GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 3, 2023

Achal Patel
Divine Life Assisted Living Center 1, LLC
2045 Birch Bluff Drive
Okemos, MI 48864

RE: License #: AM190404916
Investigation #: 2023A1029049
Divine Life Assisted Living Center 1 LLC

Dear Mr. Patel:

Attached is the Special Investigation Report for the above referenced facility. Due to the quality of care 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended due to the quality of care violation. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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 (231) 922-5309.

Sincerely,

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
Browningj1@michigan.gov - (989) 444-9614

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM190404916
Investigation #:	2023A1029049
Complaint Receipt Date:	07/18/2023
Investigation Initiation Date:	07/19/2023
Report Due Date:	09/16/2023
Licensee Name:	Divine Life Assisted Living Center 1, LLC
Licensee Address:	607 Turner Street, DeWitt, MI 48820
Licensee Telephone #:	(517) 277-0544
Administrator:	Achal Patel
Licensee Designee:	Achal Patel
Name of Facility:	Divine Life Assisted Living Center 1 LLC
Facility Address:	607 Turner Street, DeWitt, MI 48820
Facility Telephone #:	(517) 277-0544
Original Issuance Date:	11/18/2020
License Status:	REGULAR
Effective Date:	05/18/2023
Expiration Date:	05/17/2025
Capacity:	11
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

ALLEGATION(S)

	Violation Established?
On July 18, 2023, residents were forced to remain outside for over 12 hours while the facility underwent a heat treatment to address bed bugs. When residents re-entered the facility, resident bedroom temperatures remained unsafely high at over 100 degrees leading residents to be weak, lethargic, and barely responsive. Direct care staff members did not seek emergency help.	Yes
Residents did not have access to any bathroom while outdoors for over 12 hours and were told to toilet in their adult incontinence briefs because they could not access the building.	Yes
On July 18, 2023, Resident A eloped from the facility and she was found at a neighbor home approximately 30 minutes later.	Yes

II. METHODOLOGY

07/18/2023	Special Investigation Intake 2023A1029049
07/19/2023	APS Referral - Complaint was sent from a denied APS referral from Centralized Intake
07/19/2023	Special Investigation Initiated – Email to Guardian G1
07/19/2023	Contact - Telephone call made to Rose Pest Solutions (Ms. Mason), Guardian G1, Sgt. Curtis, McLaren Hospital RN Abigail Cottom
07/20/2023	Contact - Document Sent - Email to Tom Hilla APS, Leslie Herrguth, Guardian G1
07/20/2023	Contact - Telephone call made to APS Tom Hilla
07/21/2023	Contact - Document Received – received and reviewed the police report from Dewitt Police Department
07/21/2023	Contact - Telephone call made to Relative A1, Sherri Martin (Director of Resident Care), Guardian G1, Brittany Crenshaw, Terri Vallejo. All interviews completed with Tom Hilla APS
07/25/2023	Contact - Telephone call made to Tri County Office on Aging, Jaclynn Lloyd

07/25/2023	Inspection Completed On-site – Johnnie Daniels and I made face to face contact with Resident D, Ms. McKinney, Resident I, and Resident B.
09/06/2023	Contact - Telephone call made to Relative C1 and licensee designee Mr. Patel
09/07/2023	Contact – Telephone call to Relative C1.
10/03/2023	Exit conference with Licensee designee Achal Patel

ALLEGATION: On July 18, 2023, residents were forced to remain outside for over 12 hours while the facility underwent a heat treatment to address bed bugs. When residents re-entered the facility, resident bedroom temperatures remained unsafely high at over 100 degrees leading residents to be weak, lethargic, and barely responsive. Direct care staff members did not seek emergency help.

INVESTIGATION:

On July 18, 2023, several complaints were received from various Complainants via the Bureau of Community and Health Systems online complaint system alleging that 11 memory care residents were required to sit outside all day from 7AM – 7PM on July 18, 2023, while an exterminator set up numerous heaters inside the facility to raise the temperature of the facility to 120 degrees to eradicate bedbugs. According to multiple Complainants, after the exterminator left it was still 100+ degrees inside the facility, including in resident bedrooms, even though the air conditioning was turned on, all facility doors and windows remained closed. Despite the facility still being an incredibly high temperature, direct care staff members moved residents back indoors and into resident bedrooms where it was even warmer than common areas. According to multiple Complainants, because of this decision some of the residents were lethargic, weak, and barely responsive yet none of the direct care staff members working called for emergency medical attention. The complaint stated law enforcement responded to the home for another reason, and it was law enforcement officials who made the determination to call for emergency medical attention and eight emergency vehicles (EMS/fire) responded to the facility to evaluate residents not direct care staff members. The complaint stated at least one resident was transported to the hospital for treatment.

On July 18, 2023, I received additional updated complaint information which alleged that at 9:40pm an ambulance transported two or three residents who suffered from heat exhaustion to Sparrow Hospital in Lansing. According to this information, the remainder of the six residents were taken to McLaren Greater Lansing Hospital by medical transit bus at 10:45 PM. According to this information, residents were evaluated and medically cleared however, the AFC facility would not take them back due to high temperatures in

the home. The complaint stated the facility still did not have an alternate plan in place, other than to have residents be outside, despite the late night hour and residents having already spent 12 hours outside that day. The complaint stated that at approximately 5AM three of the residents were picked up from the hospital by family members or guardians and three were transported back to the AFC facility.

On July 18, 2023, I received an additional complaint stating Guardian G1 stopped by the facility on July 18, 2023, to see Resident G however upon arrival Guardian G1 found all residents sitting outside the facility under the gazebo. According to the complaint, Guardian G1 stated direct care staff members informed her they could not enter the home due to the heat treatment being performed until 5:30 p.m. Guardian G1 was advised the residents had McDonald's delivered to them for lunch and they would eat leftover burgers for dinner.

I reviewed the websites Accuweather.com and Worldweather.com which documented the high temperature was 79 degrees in Dewitt, Michigan with mostly sunny skies on the day of this incident.

On July 19, 2023, I contacted Rose Pest Solutions and spoke to Emily Mason. Ms. Mason stated she could not disclose the specifics of a facility treatment however, she was able to tell me generically a heat treatment could take a few hours to all day depending on the size of the facility. Ms. Mason stated customers are informed at the time the appointment is scheduled that this potentially a day long process so customers can make necessary arrangements. Ms. Mason refused to give any specifics regarding Divine Life Assisted Living Center 1 LLC.

On July 19, 2023, I interviewed Sgt. Curtis from the City of Dewitt Police Department. Sgt. Curtis stated their department responded initially because Resident A eloped from the facility. Sgt. Curtis stated their department became aware of Resident A's elopement after being called to a nearby neighbor's home for a welfare check upon finding Resident A at their home. Sgt. Curtis stated at that time, she was brought back to Divine Life Assisted Living Center 1 LLC but police officers noted she was dehydrated and disoriented. Sgt. Curtis stated direct care staff members noticed she was missing around 7:00 p.m. and called 911 for assistance. Sgt. Curtis stated direct care staff member Ms. Crenshaw reported they were looking for her for approximately 30 minutes. Sgt. Curtis stated upon arrival at the AFC facility, police officers observed four residents lying in their bed and not responding to the officers so the decision was made to call for emergency services to evaluate the residents because it was too hot in the facility. Sgt. Curtis stated Mr. Patel was called to the scene 45-60 minutes later. Sgt. Curtis stated direct care staff member Debra McKinney informed him she arranged for the residents to go onto the back porch at 8:00 a.m. and she thought they would be outside for approximately six hours but instead, she was not able to move them back in until about 6 p.m. but it was still very hot inside from the heat treatment.

On July 21, 2023, I reviewed the police report from Dewitt Police Department written on July 18, 2023. According to the report:

"Upon entering the residence RO's both noticed the extreme heat inside the residence. The internal temperature of the home was noticeably hotter than the temperature outside. It was learned the pest control company had arrived at approximately 7:00 a.m. and left at 1822 hours. During the pest removal process all 11 residents were moved out of the facility and sat on the patio in the rear of the residence. From approximately 8:00 a.m. to 6:00 p.m. the residents sat outside and were fed McDonalds hamburgers and fries for lunch and chips for snacks. While the residents were outside the pest control company used heaters to heat the building to 120 degrees for several hours to exterminate the bed bugs. At approximately 6:22 p.m. the pest control company left and the residents were escorted back inside by Ms. Crenshaw and Ms. McKinney. When RO's arrived with [Resident A] after she eloped, it was still over 100 degrees inside the residence. After learning that there were 10 additional residents at the facility and given the extreme heat, Ofc. Umholtz began checking the status of the other residents Ofc. Umholtz quickly returned and advised the medical professionals needed to be contacted because several of the elderly residents were not responsive and possibly suffering from heat stroke.

Medical. At 20:23 hours RO requested the dispatch send multiple ambulance and medics to evaluate each resident for heat stroke a short time later Mercy and DAFD crews arrived on scene and began evaluating their residence all 11 residents were transferred to the hospital."

Officer actions:

"While waiting for the medical professionals RO attempted to relieve some of the heat inside the building by opening windows and doors it should be noted all windows and doors were shut and it did not appear any steps had been taken to relieve the extreme heat RO did notice there was cool air coming from when I went into the living room but arrow did not observe any other vents in the building. It should be noted that after being unseen for 35 minutes and having the windows into our open by RO the thermostat still read 93 degrees in the living room which is the coolest part of the residence it was estimated to be 15 to 20 degrees warmer in the bedrooms of the facility."

According to the police report, all eleven residents were medically treated and all but Resident C were sent to the hospital for treatment. Residents A, B, F, I, J, and K were all sent to McLaren Hospital and Resident D, E, G, and H were all sent to Sparrow Main Hospital. Resident C was treated on scene and went home with a relative.

On July 20, 2023, I interviewed adult protective services (APS) specialist, Tom Hilla. Mr. Hilla stated direct care staff member Ms. McKinney is the manager and affirmed the allegations during his interview with her. Mr. Hilla stated Ms. McKinney reported on July 18, 2023, the facility was heat treated for bedbugs and no alternate plans had been

made for the 11 residents so all 11 residents remained outside from approximately 7a.m. to 7p.m. Ms. McKinney told Mr. Hilla it was “not their fault” meaning it was not the responsibility of direct care staff members to find alternate arrangements for residents or determine how residents were going to be fed, rest or use the bathroom or have their adult incontinence brief privately changed as needed throughout the day. Mr. Hilla stated he was informed by Ms. McKinney that licensee designee Achal Patel was initially told by Rose Pest Solutions it was going to be six hours and they would have bathroom access but this did not happen.

On July 21, 2023, APS Mr. Hilla and I interviewed Relative A1 and Relative A2 who both stated they were upset Resident A sat outside all day. Both also stated they were not notified of the bed bugs until July 19, 2023 nor were they notified to provide alternate arrangements for Resident A during the time the facility was treated on July 18, 2023. In addition, I received an email from Guardian G1 who confirmed she was not notified in advance of the plan to heat treat the building for bed bugs or given the opportunity to move Resident G to another location for the day.

On July 21, 2023, APS Mr. Hilla and I interviewed Director of Resident Care, Sherri Martin. Ms. Martin stated she was not onsite during this incident but tried to assist by telephone once it became clear the heat treatment was going to last longer than anticipated. Ms. Martin stated she was told by licensee designee Achal Patel the heat treatment was scheduled to last a few hours with residents having access to the facility by 2PM, so she did not see a need to make any other alternate arrangements. Ms. Martin stated she received a phone call at 5PM informing her all residents were still outdoors and called licensee designee Achal Patel to notify him. Ms. Martin stated licensee designee Achal Patel followed up by going to the facility to assess the situation however he did not arrive until three hours later at approximately 8PM when law enforcement was already on scene. Ms. Martin stated she also tried to talk to someone from Rose Pest Solutions over the phone but they would not give her any information. Ms. Martin stated she could not prepare direct care staff members to make alternate arrangements for residents as Rose Pest Solutions told Mr. Patel the treatment time would be less than six hours and bathrooms would be available. Ms. Martin stated once the treatment was not done by noon, “it all went bad from there”, yet Ms. Martin could not provide any steps taken by herself to better this situation. Ms. Martin stated guardians and family members were notified the day before by Ms. McKinney and Ms. Vallejo of the pending heat treatment which resulted in two residents being taken for the day while other family members/guardians refused or did not answer the notification.

Ms. Martin denied having any knowledge of four residents being unresponsive but was aware the residents were taken to Sparrow Hospital due to concerns of dehydration and heat exhaustion. Ms. Martin stated direct care staff members thought they were prepared for Rose Pest Solutions to treat the facility however, things went wrong when it took longer than expected. Ms. Martin also expressed concern the residents were outside all day from 8:30 a.m.- 6:30 p.m.

On July 21, 2023, I interviewed Guardian G1 who stated she went unannounced on July 18, 2023, to see Resident G around 2PM when she observed the pest control truck and the residents all sitting outside. Guardian G1 stated Resident G seemed to be okay during this time and not in distress. Guardian G1 stated she received emails from licensee designee Achal Patel which tried to "justify his actions" but did not acknowledge the risks to residents being outside or how he could have changed the situation. Guardian G1 stated licensee designee Achal Patel left her a message at 11:59PM on July 18, 2023, informing her Resident G was sent to Sparrow Hospital for medical evaluation and she would return to the facility when the temperature was cool enough. Guardian G1 stated she does not know if any of the direct care staff members reached out to licensee designee Patel for assistance.

On July 21, 2023, APS Mr. Hilla and I interviewed direct care staff member Brittany Crenshaw who worked from 2PM- 8PM. Ms. Crenshaw stated when she arrived at 2PM residents were sitting outside and remained outside until around 6:30PM. when they were allowed to re-enter the facility. Ms. Crenshaw stated at that point, she started to assist showering residents. Ms. Crenshaw stated during the time residents were outside, there was no access to a bathroom or ability to provide private personal care for toileting so residents had to use an adult incontinence brief for toileting purposes even if this was not a common practice for that resident. Ms. Crenshaw denied she told the residents to go to the bathroom in their brief but since there was no bathroom available, this was the only option. Ms. Crenshaw denied residents were upset about being outside during this time or complained it was too hot to be outside. Ms. Crenshaw stated she did not know if the guardians were notified a pest control treatment was occurring so they could take their resident for the day if preferred. Ms. Crenshaw stated Mr. Patel came to the facility around 8PM to assist with the situation. Ms. Crenshaw stated when law enforcement arrived at approximately 7PM to assist with Resident A's elopement, law enforcement officers pointed out to direct care staff member how hot it remained in the facility. Ms. Crenshaw stated law enforcement advised her it was still too hot in the facility for residents safety and based on the current medical conditions of all residents, law enforcement officers called for medical assistance. Ms. Crenshaw stated residents were taken to the hospital around 10PM or 11PM and most residents were back between 230AM – 530AM on July 19, 2023.

On July 21, 2023, APS Mr. Hilla and I interviewed direct care staff member Terri Vallejo. Ms. Vallejo stated she was called by Ms. McKinney to come to the facility and assist at 7AM to get the residents ready to go outside for the day. Ms. Vallejo stated she stayed at work until 2PM when Ms. Crenshaw arrived so she did not know what time the residents went back inside the facility. Ms. Vallejo stated she contacted four families total to notify them of the plans because they were residents she was most concerned about because they do not spend a lot of time outside. Ms. Vallejo denied she called any other relatives or guardians to notify them residents would be outside for the day. Ms. Vallejo stated she did not have direction to contact relatives or guardians to inform them what was happening however, when she asked Ms. McKinney which ones she should call, she was instructed to focus on residents who did not spend time outside due to their potential level of discomfort. Ms. Vallejo stated she purchased paper

products and snacks for residents while outside during the heat treatment and pitchers of water were available also. Ms. Vallejo stated licensee designee Achal Patel ordered McDonalds for lunch.

On July 25, 2023, I interviewed Tri County Office on Aging social worker, Jaclynn Lloyd who is the responsible agency for Resident A and Resident E. Ms. Lloyd confirmed Resident A, Resident B, Resident D, and Resident I were initially evaluated by law enforcement officers who determined medical intervention was necessary resulting in at least these four residents being taken to the hospital and diagnosed with heat exhaustion. Ms. Lloyd stated all eleven residents were outside and none of the residents were picked up by family members or guardians.

On July 25, 2023, AFC Licensing consultant Johnnie Daniels and I completed an unannounced on-site inspection and interviewed direct care staff member whose current role is home manager, Ms. McKinney. Ms. McKinney stated she was at the facility all day starting at 6AM and Rose Pest Solutions was planned to arrive and start their heat treatment of the facility at 7AM. Ms. McKinney stated the plan for the day was for residents to remain outside on the porch during the heat treatment. Ms. McKinney stated licensee designee Achal Patel had informed her residents would have continual access to the bathroom during the heat treatment so no other arrangements had been made.

Ms. McKinney stated residents were offered water, chips, snacks, crackers, and McDonald's for lunch. Ms. McKinney stated there were four residents (Resident K, Resident F, Resident G, and Resident E) she was most concerned about because they did not go outside often and she told Ms. Vallejo to notify those families the day before. Ms. McKinney stated they did not come back into the home until 630/7PM and it was still warm in the building but she did not know how warm. Ms. McKinney stated they gave all the residents showers at night and they opened the windows and had fans going to cool it down. Ms. McKinney stated the residents' families were not called to pick them up and she did not realize the residents could have gone to another licensed facility owned by licensee designee Achal Patel for the day. Ms. McKinney stated she did not have a van they could have used but she could have used the "blue bus" and law enforcement also advised her they could have picked up the residents in an emergency situation such as this.

Mr. Daniels attempted to interview Resident B who was unable to give a proper timeline of herself and other residents being outside. Resident B advised she was only able to remember all residents had McDonalds and it was really hot inside of the facility. Mr. Daniels attempted to interview Resident D but due to her dementia diagnosis, she was unable to provide any information regarding the incident. I attempted to interview Resident I however she could only recall it was hot and she liked eating McDonald's.

During the on-site investigation, I reviewed the resident records. Mr. Daniels and I reviewed all the residents *Assessment Plan for AFC Residents* and *Health Care Appraisals*. Out of the eleven residents, only two *Assessment Plan for AFC Residents*

had a specific comment under toileting which indicated those two residents wear incontinence briefs regularly however, ten out of eleven residents require assistance for toileting. According to the *Assessment Plan for AFC Residents*, Resident D is the only resident who can toilet independently.

On September 6, 2023, I contacted licensee designee Achal Patel who reported being informed by direct care staff members of issues with bed bugs at the facility. Mr. Patel stated based on this information, he made the decision to have the facility heat treated by a professional pest control company. Mr. Patel stated he was informed an AFC facility of this size required a heat treatment lasting about 6 hours at 120 degree temperature of 120, so he arranged for this to be completed by Rose Pest Solutions. Mr. Patel said he informed them they could be outside but they needed to have access to bathroom services however on the day of the treatment, they started the treatment, there were equipment issues and they were not able to get the heat high enough. In the meantime, the treatment went longer because it was supposed to be done around 1:30-2PM. Mr. Patel stated, "everything that could go wrong during the day did go wrong." Mr. Patel stated he did not have a contingency plan because he was under the impression the bathrooms would be open for the residents to use and they would only be on the porch for part of the day until early afternoon. Mr. Patel stated the residents were on the porch in a shaded area so they were not in the sun the whole day. Mr. Patel notified Ms. McKinney in advance of the heat treatment and informed her the bathrooms would be available to use. Mr. Patel stated they have had treatments like this before but the residents were able to access other parts of the building so he did not expect this treatment to be different. Mr. Patel stated the residents were taken to the hospital for observation after this occurred but they were only there for about two hours.

On September 7, 2023, I interviewed Relative C1 who stated on July 17, 2023, she was informed by Ms. McKinney the facility was scheduled to be fumigated for ants on July 18, 2023 and this process required all residents to be outside of the facility for the day starting at 7AM. Relative C1 stated she knew Resident C could not tolerate being outside all day, so she planned to pick her up early on July 18, 2023. Relative C1 stated when she picked up Resident C around 8AM on the morning of July 18, 2023, all residents were outside. Relative C1 stated when she arrived in the morning it was like opening an oven door when she opened the door and it had to be at least 90 degrees. Relative C1 stated she texted Mr. Patel a couple times and she was surprised he would know of what was occurring and not create a backup plan for the residents however he did not respond to her texts until the next day. Relative C1 asked Ms. McKinney if there were plans for the resident's dinner and she said "McDonald's doubled our order by mistake, so we will have left over burgers" so it is unknown if there was a plan for dinner. Relative C1 stated there were two other instances of bed bugs since March 2023. Relative C1 stated she was very upset being told the facility was being treated for ants and didn't tell her it was for bed bugs.

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:	All 11 residents were not treated with dignity and their personal need of protection and safety was not attended to during the pest control treatment. Licensee designee Achal Patel did not assure basic amenities were in place for residents during this pest control treatment like bathroom facilities, a place to rest, or privacy to change incontinence briefs. Licensee designee Achal Patel did not have a contingency plan in place while this heat treatment was in process instead all 11 aged residents were forced to sit outside for approximately 12 hours in the heat. Once the treatment was complete, direct care staff members made the decision to bring all 11 residents back into the facility where the temperature averaged over 100 degrees in common areas and higher in resident bedrooms. Upon arrival of law enforcement, all 11 residents were found to be in various stages of medical distress leading to medical evaluation and treatment at local hospitals. Lastly, despite knowing at 5PM all 11 residents were still outside of the facility and had been outside for the last 11 hours at that point, licensee designee did not arrive to the facility until 8PM, three hours later. Licensee designee Achal Patel did not take any steps to assist at 5PM to move residents to any other indoor area or make any decision to assure the safety and well-being of the 11 residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14406	**Room temperature.**
	All resident-occupied rooms of a home shall be heated at a temperature range between 68 and 72 degrees Fahrenheit during non-sleeping hours. Precautions shall be taken to prevent prolonged resident exposure to stale, noncirculating air that is at a temperature of 90 degrees Fahrenheit or above. Variations from the requirements of this rule shall be based upon a resident's health care appraisal and shall be addressed in the resident's written assessment plan. The resident care agreement shall

	address the resident's preferences for variations from the temperatures and requirements specified in this rule.
ANALYSIS:	On July 18, 2023, resident occupied rooms were heated to 120 degrees during a bed bug treatment program through Rose Pest Control. At approximately 7PM, direct care staff members allowed residents to re-enter the facility including resident bedrooms. Direct care staff members did not open windows or doors, but only turned on the air conditioning to cool down the facility. At 737PM, law enforcement officers were dispatched to the facility and found resident bedrooms to be over 100 degrees in temperature and observed multiple residents exhibiting signs of heat exhaustion including weakness, lethargy, and not responding to stimuli. Direct care staff members and/or licensee designee Achal Patel did not take precautions to assure resident bedroom temperatures were safe for residents to access their bedrooms upon completion of this heat treatment.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(5) An insect, rodent, or pest control program shall be maintained as necessary and shall be carried out in a manner that continually protects the health of residents.
ANALYSIS:	The pest control treatment was not carried out in a manner that protected the health and safety of the residents. All the residents except for one were transported to the hospital at the end of the day and treated for dehydration and heat exhaustion as a result of being left outside all day.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: On July 18, 2023, the residents at Divine Life Assisted Living Center 1 LLC were told to use the bathroom in their briefs because they could not access the bathroom due to the high temperatures in the facility.

INVESTIGATION:

As a result of this incident, several complaints were received alleging residents did not access to a bathroom from approximately 7AM to 7PM while the AFC facility was heat treated for bed bugs. According to the complaints, Resident G was told she needed to "do it in her briefs" because there was no bathroom and Resident E had a bowel movement which could not be cleaned due to no bathroom access. According to the

complaint, an email was sent to licensee designee Achal Patel that residents were left outdoors with no access to a bathroom but licensee designee Achal Patel did not respond in a timely manner rather he stated he had no other choice.

On July 19, 2023, I interviewed Sgt. Curtis who stated the police report includes documentation the residents were told to go into their adult incontinence briefs instead of using the bathroom since it was not available. I reviewed the police report and the following statement is included, "*They were also kept in adult diapers and had no bathroom facilities."*

On July 21, 2023, APS Mr. Hilla and I interviewed Director of Resident Care, Sherri Martin. Ms. Martin stated the residents were not able to use the bathroom and arrangements were made for residents to wear a brief to prevent an accident. Ms. Martin stated Ms. McKinney, "briefed them up and padded them up in case someone had an accident." Ms. Martin stated she did not know who created this plan because initially they thought there would be bathroom access. Mr. Hilla advised Ms. Martin of a safety plan where they can contact the "blue bus" and they will transport them to the community room at the police department which has a kitchen, television, and has a bathroom they can use with air conditioning.

On July 21, 2023, APS Mr. Hilla and I interviewed direct care staff member Terri Vallejo. Ms. Vallejo stated around 1130AM residents started to say they needed to go to the bathroom. Ms. Vallejo stated she told the residents she was trying to figure it out, however she did not know what to do. Ms. Vallejo stated there was not a plan in place for an alternative arrangement for the bathrooms because they did not know in advance they would not be able to have access to the bathrooms. Ms. Vallejo stated Ms. McKinney went into the facility and then saw how hot it was and realized the residents could not use the bathroom. Ms. Vallejo stated the residents used their briefs to use the restroom during this time because there was no bathroom for them to use and no place to change their briefs as needed.

On July 21, 2023, I interviewed Guardian G1 who stated she went unannounced on July 18, 2023, to see Resident G. Guardian G1 stated while at the facility Resident G told a female direct care staff member she needed to use the bathroom and there were no port-a-potties observed near the home. Guardian G1 stated the female staff member then told her she needed to "do it in her briefs" but it is unknown if Resident G did this. Guardian G1 forwarded an email that she sent to licensee designee Patel regarding the concerns which included the following statements she observed when she visited Resident G at Divine Life:

> *"I also learned there was no bathroom facilities available for the residents to use. While I was there [Resident G] said she needed to use the bathroom and she was told she was wearing a brief and would have to go in her brief. In addition, there was also no place for staff to take individuals who needed a brief change or to be cleaned up."*

On July 25, 2023, I interviewed Tri County Office on Aging social worker, Jaclynn Lloyd who is the responsible agency for Resident A and Resident E. Ms. Lloyd stated she received a call from Relative E2 who stated the residents were outside because of a pest control heat treatment process, so Relative E2 picked up Resident E from the facility because she had bowel incontinence and needed to be cleaned up. Ms. Lloyd stated Relative E2 took Resident E first to his apartment but could not get her up the stairs, then to a previous facility she resided in which is also licensed by licensee designee Patel but direct care staff members at this facility did not allow her to use the bathroom because she was no longer a resident. Ms. Lloyd stated Relative E2 reported trying to take Resident E to a gas station bathroom but the gas station bathroom was too dirty to change Resident E so Relative E2 took her back to the facility around 1PM and advised the female direct care staff member working that by this point all of the residents would be cleaned up when they were able to go back inside. Ms. Lloyd stated when Relative E2 contacted licensee designee Achal Patel at that time who stated residents/direct care staff would have access to a bathroom around 230PM. Ms. Lloyd stated this was not the case because when Relative E2 returned Resident E to the facility around 230PM there was still no bathroom access.

On July 25, 2023, AFC Licensing consultant Johnnie Daniels and I completed an unannounced on-site inspection and interviewed direct care staff member whose current role is home manager, Ms. McKinney. Ms. McKinney denied telling any resident to “just go in their briefs.” Ms. McKinney stated around 11AM residents were asking to use the bathroom, however Rose Pest Solutions told her they could not enter the building because the temperature was too high and she was told by one of the individuals working for Rose Pest Solutions that in another hour, they could use the bathrooms however this did not happen. Ms. McKinney stated Mr. Patel arrived later that evening to assist, however, there were no arrangements during the day to move the residents somewhere else so residents had bathroom access or so direct care staff members could change their adult incontinence briefs. Ms. McKinney stated residents came back inside the facility around 6:30-7 p.m. and they had the windows open and the fans going to try and cool the temperature and they gave showers to all the residents to assist in cooling them off. Ms. McKinney stated she did not know residents could be moved to another one of Mr. Patel’s licensed facilities for the day and Mr. Daniels and I also informed her of the safety plan to use the community room at the police department if this occurs in the future.

On September 6, 2023, I contacted licensee designee Achal Patel. Mr. Patel stated he found out around 5/5:30PM that residents were not able to use the bathrooms throughout the day. Mr. Patel stated he was originally told the bathrooms would be available however the staff from Rose Pest Solutions did not allow them to use the bathroom. Mr. Patel stated after the treatment was done, normally they put the fans out in the building. Mr. Patel stated residents used their adult incontinence briefs as a bathroom because there was no other option for residents to use a bathroom nor was there any place for direct care staff members to regularly change soiled incontinence briefs throughout that 12 hour time span. Mr. Patel stated he did not know if the staff

members told them to do this but a lot of the residents were already incontinent so “it would not be new” for the residents to do this.

APPLICABLE RULE	
R 400.14407	**Bathrooms.**
	(5) At least 1 toilet and 1 lavatory that are available for resident use shall be provided on each floor that has resident bedrooms.
ANALYSIS:	On July 18, 2023, from approximately 7AM-7PM, 11 residents did not have access to a bathroom. Instead, residents were required to urinate and defecate in adult incontinence briefs during this 12 hour timeframe. There was no place to provide personal care and toileting assistance such as changing resident adult incontinence briefs in private as needed.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 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.** **(2) A licensee shall respect and safeguard the resident’s rights specified in subrule (1) of this rule.**
ANALYSIS:	All 11 residents were not treated with consideration and respect by licensee designee Achal Patel and direct care staff members after being required to use adult incontinence briefs as a bathroom and were required to remain in soiled adult incontinence briefs due to having no place to change those soiled adult incontinence briefs.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: On July 18, 2023, Resident A eloped from the facility and she was found at a neighbor's home approximately 30 minutes later.

INVESTIGATION:

On July 18, 2023, a complaint was received via the Bureau of Community and Health Systems online complaint system with concerns that during the bed bug treatment mentioned above a gate was left open which allowed Resident A to elope from the facility.

On July 19, 2023, I interviewed Sgt. Curtis from City of Dewitt Police Department who confirmed the initial call to dispatch involved a welfare check for Resident A who had arrived unannounced and unexpectedly at a neighboring home. Sgt. Curtis stated Resident A could not tell the neighbor where she resided and because she appeared dehydrated and disoriented the neighbor allowed her to come into their home before contacting 911 for assistance.

According to the police report written by Sgt. Dave Stolzfus:

> *"While on patrol, Ofc. Umholtz was dispatched to a check subject complainant at 613 E Webb Road. A short time after arrival on scene he contacted RO for assistance. According to Ofc. Umholtz, an elderly female ID'd as [Resident A] was possibly suffering from dementia and could not provide her address.*
> *Arrival: While enroute RO contacted several local assisted living facilities. RO eventually called the Divine Life Assisted Living located at 607 Turner and spoke with Ms. Crenshaw who stated that [Resident A] was missing from the facility and she had not yet reported her missing.*
> *Transport:*
> *RO's then transported [Resident A] to the facility without incident. It was obvious to RO while transporting she suffered from possible dementia and / or declined cognitive function based on her incoherent speech and lack of orientation.*
> *Arrival:*
> *Upon arrival, RO's spoke with Ms. Crenshaw outside the facility and she advised [Resident A] had been missing for approximately 30 minutes while she was distracted passing medications and she assisted RO's in escorting [Resident A] back into the facility. Ms. Crenshaw went on to advise that [Resident A] had gotten out of the facility after a "bed bug extermination company" possibly left an exterior gate open.*

On July 21, 2023, APS Mr. Hilla and I interviewed Director of Resident Care, Ms. Martin. Ms. Martin stated law enforcement brought Resident A back to the facility after she was found down the street around 6:00 p.m. or 7:00 p.m. Ms. Martin denied Resident A was an elopement risk or had eloped from the facility before. Ms. Martin also stated there was nothing in Resident A's *Assessment Plan for AFC Residents* regarding her having a history of elopement. Ms. Martin stated her understanding is Resident A eloped from a back gate left open during the heat treatment. Ms. Martin stated Resident A was gone a

“short time” before direct care staff members had the opportunity to call law enforcement for assistance. Ms. Martin could not provide what she meant by a “short time” or how she knew this as no direct care staff member knew when Resident A was last seen in the facility.

On July 21, 2023, APS Mr. Hilla and I interviewed direct care staff member Ms. Crenshaw. Ms. Crenshaw stated she was administering medication at 730PM when a relative came to visit and Ms. Crenshaw stated she believes a gate was left open at that time allowing Resident A to elope from the facility. Ms. Crenshaw stated she could not locate Resident A when she went to administer Resident A’s medication, so she looked around the building 2-3 times because she wanted to make sure she was not on the property. Ms. Crenshaw stated she was on the phone with Ms. McKinney when local law enforcement officers called reporting Resident A had been located and was being returned to the facility. Ms. Crenshaw stated Resident A has never tried to elope from the facility in the past. Ms. Crenshaw stated the facility elopement procedure is to contact Ms. McKinney so she can licensee designee Achal Patel know any time a resident elopes. Ms. Crenshaw stated when she was on the phone making these calls, when law enforcement officers notified her they found Resident A and were bringing her back to the AFC facility.

On July 25, 2023, AFC Licensing consultant Mr. Daniels and I completed an unannounced on-site inspection and interviewed direct care staff member whose current role is home manager, Ms. McKinney. Ms. McKinney stated Ms. Crenshaw went to administer medications to Resident A and realized she was not in the facility. Ms. McKinney stated shortly after discovering this, Ms. Crenshaw called to notify her and she instructed her to notify law enforcement. Ms. McKinney stated when Ms. Crenshaw called, law enforcement informed her they had already found Resident A down the street and were returning her to Divine Life Assisted Living 1.

I reviewed an AFC Incident / Accident Report with the following information dated on July 18, 2023 written by direct care staff member Ms. Crenshaw.

“What happened: I was passing meds and went to give [Resident A] and noticed she wasn’t in her room so I looked through the house and couldn’t find her.
Action taken by staff: I called my manager Debra and she said to call the police and as I was on the phone with her the cops called and said they had [Resident A] and they were on the way. Also called [Relative A1].
Corrective Measures: Made sure the gate is locked shut correctly at all times.”

During the on-site investigation, I reviewed Resident A’s *Assessment Plan for AFC Residents* which documented she uses a walker in the community and needs one person assist with bathing, grooming, dressing, personal hygiene, and cues for toileting. Resident A’s record did not include a history of elopement. According to Resident A’s resident record, Resident A has a diagnosis of Vascular dementia, A Fib, joint pain, diabetes type 2, osteoporosis, dyslipidemia, and ringworm.

I used Google Maps to determine the distance between the facility and where Resident A was located according to the address on the police department and determined she walked at least .3 miles if she had walked directly to the location where she was found.

On September 6, 2023, I interviewed licensee designee Achal Patel. Mr. Patel stated the staff from Rose Pest Solutions left the gate open and Resident A walked out of the building. Mr. Patel stated there were two gates they left open around 5:30/6PM Mr. Patel stated Resident A normally does not leave the building. Mr. Patel stated this was the original reason law enforcement arrived at the facility before noticing the high heat temperature in the facility, the effect this had on residents, and the need for medical intervention. Mr. Patel stated Resident A was not gone long because she was found on Webb Road which is around a 2-3 minute walk from the AFC facility. Mr. Patel stated Ms. Crenshaw was giving showers that day to everyone due to the heat when law enforcement officers brought Resident A back to the facility.

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:	On July 18, 2023 Resident A was not provided supervision or protection as specified in her *Assessment Plan for AFC Residents* when she eloped from the facility without direct care staff members knowledge. Resident A eloped from the AFC facility out of an open gate while direct care staff members were providing direct care to others. It is unknown how long Resident A was gone from the facility but estimated to be at least 30 minutes. Resident A was found approximately .3 miles from the facility and could not provide her address or other identifying information to law enforcement due to her diagnosis of Vascular dementia and state of confusion after being outside for over 12 hours. Resident A left the facility located at 607 Turner Road, Dewitt and walked to a neighbor's home on East Webb which according to Google Maps was .3 miles from the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

Upon receipt of an approved corrective action plan, due to the quality of care violations I recommend modification of the license to a provisional status.

09/29/2023

Jennifer Browning
Licensing Consultant

Date

Approved By:

10/03/2023

Dawn N. Timm
Area Manager

Date