GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 26, 2023

David Fulkerson
Grace Senior Living
985 N Lapeer Rd
Orion, MI 48362

RE: License #: AH630400653
Investigation #: 2023A1019044
Grace Senior Living

Dear Mr. Fulkerson:

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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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.

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) 284-9730.

Sincerely,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630400653
Investigation #:	2023A1019044
Complaint Receipt Date:	05/15/2023
Investigation Initiation Date:	05/17/2023
Report Due Date:	07/14/2023
Licensee Name:	Conscious Senior Living Properties II LLC
Licensee Address:	985 N Lapeer Rd Lake Orion, MI 48362
Licensee Telephone #:	(248) 670-9823
Administrator:	Cynthia Tanner
Authorized Representative:	David Fulkerson
Name of Facility:	Grace Senior Living
Facility Address:	985 N Lapeer Rd Orion, MI 48362
Facility Telephone #:	(248) 977-6200
Original Issuance Date:	09/10/2020
License Status:	REGULAR
Effective Date:	03/10/2023
Expiration Date:	03/09/2024
Capacity:	71
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Notification was not provided when Resident A experienced a change in condition.	No
Resident A's briefs are not being changed often enough.	No
Resident A is out of a prescribed medication.	No
Additional Findings	Yes

III. METHODOLOGY

05/15/2023	Special Investigation Intake 2023A1019044
05/17/2023	Special Investigation Initiated - Letter Notification to APS
05/17/2023	APS Referral
05/17/2023	Inspection Completed On-site
05/17/2023	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Notification was not provided when Resident A experienced a change in condition.

INVESTIGATION:

On 5/13/23, the department received a complaint alleging that Resident A has slurred speech and difficulty forming sentences and alleges that facility staff did not provide proper notification when this change in condition occurred. The complaint did not specify when the change in condition took place.

On 5/17/23, I conducted an onsite inspection. The administrator nor authorized representative were present during my visit. Employees 1, 2, 3 and 4 were interviewed about Resident A's care. Staff interviewed confirmed that Resident A

was recently hospitalized after Relative A brought to their attention concerns over Resident A having slurred speech. Employees 1, 2, 3, and 4 reported that Resident A was immediately evaluated after becoming informed of this information and EMS was called due to her having high blood pressure.

While onsite, I was provided Resident A's progress notes. A note dated 5/15/23 at 12:31pm written by Employee 4 read:

> *Writer alerted by supervisor per daughters request on 5/15/23, that resident has slurred speech and needs to be assessed. I went into asses resident and a neurological assessment was performed as well as vitals were obtained. Vitals include HR 76, SpO2 95% RA, BP taken twice, first was 196/91, second was done 193/83 on right arm. Muscles have equal strength bilaterally. Resident had very slight RT sided facial droop and speech appeared to not be at baseline. Daughter was contacted, daughter said she was not available to talk at the moment at 12:30pm on 5/15/23. RN was notified. EMS was called to assess.*

A note dated 5/15/23 at 12:41pm written by Employee 2 read:

> *Writer spoke to aid that was on resident set, aid stated that she [sic] resident appeared tired and was just having a bad day, resident however did go down to breakfast, Supervisor assisted resident back to her room, resident asked supervisor if she could see if she was wet and was assisted to the toilet, afterwards resident thanked supervisor for helping her. Supervisor stated at the time resident did not have slur [sic] speech and was acting normal.*

A note dated 5/15/23 at 1:13pm written by Employee 4 read:

> *EMS arrived, and assessed resident. Upon assessment, blood pressure was still elevated. EMS contacted daughter. Daughter chose to send resident to Crittenton Hospital in Rochester for further evaluation via ambulance.*

Employee 4 reported that Resident A returned the facility the same day with no new orders. Resident A's hospital discharge papers were reviewed and confirm this.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, quality review program.**
	(7) The facility must have a policy and procedure to ensure that an incident, once known by facility staff, is reported as soon as possible, but not later than 48 hours after the incident, to a resident's authorized representative or designated health care professional, as appropriate. Verbal or written notification must be documented in the resident's record to reflect the date, time, name of staff who made the

	notification, and name of the representative or professional who was notified.
ANALYSIS:	Staff attestations reveal that it was Relative A herself who initially reported concerns about Resident A to staff, who then evaluated her and subsequently called EMS. Progress note documentation definitively demonstrate that Relative A was informed and aware she was being sent to the hospital.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's briefs are not being changed often enough.

INVESTIGATION:

The complaint alleged that facility staff are not following Resident A's physician's order to complete brief changes every two hours. The complaint alleged that on 5/13/23, Resident A's briefs were saturated.

Employees 1, 2, 3, and 4 stated that Resident A did not have an order instructing the frequency of brief changes but acknowledged that Resident A is incontinent of bladder and bowel and requires staff assistance with that task.
Resident A's service plan was reviewed. The "toileting" section read:

> *Resident is frequently incontinent of bladder and/or bowel (three to four times a day).*
>
> *Level of Assistance- Toileting: Extensive*
> *[Resident A] requires assistance of 1 care partners [sic]for toileting needs. [Resident A] uses adult protective underwear and will occasionally use the toilet; however she is usually incontinent of both bowel and bladder. Care partners are to check and change [Resident A] regularly throughout the day and night, care partners are to ensure good perennial hygiene is being performed to help prevent skin breakdown and odor.*

Employees 1, 2, 3, and 4 attested that the facility charts activities of daily living (ADL) on a log, however they reported that this task would not be documented every single time that staff provided assistance.

Follow up correspondence was had with Employee 5, who also was not present during my onsite. Employee 5 provided a physician's order that read "[Resident A] needs to be changed every four hours with a new brief. If not changed regularly while awake, her skin will not heal." Employee 5 also confirmed that staff document

Resident A's toileting on the ADL log but reports that this is listed as PRN ("as needed") toileting because she is toileted more frequently than every four hours.

I reviewed Resident A's "ADL Log". I observed that on 5/13/23 staff documented that toileting tasks were completed for Resident A but did not list the specific times she was changed. Employee 5 stated that she plans to re-educate staff to document each individual time Resident A is toileted moving forward.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	Resident A has an order to be toileted every four hours, not every two hours as the complaint alleges. Staff attested that this task is being completed minimally very four hours and document PRN toileting on an ADL log.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A is out of a prescribed medication.

INVESTIGATION:

The complaint read "They are not filling [Resident A's] medications in a timely order and she is currently out of one type of her prescribed meds". Employees 1, 2, 3, and 4 reported that Relative A was upset about one of Resident A's medications that she thought had run out and wasn't getting. Employees 1, 2, 3 and 4 reported that the issue arose due to the facility recently switching pharmacies and the new pharmacy did not indicate on the medication administration record (MAR) that it was only a seven-day prescription. Employee 1 reported that Resident A uses an outside physician that the facility is not contracted with, which means that the resident and/or family is responsible for refilling the medication. Employee 1 stated that she called Relative A to inform her of the situation and to request that she obtain the medication (nitrofurantoin) Employee 1 stated that Relative A got upset thinking that Resident A wasn't getting the medication at all. Employees 1, 2, 3, and 4 reported that the order for this medication was only written for seven days and that the facility administered the medication until the antibiotic course was completed.

While onsite, I obtained a copy of the physician's order and Resident A's medication administration records. The physicians order dated 5/1/23 read "Macrobid 100 mg 1 T BID #14". The MAR reveals that staff documented that the medication was administered to Resident A daily for the entire duration of the order and did not miss a dose.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.
ANALYSIS:	The nitrofurantoin (also known as Macrobid) prescription was written for seven days and did not require a refill. Medication administration records reveal that staff administered the medication to Resident A and she completed the full course of antibiotics. Staff interviewed confirm that Resident A never ran out of the medication in question.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Resident A's prescription for Macrobid (also known as nitrofurantoin) was written on 5/1/23 and was a seven-day supply, to be given to Resident A twice daily. Staff documented on Resident A's medication administration record that they administered the Macrobid on the following dates: 5/1/23 (one dose), 5/2/23-5/10/23 (two doses) and 5/11/23 (one dose). For one dose on 5/11/23 and for two doses on 5/12/23, 5/13/23, 5/14/23, 5/15/23 and 5/16/23 staff documented that the medication was unavailable. Based on the information provided in the MAR, the medication was administered to Resident A 19 times. The medication order was written for 14 pills, meaning staff documented that the medication was given an additional five times when the facility didn't physically have the medication to administer. These five instances are considered to be a documentation error.

Following my onsite, Employee 5 submitted signed statements from Employees 6 and 7 who were identified as the staff that documented administering the medication to Resident A when it wasn't available. Both employees admitted to improperly documenting that they administered the medication when in fact they had not.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following: **(a) Be trained in the proper handling and administration of the prescribed medication.** **(b) Complete an individual medication log that contains all of the following information:** **(i) The name of the prescribed medication.** **(ii) The prescribed required dosage and the dosage that was administered.** **(iii) Label instructions for use of the prescribed medication or any intervening order.** **(iv) The time when the prescribed medication is to be administered and when the medication was administered.** **(v) The initials of the individual who administered the prescribed medication.** **(vi) A record if the resident refuses to accept prescribed medication and notification as required in subdivision (c) of this subrule.** **(vii) A record of the reason for administration of a prescribed medication that is on an as-needed basis.**
ANALYSIS:	Two staff falsely documented that Resident A's medication was administered to her on five occasions after the prescription had run out.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon approval of an acceptable corrective action plan, I recommend no changes to the status of the license at this time.

05/25/2023

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

05/26/2023

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