GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 7, 2023

Angela Tuck
Tucks Health Services LLC
7236 Pawnee Trail
Rogers Cty, MI 49779

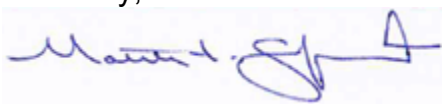
RE: License #: AL710406406
Investigation #: 2023A0360022
Golden Beach Manor

Dear Ms. Tuck:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 (866) 865-0006.

Sincerely,



Matthew Soderquist, Licensing Consultant
Bureau of Community and Health Systems
Ste 3
931 S Otsego Ave
Gaylord, MI 49735
(989) 370-8320

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL710406406
Investigation #:	2023A0360022
Complaint Receipt Date:	04/12/2023
Investigation Initiation Date:	04/13/2023
Report Due Date:	06/11/2023
Licensee Name:	Tucks Health Services LLC
Licensee Address:	18955 Us 23 N Millersburg, MI 49759
Licensee Telephone #:	(989) 351-8091
Administrator:	Angela Tuck
Licensee Designee:	Angela Tuck
Name of Facility:	Golden Beach Manor
Facility Address:	18955 Us 23 N Millersburg, MI 49759
Facility Telephone #:	(989) 351-8091
Original Issuance Date:	03/01/2022
License Status:	REGULAR
Effective Date:	09/01/2022
Expiration Date:	08/31/2024
Capacity:	20
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A's commode is not cleaned regularly.	No
Resident B was given prescription Ativan that he is not prescribed.	No
Meal portions are very small.	No

III. METHODOLOGY

04/12/2023	Special Investigation Intake 2023A0360022
04/13/2023	Special Investigation Initiated - On Site Resident A, Relative 1-A, DCS Casey Wolgast, Hospice
04/13/2023	Inspection Completed On-site
04/17/2023	APS Referral online
05/05/2023	Contact - Document Received APS Sarah Purol
05/08/2023	Inspection Completed On-site Resident A, B, Licensee Angie Tuck
05/15/2023	Inspection Completed On-site Resident B, Licensee Angie Tuck
05/30/2023	Contact - Document Received Angie Tuck
06/05/2023	Contact - Telephone call made APS Sarah Purol
06/06/2023	Contact - Telephone call made Relative 1-B
06/07/2023	Exit Conference With licensee Angie Tuck

ALLEGATION: Resident A commode is not cleaned regularly.

INVESTIGATION: On 4/12/2023 I was assigned a complaint from the LARA online complaint system.

On 4/13/2023 I conducted an unannounced onsite inspection at the facility. Direct care staff Casey Wolgast stated that Resident A recently moved in and is using a commode in her bedroom, and it is cleaned after each use. I observed Resident A's commode and bedroom to be clean. Resident A stated the staff always clean up as needed. Relative 1-A was also present and stated the commode is cleaned immediately as soon as staff notice it has been used.

While at the facility on 4/13/2023 I interviewed Hospice staff Paula Fabis. Ms. Fabis stated she is working with Resident A and she is adjusting to the home nicely. She stated there are no concerns regarding Resident A's commode not getting cleaned up as necessary.

On 5/08/2023 I conducted an unannounced onsite inspection. Resident A's bedroom was clean, and her commode was empty. She stated she has no concerns about the staff cleaning the commode regularly.

On 5/15/2023 I conducted another onsite inspection at the facility. The licensee Angie Tuck stated Resident A passed away the day prior.

On 6/05/2023 I contacted Adult Protective Services (APS) worker Sarah Purol. Ms. Purol stated she did not substantiate her APS complaint.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	The complaint alleged Resident A's commode was not being cleaned regularly. I conducted onsite inspections on 4/13/2023 and 5/08/2023 and Resident A's commode was clean. Resident A and Relative 1-A both stated it was cleaned regularly. There is not a preponderance of evidence that Resident A's personal needs were not attended to at all times.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident B was given prescription Ativan that he is not prescribed.

INVESTIGATION: On 5/05/2023 I received a call from APS worker Sarah Purol who stated that she received a complaint that Resident B was administered Ativan without a prescription.

On 5/08/2023 I conducted an unannounced onsite inspection at the facility. The licensee Angie Tuck stated Resident B is prescribed Ativan. She stated when he moved into the facility he was prescribed .5mg Ativan PRN twice a day as needed. She stated the full tab of Ativan made him very drowsy, so she contacted his wife, Relative 1-B and they had his physician reduce the prescription to .25mg Ativan PRN twice a day. She stated this greatly helped with his drowsiness. Ms. Tuck provided me with Resident B's Ativan medication and medication administration records for May 2023 documenting the change in Ativan administration from .5mg to .25mg.

While at the facility on 5/08/2023 I observed Resident B to be awake and walking around the grounds of the facility. Resident B was unable to answer any questions regarding his medications due to his diagnosis of early onset dementia.

I conducted another onsite inspection at the facility on 5/15/2023. I again observed Resident B to be awake and walking around the grounds of the facility.

On 6/05/2023 I contacted APS worker Sarah Purol who stated Resident B has been moved from the facility and she is not substantiating her APS investigation.

On 6/06/2023 I contacted Relative 1-B. Relative 1-B stated Resident B's prescription Ativan was too strong for him and the licensee Angie Tuck contacted her asking if she could get the prescription reduced because he was getting drowsy when he had the .5mg dosage. She stated she had the prescription lowered to a half tab or .25mg twice per day as needed and this has seemed to help him stay more alert. She stated she was in the facility 4-5 times per week and always observed the staff to be attentive to Resident B's needs. She stated she cannot say anything bad about the facility. She stated she did have to move Resident B to a smaller facility because he kept trying to elope and required more one-on-one staffing.

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:	The complaint alleged Resident B is given prescription Ativan that he is not prescribed. Resident B was prescribed Ativan .5mg PRN twice per day and the licensee stated it made him drowsy. The licensee contacted Resident B's wife and they had the prescription reduced to .25mg twice per day. I observed Resident B on 5/08/2023 and 5/15/2023 to be awake and walking around the grounds of the facility. Relative 1-B confirmed that Resident B is prescribed Ativan and the facility licensee requested a reduction in the prescription medication. She stated she was at the home 4-5 times a week and did not have any concerns. APS worker Sarah Purol stated she did not substantiate her APS investigation. There is not a preponderance of evidence that Resident B was given medication that is not prescribed to him.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Meal portions are very small.

INVESTIGATION: On 4/13/2023 I conducted an unannounced onsite inspection at the facility. The facility was serving the lunch meal and residents appeared to have healthy sized portions. I interviewed direct care staff Casey Wolgast. He stated the residents are provided three meals a day plus snacks as needed. He stated any resident is allowed to have additional portions as requested. I then observed the refrigerator and dry food storage and there was plenty of meats, milk, eggs, butter, fresh bread, fruits, vegetables and dry food to prepare meals based on what was posted on the menu for April.

While at the facility on 4/13/2023 I interviewed Resident A. Resident A stated she receives plenty of food and the portions are more than adequate. I then interviewed Relative 1-A who stated the meals are sufficient and he has no concerns about the food. I then interviewed Resident A's hospice staff Paula Fabis. Ms. Fabis stated hospice is in the facility several times a week and she has no complaints regarding the meals provided to residents.

On 5/08/2023 I conducted another unannounced onsite inspection at the facility. The facility was again providing a lunch meal with healthy portion sizes. Licensee Angie Tuck stated there is more than adequate food in the home and the residents are

provided three meals a day plus snacks as needed. While at the facility I interviewed Resident A and B who both stated the meals have sufficient portions.

On 5/15/2023 I conducted an onsite inspection at the facility. The licensee Angie Tuck stated the facility continues to receive food delivery every other week. I observed plenty of food in the facility to prepare meals based on what was documented on the menu. I interviewed Resident B and he stated he receives plenty of food.

On 6/05/2023 I contacted APS worker Sarah Purol. Ms. Purol stated she was not substantiated her APS complaint.

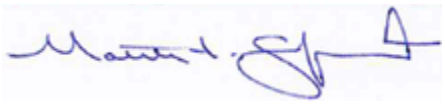
On 6/06/2023 I contacted Relative 1-B. Relative 1-B stated she was at the facility 4-5 times per week often at mealtimes, and she had no concerns. She stated the staff often offered food to her while she was visiting her husband. She stated she would occasionally eat the meal and had no complaints. She stated the portion sizes appeared adequate and her husband never complained.

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	The complaint alleged meal portions are very small. I observed meals being served on 4/13/2023 and 5/08/2023 and they both appeared to be healthy portion sizes. Residents A and B both stated the portion sizes are adequate. Relative 1-A and 1-B both stated the meal portion sizes are adequate. The licensee Angie Tuck stated the residents are provided adequate portion meals three times daily with the option for snacks. There was plenty of food in the facility to prepare the meals outlined on the menu during my onsite inspections on 4/13/23, 5/08/2023 and on 5/15/2023. There is not a preponderance of evidence that the facility is not providing three meals a day of proper form and consistency.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On 06/07/2023 I conducted an exit conference with the licensee designee Angie Tuck. Ms. Tuck concurred with the findings.

IV. RECOMMENDATION

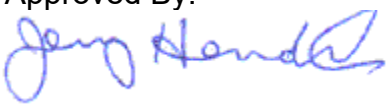
I recommend no change in the status of the license.



6/7/2023

Matthew Soderquist Date
Licensing Consultant

Approved By:



6/7/2023

Jerry Hendrick Date
Area Manager