GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 28, 2024

Ellen Byrne
Commonwealth Senior Living at East Paris
3956 Whispering Way, SE
Grand Rapids, MI 49546

RE: License #: AH410407276
Investigation #: 2024A1010044
Commonwealth Senior Living at East Paris

Dear Licensee:

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 authorized representative and a date.

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

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 241-1970.

Sincerely,

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa NW Unit 13 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410407276
Investigation #:	2024A1010044
Complaint Receipt Date:	03/26/2024
Investigation Initiation Date:	03/28/2024
Report Due Date:	05/25/2024
Licensee Name:	MCAP East Paris Opco, LLC
Licensee Address:	Suite 301 915 E. High Street Charlottesville, VA 22902
Licensee Telephone #:	(434) 963-2421
Administrator:	Mackenzie Ferguson
Authorized Representative:	Ellen Byrne
Name of Facility:	Commonwealth Senior Living at East Paris
Facility Address:	3956 Whispering Way, SE Grand Rapids, MI 49546
Facility Telephone #:	(616) 949-9500
Original Issuance Date:	08/16/2023
License Status:	REGULAR
Effective Date:	03/08/2024
Expiration Date:	07/31/2024
Capacity:	90
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 3/24/24, Resident C was left soiled for a long period of time and missed lunch as a result.	Yes

III. METHODOLOGY

03/26/2024	Special Investigation Intake 2024A1010044
03/28/2024	Special Investigation Initiated - Letter Emailed assigned Kent Co. APS worker Drew Blackall
03/28/2024	Contact - Document Received Email received from Mr. Blackall
04/04/2024	Contact – Document Received Email received from Mr. Blackall
04/08/2024	Inspection Completed On-site
04/08/2024	Contact - Document Received Received Resident C's service plan and facility internal incident investigation documents
05/09/2024	Contact – Document Received Email received from Mr. Blackall
05/28/2024	Exit Conference

ALLEGATION:

On 3/24/24, Resident C was left soiled for a long period of time and missed lunch as a result.

INVESTIGATION:

On 3/26/24, the Bureau received the allegations from Adult Protective Services (APS). The complaint read that on 3/24/24, “Today [Resident C] needed to use the restroom and called for assistance. [Resident C] was continually told that staff was busy and unable to assist. [Resident C] was left for so long that she urinated and defecated on herself. [Resident C] continued to call for assistance but was told that they were busy. [Resident C] is currently sitting in her own urine and feces due to staff not assisting her and her inability to get out of bed herself. [Resident C] was not

taken for meals today because she was not cleaned up from using the bathroom on herself. It is unknown if [Resident C] not being given meals just occurred today or has occurred on other occasions in the past."

On 3/28/24, I emailed assigned Kent County APS worker Drew Blackall. Mr. Blackall reported he interviewed Resident C at the facility on 3/26/24 and provided his written interview with her for my review. Mr. Blackall wrote that Resident C informed him "on 3/24/24, staff came in the morning to help her get up, into her power chair, and ready for the day. She reported she went down to the activites [sic] and was playing cards with friends. [Resident C] reported she began to not feel well and left the card game, in a hurry to return to her room. [Resident C] reported her stomach was very upset and she knew she was going to have a Bowel Movement, but did not want to make a scene was doing everything she could to contain the situation to her room. [Resident C] reported she has been on an antibiotic from a UTI and has had BM issues due to that. [Resident C] reported she immediately rang her buzzer at 11:20 AM after having her accident. [Resident C] reported she rang the buzzer again at 11:35 AM. She reported she knew it was during lunch prep and no one was going to respond. [Resident C] reported that [Staff Person 1 (SP1)] did arrive and indicated they were too busy and could not help, turning off the buzzer. [SP1] reported to [Resident C] they would make her a lunch, bring it to her, and get her cleaned up after lunch services. At 12:30 PM, [Resident C] buzzed again and [SP2] arrived. [SP2] told [Resident C] that lunch was over and they could not get her food, but they had other resident needs in front of hers. [Resident C] remains soiled and at 2:30 PM [Resident C] continued to ring her buzzer. At this time, [SP2] returned and [Resident C] asked to call Resident Director [SP3]. [SP2] refused this and indicated she was not willing to help at this time. [Resident C] reported she was upset and adamant that she needed to be changed and cleaned up. At this time, [Resident C] reported that [SP2] 'yelled at me like I was a child or a dog.' [Resident C] noted she was told to 'go back to your room!'

[Resident C] reported she felt defeated and demoralized. She reported at this time, she had been sitting in her own waste for more than four hours. She reported dinner time was coming and she knew the aides would be completing dinner prep and again unable to help her. She reported that human waste had dripped down onto her apartment floor. [Resident C] again buzzed and staff came in and indicated they could not change her in the current room due to waste on the floor, so they moved her to a different room around 5:30 PM. [Resident C] reported that they undressed her and began cleaning her, but would not provide her the decency of covering her with a sheet. She reported that she was finally cleaned up and in unsoiled clothing at 6:30 PM. [Resident C] reported that she sat in her own soil/waste from 11:20 AM through 6:30 PM, with more than six refusals to change her. [Resident C] reported by the time she was changed dinner service was over and she did not get served dinner either. She reported she was refused coffee in the middle of the afternoon as well."

On 4/4/24, I received an email from Mr. Blackall. Mr. Blackall reported he received a text message from Resident C that read, “Last night was another night I was left to sit in my own waste for about 4 hrs. [SP8] out today, I have reported it to [SP3] and it will be in the blue note book I am keeping. Thought this [sic] should let you know asap.”

On 4/8/24, I interviewed administrator Mackenzie Ferguson at the facility. Ms. Ferguson stated an “internal investigation” regarding the incident on 3/24/24 was completed. Ms. Ferguson reported the internal investigation that was completed found that Resident C did press her pendant multiple times on 3/24/24 because she needed her soiled brief changed. Ms. Ferguson said Resident C is incontinent and requires assistance from staff to toilet. Ms. Ferguson reported Resident C is unable to bear weight and uses an electric wheelchair to ambulate. Ms. Ferguson stated that SP1 and SP2 did respond to Resident C’s pendant multiple times, however they did not change her soiled brief when they were in her room.

Ms. Ferguson reported Resident C first pushed her pendant around lunch time. Ms. Ferguson stated Resident C’s soiled brief was not changed until approximately 4:27 pm. Ms. Ferguson said SP1 and SP2 were terminated because of the incident. Ms. Ferguson reported SP1 and SP2 did not initially change resident C’s soiled brief because they were assisting serving lunch to other residents in the dining room. Ms. Ferguson said Resident C was told by staff that she would be changed after lunch, however this did not occur.

Ms. Ferguson provided me with copies of her internal investigation documents for my review. The *Findings* section of the *Summary of Inquiry into Commonwealth Senior Living* document read, “It was found the member was made to wait to be changed for an extended period. Through various statements each employee stated she was told to wait until after they were done serving lunch through their own admission, by [SP1]. The employees from the 1st shift stated they had gotten busy serving meals, cleaning the dining room and with another member who had gotten sick. [SP4] stated that staff told her that they were instructed by the ARCD to just wait until 2nd shift because she was on the phone and did not want to hang up the phone. The member rang her call light at 11:33am and it was answered in 15 minutes. Then again at 12:59PM to be changed but still had not been changed. The member then rang her light at 1:24pm and it went off for 4 hours, 14 minutes and 19 seconds. After reviewing the cameras, it was seen that staff entered the room at the following times: [SP2] 1:39p-1:45p, then it showed [Resident C] coming down the hallway and was out of her room 1:47p-1:53p, at 1:58pm it showed [SP1] and [SP5] entering the room and leaving right back out. At 2:08PM [Resident C] once again comes out and heads down the hallway. [SP4] entered the room at 2:21PM and did not leave until 2:27PM. 3:23p-3:30p [Resident C] came back out of her room and again 3:46p-3:51p and [Resident C] spoke with [SP6] and told her no one had changed her all day and if she could please change her and at 3:52 PM [SP6] and [SP7] went into the room and changed the member.”

Ms. Ferguson provided me with a copy of Resident C's service plan for my review. The *Toileting* section of the plan read, "Toileting level of assistance Total: Resident requires physical assistance with all tasks related to toileting. May require assistance with closed drainage system/catheters. Toileting Enabling Devices and Methods Adult Briefs Bedpan Mechanical lift."

Ms. Ferguson provided me with a copy of Resident C's pendant response times for 3/24/24 for my review. The document read Resident C pushed her pendant at 11:33 am with a response time of 15 minutes and 49 seconds, at 12:59 pm with a response time of 22 minutes and 31 seconds, at 1:24 pm with a response time of 4 hours and 14 minutes.

Ms. Ferguson denied knowledge regarding Resident C being left for approximately four hours on 4/4/24. Ms. Ferguson stated this was not reported to her, therefore this is the first time she is hearing of this incident.

On 4/8/24, I was unable to interview Resident C at the facility regarding her being left soiled for an extended period on 3/24/24 and 4/4/24. Ms. Ferguson stated Resident C was admitted to the hospital for Pneumonia. Ms. Ferguson reported it is unknown when Resident C will be discharged from the hospital and return to the facility.

On 4/8/24, I interviewed SP3 at the facility. SP3's statements were consistent with the *Summary of Inquiry into Commonwealth Senior Living* document regarding the incident with Resident C on 3/24/24.

On 5/9/24, I received an email from Mr. Blackall. Mr. Blackall reported Resident C was admitted to a skilled nursing facility for rehabilitation services. Mr. Blackall stated Resident C "is working on a different placement and now refuses to return to Commonwealth." Mr. Blackall said he is closing his APS case unsubstantiated because Resident C will not be returning to the facility. Because Resident C did not return to the facility, I was unable to interview her regarding the incidents on 3/24/24 and 4/4/24.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.

ANALYSIS:	The interviews with Ms. Ferguson, SP3, along with review of the facility's *Summary of Inquiry into Commonwealth Senior Living* document regarding the incident with Resident C on 3/24/24, revealed Resident C was left soiled for several hours despite multiple staff responding to her pendant for assistance. Review of Resident C's service plan revealed she requires full assistance from staff to meet her toileting needs. On 3/24/24, staff did not provide care consistent with Resident C's plan, therefore the facility was not in compliance with this rule. I was unable to interview Resident C regarding the incidents on 3/24/24 and 4/4/24 because she no longer resides in the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Ellen Byrne on 5/28/24.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

05/17/2024

Lauren Wohlfert Date
Licensing Staff

Approved By:

05/28/2024

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section