GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 3, 2024

Jeffrey Shepard
Elder Ridge Manor II, LLC
PO Box 518
Stockbridge, MI 49285

RE: License #: AL330380274
Investigation #: 2024A0466028
Elder Ridge Manor II, LLC

Dear Mr. Shepard:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 (517) 284-9727.

Sincerely,

Julie Elkins

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 #:	AL330380274
Investigation #:	2024A0466028
Complaint Receipt Date:	02/12/2024
Investigation Initiation Date:	02/13/2024
Report Due Date:	04/12/2024
Licensee Name:	Elder Ridge Manor II, LLC
Licensee Address:	4101 Oakley Road Stockbridge, MI 49285
Licensee Telephone #:	(517) 851-7501
Administrator:	Jennifer Flores
Licensee Designee:	Jeffrey Shepard
Name of Facility:	Elder Ridge Manor II, LLC
Facility Address:	4101 Oakley Road Stockbridge, MI 49285
Facility Telephone #:	(517) 851-7501
Original Issuance Date:	04/06/2017
License Status:	REGULAR
Effective Date:	10/05/2023
Expiration Date:	10/04/2025
Capacity:	20
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATIONS:

	Violation Established?
Resident A's dentures have been broken for an extended period of time therefore she is unable to eat and is losing weight.	No
Resident B fell on 1/10/2024 and was not provided medical care.	No
Resident C is not being administered his medications as prescribed.	No
Additional Findings	Yes

III. METHODOLOGY

02/12/2024	Special Investigation Intake 2024A0466028.
02/13/2024	Special Investigation Initiated – Telephone call to Complainant, interviewed.
03/06/2024	Inspection Completed On-site.
03/12/2024	Contact- document sent/received to/from administrator Jennifer Flores.
03/14/2024	Contact- Telephone call made to PACE, Jeanette Saint-Onge, lead social worker interviewed.
03/14/2024	Contact- Telephone call made to Relative A1, message left.
03/15/2024	Contact- Telephone call made to Relative A1, interviewed.
03/18/2024	Contact- Telephone call made to Resident B's case manager Anissa Olmstead interviewed.
03/18/2024	Contact- Telephone call made to Resident B's nurse practitioner Tamber Townsend, message left.
03/18/2024	Contact- document sent to ORR Lynn McLaughlin and Greg Fox.
03/18/2024	Contact- document received from Greg Fox.
03/22/2024	Contact- document sent/received to/from Complainant.
04/01/2024	Contact- Telephone call made to Relative C1, interviewed.

04/01/2024	Contact- Telephone call made to licensee designee Jeffrey Shepard, interviewed.
04/01/2024	Exit conference with licensee designee Jeffrey Shepard.
04/02/2024	APS referral.

ALLEGATION: Resident A's dentures have been broken for an extended period of time therefore she is unable to eat and is losing weight.

INVESTIGATION:
On 02/12/2024, Complainant reported that Resident A's bottom dentures broke however there is still a peg sticking out in the bottom right of Resident A's mouth. Complaint reported that because Resident A has difficulty eating, management staff at the facility refuse her food all the time which has resulted in Resident A losing weight. Complaint reported being told that at night she was only allowed to give Resident A one graham cracker. Complainant reported Resident A can barely eat due to how sore her mouth is from the denture peg that is sticking out in her mouth.

On 03/06/2024 I conducted an unannounced investigation and I interviewed administrator Jennifer Flores who reported that Resident A's dentures did break some time ago and that she and Relative A1 have been working with Program for All-inclusive Care for the Elderly (PACE) to have the dentures replaced. Administrator Flores reported that there is a lot of "red tape within that process" that they are trying to navigate. Administrator Flores reported Resident A needs to see a specialist to be fitted for the dentures and are waiting on PACE to set that up. Administrator Flores reported she has several emails from PACE documenting that the replacement of the dentures is their responsibility and that they are working on it. Administrator Flores reported Resident A's mouth is sore and she often refuses to eat. Administrator Flores reported Resident A does have posts sticking out in her mouth which has created fissures in her mouth. Administrator Flores reported Resident A has a long history of co-morbid conditions and a long history of eating problems including bulimia. Administrator Flores reported that since Resident A's admission her eating has improved. Administrator Flores reported Relative A1 visits frequently and he has been assisting her in continuing to ask PACE when Resident A's dentures will be replaced. Administrator Flores denied that any direct care worker (DCW) has ever been trained/told to only give Resident A one gram cracker and/or to withhold or refuse Resident A food.

I interviewed DCW Michelle Swafford, DCW Madison Mazuca and DCW Jamie Angell who all reported that Resident A has never been a good eater as she prefers to eat "junk food" instead of meals. DCW Swafford, DCW Mazuca and DCW Angell all reported Resident A's dentures are broken and administrator Flores is working with PACE to get the dentures replaced. DCW Swafford, DCW Mazuca and DCW

Angell all reported that Resident A has pain in her mouth and that Relative A1 is very involved in her care. DCW Swafford, DCW Mazuca and DCW Angell all denied that they have ever been instructed to just give Resident A one graham cracker and/or to withhold or refuse Resident A food.

At the time of the unannounced investigation Resident A was visiting with Relative A1 and her grandchildren so she was not available to be interviewed.

On 03/14/2024, I interviewed lead social worker for PACE Jeanette Saint-Onge who reported that she is aware that Resident A needs new dentures due to hers being broken. Social worker Saint-Onge reported Resident A needs to see an oral surgeon and PACE does not have a contract with one, so that is being addressed. Social worker Saint-Onge reported administrator Flores has been vocal about Resident A's need for dentures and reported that she has been a good advocate for Resident A alongside Relative A1. Social worker Saint-Onge reported Resident A has a long history of mental health disorders including eating disorders which all contribute to Resident A's eating concerns. Social worker Saint-Onge reported Resident A lost weight last summer and that since then her weight has been stable. Social worker Saint-Onge reported Resident A is at PACE twice a week and meets with the nutritionist and a physical therapist. Social worker Saint-Onge stated Resident A has never reported to anyone that she is not being fed at the facility or that she is only given one graham cracker. Social worker Saint-Onge reported direct care staff members have come up with creative ways to work with Resident A and are providing her excellent care. Social worker Saint-Onge reported Relative A1 is also a great advocate for Resident A and visits her frequently both at PACE and at the facility. Social worker Saint-Onge reported she and other PACE providers have been impressed by the care Resident A receives at the facility.

On 03/15/2024, I interviewed Relative A1 who confirmed Resident A's dentures broke some time ago and that he, administrator Flores and social worker Saint-Onge have been working together to have the dentures replaced. Relative A1 reported that the most recent hurdle is that Resident A needs to see an oral surgeon however PACE does not have one contracted. Relative A1 reported Resident A's mouth is sore and she often refuses to eat but Relative A1 reported Resident A has a long history of co-morbid conditions and a long history of eating problems along with being a "picky" eater. Relative A1 reported he visits frequently and has been continuing to ask PACE when Resident A's dentures will be replaced. Relative A1 reported Resident A has never told him that any DCW would only give her one graham cracker or withheld food from Resident A. Relative A1 reported that he has been at the facility at mealtimes often and he is impressed with the meals that they serve. Relative A1 reported he has observed Resident A refuse a very nice meal. Relative A1 reported that Resident A is more of a "grazer" then a meal eater and she likes to lightly snack all day. Relative A1 reported facility direct care staff provides Resident A with supplements including the higher caloric drink Boost. Relative A1 reported that he is very happy with the care Resident A is being provided.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	Resident A did break her dentures and according to administrator Flores, DCW Swafford, DCW Mazuca, DCW Angell, Relative A1 and PACE social worker Saint-Onge Resident A needs to see an oral surgeon and PACE does not have a contract with any oral surgeons. According to social worker Saint-Onge and Relative A1, the facility administrative staff has continued to advocate for Resident A's health care needs for new dentures while waiting on instruction from PACE. Plus, Resident A has continued to receive all meals and snacks during this time and has never been refused or denied food. Therefore, there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident B fell on 1/10/2024 and was not provided medical care.

INVESTIGATION:
On 02/12/2024, Complainant reported Resident B just passed away and there is something "very off" about her recent fall. Complainant reported that it seemed that the facility administration did not take her fall or pain very serious. Complainant believed Resident B had an unwitnessed fall in the bathroom.

On 02/13/2024, Complainant provided screen shots of text messages, the first is the message Complainant sent to administrator Flores on 01/11/2024:

> *"This morning [Resident B] was awake when I opened the door, first words were I broke my leg. She was soaked with sweat, hair everything and shaking. She said she fell in the bathroom before bed (first I have heard of it.) She is not bearing any weight on her right leg. She asked to see the doctor and wanted pain meds."*

Administrator Flores response:

> *"Yesterday, it was her left side, but by the time her nurse got there, she was back to using it. The nurse just said..."This will be the start of her decline." I will check on her this am and type up a "to do" medication wise. (In regards to her comfort pack).I did not get back to your above message yesterday. I took advantage of all first shift making it in (health and icy roads) and did our aldis and pharmacy runs, then spent the rest of the day until 6pmish doing jeffs meds. As long as everyone makes it today, should be a full day of catch up finally."*

I reviewed staff notes that were dated 1/10/2024 and stated:

> *"[Resident B's] right thigh on the outside looks a little swollen. When we got her out bed she kept saying she fell in the bathroom before bed and her hip is broke. She is barely putting any weight on her right foot. -AM*
>
> *She never fell in the bathroom before I put her in bed! put her in there walked away for a minute and when I went back in she was standing up so I pulled her pants up and put her back in her wheel chair ~JN"*

I reviewed staff notes that were dated 1/11/2024 and stated:

> *"[Resident B] After her nurse evaluation it was determined that she is in the beginning stages of "her decline"(nurses' words not mine.) She has PRN Lorazepam in the top drawer of the med cart and can have 1 every four hours for anxiety, stress, high BP or other-like symptoms. For now, message me when giving it so that 1 can mentally keep track of it, but also write on back of MAR, check MAR before administrating to ensure she had not recently had a dose. I will ensure to order more and create a MAR just for her hospice comfort medication. ~JF"*

On 03/06/2024 I conducted an unannounced investigation and I reviewed Resident B's record which contained a *Health Care Appraisal* dated 9/28/2023. The *Health Care Appraisal* documented that Resident B is 90 years and in the "diagnosis" section of the report it stated, "diabetes mellitus (DM), schizoaffective disorder, chronic obstructive pulmonary disease (COPD), hypertension (HTN), Parkinson's." In the "explanation of abnormalities/treatment ordered" section of the report documented, "bilateral (BLE) edema, right foot drop, dyspnea, confused."

I reviewed Resident B's written *Assessment Plan for Adult Foster Care (AFC) Residents* (assessment plan) which documented that Resident B does not move independently in the community and that she requires supervision and transportation. In the "toileting" section of the assessment plan it stated, "full assist wears briefs." In the "mobility" section of the assessment plan it stated, "wheelchair."

I interviewed administrator Flores who reported Resident B passed away on 1/14/2024. Administrator Flores reported Resident B's care was overseen by both community mental health (CMH) and hospice. Administrator Flores reported none of the direct care workers on duty reported that Resident B fell nor did any direct care worker complete an incident report about any change in condition for Resident B. Administrator Flores reported that a staff member reported that Resident B had an unwitnessed fall in the bathroom as that is what Resident B reported. Administrator Flores reported that although Resident B is assisted with toileting, Resident B can be left alone in the bathroom for privacy. Administrator Flores reported Resident B's health had been declining and she has history of some acting out behaviors such as "throwing herself out of her chair." Administrator Flores reported Resident B can be confused at times and reports things that did not occur. Administrator Flores reported Resident B's nurse practitioner Tamber Townsend came to the facility the same day that the unwitnessed fall was reported because Resident B was not using the left side of her body. Administrator Flores reported that when nurse Townsend was out, Resident B's blood pressure was high, so she was prescribed Ativan. Administrator Flores reported that nurse Townsend came out a second time and did an x-ray where no fractures or breaks were identified because Resident B did begin to have bruising on her right side. Administrator Flores reported that Resident B was more restless and agitated then usual and she was not eating as much. Administrator Flores reported that hospice prescribed medication for restlessness and agitation. Administrator Flores reported that between 1/10/2024 and 1/14/2024, nurse Townsend was out twice to care for Resident B. Administrator Flores reported that there was never any evidence of a fall and then Resident B died on 1/14/2024 about 11 am.

On 03/18/2024, Greg Fox from the office of recipient rights reported that his investigation remains open.

On 03/18/2024, I reviewed Resident B's death certificate which documented that she died of natural causes and chronic obstructive pulmonary disease (COPD).

On 03/18/2024, I interviewed Resident B's case manager Anissa Olmstead who reported that she was not aware of Resident B falling before her death but she was aware that nurse Townsend had been out to see Resident B. Case manager Omstead reported that hospice was very involved with Resident B as she was 90 years and her health continued to decline as she aged. Case manager Olmstead reported that she saw Resident A on 01/02/2024 and she looked great. Case Manager Olmstead reported Resident B would have good days and bad days and that she had been "slowing down" and was more reliant on her wheelchair and she would "shuffle" her feet when she walked. Case manager Olmstead reported that Resident B's verbal speech was difficult to understand and that hospice had been providing her with "comfort care." Case manager Olmstead reported that Resident B was not always an accurate reporter. Case manager Olmstead reported Resident B received excellent care while she was at the facility and all of her medical needs were met.

On 03/18/2024, I called nurse Townsend and I left a message requesting a returned telephone call. As of the writing of this report nurse Townsend has not returned by call.

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:	Administrator Flores reported that between 1/10/2024 and 1/14/2024, nurse Townsend was out twice to provide care for Resident B. Administrator Flores reported that there was never any evidence of Resident B falling and then Resident B died on 1/14/2024 about 11am. When Resident B's change of condition was noticed, nurse Townsend was contacted and came out to assess Resident B. Case manager Olmstead reported that she was not aware of Resident B falling before her death on 01/14/2024 but she was aware that nurse Townsend had been out to see Resident B days before she died. Additionally, staff notes documented that Resident B's nurse had been out on 1/11/2024 therefore there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident C is not being administered his medications as prescribed.

INVESTIGATION:
On 02/12/2024, Complainant reported that Resident C is on hospice and he is not being provided with prescribed medications. Complainant reported that when she brought this to the administrator Flores attention, all names were signed to the medication log. Complainant reported facility direct care staff members are only administering Resident C Tylenol and no other medications including Ativan and morphine even though they are prescribed. Complainant reported that the morning of February 8th is when the facility made sure the medication sheets were filled out and medications were in the cart.

On 02/13/2024, Complainant provided a medication administration record (MAR) however there was no resident name or month documented on the MAR provided. The picture did document a time stamp of 02/09/2024 at 3:28 am. The medications listed on the MAR are ""Acetaminophen, 500 mg, take 2 tablet every 6 hours, Glycopyrrolate 1mg, take 1-tab QD, Amoxiclav 875-125 mg, take 1 tab daily." After

review of the MAR, it documented that from the 1st through the 8th all medication was administered as prescribed.

On 03/06/2024 I conducted an unannounced investigation and I interviewed administrator Flores who reported that licensee designee Jeffrey Shepard handles all resident medications for the facility so she is not aware of Resident C's medication regime.

I interviewed DCW Swafford, DCW Mazuca, DCW Angell who all reported that Resident C's medications were administered as prescribed. DCW Mazuca reported that she knows that Resident C is prescribed/administered Tylenol, but she was not sure about any additional pain medications. DCW Angell reported that she knows that Resident C is prescribed/administered Morphine as a PRN which is administered as needed.

On 03/12/2024, administrator Flores emailed me Resident C's February 2024 MAR which documented that he was prescribed "Acetaminophen, 500 mg, take 2 tablet every 6 hours, Glycopyrrolate 1mg, take 1 tab QD, Amoxiclav 875-125 mg, take 1 tab daily, ciprofloxacin 500 mg, take 1 tablet twice daily. "The MAR documented that all medications were administered as prescribed and initialed as required by the direct care staff member who administered medication.?

On 03/22/2024, Complainant acknowledged that the photo provided of the MAR did cut off the top right which was where the Residents name was. Complaint reported no other photos of the MAR were available for review.

On 04/01/2024, I interviewed Relative C1 who reported that licensee designee Shepard has been very communicative with him and other family members regarding the care needs of Resident C. Relative C1 reported that Resident C was 92 years and that his family was at the facility daily to be with Resident C. Relative C1 reported that morphine was prescribed to Resident C as a pro re nata (PRN) and that it was tried with Resident C but it made him groggy. Relative C1 was not sure if Ativan was prescribed as a PRN or not. Relative C1 reported that although Resident C was in the process of dying, he was only in pain when his bandages were changed and for that Tylenol was administered. Relative C1 reported that Resident C was getting out of bed, going to the dining hall and he was alert and oriented until he died on 3/19/2024. Relative C1 reported that the entire family was happy with the care that was provided at the facility. Relative C1 reported that to his knowledge all Resident C's medications were administered as prescribed and the PRN's were used only as needed as the families wishes were for Resident C to remain alert and oriented.

I interviewed licensee designee Shepard who reported that Resident C was on hospice and provided with an end of life "comfort kit" that contained morphine and Ativan as a PRN therefore those medications are only put on the MAR as they are being administered. Licensee designee Shepard reported that although all hospice

patients are provided with “comfort kits” they are not always utilized and that is why they are written as a PRN. Licensee designee Shepard reported that Resident C’s family was very involved with his care and that they were with Resident C often when the hospice nurse was out. Licensee designee Shepard reported that Resident C’s medications were administered as prescribed and that PRN’s were utilized as needed. Licensee designee Shepard reported that when DCWs administer medications they initial the MAR at the same time. Licensee designee Shepard reported that he conducts daily audits of the MARs to ensure compliance. Licensee designee Shepard reported that Resident C passed away on 03/19/2024.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	DCW Swafford, DCW Mazuca, DCW Angell, Relative C1 and licensee designee Shepard all reported that Resident C’s medications were administered as prescribed. I reviewed a MAR provided by Complainant and the MAR provided by administrator Flores and both MARs documented that all medications were administered to Resident C as prescribed and all medications were initialed by the direct care staff member who administered the medication. Therefore, there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 03/06/2024 I conducted an unannounced investigation and I observed in the medication cart that Resident A’s medications were not kept in the original pharmacy-supplied container. Resident A’s medications had been taken out of the pharmacy supplied container and put into blister packs. The blister packs had handwriting on the outside but did not contain the name of the medication, the dose or instructions for use. The blister packs only contained the residents last name and time that the medication should be administered handwritten on the blister pack.

I interviewed administrator Flores who reported licensee designee Jeffrey Shepard takes the prescribed medications out of the pharmacy-supplied container and replaces the medications in blister packs.

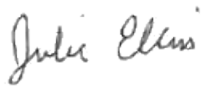
On 04/01/2024, I interviewed licensee designee Shepard who reported that because of the volume of residents and the number of medications prescribed and passed to

each resident, it is more efficient to have the medications in blister packs. Licensee designee Shepard reported that residents affiliated with PACE and veterans affairs (VA) are required to get prescribed medications from a pharmacy that does not offer blister packing therefore when the medications are delivered he counts them and puts them into blister packaging himself to ensure that the medications are set up correctly. Licensee designee Shepard reported that as of 04/01/2024, they are working with a new pharmacy which utilizes an electronic MARs system. Licensee designee Shepard reported that when a DCW administers medications they will scan the blister pack provided by the pharmacy which assists with medication counts and assures the correct medication is being administered at the correct time. Licensee designee Shepard reported that he would contact the new pharmacy to determine if it would be possible to blister package the medications for the PACE and the VA residents even though those residents have medications filled from a different pharmacy. Licensee designee Shepard reported he is aware that resident medications are required to remain in the pharmacy prescribed containers however he reported concern with the number of residents served along with the volume of medications administered, he is afraid medication errors will occur if all medication is left in the pharmacy prescribed containers and not combined in blister packages.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	While inspecting the medication cart I observed that Resident A's medication had been taken out of the pharmacy supplied container and put into blister packs. Administrator Flores and licensee designee Shepard both reported that licensee designee Shepard takes the prescribed medications out of the pharmacy-supplied container and puts them into blister packs. Therefore, a violation has been established as prescription medication is required to be kept in the original pharmacy-supplied container.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



04/01/2024

Julie Elkins Date
Licensing Consultant

Approved By:

04/03/2024

Dawn N. Timm Date
Area Manager