehabilitation center Director of Social Services, Trista Czapl, that she worries about something going wrong with wound care because the direct care staff members are not trained to handle a resident with a wound VAC. RN

Hayes stated Marcia Curtis also tried to contact Ms. Czapla on February 4, 2023 (Saturday) but she could not be reached. On February 6, 2023, when they did reach Ms. Czapla, she was informed they already found a new residence for Resident A.

APPLICABLE RULE	
R 400.15302	Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.
	(4) A licensee may discharge a resident before the 30-day notice when the licensee has determined and documented that any of the following exists: (a) Substantial risk to the resident due to the inability of the home to meet the resident's needs or assure the safety
ANALYSIS:	Based on the interviews with Mr. Fisher, RN Hays, Ms. Henry and Relative A1, because Resident A had a wound VAC after he was discharged from the rehabilitation center, Prestige Way #1 (Cedar Cottage) was unable to meet Resident A's needs in the facility, however, a written discharge notice was not given to Resident A or Relative A1.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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



Jennifer Browning
Licensing Consultant

03/17/2023

Date

Approved By:



03/20/2023

Dawn N. Timm
Area Manager

Date