GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 19, 2023

Connie Clauson
Pleasant Homes I L.L.C.
Suite 203
3196 Kraft Ave SE
Grand Rapids, MI 49512

RE: License #: AL390007090
Investigation #: 2024A0581006
Park Place Living Centre #B

Dear Connie Clauson:

Attached is the Special Investigation Report for the above referenced facility. Due to the quality of care violations identified in the report, the refusal to renew recommendation remains.

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

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 #:** | AL390007090 |
| | |
| **Investigation #:** | 2024A0581006 |
| | |
| **Complaint Receipt Date:** | 10/26/2023 |
| | |
| **Investigation Initiation Date:** | 10/30/2023 |
| | |
| **Report Due Date:** | 12/25/2023 |
| | |
| **Licensee Name:** | Pleasant Homes I L.L.C. |
| | |
| **Licensee Address:** | Suite 203<br>3196 Kraft Ave SE<br>Grand Rapids, MI 49512 |
| | |
| **Licensee Telephone #:** | (616) 285-0573 |
| | |
| **Administrator:** | Janet White |
| | |
| **Licensee Designee:** | Connie Clauson |
| | |
| **Name of Facility:** | Park Place Living Centre #B |
| | |
| **Facility Address:** | 4218 S Westnedge<br>Kalamazoo, MI 49008 |
| | |
| **Facility Telephone #:** | (269) 388-7303 |
| | |
| **Original Issuance Date:** | 01/01/1989 |
| | |
| **License Status:** | 1ST PROVISIONAL |
| | |
| **Effective Date:** | 06/05/2023 |
| | |
| **Expiration Date:** | 12/04/2023 |
| | |
| **Capacity:** | 20 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>ALZHEIMERS<br>AGED |

## II. ALLEGATIONS

| | **Violation Established**? |
|---|---|
| Resident X's health declined; however, facility staff did not seek medical treatment in a timely manner. | Yes |
| Resident X did not receive his required medication. | Yes |
| Additional Findings | Yes |

****To maintain the coding consistency of residents in multiple reports, the resident in this special investigation is not identified in sequential order.*

## III. METHODOLOGY

| | |
|---|---|
| 10/26/2023 | Special Investigation Intake<br>2024A0581006 |
| 10/26/2023 | Referral - Other<br>AG's office denied investigating the complaint. |
| 10/30/2023 | Special Investigation Initiated - Telephone<br>Interview with Complainant, via telephone. |
| 11/06/2023 | Contact - Face to Face<br>Interview with Administrator, Janet White |
| 11/15/2023 | Contact - Telephone call made<br>Interview with Nurse Practitioner, Chelsea Crouch |
| 11/15/2023 | Inspection Completed On-site<br>Interview with staff. |
| 12/04/2023 | Contact - Face to Face<br>Interview with resident |
| 12/13/2023 | Inspection Completed-BCAL Sub. Compliance |
| 12/15/2023 | APS Referral<br>Made via email. |
| 12/15/2023 | Contact – Telephone call made<br>Careline Hospice agency |
| 12/15/2023 | Contact – Telephone call made<br>Interview with Qua'Nice Robinson, direct care staff. |

| | |
|---|---|
| 12/15/2023 | Contact – Telephone call made<br>Interview with Bambi Keckler, direct care staff. |
| 12/15/2023 | Contact – Telephone call made<br>Interview with Relative X1, Resident X's power of attorney. |
| 12/15/2023 | Contact – Telephone call received<br>Interview with Ms. Crouch. |
| 12/15/2023 | Contact – Telephone call made<br>Interview with Complainant. |
| 12/19/2023 | Exit conference with the licensee designee, Connie Clauson. |

**ALLEGATION:**

**Resident X's health declined; however, facility staff did not seek medical treatment in a timely manner.**

**INVESTIGATION:**

On 10/26/2023, the Bureau of Community and Health Services (BCHS) received this complaint, which alleged Resident X, who had a diagnosis of dementia and was diabetic, was moved to Park Place Living Centre #B, which is a "memory care" facility on or around 08/15/2023 because he was "wandering more often" and required more assistance from direct care staff with shaving and showering. The complaint alleged when Resident X was admitted to the facility he was "walking around and always visiting socially", as well as, talking and engaging in conversation; however, by 08/20/2023 Resident X wouldn't get out of bed. The complaint alleged direct care staff, specifically Isabelle Sanhou, was made aware of Resident X's decline; however, by 08/22/2023, Resident X continued not to act himself as he wasn't walking straight, wasn't finishing his sentences, appeared confused, and needed the assistance of a walker.

The complaint further alleged Ms. Sanhou was made aware of concern Resident X possibly having a urinary tract infection (UTI). The complaint alleged Ms. Sanhou reported she would request a UTI test for Resident X; however, Ms. Sanhou did not follow through with requesting such a test. The complaint alleged Resident X's relatives attempted to contact Resident X's physician, Chelsea Crouch; however, Ms. Crouch did not visit Resident X at the facility until the afternoon of 08/24/2023 and immediately requested 911 be contacted as Resident X was not well.

The complaint alleged telephone contact was made with direct care staff at the facility on 08/23/2023 and the morning of 08/24/2023; however, direct care staff

reported Resident X was fine and no concerns were indicated. The complaint alleged Resident X spent seven days in the hospital due to dehydration and then an additional three weeks at a rehabilitation facility before moving to a different Adult Foster Care facility.

On 10/27/2023, I confirmed with the Attorney General's Office they also received the complaint, but their office denied investigating the allegations.

On 10/30/2023, I interviewed Relative X1 via telephone. Relative X1 confirmed the dates Resident X resided in the facility, which were consistent with the allegations. Relative X1's statement to me was also consistent with the allegations. Relative X1 stated Resident X originally resided at the licensee's neighboring licensed AFC facility; however, due to direct care staff reporting Resident X was becoming a wandering risk it was determined he needed to reside in a locked facility. Relative X1 stated she visited with Resident X on 08/15, 08/16, 08/17, 08/18, and 08/19 in the facility and each time he appeared fine; however, she stated when she visited with him on 08/22/2023 she thought something was wrong with Resident X. She stated she messaged Ms. Crouch that day; however, she didn't get a response back. She stated she also notified Guardian X1. She stated she wasn't sure if Resident X was experiencing small strokes or had a UTI, but regardless, she stated Resident X wasn't acting normal as he wasn't talking or getting out of bed.

Relative X1 stated direct care staff weren't leaving water in Resident X's bedroom, which she believed contributed to his dehydration. She stated Ms. Sanhou reported to her Resident X would get water at meals, but water wasn't being left in his bedroom. Relative X1 stated none of the direct are staff appeared concerned about Resident X. She stated none of the staff contacted Ms. Crouch either. She stated she hoped Ms. Crouch would visit with Resident X in the facility and prescribe an antibiotic, but Ms. Crouch took longer than expected.

On 11/06/2023, I interviewed the facility's Administrator, Janet White, while conducting a neighboring facility's renewal inspection. Ms. White stated Resident X was moved to Park Place Living Centre #B for safety purposes as he was wandering more frequently into other neighboring facilities. Ms. White stated she wasn't notified about Resident X's decline until 08/24/2023. She stated none of the direct care staff reported any concerns to her about Resident X declining. She stated Relative X1 and Guardian X1 reported they tried contacting Ms. Crouch for three days prior to Resident X finally being seen on 08/24/2023.

Ms. White stated residents don't keep water in their bedrooms because they forget it's there due to their diminished mental capacities. She stated direct care staff will provide water to residents during meals and when checking on residents.

On 11/15/2023 and 12/15/2023, I interviewed Careline Hospice nurse practitioner, Chelsea Crouch, via telephone. Ms. Crouch stated she reviewed Careline's Hospice's documentation system and there was no documentation any facility direct care staff member contacted her or the Careline agency prior to 08/24/2023 to report Resident X wasn't doing well and needed to be immediately seen. She stated when she visited with Resident X on the afternoon of 08/24/2023 it was her normal monthly visit. She stated Resident X appeared "very ill" and was "minimally responsive". She stated he also very lethargic, his words were jumbled, and he appeared very fatigued. She stated direct care staff reported to her when Resident X woke up that morning that is how he appeared to them.

On 11/15/2023, I conducted an unannounced inspection at the facility. I interviewed direct care staff and identified Resident Care Manager, Isabelle Sanhou. She stated when Resident X was admitted to the facility, he was "very playful" and "walking around". She stated direct care staff were offering him food and liquids and he was eating. She stated direct care staff were checking on him every two hours and providing toileting assistance. Ms. Sanhou stated she was informed by direct care staff at his previous facility to offer him water and juice, which Ms. Sanhou stated direct care staff would do. She stated Resident X wasn't requesting additional water or juice after meals and reported he was fine.

She stated Resident X declined "pretty quickly". She stated he became disorientated and was hard to redirect. She also stated he wasn't talking as much as he did when he was first admitted. Ms. Sanhou stated she contacted Resident X's medical provider; however, she stated she didn't believe there was any documentation confirming her contacts. Ms. Sanhou stated Resident X was never tested for a UTI while he was in the facility for nine days. She stated she recognized his behavior was changing and recalled his decline being within 48 hours. She stated Resident X's relatives visited with him during that 48 hours and stated there was open communication with them about Resident X's behavior. Ms. Sanhou also stated she did not recall Resident X declining so much so he needed a walker for ambulating.

During the inspection, I requested all physician contacts and/or observation notes relating to Resident X while he was residing in the facility from 08/15/2023 through 08/24/2023. Upon my review of the facility's observation notes, only two notes were documented during Resident X's admission. Direct care staff, Leonda Givhan-Tipton, documented on 08/18/2023 at 2:30 pm the following:

> "Resident X] allowed us to get him changed at 12:30 but would not go change at 2, 2:15 or 2:30 he keeps jocking[*sic*] and laughing but cant[*sic*] get him to stand uo[*sic*] so we can get him changed. he[*sic*] keeps saying he dont[*sic*] need changed. but[*sic*] he do[*sic*]"

Ms. Givhan-Tipton also documented on 08/22/2023 at 3:45 pm the following:

> "[Resident X] urine is very strong. he[*sic*] is also lil[*sic*] weak today and his daughter is concerned he may have a uti[*sic*]."

Administrator Ms. White stated direct care staff, Ms. Givhan-Tipton, was no longer employed by the licensee. She stated she hadn't worked for the licensee for one to two months.

On 12/04/2023, I attempted to interview Resident X at his new AFC; however, due to Resident X's cognitive impairment he was unable to answer any of my questions. Consequently, I was unable to obtain any information from Resident X regarding his residency at Park Place Living Centre #B.

On 12/15/2023, I interviewed direct care staff, Bambi Keckler and Qua'Nice Robinson, via telephone. Both Ms. Keckler's and Ms. Robinson's statements to me were consistent with Ms. Sanhou's statement. They both stated Resident X appeared to decline for at least one to two days before he was sent to the ER for medical treatment. They both reported Resident X initially was able to walk on his own; however, prior to being sent to the ER he relied more on the assistance of a walker. They both stated the one to two days prior to Resident X being sent to the ER he appeared "disoriented", was unable to get out of bed, and had slurred speech. Ms. Keckler stated she couldn't recall if she notified any direct care staff, medical personnel, or Guardian X1 about Resident X's decline. Ms. Robinson stated she reported to Ms. Sanhou Resident X was declining. Both Ms. Keckler and Ms. Robinson stated if direct care staff contact a resident's physician or document anything relating to a resident it would be documented in their ECP system, which is the facility's electronic system where direct care staff log medications and create notes on residents.

Ms. Keckler's and Ms. Robinson's statements to me regarding toileting and providing liquids to Resident X were consistent with Ms. Sanhou's statement.

On 12/15/2023, I interviewed Guardian X1 via telephone. Guardian X1's statement to me was consistent with Relative X1's statement.

On 12/15/2023, I interviewed Relative X1 who stated she did not have any documentation between her or Guardian X1 and facility direct care staff confirming they were informed of her concerns about Resident X's decline.

In my review of the facility record, I determined this is a repeat violation of Adult Foster Care (AFC) licensing rule, R 400.15316(1). According to renewal licensing study report, dated 11/20/2023, the facility was in violation of AFC Rule 400.15316(1) when it was established direct care staff, Isabelle Sanhou, acknowledged making telephone contacts to resident physicians and pharmacies

relating to medications; however, there was no record of these contacts in resident records. A refusal to renew recommendation was made due to the repeated quality of care violations.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.15310** | **Resident health care.** |
| | **(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.** |
| **ANALYSIS:** | Based on my investigation, which included interviews with Relative X1, Guardian X1, direct care staff, Isabelle Sanhou, Bambie Keckler, and Qua'Nice Robinson, Administrator, Janet White, and Careline agency nurse practitioner, Chelsea Crouch, and my review of the facility's electronic observation notes, Resident X began to decline on or around 08/18/23 through 08/20/2023; however, medical treatment was not sought until Ms. Crouch sent Resident X to the emergency room on 08/24/2023 after establishing he was very ill, and "minimally responsive".<br><br>Direct care staff, Leonda Givhan-Tipton, documented as early as 08/18/2023 Resident X was unable to stand and resisting staff's assistance with incontinence changes. Additionally, Ms. Givhan-Tipton documented on 08/22/2023 Resident X's relatives were concerned Resident X had a urinary tract infection; however, there was no documentation provided by the licensee designee, administrator or facility direct care staff confirming they contacted Resident X's primary physician, Dr. Crouch, or Resident A was sent to the emergency room by facility staff members despite his continued decline. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

| **APPLICABLE RULE** | |
|---|---|
| **R 400.15316** | |
| | **(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information:**<br>**(d) Health care information, including all of the following:**<br>**(i) Health care appraisals.** |

| | |
|---|---|
| | **(ii) Medication logs.**<br>**(iii) Statements and instructions for supervising prescribed medication, including dietary supplements and individual special medical procedures.**<br>**(iv) A record of physician contacts.** |
| **ANALYSIS:** | Based on my interviews with direct care staff, Isabelle Sanhou, Bambi Keckler, and Qua'Nice Robinson, and Careline nurse practitioner, Chelsea Crouch, and my review of the facility's observation notes for Resident X, there was no record of physician contacts for Resident X from 08/24/2023 when he was sent to the emergency room after Ms. Crouch visited with him at the facility and determined he needed immediate medical attention. |
| **CONCLUSION:** | **REPEAT VIOLATION ESTABLISHED**<br><br>**SEE RENEWAL LICENSING STUDY REPORT, DATED 11/20/2023, REFUSAL TO RENEW RECOMMENDATION.** |

**ALLEGATION: Resident X did not receive his required medication.**

**INVESTIGATION:**

The complaint alleged Resident X wasn't receiving all his medications because the facility staff did not submit for refills. No additional information was provided.

Complainant stated direct care staff, Ms. Keckler, reported to her direct care staff did not have all Resident X's medication, specifically his dementia medications, because direct care staff didn't request refills.

On 11/06/2023, I received and reviewed Resident X's August electronic Medication Administration Record (eMAR). According to documentation on Resident X's MAR, he was prescribed the following medication, but eMAR notations of "on order", "not available", and "waiting on doctor to send new script one on file is a year old", indicated the medication was not administered:

- Metformin ER 1,000 MG 24 HR TABLET, EXTENDED RELEASE, to be administered by giving one tablet orally twice a day. This medication was not administered to Resident X at 5 pm on 08/18, 8 am on 08/19, 5 pm on 08/19, 8 am on 08/20, 5 pm on 08/20, 8 am on 08/21, 5 pm on 08/20, 8 am on 08/21, 5 pm on 08/21, 8 am on 08/22, 5 pm on 08/22, 8 am on 08/23, and 5 pm on 08/23.

Nurse Practitioner, Ms. Crouch, stated the facility's direct care staff contacted Careline Hospice on 08/22/2023 requesting a refill on Resident X's Metformin medication. She stated either she or her assistant processed the refill request immediately upon receiving it. She stated she reviewed Careline's documentation system, which did not reveal anyone from the facility contacting Careline for any Metformin refills prior to 08/22/2023. Ms. Crouch stated there wouldn't be severe side effects from Resident X stopping the medication, Metformin, suddenly or not receiving it for several days.

Neither direct care staff, Ms. Sanhou, Ms. Keckler, nor Ms. Robinson, could recall any major issues with Resident X's medications. They all believed he was receiving his medications, as prescribed; however, Ms. Sanhou stated Resident X was admitted to the facility without his Metformin medication because it needed to be ordered. Ms. Sanhou stated she did not have any documentation relating to refilling Resident X's Metformin medication.

In my review of the facility record, I determined this is a repeat violation of Adult Foster Care (AFC) licensing rule, R 400.15312(2). According to special investigation report (SIR) 2023A0581021, dated 04/06/2023, the facility was in violation of AFC rule R 400.15312(2) when it was established residents did not receive their medications, as required, because medications were either not in the medication cart, or had not been refilled timely and therefore, had been delivered by the pharmacy.

The facility's approved Corrective Action Plan (CAP), dated 05/10/2023, documented on 03/01/2023, the facility's Administrator called the pharmacy and was able to reorder medications via telephone and direct care staff were informed of this step in the process. The CAP also documented the facility's Administrator, via text message, sent out a tutorial to staff on how to reorder medications and how to reorder through the medication que so the medications were sent to the pharmacy. The CAP also documented a pharmacist came to the facility on 03/22/2023 and provided training on the ECP system which included when and how to reorder medications. The CAP documented training included pushing refills through the medication reorder que to HomeTown Pharmacy. Additionally, the CAP documented a meeting was held with the Lead Resident Care Specialist and Resident Care Manager on 04/12/2023 to work together on process improvement. Finally, the CAP documented direct care staff would document all conversations with pharmacy, doctor/doctor's offices, personnel and family members in ECP. The CAP documented the Administrator and/or Resident Care Manager was responsible for ensuring ongoing compliance with the CAP.

According to renewal licensing study report, dated 04/19/2023, the facility was in violation of AFC rule R 400.15312(2) when it was established residents continued to not receive their medications, as required. A provisional recommendation was made due to the repeat quality of care violations. The facility's approved CAP, dated

06/02/2023, documented acceptance of the provisional recommendation and documented a similar CAP as submitted for SIR 2023A0581021.

According to renewal licensing study report, dated 11/20/2023, the facility continued to be in violation of AFC rule R 400.15312(2) when it was established residents continued to not receive their medications, as required. A refusal to renew recommendation was made due to the repeated quality of care violations.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.15312** | **Resident medications.** |
| | **(2) Medication shall be given, taken, or applied pursuant to label instructions.** |
| **ANALYSIS:** | Upon review of Resident X's August 2023 electronic Medication Administration Record, and interviews with nurse practitioner, Chelsea Crouch, Complainant, and direct care staff, Ms. Sanhou, Ms. Keckler, and Ms. Robinson, Resident X missed 13 doses of his Metformin ER 1,000 MG 24 HR tablet, extended release, from 08/18 through 08/23 because it wasn't available in the facility to administer. |
| **CONCLUSION:** | **REPEAT VIOLATION ESTABLISHED**<br><br>**SEE SIR 2023A0581021, DATED 04/06/2023, CAP DATED 05/10/2023**<br><br>**SEE RENEWAL LICENSING STUDY REPORT, DATED 04/19/2023, CAP DATED 06/02/2023**<br><br>**SEE RENEWAL LICENSING STUDY REPORT, DATED 11/20/2023, REFUSAL TO RENEW RECOMMENDATION** |

On 12/19/2023, I attempted to conduct my exit conference with the licensee designee, Connie Clauson, via telephone; however, I was unable to reach her. I emailed her my findings.

## IV. RECOMMENDATION

On 11/28/2023, I made the recommendation of refusal to renew the facility's license. Due to the continued quality of care violations, my recommendation remains unchanged.

12/18/2023

_____

Cathy Cushman Date
Licensing Consultant

Approved By:

12/18/2023

_____

Dawn N. Timm Date
Area Manager