GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 3, 2024

Nancy Posey and Theresa Posey
8470 Parshallville
Fenton, MI 48430

RE: License #: AM470078614
Investigation #: 2024A0466011
Hartland Assisted Living

Dear Nancy Posey and Theresa Posey:

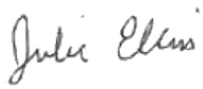
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9727.

Sincerely,



Julie Elkins, 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 #:	AM470078614
Investigation #:	2024A0466011
Complaint Receipt Date:	11/06/2023
Investigation Initiation Date:	11/06/2023
Report Due Date:	01/05/2024
Licensee Name:	Nancy Posey and Theresa Posey
Licensee Address:	8470 Parshallville Fenton, MI 48430
Licensee Telephone #:	(810) 632-7760
Administrator:	Nancy Posey
Name of Facility:	Hartland Assisted Living
Facility Address:	5978 Cullen Road Fenton, MI 48430
Facility Telephone #:	(810) 632-5509
Original Issuance Date:	11/22/1997
License Status:	REGULAR
Effective Date:	12/18/2022
Expiration Date:	12/17/2024
Capacity:	12
Program Type:	AGED ALZHEIMERS

II. ALLEGATIONS:

	Violation Established?
Resident A is being left in bed instead of being transferred to her wheelchair. Resident A has developed a bed sore.	No
Resident A was administered insulin which she was not prescribed.	No
Resident A was not provided with proper nutrition.	No
Resident A was not receiving showers.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/06/2023	Special Investigation Intake 2024A0466011.
11/06/2023	Special Investigation Initiated – Telephone call to Complainant interviewed.
11/09/2023	Inspection Completed On-site.
11/09/2023	Contact- document sent to licensee designee Nancy Posey who reported that she nor Theresa Posey were available to meet with me today.
12/08/2023	Contact- telephone call to Nancy Posey to review a file.
12/13/2023	Inspection Completed On-site- second time.
01/03/2024	Exit Conference with Nancy Posey.
01/03/2024	APS Referral

ALLEGATION: Resident A is being left in bed instead of being transferred to her wheelchair. Resident A has developed a bed sore.

INVESTIGATION:
On 11/03/2023, Complainant reported direct care workers (DCW)s are supposed to pick Resident A up and put her and put her in the wheel chair regularly. Complainant reported DCWs were not transferring Resident A out of bed as required. Complainant reported Resident A developed a bed sore because DCWs weren't

repositioning her or transferring out of bed as required. Complaint reported Resident A was upset because a DCW (name unknown) told Resident A that someone complained about Resident A's care and now DCWs told Resident A that she must get out the bed whether she likes it or not. Complainant reported DCWs are not pleasant with the residents.

On 11/09/2023, I conducted an unannounced onsite investigation and I interviewed DCW Danielle Wierenga who reported that Resident A did not want to get out of bed because she was afraid of falling. DCW Wierenga reported DCWs encourage Resident A to get out of bed but that they cannot force her to do so. DCW Wierenga reported she was not aware Resident A had any bed sores. DCW Wierenga reported Resident A can clearly express her needs and wants to direct care workers on duty. DCW Wierenga reported Resident A did not want to socialize with the other residents nor did she want to sit a chair or her wheelchair. DCW Wierenga denied ever being unpleasant toward Resident A nor did she witness any other DCW being unpleasant to her. DCW Wierenga reported that no other resident or DCW reported to her that any DCW was unpleasant to Resident A.

I interviewed DCW Jacqueline Diaz who reported that when Resident A was admitted to the facility she was recovering from c-diff and she did not feel well. DCW Diaz reported that Resident A made it clear that she did not want to get out of bed and she did not want to socialize with the other residents. DCW Diaz reported Resident A can clearly express her needs/wants directly to facility direct care workers. DCW Diaz reported Resident A refused to get out of bed. DCW Diaz reported Resident A did not have any bed sores but that she did have a spot on her heel that was being elevated. DCW Diaz reported Resident A did not want to socialize with the other residents nor did she want to sit a chair or her wheelchair. DCW Diaz reported denied every being unpleasant toward Resident A nor did she witness any other DCW being unpleasant toward Resident A. DCW Diaz reported that no other DCW or resident reported to her that any DCW was unpleasant to Resident A.

Resident A was not able to be interviewed as she was discharged from the facility prior to the these allegations being reported.

Resident A's record was not able to reviewed at the time of the unannounced investigation as it was not at the facility. DCW Wierenga and DCW Diaz reported licensee Nancy Posey had Resident A's record at another location.

On 12/13/2023, I scheduled an appointment to meet licensee Nancy Posey at the facility. Licensee Nancy Posey reported Resident A did not have any bed sores but was difficult to transfer. Licensee Nancy Posey reported Resident A would stiffen up her body and resist being transferred/getting out of bed. Licensee Nancy Posey reported Relative A1 wanted Resident A up and sitting in a chair but Resident A did not want to do that. Licensee Nancy Posey reported Relative A1 came to visit Resident A every day. Licensee Nancy Posey reported that Resident A was of

sound mind, could make her own decisions and could articulate her needs/wants to direct care workers. Licensee Nancy Posey reported Resident A did not like to socialize with other residents rather she preferred to be alone in her bedroom. Licensee Nancy Posey denied she was ever unpleasant to Resident A nor did she witness any other DCW being unpleasant to her. Licensee Nancy Posey reported that no other DCW or resident ever reported to her that any DCW was unpleasant to Resident A.

I reviewed Resident A's record which documented that she was admitted to the facility on 5/8/2023 and discharged on 9/18/2023. Resident A's record contained a written *Assessment Plan for Adult Foster Care (AFC) Residents* which was dated 5/8/2023 and signed by Relative A1. Resident A's *Assessment Plan for AFC Residents* (assessment plan) documented that she communicates her needs but is "unsocial." In the "walking/mobility" section of the document it stated, "non-weight bearing" and that she is a wheelchair user. Resident A's assessment plan did not document any expectation of her getting out of bed or sitting in a chair. Resident A's assessment plan did not document any bed sores.

I reviewed Resident A's *Health Care Appraisal* which was completed on 05/20/2023 documented that Resident A is 72 years and her general appearance is "elderly frail." This also did not mention any bed sores.

I found no documents in Resident A's record about any bed sores or treatment for bed sores.

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:	Complainant reported Resident A was being left in bed instead of being transferred to her wheelchair and had developed a bed sore due to this. DCW Wierenga, DCW Diaz and licensee Nancy Posey all denied that Resident A had a bed sore and there was no documentation in Resident A's record of any bed sore. Resident A's record did not contain any documentation or any medical recommendation for Resident A to be out of bed and/or to sit in wheelchair/recliner for any period of time. DCW Wierenga, DCW Diaz and licensee Nancy Posey all reported Resident A was capable of expressing her needs/wants and preferred to stay in bed and did not want to socialize with other residents. Resident A's protection and safety needs were attended to by direct care staff members.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A was administered insulin which she was not prescribed.

INVESTIGATION:
On 11/03/2023, Complainant reported the pharmacy used by the facility filled and delivered insulin for Resident A even though she is not an insulin user. Complainant reported she asked DCW (name unknown) confirmed Resident A was administered insulin even though Resident A denied this.

On 11/09/2023, I conducted an unannounced investigation and I interviewed DCW Wierenga who reported that Resident A was prescribed and administered insulin while at the facility.

I interviewed DCW Diaz who reported that she could not remember if Resident A was prescribed/administered insulin.

Resident A was not able to be interviewed as she has been discharged from the facility prior to these allegations being reported.

Resident A's record was not able to reviewed at the time of the unannounced investigation as it was not at the facility at the time. DCW Wierenga and DCW Diaz reported licensee Nancy Posey had Resident A's record at another location.

On 12/13/2023, I scheduled an appointment to meet licensee Nancy Posey at the facility. Licensee Nancy Posey reported that Resident A was prescribed insulin and that it was administered to her as prescribed by direct care workers on duty.

I reviewed Resident A's record which contained medication administration records (MAR)s for May 2023, June 2023, July 2023, August 2023 and September 2023. The MARs documented Resident A was prescribed, "Lantus Solostar 100 Unit/Inject

20 Units subcutaneously at bedtime." This prescription was discontinued on September 11, 2023, and according to the September 2023 MAR and that medication was not administered after that date.

I reviewed Resident A's record which contained a *Health Care Appraisal* dated May 20, 2023 with an attached list of medications which included "Lantus Solostar 100 Unit/Inject 20 Units subcutaneously at bedtime." Additionally, Resident A's record contained an Ascension Providence Hospital, Novi Campus "Final Report" from a hospital stay on May 1, 2023, prior to Resident A's admission into the facility which documented under "Reconciled Medication List, Lantus Solostar 100 Unit/Inject 20 Units subcutaneously at bedtime."

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Complainant reported that Resident A was administered insulin which she was not prescribed. According to Resident A's MARs from May 2023, June 2023, July 2023, August 2023 and September 2023, Resident A was prescribed, "Lantus Solostar 100 Unit/Inject 20 Units subcutaneously at bedtime." This prescription was discontinued on September 11, 2023 and according to the September MAR was not administered after that date. Resident A's record which contained a *Health Care Appraisal* dated May 20, 2023, which contained an attached list of medications which included "Lantus Solostar 100 Unit/Inject 20 Units subcutaneously at bedtime." Additionally, Resident A's record contained an Ascension Providence Hospital, Novi Campus "Final Report" from a hospital stay on May 1, 2023, prior to Resident A's admission into the facility which documented a prescription under "Reconciled Medication List, Lantus Solostar 100 Unit/Inject 20 Units subcutaneously at bedtime." Therefore, Resident A's insulin was being administered pursuant to label instructions.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A was not provided with proper nutrition.

INVESTIGATION:
On 11/03/2023, Complainant reported that Resident A's "ribs are sticking out" she seems to "not be fed or tended to much." Complainant was shocked when she saw how skinny Resident A was. Complainant reported that according to facility records Resident A weighed 151 pounds when she was admitted and Resident A weighed

124 when she was discharged thus documenting she lost 27 pounds while she lived there. Complainant reported DCWs were not watching her eat food rather they just dropped off food.

On 11/09/2023, I conducted an unannounced onsite investigation and I interviewed DCW Wierenga who reported Resident A did not eat a lot of her meals but she ate a lot of snacks. DCW Wierenga reported Resident A did not have teeth so it was harder for her to eat. DCW Wierenga reported Resident A was provided three regular meals daily with not more than 14 hours between the evening and morning meal. DCW Wierenga reported direct care workers on duty helped Resident A with cutting food and set up as needed. DCW Wierenga reported Resident A did not want to eat at the table with the other residents so she was assisted in her room. DCW Wierenga reported Resident A was offered multiple food options and the days she did not eat it was not necessarily because she did not like the food rather she just did not want to eat. DCW Wierenga reported Resident A was provided three regular meals daily with not more than 14 hours between the evening and morning meal. DCW Wierenga reported direct care workers on duty helped Resident A with cutting food and set up as needed. DCW Wierenga reported Resident A did not want to eat at the table with the other residents so she was assisted in her room.

I interviewed DCW Diaz who reported Resident A was a picky eater and did not eat much even though meals were offered to her and she was encouraged to eat it. DCW Diaz reported Resident A was offered multiple food options and the days she did not eat was not necessarily because she did not like the food, she just did not want to eat. DCW Diaz reported that reported that Resident A was provided 3 regular meals daily with not more than 14 hours between the evening and morning meal. DCW Diaz reported that the direct care worker on duty would help Resident A with cutting food and set up as needed. DCW Diaz reported Resident A did not want to eat at the table with the other residents so she was assisted in her room.

Resident A was not able to be interviewed as she has been discharged from the facility prior to the initiation of these allegations.

Resident A's record was not able to reviewed at the time of the unannounced investigation as it was not at the facility. DCW Wierenga and DCW Diaz reported licensee Nancy Posey had it at another location.

On 12/13/2023, I scheduled an appointment to meet licensee Nancy Posey at the facility. Licensee Nancy Posey reported Resident A either refused to eat or ate very little. Licensee Nancy Posey reported Relative A1 would bring meals for Resident A and she ate very little of what Relative A1 provided.

I reviewed Resident A's *Weight Record* which documented the following:

- 5/08/2023 151.6 pounds
- 6/01/2023 156.0 pounds
- 7/05/2023 153.2 pounds

- 8/01/2023 156.8 pounds

I reviewed Resident A's record which contained a *Health Care Appraisal* dated May 20, 2023 which documented that Resident A weighed "151" pounds and that her "ideal weight range was 108-132" pounds. According to weight records provided, at no time during her admission was Resident A within the physician order "ideal weight range."

I reviewed Resident A's record which contained MARs for May 2023, June 2023, July 2023, August 2023 and September 2023 where the facility tracked Resident A's eating daily. The MAR documented an inconsistent eating pattern for Resident A. There were numerous entries where it documented Resident A did not eat any of the meal provided, at times she ate 100% of the meal and other times 20%.

Resident A's record contained a written *Assessment Plan for AFC Residents* which was dated 5/8/2023 and signed by Relative A1. Resident A's *Assessment Plan for AFC Residents* documented that she communicates her needs, "feeds self, staff does set up."

I interviewed licensee Nancy Posey who reported Relative A1 visited every day and reported to her that Resident A was not eating well. Licensee Nancy Posey reported Relative A1 brought food for Resident A and she observed Resident A did not to eat the food Relative A1 provided also. Licensee Nancy Posey reported that Relative A1 told her that in September 2023 while hospitalized she learned that Resident A lost about 20 pounds in a 6–7-week time frame. Licensee Nancy Posey reported she was not surprised because Resident A was not eating or drinking much of anything while she lived at the facility. Licensee Nancy Posey reported Resident A was provided three regular, meals daily with not more than 14 hours between the evening and morning meal. Licensee Nancy Posey reported Resident A did not want to eat with the other residents at the table so the DCWs assisted her in her bedroom.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.
ANALYSIS:	On 12/13/2023, I reviewed Resident A's weight record which documented a steady weight range and no large weight loss.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	DCW Wierenga, DCW Diaz and licensee Nancy Posey all reported that Resident A was provide with three meals daily with no more than 14 hours between dinner and breakfast even though Resident A did not always prefer to eat at each meal.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A was not receiving showers.

INVESTIGATION:
On 11/3/2023, Complainant reported that while Resident A lived at the facility, she was hospitalized for a urinary tract infection (UTI) four times as they weren't giving Resident A showers as apparently Resident A refuses showers.

On 11/09/2023, I conducted an unannounced onsite investigation and I interviewed DCW Wierenga who reported Resident A did not want to get out of bed even to shower. DCW Wierenga reported Resident A was very afraid of falling.

I interviewed DCW Diaz who reported Resident A refused to get up and that this included to shower.

Resident A was not able to be interviewed as she has been discharged from the facility prior to the initiation of these allegations.

Resident A's record was not able to reviewed at the time of the unannounced investigation as it was not at the facility at the time. DCW Wierenga and DCW Diaz reported licensee Nancy Posey had Resident A's record at another location.

On 12/13/2023, I scheduled an appointment to meet licensee Nancy Posey at the facility. Licensee Nancy Posey reported direct care staff members document when a resident receives a shower on their individual MAR. Licensee Nancy Posey reported Resident A refused showers but reported that the expectation was that Resident A received a shower at least weekly.

I reviewed Resident A's record which documented that she was admitted to the facility on 5/8/2023 and discharged on 9/18/2023. Resident A's record contained a written *Assessment Plan for AFC Residents* which was dated 5/8/2023 and signed

by Relative A1. Resident A's *Assessment Plan for AFC Residents* documented that she is a "total assist bed bath PRN, shower PRN frequently refused."

I reviewed Resident A's record which contained MARs for May 2023, June 2023, July 2023, August 2023 and September 2023 where the facility tracked Resident A's showers:

- September 2023, documented that Resident A received a shower on September 17, 2023.
- August 2023, documented that Resident A received a shower on August 6, 2023 and August 11, 2023.
- July 2023, documented that Resident A received a shower on July 25, 2023.
- June 2023, documented that Resident A received a shower on June 13,2023 and June 23, 2023.
- May 2023, documented that Resident A received a shower on May 13, 2023.

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Resident A's record which documented that she was admitted to the facility on 5/8/2023 and discharged on 9/18/2023. During that time, Resident A's monthly MARs documents Resident A was given only seven showers therefore a violation has been established as Resident A was not provide with a weekly shower.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

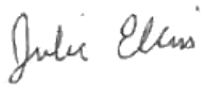
INVESTIGATION:
I conducted an unannounced investigation on 11/09/2023 and I interviewed DCW Wierega and DCW Diaz who both reported Resident A was discharged from the facility. Both DCW Wierega and DCW Diaz reported Resident A's record was not at the facility, but that licensee Nancy Posey had it therefore Resident A's record was not available for review. I contacted licensee Nancy Posey while I was at the facility, and she stated that she and licensee Theresa Posey were not available at the time of investigation to meet with me/provide me with any resident records.

APPLICABLE RULE	
R 400.14316	**Resident records.**
	(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: **(a) Identifying information, including, at a minimum, all of the following:** **(i) Name.** **(ii) Social security number, date of birth, case number, and marital status.** **(iii) Former address.** **(iv) Name, address, and telephone number of the next of kin or the designated representative.** **(v) Name, address, and telephone number of the person and agency responsible for the resident's placement in the home.** **(vi) Name, address, and telephone number of the preferred physician and hospital.** **(vii) Medical insurance.** **(viii) Funeral provisions and preferences.** **(ix) Resident's religious preference information.** **(b) Date of admission.** **(c) Date of discharge and the place to which the resident was discharged.** **(d) Health care information, including all of the following:** **(i) Health care appraisals.** **(ii) Medication logs.** **(iii) Statements and instructions for supervising prescribed medication, including dietary supplements and individual special medical procedures.** **(iv) A record of physician contacts.** **(v) Instructions for emergency care and advanced medical directives.** **(e) Resident care agreement.** **(f) Assessment plan.** **(g) Weight record.** **(h) Incident reports and accident records.** **(i) Resident funds and valuables record and resident refund agreement.** **(j) Resident grievances and complaints.**

	(2) Resident records shall be kept on file in the home for 2 years after the date of a resident's discharge from a home.
ANALYSIS:	On 11/09/2023, Resident A's record was not available in the AFC facility for department review. DCW Wierenga and DCW Diaz both reported licensee Nancy Posey had Resident A's resident record at another location. Therefore a violation as has been established as the record was not kept in the home for two years after discharge.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



01/03/2024

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Julie Elkins Date
Licensing Consultant

Approved By:

01/03/2024

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Dawn N. Timm Date
Area Manager