GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 12, 2024

Lijo Antony
Meadows Assisted Living, Inc.
71 North Avenue
Mt. Clemens, MI 48043

RE: License #: AL500388683
Investigation #: 2024A0604003
Meadows Assisted Living II

Dear Mr. Antony:

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 (248) 975-5053.

Sincerely,

Kristine Cilluffo, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 West Grand Blvd Ste 9-100
Detroit, MI 48202
(248) 285-1703

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL500388683
Investigation #:	2024A0604003
Complaint Receipt Date:	01/02/2024
Investigation Initiation Date:	01/03/2024
Report Due Date:	03/02/2024
Licensee Name:	Meadows Assisted Living, Inc.
Licensee Address:	71 North Avenue Mt. Clemens, MI 48043
Licensee Telephone #:	(586) 461-2882
Administrator:	Lijo Antony
Licensee Designee:	Lijo Antony
Name of Facility:	Meadows Assisted Living II
Facility Address:	75 North Avenue Mt. Clemens, MI 48043
Facility Telephone #:	(586) 461-2882
Original Issuance Date:	12/06/2018
License Status:	REGULAR
Effective Date:	06/06/2023
Expiration Date:	06/05/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED; ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Main area of facility mostly unattended by staff. Staff usually sleeping or on their phones.	No
Jennifer Hiller allows med techs to pass AM medications as late as 1:00 pm.	No
Jennifer Hiller gave 14 residents prune juice in attempt to teach staff a lesson about bowel movements. Images posted on "Homebase" of residents completely soiled.	Yes
Additional Findings	Yes

II. METHODOLOGY

01/02/2024	Special Investigation Intake 2024A0604003
01/03/2024	Special Investigation Initiated - Telephone TC to Complainant. Left message. Received return call. Returned call and left message.
01/04/2024	Inspection Completed On-site Completed unannounced onsite investigation. Interviewed Staff Jennifer Hiller, Macaylah Malloy, Lauren Montagne, Vickie Drumm, Gerri Orzel, Yolanda Smith, Resident A, Resident B and Resident C.
01/04/2024	Contact - Telephone call received Received message from Complainant
01/04/2024	Contact - Document Sent Email to Lijo Antony requesting documents
01/04/2024	Contact - Telephone call made TC to Complainant
01/05/2024	Contact - Document Received Email from Lijo Antony
01/05/2024	APS Referral Referral to Adult Protective Services (APS)

01/05/2024	Contact - Document Received Email from Complainant
01/05/2024	Contact - Document Received Received email from Complainant with pictures and additional information
01/10/2024	Contact - Document Received Received email from intake with additional compliant information. Notified intake that some allegations are regarding Meadows I which is HFA exempt facility.
01/17/2024	Contact - Telephone call received Returned call from APS Worker, Jose Garcia. Staff resigned. No further concerns. Resident is non-verbal.
01/19/2024	Contact - Document Received Received licensing documents by email from Lijo Antony including staff list, resident register and medication logs
01/30/2024	Contact - Document Sent Email from Complainant
01/30/2024	Contact - Document Sent Sent return email to Complainant
02/05/2024	Contact - Face to Face Face to Face Meeting with Lijo Antony at Meadows Assisted Living II.
02/15/2024	Contact- Document Received Email from Lijo Antony
02/20/2024	Contact- Document Sent Email to Lijo Antony
02/20/2024	Contact- Telephone call made TC to Lijo Antony. Left message.
02/23/2024	Contact- Document Received Email from Lijo Antony. He is out of town due to family emergency. He has asked Jen Hiller to contact me re: investigation.
02/23/2024	Contact- Telephone call received Returned call from Manager, Jen Hiller. Lijo Antony is out of country.

02/28/2024	Contact- Telephone call made Left message for Staff, Amaria Palmer. Received return call.
02/28/2024	Exit Conference Completed exit conference by phone with Manager, Jen Hiller. Lijo Antony is still out of country.

ALLEGATION:

Main area of facility mostly unattended by staff. Staff usually sleeping or on their phones.

INVESTIGATION:

On 01/02/2024, I received a licensing complaint regarding Meadows Assisted Living II. The Complainant alleged that there was an incident where Jennifer Hiller decided she wanted to teach her staff a lesson about documenting bowel movements. She gave 14 residents prune juice, and pictures documenting the date of incident as 10/20/2023. Images were posted in Homebase showing residents completely soiled. Jennifer Hiller was heard boasting about what she did. It was also alleged that Complainant overheard a staff yelling at a memory care resident for trying to get out of his wheelchair; the staff name was Shari. It was determined that resident in this allegation was residing at Meadows I, which is HFA exempt facility, and is now deceased. The Administrator did not respond to concern. The main area of the facility is mostly unattended, or staff is usually hiding in rooms sleeping or on their phone. Medication techs reported that Jennifer Hiller allowed them to pass morning meds late, medication records shows they were passing morning meds as late as 1:00 pm.

On 01/04/2024, I completed an unannounced onsite investigation at Meadows Assisted Living II. I interviewed Staff Jennifer Hiller, Macaylah Malloy, Lauren Montagne, Vickie Drumm, Gerri Orzel, Yolanda Smith, Resident A, Resident B and Resident C.

On 01/04/2024, I interviewed Manager, Jennifer Hiller at Meadows Assisted Living II. She alleged that complaints are being made by a former staff who is upset and wants to return to their job. Ms. Hiller believes they have enough staff. They always have a minimum of three staff which includes one med tech and two support staff. Ms. Hiller stated that they have not had any recent issues with staff sleeping or being on their phones. She stated that a hospice aide saw a staff sleeping and the staff is no longer working at facility.

On 01/04/2024, I interviewed Med Tech/Caregiver, Macaylah Malloy. Ms. Malloy stated that she worked for Meadows Assisted Living in 2021, left and then returned in October 2023. She stated that there is usually always a med tech in the main area of building and there is always a caregiver on the floor to change people. Ms. Malloy stated that they have enough staff. She has never seen staff sleeping or on their phones, but she

only works the day shit. Ms. Malloy stated that she has no concerns about the facility and has not seen any poor treatment of residents. She indicated that staff may have to talk loud to a resident if they have hearing issues.

On 01/04/2024, I interviewed caseworker, Lauren Montagne. She stated that she worked at Meadows in February 2023 and then came back in September 2023. She stated that there is usually a med tech in the main area of building. They typically have three caregivers on shift including one med tech. Ms. Montagne stated that she believes they could use more staff. Ms. Montagne indicated that she has seen staff speak loudly to residents but has not seen any verbal abuse or name calling.

On 01/04/2024, I interviewed caregiver, Vicke Drumm. She stated that she has worked at Meadows for seven months. She stated that there is usually enough staff in the main area. They typically have three staff per shift, including a med tech. Ms. Drumm believes they have enough staff. Ms. Drumm did indicate that she had a concern regarding observing a staff, Leah, being rough when changing Resident D and cussing at her. Resident D is on hospice and cannot walk, stand, or feed herself. Ms. Drumm stated that she did report the incident to her supervisor.

On 01/05/2024, I made an APS referral. On 01/17/2024, I received a telephone call from APS Worker, Jose Garcia who indicated that staff resigned, and APS has no further concerns. Resident D is non-verbal.

On 01/04/2024, I interviewed Dietary Director, Gerri Orzel. She stated that she has worked at Meadows for 10 months. She has seen staff on their phones, however, has not seen any staff sleeping. She has not seen any residents being verbally abused.

On 01/04/2024, I interviewed Cook, Yolanda Smith. She stated that she has not observed any verbal abuse or mistreatment of residents. She has seen staff use their phones. She is not sure if they are making phone calls. She has not seen any staff sleeping.

On 01/04/2024, Staff 1 reported a concern and asked not to be identified. They indicated that they have not seen staff sleeping on their shift. They indicated that the facility is cracking down on staff phone use, however, they have concerns regarding staff using FaceTime during shifts. They stated that staff using FaceTime during shifts could result in a possible HIPPA violation. She did not specify any incidents where HIPPA was violated, however, expressed it could occur if staff use FaceTime.

On 01/04/2024, I interviewed Resident A. She indicated that she was “doing good”. She was able to give limited responses to questions. She indicated that staff help with eating and medications. Resident A stated that she gets enough food to eat. Resident A indicated that staff treat her very well and are here to help. Staff are good all the time.

On 01/04/2024, I attempted to interview Resident B. She stated that she has lived at facility for more than a year. She indicated that the building is wonderful, but they need more activities. Resident B stated that staff treat her “ok”. Resident B stated that some staff have attitude, but she does not remember who because they change. Resident A requested staff assistance for her leg and did not answer any additional questions.

On 01/04/2024, I interviewed Resident C. He stated that he has lived at Meadows for a couple years. He stated that he does not need a lot of assistance. He gets enough food to eat and staff give him all his medications. Resident C indicated that he has had no mistreatment from staff. He has not seen any staff sleeping. He has no concerns other than the cold air.

On 01/04/2024, I interviewed the Complainant by phone. The Complainant indicated they had multiple concerns regarding resident neglect at the facility. The Complainant indicated that things used to be good, however, the licensee has changed and is not addressing concerns. Complainant indicated that residents at both Meadows I and II were given prune juice. The resident who was being yelled at in memory care is now deceased. Complainant believes that licensee needs to have unannounced inspections.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	There is not enough information to determine that there is not enough staff at facility. On 01/04/2024, during the onsite I found there were adequate staff present including manager, three caregivers and two kitchen staff. Staff interviewed stated that there are typically two caregivers and a med tech scheduled. The medication cart is located in the main area of the facility where the med tech is stationed. Staff indicated that phones are used during shifts, however, there were no reports of staff sleeping during shifts. Resident A, Resident B and Resident C did not report any issues with not receiving assistance from staff.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Jennifer Hiller allows med techs to pass AM medications as late as 1:00 pm.

INVESTIGATION:

On 01/04/2024, I interviewed Manager, Jennifer Hiller. Ms. Hiller stated that AM medications are never passed as late as 1:00 pm. She indicated that most medications can be passed one hour before or one hour after scheduled time. She stated that topicals and wound care may be given later. Staff use Quick Mar to document when medications are given.

On 01/04/2024, I interviewed Med Tech/caregiver, Macaylah Malloy. She stated that AM medications are usually passed between 7:00 am- 9:15 am/9:30 am. The latest they are passed is around 10:00 am or 10:30 am if they are training someone. Ms. Malloy stated that morning medications have never been passed at 1:00 pm. She also stated that certain topical medications have an order that allow for them to be applied later.

On 01/04/2024, I interviewed caseworker, Lauren Montagne. She stated that she does not pass medications. Ms. Montagne indicated that usually AM medications are given with breakfast and medications are given at lunch time. She indicated that she has not seen AM medications being given at 1:00 pm but she does not know about resident medications.

On 01/04/2024, I interviewed caregiver, Vicke Drumm. She stated that she is not a Med Tech but is going to be trained as one. She stated that medications are always on time. She has never seen AM medications being passed as late as 1:00 pm.

On 01/04/2024, I interviewed Resident A. She indicated that staff help with eating and medications. She gets her medication in the morning and at night.

On 01/04/2024, I interviewed Resident C. He stated that staff give him all his medications. He gets medications in the morning and at night time.

On 01/19/2024, I received Resident A, Resident B and Resident C's December 2023 and January 2024 medication logs by email from Lijo Antony by email. Resident A's medications were initiated by staff on logs and reasons for medication exceptions included out of stock, unable to take and withheld per Dr/RN orders, and medication not yet delivered. There were no notes regarding late medications.

Resident B’s medication log December 2023 was missing staff initials for the following medications:

- Aspirin 81 mg- 12/27
- Geri-Dryl 12.5 MG/ML liquid (9AM)- 12/27
- Miconazole 2% powder- 12/27
- Mouth Care (9AM) 12/27
- Senna Plus 8.6-50 MG Tab (9AM)- 12/27

In addition, Resident B’s medication log lists Metronidazole 500 MG tab. Apply one crushed tablet to wound base on coccyx every day for 7 days- for foul order. Medication log indicates that medication was given for 10 days on 12/17-12/21, 12/26, 12/28, 12/29, 12/30 and 12/31. Medication exceptions indicate that the medication was not available on 12/16 and 12/22.

Resident C’s medications were initiated by staff on logs. Medication exceptions included physically unable to take and medication not yet delivered. There were no notes regarding late medications.

On 02/28/2024, I interviewed former Staff, Amaria Palmer by phone. Ms. Palmer stated that she worked at Meadows approximately one year and two months. She was terminated on 02/01/2024. She was a med tech at the facility. She indicated that they typically start passing medications for memory care at 8:00 am and assisted living at 9:00 am. She stated that medications could be given an hour early or an hour late. She indicated that medications were never given as late as 1:00 pm. Ms. Palmer stated that there was an issue with a hospice resident having their medication possibly disposed of because it had not been used. She indicated that the hospice nurse was upset when the medication could not be located. Ms. Palmer indicated the resident passed away on hospice in December 2023.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medications shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	There is not enough information to determine that morning medications have recently been given out as late as 1:00 pm. Staff and residents interviewed did not recall any instances where medications were given as late as 1:00 pm. Medication logs for Resident A, Resident B and Resident C did not note any late medications. However, Resident B’s medication log did indicate that Metronidazole 500 MG tab was not given as prescribed. The

	instructions indicate to apply one crushed tablet to wound base on coccyx every day for 7 days- for foul order. Medication log indicates that medication was given for 10 days on 12/17-12/21, 12/26, 12/28, 12/29, 12/30 and 12/31. Medication exceptions indicate that the medication was not available on 12/16 and 12/22.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	On 01/19/2024, I received copy of Resident B's December 2023 medication log. Resident B's medication log was missing staff initials for the following medications: • Aspirin 81 mg- 12/27 • Geri-Dryl 12.5 MG/ML liquid (9AM)- 12/27 • Miconazole 2% powder- 12/27 • Mouth Care (9AM) 12/27 • Senna Plus 8.6-50 MG Tab (9AM)- 12/27
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Jennifer Hiller gave 14 residents prune juice in attempt to teach staff a lesson about bowel movements. Images posted on "Homebase" of residents completely soiled.

INVESTIGATION:

On 01/04/2024, I interviewed Manager, Jennifer Hiller at Meadows Assisted Living II. Ms. Hiller stated that prune juice was not given as a punishment and that this accusation is being made by former staff that is causing a lot of drama. She stated that they get bowel movement alerts for residents. She stated that system alerts them if

resident does not have a bowel movement for 48-72 hours. She stated that system showed that 10-12 residents did not have bowel movements. This can occur if staff are not logging bowel movements in the system. Ms. Hiller stated that these residents did not have PRN for constipation so they were given prune juice. She wanted to see if any residents needed a PRN in place for constipation. Ms. Hiller stated that Homebase is an app that they use for scheduling and pictures can be posted in app. She has instructed staff not to post pictures in app. Ms. Hiller denied that any residents were left soiled after drinking the prune juice. She believed this incident occurred in July or August 2023.

On 01/04/2024, I interviewed Med Tech/caregiver, Macaylah Malloy. She stated that she does not even know if the facility has prune juice. Ms. Malloy indicated that residents have PRN medications for constipation if needed. She stated that she did not hear of incident where 14 residents were given prune juice and may not have been working at the facility at the time it occurred. She stated Homebase is an app used to post schedule and clock in. She did not see any pictures of soiled residents on the app. She has seen pictures of laundry not being done.

On 01/04/2024, I interviewed caseworker, Lauren Montagne. She stated that she has not heard of incident involving prune juice. She stated that staff communicate on Homebase app. Ms. Montagne stated that about two or three months ago there were a few pictures saying residents were not changed. There were only pictures of dirty briefs, and no names or pictures of residents faces. She stated that she did not see any information or posts about prune juice being given. She also has not seen any residents being given prune juice at the facility.

On 01/04/2024, I interviewed caregiver, Vicke Drumm. She stated that she has no knowledge regarding prune juice incident. She stated that she uses Homebase app, however, never saw pictures of soiled residents. She stated that she has not heard of prune juice being given to residents. Ms. Drumm indicated that they mainly give residents water.

On 01/04/2024, I interviewed Dietary Director, Gerri Orzel. She stated that she was aware of prune juice incident. Ms. Orzel stated that med passer, Amaria, requested 14 prune juices for 14 residents. Jen said she would give out prune juice to residents who had no documented bowel movements for what she believes was 24 hours. Amaria had a list of the 14 residents and the lead cook, Yolanda, got the juices. Ms. Orzel indicated that she thought that staff were going to be in for a long day when she heard about giving them the prune juice. Ms. Orzel stated that the kitchen has never been asked for 14 prune juices before at the same time. Ms. Orzel stated that there is a chat feature in the Homebase app. Ms. Orzel showed there were pictures of soiled bedding in app on 10/20/2023. Ms. Orzel stated that she did not see pictures with resident faces or identifying information, only diapers and bedding.

On 01/04/2024, I interviewed Cook, Yolanda Smith. She stated that Med Tech, Amaria, has asked for 14 prune juices. They keep cups of prune juice in kitchen that have a peel

off top. Ms. Smith stated that she had never been asked for that many prune juices before. She believed this maybe occurred in November 2023. Ms. Smith said she assumed residents needed juice because they had not used the bathroom. Ms. Smith stated that it was unusual for that many prune juices to be requested. She indicated that she has not seen any pictures of soiled residents on Homebase app. She has seen staff post pictures of laundry not being done. She stated that she only downloaded the app in December 2023.

On 01/04/2024, I interviewed Resident A. She has drank prune juice at the facility. She likes drinking prune juice.

On 01/04/2024, I interviewed Resident C. He stated that he does not think he has drunk prune juice at facility. He also stated that he has quit drinking coffee. He thinks they have prune juice available, but he is now drinking tea and honey.

On 01/05/2024, I received email from Complainant. The email contained five pictures showing soiled briefs and linens. Some are repeat images. One image shows residents thighs and resident sitting in soiled brief. I also received four pictures of messages written in a chat titled, "Entire Team". The images and messages do not reveal resident's faces or names; however, one resident is identified in chat by room number. One message is dated October 20 and states, "Whoever had AI side today left (Room Number) in bed wet and messy all day she have not been changed at all and this is just insane why do she have to sit in a wet bed all day when she's paying for her services to get do by the staff that get paid every week. Also, most of AI people that was left in their bed is all wet messy and nasty. I'm just trying to figure out what did you do all day that you couldn't change them. If they could do it by themselves it would be done but they still need assistance and help with changes and making sure they are clean and up for the day. This is just beyond crazy".

On 02/28/2024, I interviewed former Staff, Amaria Palmer, by phone. She stated that Jennifer Hiller indicated that med techs were not documenting bowel movements. She was given a list of 12-13 residents and told to get prune juice for them from the kitchen. She stated that each resident was given 4–8-ounce prune juice cups at lunch time. Ms. Palmer believed the juice was used as a lesson because staff were forgetting to log bowel movements. She felt that some of the residents that were given prune juice were using the bathroom and did not need the juice. Ms. Palmer stated that there have been issues at facility with residents being left in soiled briefs and bedding. She stated that management was notified of these issues. There has also been issues with laundry piling up. Ms. Palmer felt that the facility is unorganized and there have been management and scheduling issues.

I completed an exit conference with Manager, Jennifer Hiller, by phone on 02/28/2024. I informed Ms. Hiller of the findings and that a copy of the special investigation report would be mailed once approved. I also informed her that a corrective action plan would be requested. Ms. Hiller indicated that no facility is perfect, and that staff have been terminated when they cannot keep up with their shift tasks such as changing briefs and

linens. This issue has been brought to her attention and seems to be mostly an issue on midnight shift. She also indicated that the facility has given out prune juice multiple times when residents have not had bowel movements, however it is usually only for a few people.

APPLICABLE RULE	
R 400.15305	**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:	In October 2023, between 10-14 residents were given prune juice at Meadows I and II. It was reported that the prune juice was given after it was found that bowel movements were not being logged in the system. Manager, Jennifer Hiller, instructed Amaria Palmer to get juice from kitchen staff for residents. Around the time of the incident, pictures were posted in Homebase app of soiled briefs and linens. Also, message posted in app indicated that staff was upset due to residents being left in these conditions. Ms. Hiller stated that this issue has been reported and staff who are unable to keep up with shift tasks such as changing briefs and linens have been terminated.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

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

02/28/2024

Kristine Cilluffo — Date
Licensing Consultant

Approved By:

04/12/2024

Denise Y. Nunn — Date
Area Manager