GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN
ACTING DIRECTOR

August 9, 2023

Daniela Marit
Selah Senior Living LLC
1825 Hiller Rd
West Bloomfield, MI 48324

RE: License #: AS630410571
Investigation #: 2023A0611026
Selah Senior Living LLC

Dear Ms. Marit:

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,

Sheena Worthy, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd, Suite 9-100
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630410571
Investigation #:	2023A0611026
Complaint Receipt Date:	07/06/2023
Investigation Initiation Date:	07/12/2023
Report Due Date:	09/04/2023
Licensee Name:	Selah Senior Living LLC
Licensee Address:	1825 Hiller Rd West Bloomfield, MI 48324
Licensee Telephone #:	(248) 860-3101
Administrator:	Daniela Marit
Licensee Designee:	Daniela Marit
Name of Facility:	Selah Senior Living LLC
Facility Address:	760 Robar Circle White Lake, MI 48324
Facility Telephone #:	(248) 860-3101
Original Issuance Date:	09/23/2022
License Status:	REGULAR
Effective Date:	03/23/2023
Expiration Date:	03/22/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The owner put furniture on the side of Resident M's bed to prevent her from falling instead of a railing.	No
The owner is watching the employees through the camera, so there is a concern for HIPAA privacy for the residents. The staff ratio is off.	No
Additional Findings	Yes

III. METHODOLOGY

07/06/2023	Special Investigation Intake 2023A0611026
07/12/2023	Special Investigation Initiated - On Site I completed an unannounced onsite. I interviewed staff member, Viorica Ardeleah, the licensee designee, Daniela Marit, and Resident A. I received copies of the residents assessment plans and a staff schedule.
07/25/2023	Contact - Telephone call made I attempted to contact staff member, Ayesha Owens however; there was no answer. A message was not left because the mailbox is not set up.
07/25/2023	Contact - Telephone call made I left a voice message for staff member, Yvonne Peccoo requesting a call back.
07/25/2023	Contact - Telephone call received I received a return phone call from staff member, Ayesha Owens. The allegations were discussed.
07/25/2023	Contact - Telephone call made I made a telephone call to staff member, Amanda Beeler. The allegations were discussed.
07/25/2023	Contact - Telephone call made I made a second phone call to the licensee designee, Daniela Marit. I inquired about a live-in staff member.

07/25/2023	Exit Conference I completed an exit conference with the licensee designee, Daniela Marit via telephone.

ALLEGATION:

The owner put furniture on the side of Resident M's bed to prevent her from falling instead of a railing.

INVESTIGATION:

On 07/06/23, a complaint was received and assigned for investigation alleging that Resident M is in a wheelchair and a fall risk. She sleeps with a sensor on her, so they know when she is moving in bed. The alarm isn't loud for them to hear it on the other side of the floor or when they aren't close to Resident M's room. The caller asked the owner to put on a bed rail for Resident M's bed, so she doesn't fall off. Instead of a rail they arranged the room so that they put furniture on the side of her bed to stop her from falling. The owner said they need a doctor's approval to get the bed rail. Caller is concerned that the furniture should not be holding Resident M in her bed. The ratio is off for residents to staff and the hours they work are very long. There are multiple residents that are a fall risk and there will be one person on staff. The owner is watching the employees through the camera, so they are concerned for HIPAA privacy for the residents.

On 07/12/23, I completed an unannounced onsite. I interviewed staff member, Viorica Ardeleah, the licensee designee, Daniela Marit, and Resident A. I received copies of the resident's assessment plans, prescriptions for hospital beds and/or bed rails, and a staff schedule.

On 07/12/23, I interviewed staff member, Viorica Ardeleah. It was difficult to interview Ms. Ardeleah due to a language barrier. Ms. Ardeleah's native language is Romanian. Ms. Ardeleah stated there are six residents in the home. Ms. Ardeleah stated Resident M does not fall out of bed. Ms. Ardeleah stated Resident M does not talk much. Ms. Ardeleah contacted the licensee designee, Daniel Marit as she could not understand my questions. I spoke to Mrs. Marit, and she stated she will arrive at the AFC group home shortly.

On 07/12/23, I observed Resident M sitting in the living room on the couch. Resident M's wheelchair was observed in the living room. I attempted to engage Resident M but she would not respond. I observed Resident M's bedroom. Resident M sleeps in a hospital bed. There were no bed rails observed on Resident M's bed. A nightstand was observed next to Resident M's bed. There was a reclining chair located across the room and a small dresser in the corner underneath the TV next to the bedroom door. There was no furniture big enough to position next to Resident M's bed to prevent her from falling out of bed other than the reclining chair.

On 07/12/23, I observed Resident J in her bedroom. Resident J appeared to be legally blind. I attempted to engage Resident J but she would not respond. I observed a hospital bed in Resident J's bedroom. There were no bed rails observed on Resident J's bed. I observed Resident S in her bedroom. Resident S was sitting in a chair mumbling incoherently to herself. I observed a hospital bed with no rails in Resident S bedroom. I observed Resident E sitting in her bedroom. I attempted to engage with Resident E, but she did not understand any of my questions. Resident B was observed sleeping in her chair.

On 07/12/23, I interviewed Resident A in her bedroom. I observed a hospital bed with rails in Resident A's bedroom. Resident A stated she likes living at the AFC group home. Resident A stated she is treated well at the AFC group home. Resident A has lived at the AFC group home for a couple of months, and she plans to be moving out soon into her own home. Resident A uses a walker. Resident A stated she fell out of her bed the first night she moved into the AFC group home. The staff helped Resident A back into bed and; since then bed rails were placed on her bed. Resident A stated when she goes to bed the staff put her bed rails up and when she wakes up in the morning the staff put her bed rails down.

Resident A stated she knows Resident M. Resident A stated Resident M can talk but she is quiet. Resident A does not know if Resident M has ever fallen out of her bed. Resident A is not aware of any resident falling out of bed. Resident A stated she thinks there is two staff members working each shift.

On 07/12/23, I interviewed the licensee designee, Daniela Marit. Regarding the allegations, Mrs. Marit stated Resident M has never fallen out of bed. When Resident M wakes up in the morning, she will stretch one of her legs out of bed but, she does not fall. Mrs. Marit stated all of the residents have Dementia and they all struggle with standing up on their own. Mrs. Marit stated she has call buttons and bed alarms for residents who need them. Resident M does not require a call button or a bed alarm because she is not a fall risk. I observed a keypad for the call buttons in the living room area. Mrs. Marit pressed the call button, and an alert goes off on the keypad and the bedroom number assigned to the keypad is announced. The volume on the keypad can be adjusted to a higher volume.

Mrs. Marit is unaware of anyone re-arranging furniture around Resident M's bed. The staff are not allowed to move furniture around a residents bed. Mrs. Marit stated staff member, Ayesha Owens asked her to put bed rails on Resident M's bed. Mrs. Marit believes Ms. Owens made this request because she does not want to check on Resident M during her midnight shift. Mrs. Marit denied Ms. Owens request because she does not have a prescription to place bed rails on Resident M's bed. Mrs. Marit explained to Ms. Owens that bed rails are not used to restrain residents in their beds. Mrs. Marit instructed Ms. Owens to lower Resident M's bed to be safe if she thinks Resident M may jump out of bed.

On 07/25/23, I received a call back from Ayesha Owens. Regarding the allegations. Ms. Owens stated Resident M cannot walk but, she will try to sit up and get out of bed. Ms. Owens was informed by staff members to place either a sit to stand, a wheelchair, or the recliner chair located in Resident M's bedroom next to her bed to prevent her from getting out of bed. Ms. Owens would not disclose any staff members name, nor did she reveal who instructed her place furniture around Resident M's bed. Ms. Owens denied ever witnessing Resident M falling out of bed. Ms. Owens stated the company told her that Resident M was a fall risk.

Ms. Owens works the midnight shift from 7:00pm to 7:00am. There is one staff on each shift. Ms. Owens stated a live-in staff was hired about a month ago who sleeps in the basement. Ms. Owens observed the live-in staff put a wheelchair and a sit to stand around Resident M's bed. Ms. Owens stated the only way a new staff member would do this is because she was instructed to do so. Ms. Owens stated she does not have pictures of any furniture being placed around Resident M's bed.

Ms. Owens stated all of the residents either have a call button or bed pad sensor except for Resident S and Resident B. Resident M has a magnet that is placed under her fitted sheet that clips to her shirt. Ms. Owens stated if Resident M tries to move out of bed the clip will come off and an alarm will go off. Ms. Owens stated the volume of the alarm is not loud enough to hear unless you are close to Resident M's bedroom. Ms. Owens stated Resident M's alarm is not connected to the keypad in the home as that is only for the call buttons/bed pad sensors. Ms. Owens stated Mrs. Marit told her that Resident M has a bed pad sensor however; Ms. Owens has never seen a bed pad sensor for Resident M.

Ms. Owens stated during one of her shifts, Resident M would not go to sleep and she stayed up during her entire shift. Ms. Owens contacted Mrs. Marit husband via text message on 06/29/23 and; informed him about Resident M staying up. Ms. Owens asked Mr. Marit about getting bed rails for Resident M. Mr. Marit informed Ms. Owens that a doctor has not signed an order for bed rails. Mr. Marit advised Ms. Owens to keep an eye on Resident M. Ms. Owens spoke to Mrs. Marit about bed rails for Resident M and she was informed that Resident M's family does not want her to have bed rails.

On 07/25/23, I made a telephone call to staff member, Amanda Beeler. Ms. Beeler has been on medical leave since 06/05/23 due to being in a car accident. Regarding the allegations, Ms. Beeler stated Resident M was determined by a doctor that she is not a fall risk. Ms. Beeler has never witnessed Resident M falling out of bed. Ms. Beeler is not aware of any staff member placing furniture around Resident M's bed to prevent her from getting out of bed. Ms. Beeler works the day shift (7:00am to 7:00pm). Ms. Beeler stated when she gets Resident M out of bed in the morning, she spends the day in the living area. Ms. Beeler stated at the end of her shift she puts Resident M to bed. Ms. Beeler denied ever putting any furniture or device around Resident M's bed nor has she witnessed another staff member doing so. Resident M does not have a call button because she is capable of using one due to her dementia.

APPLICABLE RULE	
R 400.14305	**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:	Based on the information gathered, there is no evidence to support the allegation pertaining to Mrs. Marit or any staff member placing furniture next to Resident M's bed to prevent her from getting out of bed. Mrs. Marit and Ms. Beeler denied this allegation. Mrs. Marit and Ms. Beeler also denied Resident M being a fall risk. Although Ms. Owens confirmed this allegation and stated that she witnessed a staff member placing furniture next to Resident M's bed, there was no proof as Ms. Owens would not provide anyone's name to verify her statements.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

The owner is watching the employees through the camera, so there is a concern for HIPAA privacy for the residents. The staff ratio is off.

INVESTIGATION:

On 07/12/23, Mrs. Marit explained that the cameras in the home are disconnected. Mrs. Marit denied ever watching staff on the cameras. Mrs. Marit stated she is present a lot at the AFC group home. Mrs. Marit stated the cameras were installed by the previous owner of the home. I observed cameras near the front door, in the living room, and near Resident M's bedroom. There were no cameras inside Resident M's bedroom. I did observe cameras in all of the other resident's bedrooms. Mrs. Marit insisted that the cameras did not work. During the onsite, Mrs. Marit's daughter took down all of the cameras in the residents bedroom. Mrs. Marit showed me the app to the camera system (Nvsee) on her phone. Mrs. Marit could not log in to the camera system because the account is closed. I did not observe any cameras in the bathroom.

On 07/25/23, Ms. Owens stated she noticed cameras in three resident's bedrooms. Ms. Owens does not know if the cameras work.

On 07/25/23, Ms. Beeler stated there are no cameras in the residents bedrooms but, there are cameras in the living area. Ms. Beeler is not sure if the cameras work but she assumed that they do work.

On 07/12/23, Mrs. Marit provided copies of Resident M's assessment plan and I took pictures of the other residents assessment plans. Resident M's assessment plan indicates that she does not move independently in the community as she requires assistance with daily living activities. Resident M's assessment plan does not indicate that Resident M requires 1:1 staffing.

Resident B's assessment plan does not indicate that Resident B requires 1:1 staffing.
Resident S assessment plan does not indicate that Resident S requires 1:1 staffing.
Resident A assessment plan does not indicate that Resident A requires 1:1 staffing.
Resident E's assessment plan does not indicate that Resident E requires 1:1 staffing.

Resident J's assessment plan does not indicate that Resident J requires 1:1 staffing. It is written in Resident J's assessment plan that she has half rails. Resident J's bed rails were not observed in her bedroom during the onsite. Mrs. Marit did not know what happened to Resident J's bed rails.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.**
ANALYSIS:	Based on the information gathered, there is no evidence to support that cameras located in the residents bedrooms were functioning. The staff interviewed were unable to confirm if the cameras were operating. Mrs. Marit explained that the cameras in the home are disconnected. Mrs. Marit denied ever watching staff on the cameras. The cameras located in the residents bedrooms were taken down during the onsite.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14303	**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:	According to all of the residents assessment plans, none of the residents require 1:1 staffing. Therefore, the AFC group home is in compliance with regards to having one staff on shift to care for six residents. However, it is written in Resident J assessment plan that she has half rails. Resident J's bed rails were not observed in her bedroom and Mrs. Marit does not know where the bed rails are. Therefore, Resident J is not receiving the protection as specified in her assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 07/12/23, Mrs. Marit stated there is one staff on duty per shift. The staff work 12-hour shifts from 7:00am to 7:00pm. I received a copy of the most recent staff schedule which was from April, 2023. Mrs. Marit stated the staff have a set schedule and they are aware of the days they work. According to the schedule, there are two staff names listed for each day. The staff schedule did not include job titles, hours or shifts worked.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.** **(b) Job titles.** **(c) Hours or shifts worked.** **(d) Date of schedule.** **(e) Any scheduling changes.**

ANALYSIS:	The most recent staff schedule provided by Mrs. Marit was from April 2023. The staff schedule did not include job titles, hours or shifts worked.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 07/12/23, Mrs. Marit provided copies of Resident M's assessment plan and I took pictures of the other residents assessment plans.

Resident M assessment plan was signed by Mrs. Marit and the guardian on 12/30/22.
Resident S assessment plan was signed by Mrs. Marit and the guardian on 09/12/22.
Resident A assessment plan is signed by Mrs. Marit and the guardian on 04/21/23.
Resident J assessment plan is signed by Mrs. Marit and the guardian on 03/21/23.

Resident B's assessment plan was not signed by her guardian nor was it dated by Mrs. Marit. Resident E assessment plan is signed by the guardian only on 06/30/23. Mrs. Marit did not sign Resident E's assessment plan.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Mrs. Marit did not sign Resident E's assessment plan. Resident B's assessment plan was not signed by her guardian nor was it dated by Mrs. Marit.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 07/12/23, I received copies of the resident's assessment plans and I took pictures of the prescriptions for hospital beds and other assistive devices for all the residents.

According to Resident M's assessment plan, her assistive devices include a hospital bed, wheelchair, and walker. Resident M's prescription for assistive devices is dated 12/30/22. Resident M is prescribed a hospital bed, wheelchair and cushion, four-wheel walker, and sit to stand lift.

According to Resident B's assessment plan, her assistive devices include hearing aids, walker, wheelchair, hospital bed, bed rails, and sit to stand lift. Resident B's prescription for assistive devices is dated 06/02/23. Resident B is prescribed a hospital bed with full rails, rolling walker, APM mattress, wheelchair, and sit to stand lift.

According to Resident S assessment plan, her assistive devices include a wheelchair, hospital bed, and full rails. Resident S prescription for assistive devices is dated 10/20/22. Resident S is prescribed a hospital bed with full rails, wheelchair and seatbelt, and a sit to stand lift for transfers.

According to Resident A's assessment plan, her assistive devices include a wheelchair, APM mattress, ROHO cushion, and rails. Resident A also has a sit to stand listed under special equipment. Resident A prescription for assistive devices is dated 04/21/23. Resident A is prescribed a hospital bed, alternating pressure mattress, ½ bed rails, wheelchair and cushion, and sit to stand for transfers.

According to the Resident J's assessment plan, her assistive devices include a hospital bed, Unna boots, walker, wheelchair, and half rails. Resident J prescription for assistive devices is dated 03/21/23. Resident J is prescribed a hospital bed with half side rails, wheelchair, and walker.

According to Resident E's assessment plan, her assistive devices include a walker, wheelchair, hospital bed, and a APM mattress. Resident E prescription for assistive devices is dated 06/30/23. Resident E is prescribed a hospital bed, APM mattress, walker, and wheelchair.

On 07/25/23, I completed an exit conference with the licensee designee, Daniela Marit via telephone. Mrs. Marit stated Ms. Owens has not returned to work since her surgery from a couple weeks ago. Mrs. Marit has not heard from Ms. Owens therefore; she plans to terminate her. Mrs. Marit was informed of the rule violations she will be cited on. Ms. Mari was informed that a corrective action plan will be required.

On 07/25/23, I made a second phone call to the licensee designee, Daniela Marit. Mrs. Marit denied having any live-in staff member. Mrs. Marit stated she recently hired Yvonne Peccoo who moved to Detroit from New Jersey. Mrs. Marit agreed to allow Ms. Peccoo to leave some of her luggage in the basement of the AFC group home. Mrs. Marit stated Ms. Peccoo lives in Detroit.

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(2) An assistive device shall be specified in a resident's written assessment plan and agreed upon by the resident or the resident's designated representative and the licensee.
ANALYSIS:	On 07/12/23, I observed a prescription for a sit to stand for Resident M and Resident S. However, this assistive device is not documented in Resident M or Resident S assessment plans.
CONCLUSION:	**VIOLATION ESTABLISHED**

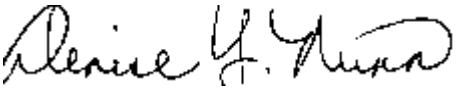
IV. RECOMMENDATION

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

07/25/23

Sheena Worthy
Licensing Consultant
Date

Approved By:



08/09/2023

Denise Y. Nunn
Area Manager
Date