GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 15, 2024

Claudiu Marit
5670 Greer Road
West Bloomfield, MI 48324

RE: License #: AS630377608
Investigation #: 2024A0612015
Ahava Senior Care

Dear Mr. Marit:

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,

Johnna Cade, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
Phone: 248-302-2409

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630377608
Investigation #:	2024A0612015
Complaint Receipt Date:	02/22/2024
Investigation Initiation Date:	02/23/2024
Report Due Date:	04/22/2024
Licensee Name:	Claudiu Marit
Licensee Address:	1825 Hiller Road West Bloomfield, MI 48324
Licensee Telephone #:	(248) 760-6543
Administrator:	Claudiu Marit
Licensee Designee:	Claudiu Marit
Name of Facility:	Ahava Senior Care
Facility Address:	1825 Hiller Road West Bloomfield, MI 48324
Facility Telephone #:	(248) 760-6543
Original Issuance Date:	04/20/2016
License Status:	REGULAR
Effective Date:	10/20/2022
Expiration Date:	10/19/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED ALZHEIMERS; AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was neglected care in his declining health, family was told by staff that he was OK. However, Resident A was exhibiting signs of a urinary tract infection and it progressed to sepsis and septic shock/renal failure.	No
Complainant's mother was defrauded out of $17,550.00 for eight days Resident A was a resident in Ahava Group Home.	Yes

III. METHODOLOGY

02/22/2024	Special Investigation Intake 2024A0612015
02/23/2024	APS Referral I made a referral to Adult Protective Services.
02/23/2024	Special Investigation Initiated - Letter APS referral made via electronic file.
03/07/2024	Contact - Telephone call made Telephone interview completed with the complainant.
03/11/2024	Contact - Document Received Documents received from complainant via email.
03/12/2024	Contact - Document Received Documents received from complainant via email.
03/13/2024	Contact - Document Received Documents received from complainant via email.
03/19/2024	Inspection Completed On-site I completed an unscheduled onsite investigation. I interviewed licensee Claudiu Marit and home manager Daniela Marit.
03/20/2024	Contact - Document Received Facility documents received from licensee via email.

04/10/2024	Contact - Telephone call made Telephone interview completed with Kristin Thompson, Ahava Senior Care Nurse.
04/11/2024	Contact - Telephone call made Telephone interview competed with Dr. Svetlana Mishulin.
04/11/2024	Contact - Telephone call made Telephone call to nurse practitioner, Grace. Telephone number no longer in service.
04/11/2024	Contact - Telephone call made Telephone interview with Optimal Health Care Case Manager, Jenny Myrick and Optimal Health Care HR and Compliance Director, Sarah Gerrity.
04/12/2024	Contact - Document Received Copies of prescriptions received via email.
04/12/2024	Exit Conference Telephone call to licensee, Claudiu Marit to conduct an exit conference.

ALLEGATION:

Resident A was neglected care in his declining health, family was told by staff that he was OK. However, Resident A was exhibiting signs of a urinary tract infection and it progressed to sepsis and septic shock/renal failure.

INVESTIGATION:

On 02/22/24, I received an intake that stated Resident A was neglected care in his declining health, family was told by staff he was ok. Resident A was exhibiting signs of a urinary tract infection and progressed to sepsis and septic shock/renal failure. Resident A's family member was defrauded out of $17,550.00 for eight days that Resident A was a resident at Ahava Senior Care. On 02/23/24, I initiated my investigation by making a complaint to Adult Protective Services (APS) via electronic file. APS did not open the case for investigation.

On 03/07/24, I completed a telephone interview with the complainant. The complainant provided written correspondence detailing her complaint. In summary, the complainant indicates, on May 24, 2023, Resident A fell and broke his shoulder. He was taken to Beaumont Hospital. The hospital discharged him to the West Bloomfield Health and Rehabilitation Center where he resided through August 2023. During that time, he was having issues with recurring urinary tract infections (UTI's), and he lost his hearing. The rehab facility gave the name of the Ahava Group Home. Prior to discharge from the

rehab facility, Resident A was sent to the hospital for a suspected UTI. Upon discharge from the hospital, the plan was for Resident A to return to the rehab facility. Unfortunately, the hospital said that was no longer an option. Resident A's family contacted Ahava Group Home, they were told that nursing care was available 24/7, there would be physicians to oversee Resident A's medical needs, and they would schedule physical therapy. Resident A was admitted to Ahava Senior Care on Wednesday, 08/30/2023. Upon review of Resident A's medical records, it became apparent that he was a victim of neglect and elder abuse which ultimately led to his wrongful death. On Thursday, 08/31/2023, the medical records indicate that Resident A's BP was 150/70 mmHg, Resident A had a history of hypertension. On Friday 09/01/2023, his BP dropped to 90/60 mmHg which falls into the category of hypotension. The literature shows that when an individual is approaching death, the systolic BP will typically drop below 95 mmHg. Resident A's family was not notified of the drop in his blood pressure and based on the records there is no indication that they ever checked his BP or temperature again.

Ahava Senior Care Nurse, Kristin Thompson noted that Resident A was confused and hallucinating on Friday, 09/01/2023. Ms. Thompson arranged a facetime consult with Dr. Mishulin. Ms. Thompson was instructed to draw blood for lab testing, obtain a urine sample to rule-out a UTI and give Resident A 500 mls of IV fluids. Resident A's family inquired about the lab results and were told that they were normal. This was a lie because Resident A's BUN (kidney value) was elevated at 34 (7-25 mg/dL). They also told us that the urine sample was pending, however, the record indicates that Ms. Thompson was unable to collect a urine sample. She documented that she would try again but never did. Also, they never checked his bloodwork again to monitor for increasing kidney values. The doctor did not follow up until after 09/01/2023. The hypotension, confusion, hallucinations, and Ms. Thompson's inability to collect a urine sample should have prompted her to send Resident A to the hospital where he could receive the care that he needed. Also, the medical records do not include notes regarding medications given, food/water consumption and urine/stool output.

On Sunday, 09/03/2023, Resident A spent the day in his bed hallucinating. There was a piece of corn in his mouth as if someone tried to feed him while he was unconscious. The complainant called Mr. Marit expressing concern that Resident A was going to get dehydrated because he was not awake to consume food and fluids. Mr. Marit said that Resident A received IV fluids on Friday, 09/01/2023, and Ms. Thomspon would return Wednesday, 09/06/2023. On Wednesday, 09/06/2023, Resident A was unconscious/ unresponsive. Direct Care Staff, Amanda was worried about Resident A and further stated that Ms. Thompson evaluate him that morning and said he was fine, and he was even urinating fine. We were told that Resident A was sleeping and getting acclimated to the new surroundings. On Thursday, 09/07/2023, Resident A seemed worse. He was unresponsive and feeling cold to the touch. Mr. Marit called the complainant on Thursday, 09/07/2023, and informed her that he was going to send Resident A to the hospital because he had blood in his stool and his blood pressure was low. The hospital had to give him an immediate blood transfusion, his BP was 60/24 mmHg and he was in septic shock/renal failure. His BUN was 80 mg/dL (up from 34 just 6 days prior) and his

urine was a “vanilla, milkshake color.” The nurse at DMC Commerce said that they were keeping him alive with IV fluids and pressors. They implemented antibiotics and gave him 5L of fluids that night. The fluids put him into heart failure. After one week, it became apparent that Resident A would not recover. On 09/14/2023, Resident A was placed on hospice. He died the next day, 09/15/2023. Resident A died a painful and horrific death that could have been prevented if the Ahava Group Home sent him to the hospital on 09/01/2023, when he first began showing signs of a UTI. Several months later, Resident A’s family received a bill from LTC Med Ex Direct Pharmacy. The complainant inquired why Ahava Senior Care ordered Quetiapine (Seroquel) on 08/30/2023, and 09/01/2023. The complainant was informed that the dose was doubled. Henry Ford Hospital had previously prescribed Quetiapine 25 mg: ½ T once/day. The dose was doubled by Ahava Senior Care, and they added Trazodone, which Resident A was not taking previously. The combination of these drugs is dangerous for the heart and can cause EKG abnormality which was diagnosed on an EKG that was run at the hospital. Resident A had no prior history of this abnormality. The complainant believes they were over medicating Resident A to keep him sedated. Resident A’s family was never apprised of what they were doing with Resident A’s medications.

On 03/19/24, I completed an unscheduled onsite investigation. I interviewed licensee Claudiu Marit and home manager Daniela Marit.

On 03/19/24, I interviewed licensee Claudiu Marit. Mr. Marit stated Resident A moved into the home on 08/30/23. He was transferred from Henry Ford West Bloomfield hospital. Mr. Marit stated Resident A was “in rough shape” upon admission. Ahava Senior Care Nurse, Kristin Thompson recommended that Resident A be placed on hospice, but the family declined. Mr. Marit stated Resident A received in home skilled nursing provided by Optimal Health Care. Mr. Marit cannot recall how often Optimal Health Care staff were coming to the home, but he stated during each visit they completed a full body assessment of Resident A including blood work if needed. After each visits Optimal Care staff provided a verbal summary of Resident A’s condition and they kept electronic case notes. Mr. Marit stated when Resident A moved into the home his family refused to sign a lot of the required documentation. Mr. Marit remarked, they were unorganized, and they did not know who Resident A’s power of attorney was and they never provided power of attorney paperwork. Mr. Marit stated direct care staff, Amanda spent almost half a day with Resident A’s family doing intake paperwork including his assessment plan. Mr. Marit stated Resident A required full care for all activities of daily living. Mr. Marit stated when Resident A moved into the home he was not being treated for a UTI and he was not treated for a UTI while he was living at the home. Resident A was on a regular diet, he was eating and drinking normally. Mr. Marit stated Resident A physician was Dr. Mishulin. If there were any medication changes, they were coordinated between Ms. Thompson and Dr. Mishulin. On 03/20/24, I received written correspondence from Mr. Marit that reflected the same information provided during my interview with him.

On 03/19/24, I interviewed home manager, Daniela Marit. Ms. Marit stated on 09/07/23, direct care staff, Amanda told her that Resident A looked pale and appeared to be

actively dying. Amanda asked Ms. Marit to assist her with changing Resident A's brief at which time they observed that he had a bowel movement that was the consistently of coffee grounds and he was bleeding from his rectum. 911 was called and Resident A was transferred to the hospital via EMS. Ms. Marit stated Resident A did not return to the home. Ms. Marit stated when Resident A moved into the home, he was very sick. He ate but only small portions. Resident A was on IV fluids. Ms. Marit stated there were no changes to Resident A's health status until he left the home via EMS on 09/07/23. Ms. Marit stated Resident A's family visited daily. Therefore, they were present to witness his health every day he lived at the home.

On 04/10/24, I interviewed Kristin Thompson, Ahava Senior Care Nurse via telephone. Ms. Thompson is no longer employed by Ahava Senior Care. Ms. Thomspon stated Resident A was total care, when he moved into the facility, he was very dry. He was receiving IV hydration on a bolus, 500 cc. Ms. Thompson stated Resident A did not show any signs or symptoms of sepsis. Lab work was completed, and a urine specimen was collected. On the second and third day he was at the home he was sitting at the kitchen table eating. Resident A was on a regular diet, and he was able to feed himself. There were no concerns that Resident A was not consuming enough food or water. Resident A sat in the recliner chair and read the newspaper; his family visited regularly. Ms. Thompson stated Resident A's family was very involved, and they asked questions. Ms. Thompson stated because Resident A was new, she met with him every day. Any changes to his medication were made by *Dr*. Svetlana Mishulin or the psychiatric nurse practitioner, Darcie. Ms. Thompson stated Resident A did not require continuous nursing care. Ms. Thompson stated Resident A did not display any signs, symptoms, or concerns or significant changes to his health until he was sent out to the hospital via EMS.

On 04/11/24, I interviewed Dr. Svetlana Mishulin via telephone. Dr. Mishulin stated she did not meet Resident A face to face she worked in collaboration with Ahava Senior Care Nurse, Ms. Thomson. Dr. Mishulin stated at this time, she does not have any records on Resident A. Dr. Mishulin stated her nurse practitioner, Grace may have met with Resident A face to face and would be better able to speak to the care that he received however, Grace no longer works at her practice. Dr. Mishulin provided the phone number she had on file for Grace. I called the telephone number on 04/11/24, it was disconnected.

On 04/11/24, I interviewed Optimal Health Care Case Manager, Jenny Myrick and Optimal Health Care HR and Compliance Director, Sarah Gerrity via telephone. Ms. Myrick and Ms. Gerrity consistently stated that Optimal Health Care has worked closely with Ahava Senior Care for a long time. Optimal Health Care serves 100 homes and of the AFC's that they go into Ahava Senior Care is the best. The home is clean, well run, and the residents are cared for. Ms. Thompson manages the resident's health care needs which is a level of protection that other AFC homes do not have. Mr. Marit advocates for his residents and demands good quality care. Ms. Myrick and Ms. Gerrity consistently stated they have completed unannounced visits to the home and all the

residents are clean, cared for, and well fed. Mr. Marits records are always in order and organized. They would never suspect a resident be neglected while living at this home.

Ms. Myrick and Ms. Gerrity stated Optimal Health Care staff completed four visits with Resident A while he was residing at the home for seven days. Ms. Myrick and Ms. Gerrity remarked, Resident A was a “sick man.” His physician was Dr. Mishulin and nurse practitioner, Grace. The physician is responsible for prescribing medications. However, Optimal Health Care is required to report any medication interactions. Ms. Myrick and Ms. Gerrity stated the visit notes do not indicate that there were any concerns with Resident A’s medications or that Resident A was not receiving proper food or water. If caregivers were noncompliant, it would be documented in the resident’s record and APS would be notified. Ms. Myrick and Ms. Gerrity stated Resident A did not require continues nursing care. The hospital is responsible for doing a safe discharge and recommending placement. Resident A was safely discharged from the hospital and referred to Ahava Senior Care. In the referral from the hospital, it is documented that Resident A could not return to his personal residence because of the stairs. Henry Ford West Bloomfield referred Resident A for Home Health, which is intermittent visits not around the clock nursing care. Ms. Myrick and Ms. Gerrity stated Ahava Senior Care has a relationship with Quest Diagnostic, as such Optimal Health Care did not receive the result of the urinalysis because Resident A was not sent back to the home. Ms. Myrick and Ms. Gerrity consistently stated Resident A did not exhibit signs or symptoms of decline prior to being sent out to the hospital on 09/07/23. Optimal Health Care kept a close watch on Resident A as their goal is to keep him safe and out of the hospital. Ms. Myrick and Ms. Gerrity remarked, Resident A’s death was due to his disease state, not neglect.

I reviewed the following relevant documentation which includes Resident A’s medical records. The following is a summary of relevant information:

- **Thursday, 08/31/2023**, Resident A’s BP was 150/70 mmHg.
- **Friday, 09/01/2023**, Resident A’s BP dropped to 90/60 mmHg.
- **Friday, 09/01/2023,** Ahava Senior Care Nurse Kirstin Thompson noted that Resident A was confused with hallucinations. Eating well, feeding self, most of the time. New orders obtained. FaceTime call with Dr. Svetlana Mishulin. The doctor gave orders to draw labs, collect a urine sample to rule out UTI, and give IV fluids - 500 cc normal saline bolus. Labs were drawn per order. Ms. Thompson was unable to pass a urinary catheter to collect the urine sample – will continue to attempt to collect.
- **Sunday, 09/03/2023**, Resident A was in bed hallucinating.
- **Wednesday, 09/06/2023,** Resident A was unconscious/unresponsive. Resident A was sent to the hospital when blood was found in his stool (melena), his BP pressure dropped further to 60/24 mmHg and he was in kidney failure (BUN=80 mg/dL).
- **Thursday, 09/07/2023,** Resident A was resuscitated at the hospital with a blood transfusion, 5L of IV fluids and pressors to keep his blood pressure up.

- **DMC hospital admission paperwork dated 09/08/2023,** states, patient was found to have a UTI with urosepsis started on IV fluid hydration with resuscitation. Upon EMS arrival patient was hypotensive at 60/20. Heart rate = 48 with O2 sat at 84% RA. Patient received blood transfusion.
- **Ahava Senior Care website** which states, “nurse on- call 24/7.”
- **Resident A’s Death Certificate** – date of death 09/15/2023. Manner of death- Sepsis. Approximate onset – 3 days prior to death.
- **Resident A’s health care appraisal dated 08/30/23**, states Resident A is frail, confused, dx HTN, postherpetic neuralgia at T3 – T5 left, radius, fractured left, UTI, hallucinations. Resident A was on a regular diet.
- **Incident Report dated 09/07/2023**, written by Kristin Thompson in summary stated 911 was called and Resident A was transferred to Huron Valley Hospital as he was observed breathing but unresponsive in his bedroom.
- **Resident A’s AFC Assessment Plan,** Resident A required total care with all activities of daily living.
- **Resident A’s plan of care.**
- **Ahava Group Home Blood pressure monitoring log** dated 08/31/23 – 09/07/2023. Resident A’s blood pressure and pulse was taken every day at 8:00 am. BP chart indicates to hold Lisinopril 5 mg and Atenolol 50 mg if BP is <100/60.
- **Quest Diagnostics Lab reports.**
- **Hospital Physician Network Discharge paperwork** dated 08/18/23 – 08/19/23. Reason for admission: altered mental state, hallucinations.
- **Hospital Physician Network Discharge** paperwork dated 08/18/23 – 08/29/23. Reason for admission: foot cellulitis. Antibiotics stopped as it was not felt to be a UTI. Resident A is not septic. Discharge when bed is available 45 minutes spent educating family on anticipated discharge.
- **Henry Ford prescription**
  Quetiapine (Seroquel) 25 mg – take 0.5 tablets my mouth nightly.
- **August 2023 Medication Administration Record**
  Quetiapine (Seroquel) 25 mg – take 0.5 tablets by mouth nightly. The medication was administered on 08/30/23 and 08/31/23.
- **September 2023 Medication Administration Record**
  Quetiapine (Seroquel) 25 mg – take one half tablet by mouth at bedtime in addition to current dose to equal take one tablet by mouth at bedtime. The medication was administered on 09/01/23 – 09/06/23.
  Trazodone 50 mg – take one tablet by mouth at bedtime. The medication was administered on 08/30/23 and 08/31/23.
  Note – Lisinopril 5 mg and Atenolol 50 mg was held on 09/01/23, 09/06/23, and 09/07/23 due to Resident A’s BP not being within appropriate range.
- I**nvoice from LTC Med Ex Direct Pharmacy**
  Quetiapine ordered 08/30/2023 and 09/01/2023.
  Trazodone ordered 09/01/2023.

- **Resident A's prescriptions for Quetiapine & Trazadone**
  Quetiapine (Seroquel) 25 mg – take 0.5 tablet by mouth nightly. Script dated 08/29/23. Authorized by Samantha Mah, PA (Henry Ford W. Bloomfield Hospital).
  Quetiapine (Seroquel) 25 mg – take one half tablet by mouth at bedtime in addition to current dose to equal take one tablet by mouth at bedtime. Script dated 09/01/23. Authorized by Dr. Mishulin.
  Trazodone 50 mg – take one tablet by mouth at bedtime. Script dated 09/01/23. Authorized by Dr. Mishulin.
- **Optimal Care Visit Notes dated:** 08/31/23, 09/02/23, 09/05/23, 09/06/23, and 09/08/23.

  All visit notes indicate, "Negative sepsis screen, patient without signs or symptoms of sepsis or infection." Resident A's vitals including BP were documented during each visit.

  Note dated 08/31/23, in summary indicates, that the patient has an illness or condition which made him change the kind and/or amount of food he eats. The patient eats fewer than 2 meals per day. The patient drinks less than four glasses of water per day and is at extensive nutritional risk. "Focus today was on hydration making sure that patient gets at least eight cups of water per day pushing with straws it's most successful way of drinking as evidenced by nurse visualizing patient and pushing fluids at visit."

  Note dated 09/05/23, in summary states, reinforced importance of adequate oral intake and hydration status. Encourage adequate nutrition and hydration (good caloric intake and include protein)

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(1) A licensee shall not accept, retain, or care for a resident who requires continuous nursing care. This does not preclude the accommodation of a resident who becomes temporarily ill while in the home, but who does not require continuous nursing care.
ANALYSIS:	Based on the information gathered through my investigation there is insufficient information to conclude that Resident A required continuous nursing care. Optimal Health Care Case Manager, Jenny Myrick and Optimal Health Care HR and Compliance Director, Sarah Gerrity consistently stated the hospital is responsible for doing a safe discharge and recommending placement. Resident A was safely discharged

	from the hospital and referred to Ahava Senior Care. In the referral from the hospital, it is documented that Resident A could not return to his personal residence because of the stairs. Henry Ford West Bloomfield referred Resident A for Home Health, which is intermittent visits not around the clock nursing care. Resident A's Hospital Physician Network Discharge paperwork dated 08/18/23 – 08/29/23, indicates the plan was to discharge Resident A when a bed is available, 45 minutes were spent educating Resident A's family on anticipated discharge.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14310	**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 the information gathered through my investigation there is insufficient information to conclude that Ahava Senior Care did not obtain need care immediately when Resident A's physical condition changed. Resident A was receiving in home skilled nursing provided by Optimal Health Care. Optimal Health Care staff completed in home visits four of the eight days Resident A lived in the home (08/31/23, 09/02/23, 09/05/23, and 09/06/23). All visit notes state, "Negative sepsis screen, patient without signs or symptoms of sepsis or infection." Resident A's vitals including his BP were documented during each visit. In addition, Ahava Senior Care staff were taking Resident A's blood pressure and pulse every day at 8:00 am. Optimal Health Care's visit notes do not indicate that Resident A was experiencing a sudden or adverse change in health. There were no orders or instructions issued that Ahava Senior Care staff failed to follow. On 09/07/24, when Resident A's physical condition changed and it was observed that he was bleeding from his rectum, 911 was called immediately and Resident A was transferred to the hospital via EMS.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14312	**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: (e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.
ANALYSIS:	Based on the information gathered through my investigation there is insufficient information to conclude Resident A's medications were adjusted or modify without instructions from a physician. In addition to other medications, Resident A was discharged from Henry Ford W. Bloomfield Hospital with a prescription for Quetiapine (Seroquel) 25 mg – take 0.5 tablet by mouth nightly. While residing at Ahava Senior Care Resident A was under the care of Dr. Mishulin. Dr. Mishulin changed Resident A's prescription for Quetiapine (Seroquel) 25 mg and prescribed Trazodone 50 mg. Per Resident A's August 2023 and September 2023 Medication Administration Records Ahava Senior Care staff were administering Resident A's medication as they were prescribed. Optimal Health Care Case Manager, Jenny Myrick and Optimal Health Care HR and Compliance Director, Sarah Gerrity consistently stated the physician is responsible for prescribing medications. However, Optimal Health Care staff is required to report any medication interactions. There were no documented concerns with Resident A's prescribed medications.
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:	Based on the information gathered through my investigation there is insufficient information to conclude that Resident A was not provided with proper nutrition. Resident A was receiving in home skilled nursing provided by Optimal Health Care. Optimal Health Care staff completed in home visits four of the eight days Resident A lived in the home (08/31/23, 09/02/23, 09/05/23, and 09/06/23). Optimal Health Care visit note dated 08/31/23, indicates Resident A has an illness or condition which made him change the kind and/or amount of food he eats. Resident A eats fewer than 2 meals per day and drinks less than four glasses of water per day. Adequate oral intake and hydration status was discussed during visits. Ahava Senior Care Nurse, Kristin Thompson stated Resident A was on a regular diet, and he was able to feed himself. He also received IV fluids. There were no concerns that Resident A was not consuming enough food or water. Optimal Health Care Case Manager, Jenny Myrick and Optimal Health Care HR and Compliance Director, Sarah Gerrity consistently stated there were no concerns that Resident A was not receiving proper oral intake or hydration. If caregivers were noncompliant with Resident A's nutrition, it would have been documented in the resident's record and APS would have been notified.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Complainant's mother was defrauded out of $17,550.00 for eight days Resident A was a resident in Ahava Group Home.

INVESTIGATION:

On 03/07/24, I completed a telephone interview with the complainant. The complainant provided written correspondence detailing her complaint. In summary, the complainant indicates, Resident A was admitted to the Ahava Group Home on Wednesday, 08/30/2023. The family was surprised at the exorbitant charges that Mr. Marit presented. He charged $8,500.00 for a deposit. $8,500.00 for September, $8,500.00 and two days in August (30th & 31st) pro-rated at $275.00/day. The total amount was $17,550.00. The complainant was working and was not able to be there upon admittance. The complainant's mother and sister were present, and the complainant's mother wrote Mr. Marit the check. The complainant's sister inquired with Mr. Marit if he would return the deposit if Resident A passed in his care. He verbally agreed to her request. The complainant notified Mr. Marit on 09/11/2023, that Resident A was likely to pass and would not be returning to the Ahava Group Home as the contract mentions a 30-day notice. The complainant later contacted him regarding what she thought would be a fair refund. Although, he promised to return the $8,500.00 deposit, he now

changed it to $5,852.45 based on the 30-day notice clause. Mr. Marit said the family could expect a refund after 09/30/2023.The refund never arrived. Mr. Marit never sent a letter by registered mail stating that he had a box of Resident A's belongings that the family could arrange to pick up. Rather, on 10/07/2023, Mr. Marit sent the complainant an email threatening to charge another month's rent if the box was not picked up by 10/10/2023. He said that it precluded him from renting out his room, however, when the box was picked up it was in a different room, so it was not inhibiting him from renting out the room. The complainant's sister called Mr. Marit on Friday, 11/10/2023, inquiring if he would send a refund, as he initially promised to return the $8,500.00 deposit. He said he would send the refund of $5,852.45 the next day. Again, the amount was based on the "30-day notice". Resident A's family never received a check from him. The complainant emailed him on Wednesday, 12/06/2023, regarding this issue and never received a response. The complainant stated Mr. Marit defrauded her mother out of $17,550.00 for 8 days of care. Mr. Marit agreed to some form of a refund on three occasions however, he never sent a check.

On 03/19/24, I interviewed licensee Claudiu Marit. Mr. Marit stated his cost of care is billed month to month. When a resident is moving out of the home for any reason, they are expected to give a 30-day notice. Mr. Marit stated Resident A was transferred to Huron Valley Hospital on 09/07/23, he did not return to the home. Mr. Marit exchanged an email with the complainant on 10/07/23, at which time he agreed to issue a refund of $5,852.00. On 10/10/23, he exchanged another email that indicated if Resident A's belongings were not picked up, he would not issue the refund and he would charge for another month's rent. Mr. Marit stated Resident A's belongings (which consisted of clothing and pictures) were not picked up until 11/11/23. Mr. Marit held the deposit to cover the monthly cost of the occupied room.

I reviewed Ahava Group, LLC Billing Invoice # 2040
Deposit - $8,500.00
August - $550.00 (rate $275.00)
September - $8,500.00
Payment: $17,550.00

I reviewed Ahava Senior Care Deposits and Refund policy. The policy indicates:
* When a family decides to move a family member into our home, a full month's deposit is required which will hold the room, and upon move in the first month's rent will be due. The full month deposit will cover the last month of the residents stay.
* In the event the resident is admitted to the hospital and the resident will not return, or due to any other reason, the monthly fee will not be refunded at any point.
* A 30-day notice is needed for anyone who decides to move out due to dislikes of the facility, or the dislike of other residents, and/or any other reason.

I reviewed the following relevant documentation. Below is a summary of the correspondence:

- **09/11/2023 -** Email sent from the complainant to Mr. Marit
  The complainant states that she does not anticipate Resident A will be returning to the group home and wanted to give an advanced notice.
- **09/15/2023** – Text message from the complainant to Mr. Marit
  Resident A died today. Can we make arrangements to pick up his belongings next week. I sent you an email on 09/11/23, informing you that Resident A would not be returning to Ahava Senior Care. My mother mentioned that you would provide a refund if he did not return to the home.
- **09/15/2023** – Text message from Mr. Marit to the complainant
  I received your email on 09/11/2023. I will calculate the refund and send a check at the end of the month.
- **10/01/2023** – Text message from the complainant to Mr. Marit
  Can I come by tomorrow and pick up Resident A's belongings.
- **10/05/2023** – Text message from the complainant to Mr. Marit
  I cannot come today to pick up Resident A's belongings. Is it possible to set up a time on Sunday. Mr. Marit said sure and asked what time the complainant would like to come. The complainant said afternoon. Mr. Marit said, okay thanks.
- **10/07/2023** – Email sent from complainant to Mr. Marit
  Resident A resided at Ahava Senior Care for 8 days. On 09/11/23, it was reported that he would not be returning to the home. A payment of $17,550.00 was already made with the two days in August charged at $250.00 a day. Taking that into consideration they feel it is fair to pay for the 8 days he was in the home plus the 4 days he was at the hospital. Therefore, they expect a refund of $14,500.00.
- **10/07/2023 -** Email sent from Mr. Marit to the complainant
  The email sent on 09/11/23, will serve as a 30-day notice to leave. Your refund will be for the 21 remaining days in the amount of $5,852.45. "I should charge you still for not emptying out the room as I cannot rent until your belongings are out." You can pick the belongings up at any time. After 10/10/23, another month's rent is due, and I will invoice you for it.
- **10/07/2023** – Email sent from complainant to Mr. Marit
  It would be fair to pay for the 8 days that Resident A resided at Ahava Senior Care in the amount of $2,200.00 ($250.00 per day). Since a payment of $17,550.00 was already made a refund of $14,500.00 is due.
- **10/29/2023** – Email sent from complainant to Mr. Marit
  It would be fair to pay for the 8 days that Resident A resided at Ahava Senior Care in the amount of $2,200.00 ($275.00 per day). Since a payment of $17,550.00 was already made a refund of $15,350.00 is due.

- **11/04/2023** – Email sent from complainant to Mr. Marit
  It would be fair to pay for the 8 days that Resident A resided at Ahava Senior Care in the amount of $2,200.00 ($275.00 per day). Since a payment of $17,550.00 was already made a refund of $15,350.00 is due.
- **11/05/2023** - Email sent from Mr. Marit to the complainant
  The contract states that the payment is monthly. Not daily.
- **12/06/2023** – Email sent from complainant to Mr. Marit
  You promised my sister over 3 weeks ago that you would send a refund to my mother. We have not received a check.

I reviewed a picture of a box of Resident A's belongings. The box was photographed sitting on the trunk of a car parked outside of Ahava Group home. I also reviewed Resident A's Resident Care Agreement which indicates the monthly cost of care is $8,500.00.

On 04/12/24, I placed a telephone call to licensee, Claudiu Marit to conduct an exit conference and review my findings. Mr. Marit acknowledged the rule violations and his understanding that a corrective action plan is required.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(14) A licensee shall have a written refund agreement with the resident or his or her designated representative. The agreement shall state under what conditions a refund of the unused portion of the monthly charge that is paid to the home shall be returned to the resident or his or her designated representative. The refund agreement shall provide for, at a minimum, refunds under any of the following conditions: (a) When an emergency discharge from the home occurs as described in R 400.14302. (b) When a resident has been determined to be at risk pursuant to the provisions of sections 11 and 11a to 11f of Act No. 280 of the Public Acts of 1939, as amended, being SS400.11 and 400.11a to 400.11f of the Michigan Compiled Laws. (c) When a resident has been determined to be at risk due to substantial noncompliance with these licensing rules which results in the department taking action to issue a provisional license or to revoke or summarily suspend, or refuse to renew, a license and the resident relocates. The amount of the monthly charge that is returned to the resident shall be

	based upon the written refund agreement and shall be prorated based on the number of days that the resident lived in the home during that month.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Ahava Senior Care owes the complainant a refund. Resident A paid a deposit of $8,500.00, $550.00 for two days in August, and $8,500.00 for September totaling, $17,550.00. Ahava Senior Care's discharge policy indicates the full month deposit will cover the last month of the resident's stay. Resident A's last month was September 2023. Therefore, the complainant is owed a refund for the deposit in the amount of $8,500.00.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(15) Personal property and belongings that are left at the home after the death of a resident shall be inventoried and stored by the licensee. A licensee shall notify the resident's designated representative, by registered mail, of the existence of the property and belongings and request disposition. Personal property and belongings that remain unclaimed, or for which arrangements have not been made, may be disposed of by the licensee after 30 days from the date that written notification is sent to the designated representative.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that licensee, Mr. Marit, and the complainant corresponded regarding Resident A's belongings. However, Mr. Marit did not notify the resident's designated representative, by registered mail, of the existence of the property and belongings and request disposition. Instead, Mr. Marit held Resident A's deposit of $8,500.00 as he indicated this was to cover the monthly cost of the occupied room as he was storing Resident A's belongings which prohibited him from renting the room. This is not permissible and furthermore, it is not in agreement with Ahava Senior Care's discharge policy.
CONCLUSION:	**VIOLATION ESTABLISHED**

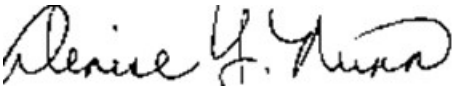
IV. RECOMMENDATION

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

04/15/2024

Johnna Cade — Date
Licensing Consultant

Approved By:



04/15/2024

Denise Y. Nunn — Date
Area Manager