GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 27, 2023

Krishelle Wiley
The Coach Stop Manor, LLC
2003 W. Jefferson
Trenton, MI 48183

RE: License #: AS820410244
Investigation #: 2023A0116037
Island House

Dear Ms. Wiley:

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 (313) 456-0380.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820410244
Investigation #:	2023A0116037
Complaint Receipt Date:	05/16/2023
Investigation Initiation Date:	05/17/2023
Report Due Date:	07/15/2023
Licensee Name:	The Coach Stop Manor, LLC
Licensee Address:	2003 W. Jefferson Trenton, MI 48183
Licensee Telephone #:	(734) 692-9291
Administrator:	Krishelle Wiley
Licensee Designee:	Krishelle Wiley
Name of Facility:	Island House
Facility Address:	8504 Macomb Street Grosse Ile, MI 48138
Facility Telephone #:	(734) 692-0564
Original Issuance Date:	03/29/2022
License Status:	REGULAR
Effective Date:	09/29/2022
Expiration Date:	09/28/2024
Capacity:	6
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The home is understaffed.	No
In March of 2023 staff failed to give Resident A her medication for a urinary tract infection (UTI).	Yes
Resident A is not given adequate food to eat.	No

III. METHODOLOGY

05/16/2023	Special Investigation Intake 2023A0116037
05/16/2023	APS Referral Received.
05/17/2023	Special Investigation Initiated - Telephone Interviewed Relative (A).
05/22/2023	Inspection Completed On-site Visually observed Resident A and B, interviewed staff, Shana Benson, and reviewed Resident A's March 2023 medication administration record (MAR).
05/24/2023	Contact - Telephone call made Spoke with Relative A.
05/25/2023	Contact - Document Received Received physician order for Resident A's Ciprofloxacin 250mg tablets.
05/26/2023	Contact - Telephone call made Interviewed licensee designee, Krishelle Wiley, and requested that she email me copies of Resident A's February 2023 MAR.
05/26/2023	Contact - Document Received Received Resident A's February 2023 MAR.
06/14/2023	Contact - Telephone call made Interviewed staff, Kimberly Dale.

06/14/2023	Inspection Completed-BCAL Sub. Compliance
06/14/2023	Exit Conference With licensee designee, Krishelle Wiley.

ALLEGATION:

The home is understaffed.

INVESTIGATION:

On 05/17/23, I interviewed Relative A and she reported that she believed back in March of 2023 the home should have had additional staff as there was a resident that was bed bound. I informed Relative A that although staffing ratios are determined by the needs of residents, just having a resident that is bed bound does not always require an increase in staff to resident ratios. Relative A reported an understanding. Relative A reported that since Resident A has lived in the home there has not been more than three residents at any time. Relative A reported that the resident who was bedbound, is no longer at the facility.

On 05/22/23, I conducted an unscheduled onsite inspection and interviewed staff Shana Benson, and visually observed Resident A. Ms. Benson reported that she started working in the home yesterday and is not aware of what the staffing ratios were in the past. Ms. Benson reported that she has worked in this field for years and previously worked for Ms. Wiley's home health care company. Ms. Benson confirmed that the home currently has three residents and reported that Resident A was moving to her new home today.

I visually observed Resident A as she was being wheeled into the bathroom to be showered by her Elara Caring Hospice Aide. I also visually observed Resident B who was talking to her daughter who was at the home visiting. I observed that Resident B is ambulatory.

On 06/14/23, I interviewed staff, Kimberly Dale, and she reported that the home is not and has not been understaffed. Ms. Dale reported that since the home has been operating (March of 2022) there has not been more than three residents in the home. Ms. Dale also reported that all but one of the past residents have been ambulatory and able to complete some of their activities of daily living (ADLS) without staff assistance. Ms. Dale also confirmed that the three current residents living in the home are ambulatory with their walkers.

On 06/14/23, I conducted the exit conference with licensee designee, Krishelle Wiley and informed her of the findings of the investigation. Ms. Wiley agreed with the findings and reported that the home is not and has not been understaffed. Ms. Wiley

reported that she is aware of the rules and knows that staffing is based on the needs of the residents. Ms. Wiley added that the home has only has three residents at one time in the home since it opened last year, and based on their needs one staff to the three residents was sufficient.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on the findings of the investigation, I am unable to corroborate the allegation. Relative A reported her belief that more than one staff on shift was required in March of 2023, as there was one resident that was bed bound. I explained to Relative A that this alone does not require additional staff. Relative A reported an understanding. Ms. Dale and Ms. Wiley both reported that since the home has opened (March of 2022) there has not been more then three residents living in the home at any one time. They further reported that the residents in the home were either ambulatory, ambulatory with walkers, and their needs did not require a second staff on shift. This violation is not established as the licensee designee has sufficient staff on duty for supervision, personal care, and protection of the residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

In March of 2023 staff failed to give Resident A her medication for a urinary tract infection (UTI).

INVESTIGATION: On 05/17/23, I interviewed Relative A and she reported that during the first week of March 2023 she was going out of town and reported that Resident A had been prescribed Ciprofloxacin for a possible urinary tract infection

(UTI) to be given two tablets for five days. Relative A reported that when she returned from out of town and went to visit Resident A she observed that Resident A had not been giving the medication over the weekend and reported she believes it was about six tablets left. Relative A reported that the medication course should have been completed that Monday evening or at the latest Tuesday morning (Relative A was unable to provide the dates at time of this interview). Relative A reported that when staff Kimberly Dale works there are no issues, however, on the weekends when she is not working, is when things always go wrong.

Relative A reported she would review the prescription order, confirm the dates and send them to me for review. Relative A reported that the staff person who was responsible for administering the medication no longer works in the home and reported that she knows that her first name was Rachel. Relative A reported that her concerns were reported to Adult Protective Services, however, they did not investigate the allegations.

On 05/22/23, I conducted an unscheduled onsite inspection at the home and interviewed staff Shana Benson. Ms. Benson reported that she just started yesterday (05/21/23) and was not aware of the incident.

I reviewed Resident A's March 2023 MAR and did not observe Ciprofloxacin listed.

On 05/24/23, I spoke with Relative A and informed her that I did not observe the Ciprofloxacin listed on the March 2023 MAR. Relative A reported that she may have stated the incorrect month. Relative A reported that she would review the prescription order and bottle and forward the information to me.

On 05/25/23, I received a copy of the prescription order from Relative A. Resident A was prescribed 10 250mg Ciprofloxacin tablets on 02/02/23. The order states to give one tablet every 12 hours for five days.

On 05/26/23, I interviewed licensee designee, Krishelle Wiley, and she reported that the allegation was true. Ms. Wiley reported that staff, Rachel Lion, reported that she did not see the medication bottle with the Ciprofloxacin tablets and reported that the MAR that had the Ciprofloxacin documented on it was in back of the medication and not with the other MARs. Ms. Wiley reported that when the error was caught on the morning of 02/06/22, staff, Kimberly Dale, administered that morning's tablet and continued until the medication was finished. I requested Resident A's February 2023 MAR be sent to me for review.

On 05/26/23, I received and reviewed Resident A's February MAR. I observed the 250mg Ciprofloxacin tablets documented on the MAR with the instructions to administer one tablet every 12 hours for five days. The MAR documented the times of administration as 8:00 a.m. and 8:00 p.m. The first dose was administered Thursday 02/02/23 at 8:00 p.m. and initialed as given by staff Kimberly Dale. Ms. Dale's initials were the only ones documented on the MAR as administering this

medication. The 8:00 p.m. doses were not administered at 8:00 p.m. on 02/03/23 or 02/04/23/. Neither the 8:00 a.m. nor 8:00 p.m. dose was administered on 02/05/23. The medication course resumed at 8: 00 a.m. on 02/06/23 and the course completed, according to the MAR, with the final dose being administered at 8:00 a.m. on 02/09/23.

On 06/14/23, I interviewed staff, Kimberly Dale, and she reported that she remembers the medication error. Ms. Dale reported that she administered the medication as prescribed when she was working and initialed the MAR as required. Ms. Dale reported she is not aware of how or why the medication was missed or not given on the days she was not working. Ms. Dale reported when she returned to work on Monday 02/06/23, she observed that the medication had not been given as prescribed and she resumed the course as the medication still needed to be administered based on the label and prescription instructions.

On 06/14/23, I conducted the exit conference with licensee designee, Krishelle Wiley and informed her of the findings of the investigation and the specific rule cited. Ms. Wiley reported understanding.

APPLICABLE RULE	
R 400.14312	**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 findings of the investigation, which included interviews with Relative A, Ms. Dale, Ms. Wiley and consultant observation, I am able to corroborate the allegation. Relative A reported and confirmed that Resident A was prescribed 250mg tablets of Ciprofloxacin on 02/02/23 that were to be given twice per day for five days. On 02/06/23, Relative A was at the home visiting and observed that the staff failed to administer Resident A's medication as prescribed. Ms. Wiley admitted that staff, Rachel Lion, was the staff that failed to administer the medication as prescribed. Ms. Wiley reported that Ms. Lion reported that she did not see the medication bottle and that the MAR that documented the Ciprofloxacin medication was not with the MARs. Ms. Dale reported that she gave the medication as prescribed when she was on shift. Ms. Dale reported that when she returned to work on 02/06/23, she observed that several doses of the medication had not been administered. This violation is established as Resident A's 250mg Ciprofloxacin tablets were not given as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A is not given adequate food to eat.

INVESTIGATION:

On 05/17/23, I interviewed Relative A and she reported that she had concern sometimes about how the food was prepared. Relative A also reported that on one occasion Resident A was only given a half of tuna salad sandwich. Relative A reported that some of the staff do not know how to cook or did not care to prepare the meals the way they should.

On 05/22/23, I conducted an unscheduled onsite inspection and interviewed staff Shana Benson. Ms. Benson reported that the home has an adequate food supply and reported that yesterday was her first day working in the home so she has no knowledge of what may have occurred in the past.

Resident A was not interviewed as she was being prepped to be showered by her Hospice aid. Ms. Benson reported that Resident A was also moving to her new home today.

I observed the food supply and found it to be more than adequate. There were fresh fruit and vegetables available, and the both the refrigerator, freezer and cabinets were stocked with food.

On 05/26/23, I interviewed licensee designee, Krishelle Wiley, and she reported that the home is always stocked with food and the residents get plenty of food to eat. Ms. Wiley reported that the meals are nutritious, and the residents eat three meals per day. Ms. Wiley reported there are times that they make substitutions to the menus for holidays, birthdays etc. where they may order out, but she reported the residents always get plenty to eat. Ms. Wiley reported that there may have been a day where Resident A only ate a half of tuna sandwich, but it could have been because that's all she wanted, she may not have been as hungry as the residents sometimes snack on fruit or other items during the day. Ms. Wiley reported it was not because more was not available to her.

On 06/14/23, I interviewed staff, Kimberly Dale, and she reported that there is always healthy and nutritious food in the home for the residents. Ms. Dale reported that the residents eat very well. Ms. Dale reported that she follows the menus and reported that the meals consist of a protein, starch/carbohydrate, vegetable and/or fruit. Ms. Dale reported that she can not speak to what happens when she is not working but reported food is not and has never been an issue in this home.

On 06/14/23, I conducted the exit conference with licensee designee, Krishelle Wiley and informed her of the findings of the investigation. Ms. Wiley agreed with the findings.

APPLICABLE RULE	
R 400.14313	**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:	Based on the findings of the investigation, which included interviews of Relative A, Ms. Dale, Ms. Wiley and consultant observation, I am unable to corroborate the allegation. Relative A reported that her concern was more about the preparation of the food but did not elaborate. Relative A also only provided one instance where she believed Resident A was not adequately fed and her concern was that Resident A was only given a half of tuna salad sandwich. Ms. Dale and Ms. Wiley both reported that the home is stocked with healthy and nutritious food and the residents eat well. Ms. Dale reported that when she works, she follows he menus and makes sure the residents eat from all of the food groups. Ms. Wiley also reported that if there was a time when Resident A only ate half of tuna salad sandwich, it wasn't because it was not more available to her and reported she may not have been hungry and/or was satisfied with the portion provided to her. I observed the home to have an ample food supply with fresh fruit and vegetables available. The cabinets, refrigerator, and freezers were stocked with food.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

Pandrea Robinson
Licensing Consultant

06/21/23
Date

Approved By:

06/27/23

_____

Ardra Hunter Date
Area Manager