GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 17, 2023

Jill Long
393 East Girard Road
Coldwater, MI 49036

RE: License #: AS130397946
Investigation #: 2023A0581043
Kerak

Dear Mrs. Long:

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 (517) 284-9730.

Sincerely,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS130397946
Investigation #:	2023A0581043
Complaint Receipt Date:	06/29/2023
Investigation Initiation Date:	07/03/2023
Report Due Date:	08/28/2023
Licensee Name:	Jill Long
Licensee Address:	393 East Girard Road Coldwater, MI 49036
Licensee Telephone #:	(269) 565-3109
Administrator:	Dwayne Long
Licensee Designee:	N/A
Name of Facility:	Kerak
Facility Address:	14077 Stone Jug Rd. Battle Creek, MI 49015
Facility Telephone #:	(931) 217-7606
Original Issuance Date:	09/23/2019
License Status:	REGULAR
Effective Date:	03/23/2022
Expiration Date:	03/22/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
There is insufficient staffing for the residents who require two people for transferring.	Yes
Narcotic medications are not being destroyed or administered properly.	No
Residents who are confined to their bed are skipped over during mealtimes.	No
Residents are not being showered on a regular basis.	No
Food isn't being stored properly.	No
Additional Findings	Yes

III. METHODOLOGY

06/29/2023	Special Investigation Intake 2023A0581043
06/30/2023	APS Referral via email
07/03/2023	Special Investigation Initiated - On Site Interviewed residents, staff, and reviewed resident documentation.
08/09/2023	Contact - Telephone call made Interview with Talia Paul
08/09/2023	Contact - Telephone call made Message left with PACE coordinator
08/09/2023	Contact - Telephone call made Interview with licensee, Jill Long.
08/09/2023	Contact - Document Sent Email to Ms. Paul.
08/09/2023	Contact - Telephone call made Interview with John Seiler, office administrative assistant.
08/09/2023	Contact - Telephone call made Interview with direct care staff, D'Nasia Wilson.
08/09/2023	Contact - Document Received Email from Mr. Seiler.

08/10/2023	Contact - Telephone call received Received message from PACE care coordinator supervisor, Sarah Howard
08/11/2023	Contact - Telephone call made Interview with direct care staff, Erma Ogo
08/11/2023	Contact - Telephone call made Interview with Ms. Howard.
08/11/2023	Contact - Telephone call made Interview with Ms. Paul.
08/11/2023	Contact - Document Received Emails from Ms. Paul.
08/14/2023	Inspection Completed-BCAL Sub. Compliance
08/16/2023	Exit conference with the licensee, Jill Long, via telephone.

ALLEGATION:

- **There is insufficient staffing for the residents who require two people for transferring.**

- **Residents are left soiled for hours.**

INVESTIGATION:

On 06/30/2023, I received this anonymous complaint through the Bureau of Community Health System (BCHS) online complaint system. The complaint alleged any resident who was a “two-person assist” was not being transferred with two direct care staff or with the assistance of the Hoyer lift. Additionally, the complaint alleged residents are left soiled for hours.

On 07/03/2023, I conducted an unannounced inspection. I interviewed direct care staff, Melberson Poll, who stated he was only the direct care staff working in the facility. Mr. Poll identified Resident A as the only resident who required two direct care staff to transfer. Mr. Poll stated only one direct care staff was needed to utilize a Hoyer lift in the facility, which I did observe a Hoyer lift in Resident A’s bedroom.

Mr. Poll stated Resident A was confined to her bed while the other residents were ambulatory. Mr. Poll stated he could assist Resident A by himself without the

assistance of any other staff. For example, Mr. Poll stated he could turn Resident A on her side when she required her incontinence briefs changed. He stated Resident A is verbal; therefore, she can also request staff assistance when needed like when she's experienced incontinence. Mr. Poll stated Resident A is provided with bed baths and her incontinence briefs are changed regularly.

I interviewed Resident A who confirmed she doesn't get out of her bed because she is unable to stand by herself. She stated if staff have to get her out of bed, then only one direct care staff is needed to utilize the Hoyer lift. Resident A stated her incontinence briefs are "changed often". Resident A stated she is not left sitting in her soiled incontinence briefs for hours. Resident A did not indicate any concerns regarding her care. She stated she feels she's taken care of, there is always a direct care staff in the facility, and she feels safe.

Resident B and Resident C both stated direct care staff are always in the facility. They both stated they can toilet independently without the assistance of staff. Although they both were aware Resident A was confined to her bed they were unable to provide any information as to the care she required from staff. Both Resident B and Resident C stated staff provide adequate care to them. They both stated they had no concerns with how they were cared for by direct care staff members.

Neither Resident A, B, nor C were observed in need of personal care or unclean. Additionally, I didn't smell any notable odors indicating any of the residents were being left in a soiled incontinence brief.

Direct care staff and identified property manager, Talia Paul, stated two staff are used to transfer Resident A out of bed, but when the Hoyer lift is used only one direct care staff is needed. She stated Resident A's *Assessment Plan for AFC Residents* (assessment plan) does not document or identify Resident A needing two direct care staff in transferring Resident A. She stated the Senior Care Partners Program of All-Inclusive Care for the Elderly (PACE) agency trained facility staff that only one person is needed to operate the Hoyer lift.

Direct care staff and identified home manager, Katie Paul's, statement to me was consistent with Ms. Talia Paul's statement to me. She stated only one direct care staff is needed to "move or change" Resident A. She stated every resident in the facility is a "one person assist." Additionally, Ms. Katie Paul checked Resident A's incontinence brief during the inspection and confirmed it wasn't soiled or wet.

I reviewed Resident A's assessment plan during the inspection; however, it was only signed, but not dated, by the licensee, Jill Long. The assessment plan documented Resident A requires help with walking/mobility with the use of a Hoyer. I also requested to review Resident A's *Health Care Appraisal*; however, one was not available for review.

I also reviewed Resident B's, C's, D's, and E's *Assessment Plans for AFC Residents*; however, none of these assessments indicated any of the residents required the use of a Hoyer lift or the need for two direct care staff in transferring, walking/mobility or in any other capacity to assist with their personal care.

On 08/09/2023, I interviewed licensee Jill Long via telephone. Ms. Long stated she did not believe any of the residents in the facility required two direct care staff to transfer or ambulate. Ms. Long statement to me regarding direct care staff being trained to operate Hoyer lifts by PACE staff was consistent with Ms. Talia Paul's statement to me.

On 08/09/2023, I interviewed direct care staff, D'Nasia Wilson, via telephone. Ms. Wilson stated she's worked at the facility for approximately six months and primarily works the overnight shift. Ms. Wilson denied residents being left soiled or wet for hours. She stated Resident A is the only resident who is confined to her bed, but she stated only one direct care staff is needed to rotate Resident A and change her incontinence briefs. She stated Resident A can also communicate with staff and let staff know if she needs a brief change. Ms. Wilson stated Resident A requires the use of a Hoyer lift if she had to be transferred; however, she stated she's never observed Resident A taken out of her bed. Ms. Wilson stated Resident B and Resident C can toilet themselves while Resident D requires staff assistance with getting on and off the toilet.

On 08/10/2023, I interviewed the licensee's Office Administrator, John Seiler. Mr. Seiler stated PACE staff train the facility's direct care staff on how to use Hoyer lifts. Following my interview with Mr. Seiler, he emailed me a copy of the Hoyer training, which was titled "Mechanical Lift Hoyer – Check on Points". According to my review of this training the third bullet point listed on the training documented "Obtain assistance – hoyer mechanical lift should always been[*sic*] done with two people."

On 08/11/2023, Ms. Talia Paul sent via email an additional copy of the training, along with a copy of the Hoyer lift's safety guide, which documented "most lifts require two or more caregivers to safely operate lift and handle patient."

Ms. Talia Paul also included the training sign in sheet titled "Safe machanical[*sic*], sit to stand, transfer boards", dated 06/05/2023. The training sign in confirmed direct care staff, D'Nasia Wilson, Erma Ogo, and Melberson Poll, all attended this training.

Ms. Talia Paul also sent me a copy of the facility's July staff schedule, which identified two shifts in the facility, 7 am until 7 pm and 7 pm until 7 am. According to my review of the schedule, only one direct care staff was assigned to work each shift.

On 08/11/2023, I also interviewed direct care staff, Erma Ogo. Ms. Ogo stated she's worked at the facility since approximately March 2023 and primarily works the overnight shift, but also picks up shifts during the day, as well. Ms. Ogo's statement

to me regarding the overnight staff shift and Resident A's use of a Hoyer lift was consistent with Ms. Wilson's statement to me. Ms. Ogo stated two staff are needed to operate the Hoyer lift; however, Resident A stays confined to her bed. Ms. Ogo stated if she needed assistance with moving Resident A during the overnight shift, she would contact staff from the neighboring facility.

On 08/11/2023, I interviewed PACE transition navigator, Sara Howard. Ms. Howard stated PACE nurses visited the home at least once a month and did not disclose any concerns pertaining to resident care. She confirmed PACE provided the facility's staff with Hoyer lift training. Ms. Howard stated Resident A came to the PACE agency on or around 08/09/2023 and requested not to be sent back to the facility. Ms. Howard stated Resident A is now residing with relatives.

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 my investigation, which included interviews with Residents A, B, and C, as well as my observations of them, and interviews with direct care staff, Melberson Poll, Katie Paul, Talia Paul, Erma Ogo, and D'Nasia Wilson, there is no evidence supporting any of the residents, including Resident A, are being left soiled or wet for extended periods of time, as alleged. However, upon review of Resident A's *Assessment Plan for AFC Residents*, and PACE's training documentation for mechanical Hoyer lifts, two direct care staff are needed to operate a Hoyer lift, which Resident A requires to walk/ambulate. Despite two direct care staff being needed to utilize the Hoyer lift, the facility only provides one direct care staff to work during the day and overnight shift leaving the facility insufficiently staffed to meet the personal care needs of Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Narcotic medications are not being destroyed or administered properly.

INVESTIGATION:

No additional information was provided pertaining to the allegations.

Direct care staff, Melberson Poll, denied the allegations and stated there were no issues or concerns regarding medications not being destroyed or administered, as required. Mr. Poll stated if medications are no longer needed then staff will contact Talia Paul, the facility's property manager, who then disposes of the medication.

Mr. Poll identified Resident A as receiving narcotic medication. I reviewed both Resident A's Medication Administration Record (MAR) and Resident A's "MEDICATION COUNT SHEET" provided by Mr. Poll. Resident A's medication count sheet indicated the medication, Hydrocodone 325 mg, started on 06/28/2023. I counted the number of pills in the corresponding bubble pack, which were the same number of pills staff documented as being left on the medication count sheet. Subsequently, I did not identify any medication concerns on Resident A's MAR or her medication count sheet.

I also reviewed Resident B's, C's, D's, and E's, MARs, which indicated no concerns in the administration of their medications.

Resident A, B, and C all stated they receive their medication, as required. None of the residents indicated any concerns relating to their medications.

Direct care staff, Katie Paul, Talia Paul, Erma Ogo, and D'Nasia Wilson, all denied there being any issues with the administration of medications, as required, or any issues/concerns with the proper disposal of medications. Ms. Katie Paul, Ms. Talia Paul, and Ms. Ogo all stated discontinued medications are disposed of in jars brought in by Long Term Pharmacy, which is the facility's identified pharmacy. They also stated medications may be sent back to the pharmacy or local Red Med Boxes. Ms. Wilson stated she would inform the facility's management, Ms. Katie Paul and Ms. Talia Paul about any discontinued medication for them to properly dispose of it.

Ms. Howard stated PACE nurses reviewed resident MARs each month when visiting with residents in the facility. She stated none of the nurses identified any concerns regarding resident medications after visiting the facility.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on my interviews with Resident A, B, and C, and direct care staff, Melberson Poll, Katie Paul, Talia Paul, Erma Ogo, and D'Nasia Wilson, and my review of the resident's Medication Administration Records, there was no evidence supporting the allegation resident medications are not being administered properly.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(7) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a physician or a pharmacist.
ANALYSIS:	Based on my interviews with care staff, Melberson Poll, Katie Paul, Talia Paul, Erma Ogo, and D'Nasia Wilson the licensee has established a protocol for properly disposing of resident medication after it is no longer required. Subsequently, there is no evidence supporting the licensee is not properly disposing medication, as alleged.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents who are confined to their bed are skipped over during mealtimes.

INVESTIGATION:

The complaint provided no additional information to the allegations.

Direct care staff, Melberson Poll, identified Resident A as the only resident in the facility confined to her bed. My observation of Resident A and the other residents corroborated Mr. Poll's statement to me. Mr. Poll denied the allegations and stated meals and food is provided to Resident A at least three times a day. He stated there were no concerns with Resident A not eating.

Resident A stated staff provide her with three meals a day. She indicated no concerns with not having access or not being provided with food or meals. Resident A stated she also has relatives that bring in snacks for her, which staff also provide to her.

Resident B and Resident C both stated they receive three meals per day. Neither resident indicated any concerns with any residents, including Resident A, not being provided any meals throughout the day.

Direct care staff, Katie Paul, Talia Paul, Erma Ogo, and D'Nasia Wilson, all stated residents receive three meals a day. They all denied the allegations of skipping over Resident A during mealtimes. Ms. Wilson stated there have been incidences where Resident A states she isn't hungry; however, staff will still provide her with a plate in case she becomes hungry.

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:	There is no evidence Resident A, the only resident who is confined to her bed, is not provided at least three meals daily, as required, or that she is skipped over at mealtimes, as alleged.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents are not being showered on a regular basis.

INVESTIGATION:

There was no additional information provided in the complaint.

Residents A, B, and C all stated they are bathed at least weekly or more often, if necessary. Resident A stated that due to her being confined to her bed, staff give her weekly bed baths.

Upon observing Residents A, B, and C, there was no indication any of the residents appeared dirty, unclean or had any odors indicating they needed bathing.

Direct care staff, Melberson Poll, Katie Paul, Talia Paul, Erma Ogo, and D'Nasia Wilson, all stated residents have a shower schedule to receive assistance with showering at least twice a week. They all stated residents can bathe more often, as well.

During my inspection, I reviewed the facility's shower schedule, which confirmed each resident has two assigned bathing or shower days.

Resident A's assessment plan documented staff provide Resident A with bed baths.

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions, when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Based on my interviews with Resident A, B, and C, and direct care staff, Melberson Poll, Katie Paul, Talia Paul, Erma Ogo, and D'Nasia Wilson, and my review of the facility's shower schedule, there is no evidence the licensee isn't ensuring residents bathe at least weekly or more often, if necessary, as required.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Food isn't being stored properly.

INVESTIGATION:

The complaint alleged the facility's food is not being stored properly and is being left out of the counters overnight and during the day until dinner is served at 5 pm.

During my inspection, I did not observe any food on the kitchen counters. I checked the facility's refrigerator and did not observe any contamination concerns regarding any food or leftovers.

Residents A, B, and C all stated food is stored properly at the facility. They all denied ever seeing food left out on the kitchen counters for extended periods of time causing contamination concerns.

Direct care staff, Melberson Poll, Katie Paul, Talia Paul, Erma Ogo, and D'Nasia Wilson, all denied the allegations. They all stated food is prepped during the overnight shift; however, it is put in the refrigerator after it is prepared. Ms. Wilson stated food may be placed in warmer or the oven prior to being served to keep it warm. She stated any food that is leftover is also dated.

APPLICABLE RULE	
R 400.14402	**Food service.**
	(2) All food shall be protected from contamination while being stored, prepared, or served and during transportation to a facility.
ANALYSIS:	There is no evidence the facility's food is at risk of contamination by being left out on the kitchen counters for extended periods of time when stored, prepared, or served.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

As part of my investigation, I requested to review Resident A's *Health Care Appraisal* (HCA); however, one was not available for review, as required. I reviewed Resident A's face sheet, which identified Resident A's admission date as 04/17/2023.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall

	be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	Resident A was admitted into the facility on 04/17/2023; however, a *Health Care Appraisal* was not obtained at the time of her admission. Consequently, Resident A had no completed *Health Care Appraisal* at the time of my inspection, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

As part of my investigation, I reviewed Resident A's *Assessment Plan for AFC Residents*. Upon review of this required AFC document, I established only the licensee, Jill Long, signed the form; however, she did not date it. Additionally, there were no signatures for either Resident A, her designated representative, or her responsible agency, Senior Care Partners (PACE), verifying their participation in the creation of this document.

On 08/11/2023, Talia Paul, sent via email a signed *Assessment Plan for AFC Residents* for Resident A. According to my review of this assessment plan, it was signed and dated, 07/08/2023, by Resident A's designated representative, the licensee, Jill Long, and Talia Paul. There was no indication Resident A's responsible agency signed the document to verify participation.

In my review of the facility's electronic file, I determined the licensee had a repeat finding of Adult Foster Care licensing rule, R 400.14301(4). According to the Renewal Licensing Study report, dated 03/07/2022, the licensee was in violation of Adult Foster Care licensing rule 400.14301(4), when it was established *Assessment Plan for AFC Residents* were not completed annually for residents. The licensee's approved corrective action plan (CAP), dated 03/04/2022, documented the licensee would obtain updated assessment plans, monitor, and maintain them.

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:	Resident A's *Assessment Plan for AFC Residents* was neither signed nor dated by Resident A or her designated representative, if applicable, or her responsible agency, Senior Care Partners (PACE). Though the licensee, Jill Long, signed the assessment plan; she did not date it. Signatures of the Licensee, resident and/or resident's representative and responsible agency, demonstrate all required persons have participated in the development of the written assessment plan. If the responsible agency refuses to sign the resident's written assessment plan, this should be noted on the assessment plan.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[SEE RENEWAL, DATED 03/07/2022, CAP DATED 03/04/2022]**

On 08/16/2023, I conducted the exit conference with licensee, Jill Long, via telephone. Ms. Long acknowledged the findings. She stated she would work with facility staff on completing an acceptable corrective action plan. She indicated resident binders would be reviewed to ensure proper organization and she would either reach out to PACE to obtain updated Hoyer training information or not accept residents who require a Hoyer lift.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

Cathy Cushman

08/16/2023

Cathy Cushman — Date
Licensing Consultant

Approved By:

Dawn Timm

08/17/2023

Dawn N. Timm — Date
Area Manager