GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

Carol Del Raso
Senior Living Forest Glen, LLC
7927 Nemco Way, Ste 200
Brighton, MI 48116

June 6, 2023

RE: License #: AL140412989
Investigation #: 2023A1030034
Forest Glen Assisted Living

Dear Mrs. DelRaso:
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.

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.

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 (616) 356-0183.

Sincerely,

Nile Khabeiry, LMSW

Nile Khabeiry, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL140412989
Investigation #:	2023A1030034
Complaint Receipt Date:	04/28/2023
Investigation Initiation Date:	05/01/2023
Report Due Date:	06/27/2023
Licensee Name:	Senior Living Forest Glen, LLC
Licensee Address:	7927 Nemco Way, Ste 200 Brighton, MI 48116
Licensee Telephone #:	(810) 220-0200
Administrator:	Kelsey Kline
Licensee Designee:	Carol Del Raso
Name of Facility:	Forest Glen Assisted Living
Facility Address:	29601 Amerihost Drive Dowagiac, MI 49047
Facility Telephone #:	(269) 782-5300
Original Issuance Date:	03/10/2023
License Status:	TEMPORARY
Effective Date:	03/10/2023
Expiration Date:	09/09/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was not properly cleaned after having her adult brief changed.	Yes
Resident A was not given her 4:00pm medication on time.	No
Additional Findings	Yes

II. METHODOLOGY

04/28/2023	Special Investigation Intake 2023A1030034
05/01/2023	Special Investigation Initiated - Telephone Interview with complainant
05/02/2023	Contact - Face to Face Interview with Relative A1
05/03/2023	Contact - Telephone call made Interview with Case Manager
05/03/2023	Contact - Face to Face Contact with Resident A
05/03/2023	Contact - Face to Face Interview with Carol Del Raso
05/03/2023	Contact - Document Received Review of Resident A documents
05/03/2023	Contact - Face to Face Interview with Kristen Deans
05/04/2023	Contact - Telephone call made Interview with Relative A2
05/04/2023	Contact - Telephone call made Interview with Relative A3
05/22/2023	Contact - Document Received Reviewed Resident A's MAR

05/22/2023	Contact - Face to Face Interview with Kayla Lyons
05/25/2023	Contact - Telephone call received Interview with APS worker
05/25/2023	Contact - Telephone call made Interview with Keisha Martinez
06/05/2023	Contact - Telephone call made Interview with Willie Ellison
06/06/2023	Exit Conference Exit conference by phone

ALLEGATION:

Resident A was not properly cleaned after having her adult brief changed.

INVESTIGATION:

On 5/1/23, I interviewed the complainant by phone. The complainant reported the family visits Resident A almost daily and were concerned because the staff will not come in to check on her during the time that they are with her and have found her with a soiled brief and bowel movement under a bandage that should have been cleaned. The complainant reported Resident A is receiving Hospice services and gets a bath aid twice per week and one to two nursing visits per week. The complainant provided Resident A's Hospice case manager's name and phone number.

On 5/3/23, I interviewed Resident A's case manager Matthew Hauch by phone. Mr. Hauch reported he is aware that Resident A's family members expressed concern about the staff not checking on Resident A for several hours at a time and has heard similar concerns from another resident's family members. Mr. Hauch reported he noted that while visiting Resident A for a period of time none of the direct care staff members (DCSM) came in to provide any care or check on her which he expressed to the home's management. Mr. Hauch reported that the next time he was in the home, the DCSM were in and out of the room several times to provide care and check on Resident A.

On 5/3/23, I attempted to interview Resident A however she is mostly non-verbal. I noted Resident A appeared to be neat and clean and her room did not smell of urine.

On 5/3/23. I interviewed Relative A1 who was visiting at the home. Relative A1 reported she is satisfied with the care Resident A receives from the home.

On 5/3/23, I interviewed licensee designee Carol Del Raso at the home. Ms. Del Raso reported she is aware of the concerns as she met with four of Resident A's family members on 4/27/23 to discuss their concerns. Ms. Del Raso reported they discussed the schedule to reposition Resident A to help avoid skin break down as she is bed bound. Ms. Del Raso reported the family also expressed concern about the lack of care and a particular DCSM who almost made a medication error on 4/22/23. Ms. Del Raso provided the name and contact information of the DCSM who were working on 4/22/23.

On 5/3/23, I received and reviewed Resident A's Resident Care Agreement (RCA), Assessment Plan for AFC Residents (AP) and Resident Evaluation (RE.) The RE is an agency document that determines the level of care and services provided to Resident A. The AP indicates Resident A requires total assistance with toileting and needs staff assistance with bathing, grooming and dressing.

On 5/3/23, I interviewed DCSM Kristen Deans at the home. Ms. Deans reported she has worked at the home for six years and works first shift. Ms. Deans reported she was working on 4/22/23. Ms. Deans reported she is aware the Resident A has a pressure wound on her bottom. Ms. Deans reported she checks on the all the residents every two hours and will change Resident A's adult briefs if needed. Ms. Deans reported she does not remember anything specific on 4/22/23 regarding Resident A and would have cleaned her if she had a BM during her shift. Ms. Deans reported there are times when the staff may not check on Resident A for three or four hours. Ms. Deans reported Resident A's family visits almost every day and the DCSM will still provide care while they are visiting.

On 5/4/23, I interviewed Relative A2 by phone. Relative A2 reported Resident A has lived at the home for twelve years and has noted some problems with the care she receives in the last few months. Relative A2 reported she has noted stool on Resident A a couple of times when she comes to visit as well as food on her face which was not cleaned from the most recent meal as Resident A needs assistance with feeding. Relative A2 reported she was not present on 4/22/23 but did speak with Relative A3 about the situation and that she would be happy to speak with me as well. Relative A2 reported the staff seem to disappear when they visit Resident A and should continue to provide care and at least check on her because the visitors are not there to change her brief or clean her up. Relative A2 reported having a meeting with the current administrator, Carol Del Raso where they expressed their concerns and a plan to improve the care going forward.

On 5/4/23 I interviewed Relative A3 by phone. Relative A3 reported she is concerned about the care Resident A is receiving at the home and provided the details of concerns. Relative A3 reported on 4/20/23 she witnessed DCSM Willie Ellison crush up the wrong medication and would have given it to Resident A if she did not intervene and question the medications being given. On 4/21/23 Relative A3 was visiting and noted

Resident A lying in urine in her bed with stool on her body and clothes. Relative A3 alerted Mr. Ellison about the situation, and he came in to change her and placed the urine soaked and stool covered clothes and sheets on the bedroom floor instead of getting a plastic bag or laundry basket and did not remove them for several minutes before removing them from her room. Relative reported on 4/22/23 she again came to visit at 4:30pm and noted a strong urine odor and found Resident A's foley catheter was leaking and she was again lying in urine. Relative A3 reported she began changing Resident A rather than contact Mr. Ellison and noted there was stool from 10:00am on Relative A's back and wiped "into the bandage on her bottom" as she has pressure wounds on her bottom. Relative A3 reported she was very upset that the staff did not change the bandage after Resident A had a bowel movement and spoke with house management about her concerns.

On 5/25/23, I interviewed the adult protective services worker (APSW) assigned to this investigation from Cass County. APSW reported she has concerns about the care provided to Resident A based on interviews with the family and DCSM.

On 5/25/23, I interviewed DCSM Keisha Martinez by phone. Ms. Martinez reported she works first shift and has been at the home for eight years. Ms. Martinez reported she provides care to Resident A and she helps with rotating her and checks her adult briefs and changes them when necessary. Ms. Martinez reported she is aware of the complaints made about the care Resident A receives at the home. Ms. Martinez reported the staff check on residents every two hours and at the end of their shifts. Ms. Martinez was unsure how the DCSM missed changing Resident A between shifts on 4/22/23 but speculated Resident A went to the bathroom after the last check on first shift and before the bowel movement was discovered on second shift. Ms. Martinez reported there are times that the family will tell them it's ok not to check on her while they are visiting.

On 6/5/23, I interviewed DCSM Willie Ellison by phone. Mr. Ellison reported he has worked at the home for six months and usually works second shift. Mr. Ellison confirmed that provides care to Resident A and that he was told by the family that they had concerns about the care she received on 4/22/23. Mr. Ellison reported that they were concerned about Resident A not being fully cleaned after a bowel movement however it happened on first shift and not on second shift. Mr. Ellison reported he remembers Resident A's catheter leaking but it was fixed, and the room was cleaned so it did not smell of urine. Mr. Ellison reported they check the resident's adult brief every two hours however there were times when they would go longer than the two-hour checks when the family was visiting.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	It was reported Resident A was not properly cleaned after having her adult brief changed. Based on interviews with family members and DCSM this violation will be established. Several family members noticed a decline in the personal care received by Resident A and on 4/22/23 she was found with bowel movement under a bandage which should have been cleaned after changing her adult brief. In addition, two DCSM reported there have been times that Resident A will not be checked on for greater than two hours.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A was not given her 4:00pm medication on time.

INVESTIGATION:

Relative A2 reported they are also concerned about medication errors as Resident A takes a medication for Parkinson’s Disease that has to be administered either ten minutes before 4:00pm or ten minutes after 4:00pm and a DCSM named Wille Ellison tried to give her the medication at 8:00pm along with her other medications. Relative A2 reported she stopped Mr. Ellison from passing the medication however he had to dump all of her 8:00pm medications because they are all in liquid form. Relative A2 reported she was concerned that if she did not stop him Resident A would have been given a medication that is not prescribed to her at 8:00pm.

On 5/22/23, I reviewed Resident A’s Medication Administration Record (MAR). I noted the home uses a computer-based MAR system and that Resident A is prescribed Sinemet that is passed at 4:00pm. The MAR indicated Resident A receives her Sinemet at 4:00pm and has not missed a dose or received the medication late. I also noted that the MAR does not automatically time stamp when the medication is passed and that the individual passing the medication would have to manually input a late medication passed or a medication error.

On 5/22/23 I interviewed supervisor, Kayla Lyons at the home. Ms. Lyons reported she is aware of the concerns raised about the Resident A. Ms. Lyons reported Resident A's medications have to be passed through a liquid or if the medication is a pill it needs to be crushed. Ms. Lyons reported the medications can be mixed and passed together if they are given at the same time. Ms. Lyons confirmed that the electronic MAR does not record the specific time a medication is passed ad that the DCSM would have to enter a special note if there was an error.

I interviewed DCSM Willie Ellison by phone. Mr. Ellison reported being one of the DCSM that passes medications. Mr. Ellison denied ever passing medications incorrectly or outside of the time frames allowed for the 4:00pm 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:	It was alleged Resident A was not given her 4:00pm medication on time. Based on interviews and review of Resident A's MAR this violation will not be established. On 4/22/23 a staff member was observed to be preparing to pass Resident A's 4:00pm medication at 8:00pm but was prevented form doing so. Resident A's MAR was reviewed and it did not document any medication errors.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 6/6/23, I shared the findings of my investigation with Licensee Designee, Carol Del Raso by phone. Ms. Del Raso acknowledged and agreed to submit a corrective action plan.

III. RECOMMENDATION

Based on the submittal of an acceptable corrective action plan, I recommend no change in the current license status.

Nile Khabeiry, LMSW 6/7/23

Nile Khabeiry Date
Licensing Consultant

Approved By:

Russell Misiak 6/20/23

Russell B. Misiak Date
Area Manager