GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 11, 2023

Megan Fry
MCAP DeWitt Opco, LLC
Suite 115
21800 Haggerty Road
Northville, MI 48167

RE: License #: AL190404713
Investigation #: 2023A0790062
Serene Gardens of DeWitt 2

Dear Megan Fry:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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. If I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Rodney Gill, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL190404713
Investigation #:	2023A0790062
Complaint Receipt Date:	09/13/2023
Investigation Initiation Date:	09/13/2023
Report Due Date:	11/12/2023
Licensee Name:	MCAP DeWitt Opco, LLC
Licensee Address:	Suite 115 21800 Haggerty Road Northville, MI 48167
Licensee Telephone #:	(517) 484-6980
Administrator:	Megan Fry
Licensee Designee:	Megan Fry
Name of Facility:	Serene Gardens of DeWitt 2
Facility Address:	1177 W. Solon Road Ste 2 DeWitt, MI 48820
Facility Telephone #:	(517) 484-6980
Original Issuance Date:	11/02/2020
License **Status:**	REGULAR
Effective Date:	05/02/2023
Expiration Date:	05/01/2025
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was prescribed an anti-biotic medication and it was not administered as prescribed.	Yes

III. METHODOLOGY

09/13/2023	Special Investigation Intake 2023A0790062
09/13/2023	Special Investigation Initiated – Telephone call made. Interviewed Complainant.
09/18/2023	Contact - Document Sent- Emailed the Complainant Letter to Complainant.
09/18/2023	APS Referral not necessary because the allegations do not meet assignment criteria. Adult Protective Services (APS) does not investigate allegations involving vulnerable adults who are deceased.
09/18/2023	Inspection Completed On-site. Interviewed executive director Kelly McCann, DCSMs Minette Charrier, and Aimee Nelson.
09/18/2023	Contact – Telephone call made- Interviewed registered nurse Kathy McMonagle.
10/10/2023	Inspection Completed-BCAL Sub. Compliance
10/10/2023	Corrective Action Plan Requested and Due on 10/25/2023.
10/10/2023	Contact – Telephone call made. Interviewed licensee designee Megan Fry.
10/10/2023	Exit Conference and interview with licensee designee Megan Fry.

ALLEGATION: Resident A was prescribed an anti-biotic medication and it was not administered as prescribed.

INVESTIGATION:

I reviewed a BCHS Online Complaint dated 09/12/2023. The complaint stated Resident A was found unresponsive on 08/10/2023 and that Resident A died 41 hours later with a diagnosis of sepsis. The complaint documented that when Resident A arrived at the

hospital her organs were already in advanced stages of shutting down. The complainant indicated evidence of neglect due to improper administration of antibiotics for an urinary tract infection (UTI). Complainant reported Resident A had been showing signs of illness for weeks and Complainant had been trying to get answers but no one was taking them seriously at the facility or addressing their concerns. Complainant said they have proof of all the neglect and improper administration of antibiotics, which included photographs. Complainant said they are requesting an investigation be conducted because they want the facility to have the proper amount of DCSMs working and to be properly trained.

Former AFC licensing consultant Leslie Herrguth interviewed Complainant via phone on 09/13/2023 and Complainant stated direct care staff members (DCSMs) are not trained well and Complainant brought this concern to administration many times. She said administrators did not address her concerns. Complainant said she offered to train the DCSMs, but the administrators refused her offer and will no longer communicate with her.

I interviewed Complainant on 09/13/2023 via phone and requested she email me any documentation she has demonstrating evidence of neglect and improper administration of antibiotics for an urinary tract infection (UTI).

I conducted an unannounced onsite investigation on 09/18/2023. I interviewed executive director Kelly McCann who stated she has been employed at the facility for 1.5 years. Ms. McCann said Resident A was a resident at the facility from 12/2022 until 08/10/2023 when transported by ambulance to the hospital. Ms. McCann stated she and all the DCSMs loved interacting and caring for Resident A. She said Resident A had a bright and pleasant affect, was very cooperative, and physically active upon admission and most of the time she resided at the facility. Ms. McCann said she and DCSMs working with Resident A began noticing concerning changes in her affect and behavior beginning in 07/2023. She stated it had been extremely hot and she felt the extreme heat may have played role in Resident A's change in affect and behavior. Ms. McCann stated Resident A began showing signs and symptoms she may be cognitively, physically, and medically decompensating. Ms. McCann said Resident A was lethargic, sleeping more, not as talkative, not responding to questions, and at times appeared catatonic. Ms. McCann stated Resident A had become combative, not sleeping, refusing daily care (i.e., showers, toileting, trips to bathroom, changing adult briefs), and begun slapping DCSMs and other residents. Ms. McCann said Resident A had scratched, bitten, and grabbed DCSMs by the neck. Ms. McCann said she began advocating for Resident A by contacting Program of All-Inclusive Care for the Elderly (P.A.C.E.) and requesting Care Conferences be held to address Resident A's changes in behavior and physical health status. Ms. McCann stated she was fighting hard to get Resident A the care she needed and felt she was receiving push back from PACE and refusal to make changes in the name of resident rights. Ms. McCann provided notes from a Care Conference scheduled by her to discuss Resident A's cognitive, physical, and medical decompensation. The Care Conference Notes were dated 07/03/2023, were titled *PACE Care Conference for [Resident A].* The notes listed those in

attendance which included representatives from P.A.C.E., the facility, and family. The notes listed topics discussed which included Resident A's behaviors – Combative, not sleeping, refusing daily care (showers), refusing to allow DCSMs to take her to the bathroom or change her adult brief, and slapping DCSMs and other residents. The notes went on to discuss treatment options such as medication management. The notes stated the following: "Can we look at medications [Resident A] is taking to see if changes may be needed to help give [Resident A] some peace and rest?" The notes indicated P.A.C.E. representatives brought up Resident Rights and facility representatives stated they understood residents have rights but what about ensuring residents are clean and well cared when refusing to comply with daily care routines. The notes indicated a decision was made to begin holding Care Conferences for a half hour every third Tuesday of the month to discuss issues and keep good communication. Ms. McCann stated a second Case Conference was held on 08/10/2023.

Ms. McCann said Resident A was involved with services through P.A.C.E. and received most of the services onsite at the P.A.C.E. Center. Ms. McCann indicated Resident A had been at the P.A.C.E. Center the entire day on 08/10/2023 prior to being hospitalized. She said when Resident A left the morning of 08/10/2023 she appeared to be fine with no unusual cognitive, physical, or medical concerns.

Ms. McCann stated when Resident A returned from the P.A.C.E. Center on 08/10/2023, she appeared cold, clammy, and unresponsive. Ms. McCann said she was still working and witnessed the drastic changes in Resident A's affect, physical wellbeing, and medical condition. Ms. McCann said she contacted registered nurse Kathy McMonagle to examine Resident A. She stated Ms. McMonagle saw Resident A and immediately called 911 and requested an ambulance to transport Resident A to the emergency room. Ms. McCann stated she never received documentation regarding Resident A's cause of death. Ms. McCann stated Resident A passed away the morning of 08/12/2023. She said she was informed by registered nurse Kathy McMonagle Resident A had pneumonia at time of death.

I reviewed an *AFC Licensing Division – Incident / Accident Report* dated 08/102/2023. The report stated DCSM Ebony Morgan called registered nurse Kathy McMonagle via walkie to building 4 where Resident A was. Resident A was slumped over in her wheelchair, breathing, but not responsive. Ms. McMonagle stated she tried sternal rub, unable to obtain B/P reading. EMS was called and Ms. Morgan called a second time to request estimated time of arrival (ETA). Under Action taken by staff the report indicated DCSMs remained with Resident A until EMS arrived. The report also stated Resident A was at the P.A.C.E. Center all day prior to incident due to change of condition, unable to walk and had to put her in a wheelchair when she arrived at the facility at 3:00 p.m. EMS placed Resident A inside the ambulance, stated they were taking her to the emergency room at Sparrow Hospital for evaluation but with no lights or sirens. Under Corrective Measures Taken to Remedy and/or Precent Recurrence it read: "Will call P.A.C.E. for any change in mental or physical status."

I interviewed DCSM Minette Charrier. Ms. Charrier stated upon admission and most of the time Resident A was at the facility she had a bright and pleasant affect, was active, ambulated throughout the facility, was talkative, and enjoyed communicating with DCSMs and other residents. Ms. Charrier said beginning in 07/2023 Resident A's affect, physical, and medical condition began to change. Ms. Charrier stated she began noticing many changes. She said Resident A began slowing down. Ms. Charrier said instead of walking throughout the facility, Resident A began pacing and shuffling back and forth. She stated Resident A stopped eating as much and appeared lethargic. Ms. Charrier stated it became harder to care for Resident A because she began refusing to cooperate when DCSMs attempted to assist with activities of daily living (ADLs). Ms. Charrier stated Resident A began refusing to shower, use the bathroom, change her adult briefs, get dressed, brush her teeth, comb her hair, eat meals, etc. She said Resident A became combative and hit, scratched, bit, and grabbed DCSMs who were trying to care for her. Ms. Charrier stated it became hard for her to care for Resident A. She said she would describe Resident A's behavior as stand offish, forceful, aggressive, and uncooperative. Ms. Charrier stated she is unsure why P.A.C.E. did not attempt medication or other changes when Resident A's cognitive, physical, and medical condition drastically changed.

Ms. Charrier said DCSMs contacted registered nurse Kathy McMonagle on 08/10/2023 and asked for her to come and examine Resident A upon her return from P.A.C.E. programming. She stated Ms. McMonagle immediately contacted 911 and requested an ambulance to transport Resident A to the emergency room at Sparrow Hospital. Ms. Charrier stated she would describe Resident A's affect on 08/10/2023 after returning from PACE as catatonic. Ms. Charrier stated she is unaware of any medication administration errors occurring involving Resident A. She said when she administered medications to Resident A she followed the instructions in Resident A's *electronic medication administration record (eMAR).*

I interviewed DCSM Aimee Nelson and Ms. Nelson stated she worked a lot with Resident A. Ms. Nelson said she was unaware of any medication administration errors occurring involving Resident A. She stated she did not administer medication incorrectly and said when administering medications, she follows the instructions in the resident's *eMAR.* Ms. Nelson stated most of the time Resident A was at the facility she had a bright and pleasant affect, was active, ambulated throughout the facility, was talkative, and enjoyed communicating with DCSMs and other residents. Ms. Nelson said toward the end Resident A was difficult to provide care for and it took a lot of coaxing to talk Resident A into taking a shower, use the bathroom, and basically complete any ADL. Ms. Nelson stated she had to work hard to talk Resident A into it. She said even though it was hard, DCSMs continued to meet Resident A's needs and ensure her needs were met. Ms. Nelson said Resident A began slowing down too. She said Resident A became quiet and did not speak a whole lot. Ms. Nelson stated Resident A stopped drinking and eating as much and appeared lethargic. She said it became difficult for Resident A to take her medications.

Ms. Nelson explained Resident A was very different and she was concerned Resident A may have had a stroke. Ms. Nelson said Resident A was sleeping more, barely stood up, and remained in her wheelchair much of the time. Ms. Nelson said when Resident A did get up, she would pace back and forth. She stated instead of walking Resident A would shuffle her feet. Ms. Nelson said Ms. McCann and DCSMs frequently contacted PACE informing them of the changes in Resident A's cognitive, physical, and medical condition.

Ms. Nelson said DCSMs were never provided any answers or a clear understanding as to the decline in Resident A's physical, mental, and emotional condition.

Ms. Nelson stated she was with Resident A when she returned from P.A.C.E. programming on 08/10/2023. She said she sat with Resident A and held her hand. Ms. Nelson stated she gave Resident A some yogurt and Ensure. She said she administered Resident A's medication. Ms. Nelson said she asked Resident A how she felt but Resident A just looked at her with a blank stare. Ms. Nelson stated DCSMs contacted nurse Ms. McMonagle and Ms. McMonagle contacted EMS and requested an ambulance transport Resident A to the emergency room at Sparrow Hospital.

I reviewed Resident A's *Resident Record.* I reviewed Resident A's most recent *Health Care Appraisal* and found Resident A was diagnosed with psychosis and dementia. She had no known allergies. Resident A was well nourished at the time of the appraisal on 12/01/2022, was "pleasantly confused", and had no physical limitations.

I reviewed Resident A's *Assessment Plan for AFC Residents.* I found Resident A was incontinent of bowel and bladder and required assistance with all ADLs. Resident A did not require assistance with walking/mobility. Resident A's was able to walk independently according to her assessment plan.

I reviewed Resident A's *eMAR* for the months of 07/2023 and 08/2023. I also reviewed a physician's order from Dr. Elizabeth Hengstebeck. The order specified Resident A was to take cephalexin (cephalexin) 500 mg capsule / Disp #28 / twenty-eight / Sig: 1 cap by mouth 4 times per day for 7 days. The order was dated 07/08/2023. Cephalexin is an antibiotic known to treat several bacterial infections. It is used in treating minor respiratory and urinary tract infections and as a backup or alternative to penicillin treatment.

Resident A's *eMAR* from 07/2023 listed the order for cephalexin CAP 500 mg. The order had been filled on 07/10/2023 and DCSMs began administering the medication the same day with three doses administered. DCSMs did not administer the medication at 12:00 p.m. on 07/13/2023. DCSMs did not administer the medication beginning on 07/14/2023 at 12:00 p.m. and did not resume administering the medication again until 07/17/2023 at 12:00 p.m. It appears DCSMs continued administering the medication up until 07/20/2023 at 08:00 a.m. to satisfy the physician's request to administer the medication four times a day for 7 days.

I interviewed registered nurse Kathy McMonagle via phone on 09/18/2023. Ms. McMonagle explained she oversees medication administration at the facility. She said she conducts a monthly medication cart audit. Ms. McMonagle said when she conducted the medication cart audit in 07/2023, she found two bottles of cephalexin with Resident A's medication when there should have only been one, so she removed one of the two bottles and properly discarded it.

Ms. McMonagle said Resident A had frequent UTIs and received physician's orders for antibiotics when diagnosed with an UTI. She stated one of the two bottles may have been from an old prescription.

Ms. McMonagle stated later when she discovered the cephalexin had not been administered to Resident A over the above-mentioned period, she stated she asked DCSMs what had occurred. DCSMs informed Ms. McMonagle there was no cephalexin with Resident A's medications, so they did not administer it. Ms. McMonagle said she was sure there were two bottles when she conducted the monthly medication cart audit on the 12th or 13th of 07/2023. Ms. McMonagle said after she discovered the cephalexin had not been administered, she called P.A.C.E., located the bottle of cephalexin, and instructed DCSMs to continue administering the cephalexin until 07/20/2023 with her 0800 a.m. medications to satisfy the specifications of the physician's order. Ms. McMonagle stated Resident A did receive cephalexin 500 mg capsules by mouth 4 times per day for 7 days but did not receive the medication consecutively.

Ms. McMonagle stated Resident A had begun showing signs she had been decompensating cognitively and physically in 07/2023. She said Resident A was lethargic, sleeping more, and not speaking as much. Ms. McMonagle stated Ms. McCann had contacted P.A.C.E. and kept them fully aware of the changes in cognition and behavior. She said P.A.C.E. failed to make any medication changes or changes in the care or services Resident A was received. Ms. McMonagle said P.A.C.E. did begin conducting monthly Case Conferences to discuss Resident A's condition and concerns Ms. McCann, DCSMs, and family members had regarding Resident A's cognitive, physical, and medical decline.

Ms. McMonagle stated when she assessed Resident A on 08/10/2023 after Resident A returned from P.A.C.E. programming around 3:00 p.m., she found Resident A unable to walk and had to put her in a wheelchair. Ms. McMonagle stated Resident A was slumped over in the wheelchair, was breathing, but was unresponsive. She said she immediately had EMS contacted to transport Resident A to the emergency room at Sparrow Hospital. Ms. McMonagle stated when Resident A was transported to the P.A.C.E. Center for programming that morning, Resident A was not demonstrating the same signs and symptoms. Ms. McMonagle stated she does not know why Resident A was not sent to the emergency room while at the P.A.C.E. Center.

Ms. McMonagle said Resident A remained at the hospital on 08/10/2023, did not return to the facility, and passed away the morning of 08/12/2023. She stated she is unaware of Resident A's cause of death.

I reviewed Resident A's *Certificate of Death* and found Resident A had several causes of death listed. The first cause of death was cardiopulmonary arrest with the approximate interval between onset and death being 24 hours, the second was sepsis with the approximate interval between onset and death being 4 days, the third was aspiration pneumonia with the approximate interval between onset and death being 4 days, and the fourth and final was advanced dementia with the approximate interval between onset and death being 3 years.

An exit conference was conducted with licensee designee Megan Fry informing her a rule violation was established because of this special investigation. Ms. Fry was asked to submit an acceptable corrective action plan (CAP) within the timeframe indicated in this report.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the information gathered during this special investigation through review of documentation and interviews with the complainant, executive director Kelly McCann, DCSMs Minette Charrier, Aimee Nelson, and registered nurse Kathy McMonagle there is evidence indicating Resident A was prescribed cephalexin and it was not administered as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, it is recommended that the status of the license remains unchanged.

10/10/2023

Rodney Gill — Date
Licensing Consultant

Approved By:

10/10/2023

Dawn N. Timm — Date
Area Manager