GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 6, 2023

Gursharanjit Dhillon
Pine Tree Place LLC, Suite 3
2710 S. Rochester Road
Rochester Hills, MI 48307

RE: License #: AL630079545
Investigation #: 2023A0602014
Pine Tree Place

Dear Mr. Dhillon:

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 (248) 975-5053.

Sincerely,

Cindy Berry, Licensing Consultant
Bureau of Community and Health Systems
3026 West Grand Blvd
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 860-4475

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630079545
Investigation #:	2023A0602014
Complaint Receipt Date:	01/25/2023
Investigation Initiation Date:	01/26/2023
Report Due Date:	03/26/2023
Licensee Name:	Pine Tree Place LLC
Licensee Address:	2710 S. Rochester Road, Suite 3 Rochester Hills, MI 48307
Licensee Telephone #:	(248) 620-2420
Administrator:	Gursharanjit Dhillon
Licensee Designee:	Gursharanjit Dhillon
Name of Facility:	Pine Tree Place
Facility Address:	5480 Parview Clarkston, MI 48346
Facility Telephone #:	(248) 620-2420
Original Issuance Date:	02/12/1999
License Status:	REGULAR
Effective Date:	07/17/2022
Expiration Date:	07/16/2024
Capacity:	20
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
On Sunday 01/22/23, staff member Denise Burton, set up the residents' medications in medication cups prior to passing them.	Yes
Staff did not pass medications to two residents. The residents' unpassed medications were later located in the top drawer of the medication cart.	Yes
The facility is dirty and is furnished with secondhand furniture.	No
Additional Findings	Yes

III. METHODOLOGY

01/25/2023	Special Investigation Intake 2023A0602014
01/26/2023	Special Investigation Initiated - Telephone Call made to the facility.
02/03/2023	Contact – Telephone call made Message left for staff member, Denise Burton.
02/15/2023	Contact – Telephone call made Message left for staff member, Denise Burton.
03/02/2023	Inspection Completed On-site Interviewed the manager, Ashley Liskey.
03/07/2023	Contact – Document received Received requested documents from Ms. Liskey.
03/07/2023	Contact – Telephone call made Call made to staff member Melissa Towne – unable to leave a message.
03/10/2023	Contact – Document received Received requested documents from Ms. Liskey.
03/28/2023	Contact – Telephone call made Spoke with staff member, Melissa Towne.

04/03/2023	Exit Conference Call made to the licensee designee, Gursharanjit Dhillon – mailbox full, unable to leave a message.

ALLEGATION:

- **On Sunday 01/22/2023, staff member Denise Burton, set up the resident's medication in medication cups prior to passing them.**
- **Staff did not pass medications to two residents. The resident's unpassed medications were later located in the top drawer of the medication cart.**

INVESTIGATION:

On 1/25/2023, a complaint was received and assigned for investigation alleging that on Sunday, 01/22/2023, staff member Denise Burton set up the resident's medication in medication cups prior to passing them. Staff did not pass medications to two residents and the unpassed medication was later located in the top drawer of the medication cart.

On 3/02/2023, I conducted an unannounced on-site investigation at which time I interviewed the home manager, Ashley Liskey. Ms. Liskey stated she has worked as the administrator for about two years. On 1/22/2023, staff member Melissa Towne contacted her and reported that she found medications on the medication cart in cups that were labeled as room #11 and room #13. It was documented in the medication log that those same medications had been administered by Ms. Burton. Ms. Liskey stated when she arrived at the facility, she contacted Resident A's hospice nurse and Resident B's physician and informed them of the incident. She was informed both residents should not experience any side effects because of the missed medication. Ms. Liskey went on to state that Ms. Burton was terminated.

On 3/02/2023, I observed Resident A and Resident B's medication logs. According to Ms. Liskey, on 1/22/2023 Resident A and Resident B did not receive the following morning medication:

Resident A:

- Acetamin Tab 500 mg – 2 Tabs
- Aspirin Low Chewable 81 mg
- Ferrous Sulfate Tab 325 mg
- Fish Oil CAP 1200 mg
- Isosorb Din Tab 30 mg
- Lisinopril Tab 10 mg
- Pantoprazole Tab 40 mg
- Polyeth Glyc Power 3350 NF
- Sertraline Tab 50 mg
- Vitamin B-12 Tab 100 mcg
- Vitamin D3 Tab 25 mcg

Resident B:

- Divalproex CAP 125 mg
- Folic Acid Tab 1000 mcg
- Metformin Tab 1000 mg
- Methenam HIP Tab 1 gm
- Pantoprazole Tab 40 mg
- Quetiapine Tab 50 mg
- Vitamin C Tab 1000 mg

On 3/28/2023, I interviewed staff member Melissa Towne by telephone. Ms. Towne stated on 1/22/2023 she worked the second shift between the hours of 7 pm and 7 am. Staff member, Denise Burton had worked the shift prior to hers between the hours of 7 am and 7 pm. When Ms. Towne accessed the medication cart, she observed two medication cups in the top drawer where the eyedrops and creams are stored. The cups contained pills and were labeled room #11 (Resident A) and room #13 (Resident B). Ms. Towne checked the Quick MAR (electronic system), and it was documented on 1/22/2023 as if all 7 am medication had been passed during Ms. Burton's shift. Ms. Towne stated she immediately contacted Ms. Liskey, reported the incident, and disposed of the medication.

APPLICABLE RULE	
R 400.15312	**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:	Based on the information obtained from Ms. Liskey and Ms. Towne, there is sufficient information to determine that on 1/22/2023 Resident A and Resident B's medication was not kept in the original pharmacy-supplied container. Ms. Towne observed Resident A and Resident B's morning medication in two medication cups that were labeled room #11 and room #13.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the information obtained from Ms. Liskey and Ms. Towne, there is sufficient information to determined that Resident A and Resident B did not receive their morning medication on 1/22/2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility is dirty and is furnished with secondhand furniture.

INVESTIGATION:

On 3/02/2023, I conducted an unannounced on-site investigation at which time I observed the living area, dining area, kitchen, and several resident rooms. The living area was neat and clean and was furnished with recliner chairs, a television, tables, and other home décor. The furniture appeared to be in good condition as I did not observe any tears, holes, or damages. The flooring and all the furniture in the dining area had been removed. The flooring and all the lower cabinets in the kitchen had also been removed. Each resident room contained a bed, dresser, mirror, and chair. The bedroom furniture appeared to be in good condition. I did not observe the facility to be dirty.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	Based on my own observation of the living area, dining area, kitchen, and resident rooms, I determined that the home furnishings and housekeeping standards presented a comfortable, clean, and orderly appearance. During the onsite, I did not observe the facility to be dirty and the furnishings appeared to be in good condition.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 3/02/2023, I conducted an unannounced on-site investigation at which time I observed the flooring and all the furniture in the dining area had been removed. The flooring and all the lower cabinets in the kitchen had also been removed. Ms. Liskey stated about two weeks ago the toilet in a resident room overflowed and it was not observed until the next morning. The overflow caused water damage to a couple of the resident rooms as well as the dining and kitchen areas. The flooring, some drywall and the lower kitchen cabinets had to be removed. Residents were placed in other rooms until the repairs are completed. The licensee designee, Gursharanjit Dhillon is aware of the situation and the damages are currently scheduled to be repaired.

On 3/10/2023, Ms. Liskey provided a receipt from the insurance claims adjuster, Up Front Settlements, Inc. According to the adjuster, water damaged several walls in three resident units requiring new drywall, paint, and flooring to be installed. The main dining hall will also require drywall repairs with fresh paint and new laminate flooring. The kitchen cabinets and countertops will be replaced along with new flooring. The carpeting in the recreation/living area will be cleaned and deodorized. The repairs are expected to be completed within 4-6 weeks from 3/09/2023.

On 4/04/2023, I attempted to conduct an exit conference with the licensee designee, Gursharanjit Dhillon by telephone. Mr. Dhillon did not answer, and I was unable to leave a message as his mailbox was full.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(5) Floors, walls, and ceilings shall be finished so as to be easily cleanable and shall be kept clean and in good repair.
ANALYSIS:	Based on my own observation during the onsite, I determined that the floors and walls in the dining area, kitchen and three resident rooms were not in good repair. According to Ms. Liskey, a toilet overflowed in a resident's room causing the damages to the dining area kitchen and two other resident rooms. The overflow was not observed until the next morning. I reviewed a statement from the insurance claims adjuster, Up Front Settlements, Inc., that documented the floors and walls in the dining area, kitchen and three resident rooms were water damaged. The repairs are estimated to be complete within 4-6 weeks from 3/09/2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

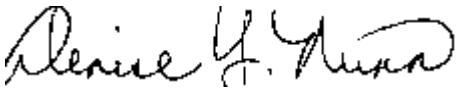
IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.

04/04/2023

Cindy Berry Date
Licensing Consultant

Approved By:



04/06/2023

Denise Y. Nunn Date
Area Manager