GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 11, 2024

Liz Kimberly Vidana
Prime Residential Care LLC
496 E Lovell Dr
Troy, MI 48085

RE: License #: AS630403736
Investigation #: 2024A0611021
Prime Residential Care

Dear Ms. Vidana:

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, Suite 9-100
Detroit, MI 48202

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AS630403736 |
| | |
| **Investigation #:** | 2024A0611021 |
| | |
| **Complaint Receipt Date:** | 04/12/2024 |
| | |
| **Investigation Initiation Date:** | 04/17/2024 |
| | |
| **Report Due Date:** | 06/11/2024 |
| | |
| **Licensee Name:** | Prime Residential Care LLC |
| | |
| **Licensee Address:** | 496 E Lovell Dr<br>Troy, MI 48085 |
| | |
| **Licensee Telephone #:** | (248) 797-4536 |
| | |
| **Administrator:** | Liz Kimberly Vidana |
| | |
| **Licensee Designee:** | Liz Kimberly Vidana |
| | |
| **Name of Facility:** | Prime Residential Care |
| | |
| **Facility Address:** | 496 E Lovell Dr<br>Troy, MI 48085 |
| | |
| **Facility Telephone #:** | (248) 797-4536 |
| | |
| **Original Issuance Date:** | 10/26/2020 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 04/26/2023 |
| | |
| **Expiration Date:** | 04/25/2025 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>AGED<br>ALZHEIMERS |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| • Staff gave Resident A meat despite her being a vegetarian.<br>• Resident A got a stage 3 bed sore. | Yes |
| Upon discharge from the facility, Resident A was sent home with the wrong wheelchair. | No |

## III. METHODOLOGY

| | |
|---|---|
| 04/12/2024 | Special Investigation Intake<br>2024A0611021 |
| 04/17/2024 | APS Referral<br>An Adult Protective Service (APS) referral was made. |
| 04/17/2024 | Special Investigation Initiated - Telephone<br>Telephone call to the reporting source. |
| 05/09/2024 | Inspection Completed On-site<br>I completed an unscheduled onsite inspection. |
| 05/09/2024 | Contact - Telephone call made<br>Telephone interviews completed with Program Director Susana Cox, licensee Liz Vidana and Resident A's guardian. |
| 05/13/2024 | Contact - Document Received<br>Facility documentation received via email. |
| 05/15/2024 | Contact - Telephone call made<br>Telephone interview with Optimal Home Care HR and compliance director, Sarah Gerrity. |
| 05/16/2024 | Contact - Telephone call made<br>Telephone interview with Program Director Susana Cox. |
| 05/16/2024 | Contact – Document Received<br>Three photos of Resident A in her wheelchair received via email from Program Director Susana Cox. |
| 05/20/2024 | Contact – Telephone call made<br>Telephone interview completed with Resident A's guardian. |

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|---|---|
| 05/30/2024 | Contact – Telephone call made<br>Telephone interview completed with direct care staff, Josie Francis. |
| 05/30/2024 | Contact – Document Received<br>Photo of a wheelchair received via email from direct care staff, Josie Francis. |
| 05/31/2024 | Exit Conference<br>Telephone call to licensee designee, Liz Kimberly Vidana to hold and exit conference and review my findings. |
| 05/31/2024 | Contact – Document Received<br>Photos of wheelchair received from Resident A's guardian via text message. |

**ALLEGATION:**

- **Staff gave Resident A meat despite her being a vegetarian.**
- **Resident A got a stage 3 bed sore.**

**INVESTIGATION:**

On 04/12/24, a complaint was received and assigned to licensing consultant Sheena Worthy for investigation. The complaint indicated the facility brought in a new staff which was jarring on the residents. The new staff ignored the family's request for care and gave the resident meat despite her being a vegetarian. The resident has gotten a stage 3 bed sore and caught Covid while at the facility. The resident's wheelchair was missing an arm on the chair, and it appears that the facility took the residents original wheelchair. On 04/17/24, Ms. Worthy initiated the investigation with a telephone call to the complainant. The complainant identified Resident A as the resident who has the bed sore and is missing her original wheelchair. Resident A is not prescribed a special diet; however, she is a vegetarian. The complainant stated the allegations are against direct care staff, Amy (last name unknown). On 05/09/24, this investigation was reassigned to licensing consult, Johnna Cade as Ms. Worthy is on an extended leave.

On 05/09/24 and 05/20/24, I completed telephone interviews with the Resident A's guardian. Resident A's guardian stated Resident A has dementia. Prime Residential Care said Resident A was eating well and gaining weight however, that was untrue. Resident A went to the hospital for a urinary tract infection (UTI) and when she was weighed it was found that she had not been gaining weight. Resident A's guardian stated, Resident A has a peg tub however, she can also eat food by mouth. Resident A is a vegetarian. The home was feeding her meat. On one occasion when Resident A's guardian went to the home to visit, she brought one of Resident A's former staff with her. While they were at the home Resident A was eating chicken spaghetti with her

fingers. Resident A is a vegetarian, and she is at risk of aspiration. Chicken spaghetti is not an appropriate meal for her. Resident A's guardian stated she bought vegetarian Morning Star "chicken" fingers and veggie burgers for Resident A, but she never gave approval/ permission to feed Resident A real chicken. Resident A's guardian stated the home got a new staff named, Amy. Amy is Program Director, Susana Cox's sister. When Amy started working at the home things became worse. Resident A's weight decreased. This is because Resident A's feeding tube was not being administered correctly. They were only giving it to her at night.

Resident A's guardian stated whenever she went to the home Resident A she was in bed. She was concerned about bed sores. When she inquired about why she was always in bed Prime Residential Care staff would give her an excuse. Resident A's guardian stated prior to moving into Prime Residential Care Resident A was much more flexible, but because they kept her in bed most of the time she declined. Resident A's guardian stated she was advised by Infinity Home Care to move Resident A out of Prime Residential Care because she was not thriving. Infinity Home Care enrolled her in Chronic Care Management. Resident A's guardian stated she moved Resident A to her home the first week of March 2024. The day she moved Resident A home she was informed via text message that Resident A had a sore on her buttocks, that staff referred to as a "blister." Optimal Home Care and Infinity Home Care both sent a nurse to see Resident A the day after she moved home. Resident A was diagnosed with a stage 3 bed sore on her buttock. Resident A was hospitalized, and it has progressed to a stage 4 wound. On 05/20/24, Resident A was discharged from the hospital and transferred to a lower level of care. Resident A's guardian stated the hospital physician told her that the wound did not look as bad as it actually was. However, the wound was very deep, down to the bone. Wounds takes time to form which is likely why it did not look as bad initially. During both telephone interviews with Resident A's guardian on 05/09/24, and 05/20/24, she was encouraged to provide the licensing consultant with any relevant documentation to support this allegation. No documentation was received.

On 05/09/24, I completed an unscheduled onsite inspection. A gentleman answered the door and stated the home does not have any residents. He stated that they have not had any residents since January 2024. He said he is not a staff, he moved from Virgina to Michigan, and with permission from the homeowner he is currently staying at the home. The gentleman was unable to provide any information regarding the residents.

On 05/09/24, I completed a telephone interview with Program Director, Susana Cox. Ms. Cox stated the home had two residents. One of the residents died and Resident A moved to her family home on 02/05/24. The home is accepting new residents. They recently did a tour for a potential new resident. Ms. Cox stated she is out of town in Virgina. She does not have access to any facility documentation. Ms. Cox agreed to send relevant facility documentation regarding this investigation upon her return.

On 05/16/24, I completed a second telephone interview with Program Director, Susana Cox. Ms. Cox stated Resident A is a vegetarian she ate vegetables, fruit, eggs, and her guardian wanted her to have chicken nuggets. Ms. Cox explained that Resident A's

guardian was okay with Resident A eating chicken nuggets because chicken is a bird. Resident A was able to feed herself and when she needed assistance staff would support her. Resident A gained weight because she was eating well. Ms. Cox stated Resident A did not have any bed sores. On the day she moved out of the home one small blister was noticed on her buttock. The skin was not broken. Resident A's guardian was made aware of this when she picked her up. Ms. Cox stated Resident A was kept clean and dry. She was showered and changed regularly. She was turned every two hours, and she was cared for like family. Ms. Cox stated the home does not have a staff named Amy. Her sister, Reneide came to the home in January 2024, however she did not provide direct care to the residents. Reneide met Resident A's guardian while she was at the home.

On 05/09/24, I completed a telephone interview with licensee, Liz Vidana. Ms. Vidana stated the home had two residents neither of them are living at the home any longer. The home is currently seeking new clients. Ms. Vidana stated they do not have a staff named, Amy or anyone whose name is similar to Amy. Ms. Vidan stated Resident A was receiving in-home care provided by Optimal Home Care. She was doing well and gaining weight. Resident A had a peg tub, she could also eat food by mouth. She was encouraged to eat soft foods. Ms. Vidana stated Resident A's family was upset because they wanted her to have finger foods such as, chicken tenders and the staff did not support this. They prefer to feed residents healthy meals. Ms. Vidana denied that Resident A had any bed sores while she was in their care.

On 05/15/24, I completed a telephone interview with Optimal Home Care HR and compliance director, Sarah Gerrity. Ms. Gerrity stated Resident A opened for services with Optimal Home Care on 12/23/23. Her services were terminated in April 2024, when she was admitted into the hospital. Ms. Gerrity stated the first note that indicates Resident A has a stage 2 pressure ulcer on her left buttock is dated February 6, 2024. Resident A was seen at her guardian's home upon moving out of Prime Residential Care. Ms. Gerrity stated Optimal Home Care called Resident A's guardian on 01/30/24, 01/31/24, and 02/01/24, to schedule an appointment to see Resident A after she moved out of the AFC home. There was a missed visit at Resident A's guardian's home on 02/02/24. Ms. Gerrity stated if Optimal Home Care staff suspected noncompliance from caregivers this would be noted in the visit summary and Adult Protective Services would have been contacted if necessary. Ms. Gerrity stated Resident A is bedbound, thin, incontinent, and confused. As such, she is at risk of bedsores. There is no indication that the caregivers were negligent resulting in the stage 2 pressure ulcer to her left buttock. Ms. Gerrity stated Optimal Home Care provided Prime Residential Care Staff with information regarding tube feeding, urine output, transfer safety, the importance of developing a daily routine, and wound care. Resident A is restricted to bed. Her chair sitting is limited to two hours, and she should be turned every two hours. Ms. Gerrity stated Resident A had a history of bilateral thigh blisters that were treated and no longer present. Ms. Gerrity stated Resident A was on a feeding tube, she could also take food by mouth. There is no documentation that indicates food was not being administered properly or that there was any concern regarding her weight. Ms. Gerrity stated Optimal

Home Care weighed Resident A on 12/29/24, at Prime Residential Care she was 103.2 lbs. Optimal Home Care staff spoke to Resident A's guardian regarding her weight as the guardian was concern that she weighed 95 lbs. when she was in the hospital.

On 05/30/24, I completed a telephone interview with direct care staff, Josie Francis. Ms. Francis stated Resident A was well care for, loved, and treated as family while she was living in the home. Resident A received services from Optimal Home Care and the staff always said how good Resident A was doing. Ms. Francis stated when Resident A moved into the home, she weighed 95 lbs. when she moved out her weight had increased to 105 lbs., which was good. Resident A is a vegetarian. She received a tube feeding and in addition her family wanted her to eat finger foods, such as French fries. Ms. Francis stated she cooked Resident A a variety of food and staff assisted her with eating to ensure that she ate well. Ms. Francis stated one day she prepared pasta with turkey meatballs. While Resident A was eating her guardian came to the home. She brought a woman with her who use to work as Resident A's staff. Ms. Francis stated the woman became verbally aggressive, yelling at her because Resident A was eating meat. Ms. Francis stated turkey and chicken are birds. Therefore, she did not see an issue with serving Resident A turkey meat balls despite her being a vegetarian. Ms. Francis stated Resident A ate the food without issue and asked for more. Ms. Francis stated on the day Resident A was scheduled to move out of the home she texted Resident A's guardian and informed her that she observed a blister on Resident A's buttock while she was changing her. Ms. Francis stated that was the first day the blister was observed. Ms. Francis denied that Resident A had a bedsore while living in the home. Ms. Francis stated Resident A was bathed 3 x weekly, she was always kept clean and dry, and she was repositioned regularly.

I reviewed the following relevant documentation:

- Resident A's assessment plan which indicates Resident A is a vegetarian. Resident A uses a wheelchair. Resident A can communicate her needs, she is alert to her surroundings, and she understands verbal instruction.
- Resident A's Weight Records:
  0/9/09/23 95.8 lbs.
  10/15/23 100.2 lbs.
  11/24/23 99.3 lbs.
  12/29/23 103.2 lbs.
  01/17/24 105.4 lbs.
- Resident A's Health Care Chronological –Optimal Home Care provided brief visit summaries. There was no documentation of a pressure ulcer and/or issues related to Resident A's weight/ diet. Optimal Home Care note dated 12/26/23 indicates Resident A had a bilateral thigh blister. Note dated 01/17/24, indicates Resident A no longer has bilateral thigh blisters.

| APPLICABLE RULE | |
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| **R 400.14303** | **Resident care; licensee responsibilities.** |
| | **(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.** |
| **ANALYSIS:** | Based on the information gathered through this investigation there is sufficient information to conclude that Prime Residential Care staff failed to provide personal care as it is written in Resident A's assessment plan. Resident A's assessment plan indicates Resident A is a vegetarian. Direct care staff, Josie Francis, and Resident A's guardian consistently stated Resident A ate pasta with chicken and/or turkey. Program Director, Susana Cox further confirms Resident A was fed chicken on occasion. Ms. Francis and Ms. Cox stated that they believed feeding Resident A chicken and turkey was acceptable because they are birds.<br><br>There is insufficient information to conclude that Prime Residential Care staff failed to provide supervision, protection, and personal care resulting in Resident A developing a stage 3 bed sore. Optimal Home Care HR and compliance director, Sarah Gerrity stated Resident A has a stage 2 pressure ulcer on her left buttock. The stage 2 pressure ulcer was first noted on February 6, 2024. Resident A was living at her guardian's home. Ms. Gerrity stated Resident A is bedbound, thin, incontinent, and confused. As such, she is at risk of bedsores. There is no indication that the caregivers were negligent resulting in the stage 2 pressure ulcer to her left buttock. Ms. Gerrity stated if Optimal Home Care staff suspected noncompliance from caregivers this would be noted in the visit summary and Adult Protective Services would have been contacted if necessary. Program Director Susana Cox and direct care staff, Josie Francis consistently stated on the day Resident A moved out of the home they observed one small blister on her buttock. This was the first time that they observed the blister. Resident A's guardian was notified. Resident A's guardian confirmed that staff told her that Resident A had a blister on her buttock upon moving out of the home. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION:**

**Upon discharge from the facility, Resident A was sent home with the wrong wheelchair.**

**INVESTIGATION:**

On 05/09/24, and 05/20/24, I completed telephone interviews with the Resident A's guardian. Resident A's guardian stated Resident A's wheelchair was purchased over a year ago. Prime Residential Care discharged Resident A in a wheelchair that does not belong to her. The wheelchair only has one arm, and it has a place for an oxygen tank. Resident A's guardian called Advanced Medical, the company who supplied the wheelchair and obtained the serial number to the wheelchair that was issued to Resident A (1f4402967). Resident A's guardian stated the serial number on the wheelchair Resident A was discharged from Prime Residential Care with is (451504050038). Further, Resident A has no history of using oxygen. Advanced Medical stated that they would not have issued a chair with an oxygen holder if Resident A does not use oxygen because it would not have been approved by the insurance company. Resident A's guardian stated she did not notice the issues with the wheelchair on the day that Resident A was discharged from Prime Residential Care.

On 05/09/24, I completed a telephone interview with licensee, Liz Vidana. Ms. Vidana denied that Resident A was discharged from the home with the wrong wheelchair. Ms. Vidana stated the wheelchair Resident A moved in with is the wheelchair that she was sent home with.

On 05/15/24, I completed a telephone interview with Optimal Home Care HR and compliance director, Sarah Gerrity. Ms. Gerrity did not have any specific information regarding Resident A's wheelchair.

On 05/16/24, I completed a telephone interview with Program Director, Susana Cox. Ms. Cox stated Resident A was discharged home in the wheelchair that she always used. The wheelchair was never missing an arm. Ms. Cox stated she was never contacted regarding a concern about Resident A receiving the wrong chair. Ms. Cox stated the home has two or three wheelchairs in the garage that have been left at the home when residents have passed away, she will inspect those wheelchairs to ensure none of them belong to Resident A.

On 05/30/24, I completed a telephone interview with direct care staff, Josie Francis. Ms. Francis stated Resident A was sent home in the wheelchair she moved in with. Ms. Francis stated she never observed Resident A using a wheelchair that was missing an arm or had a place for an oxygen tank. Ms. Francis stated the home has three wheelchairs in the garage that were left at the home when previous residents who died. These wheelchairs are much bigger than the wheelchair Resident A uses. Ms. Francis stated the staff never exchange a resident's wheelchair.

I reviewed the following relevant information:

- Resident A's Inventory of Valuables which indicates Prime Residential Care received Resident A's wheelchair on, 09/05/23. It was returned on 02/05/24. A description of the wheelchair was not provided.
- Three photos of Resident A sitting in her wheelchair at Prime Residential Care. The wheelchair is black and has two arms. The brand is Drive. The wheelchair has a seatbelt. There is a small tear on the right arm of the wheelchair. There is a yellow warning label with red writing on the side of the chair under the word Drive. Although Resident A is sitting in the wheelchair in these pictures, it appears that the chair has an oxygen holder that can be seen on the left side.
- A photo of a wheelchair that is in the garage at Prime Residential Care. The wheelchair is black, has two arms. The brand is McKesson and it is printed on the right side of the wheelchair. The ticket on the wheelchair contains the number 255697.
- 11 photos of the wheelchair received from Resident A's guardian. The wheelchair is black, has a seatbelt and an oxygen holder. It is missing the left arm. The brand of the wheelchair is Drive. There is a small tear on the right arm of the wheelchair. There is a yellow warning label with red writing on the side of the chair under the word Drive.

On 05/31/24, I called licensee designee, Liz Kimberly Vidana to hold and exit conference and review my findings. There was no answer. I left a detailed voicemail and advised that a corrective action plan is required.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14304** | **Resident rights; licensee responsibilities.** |
| | **(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights:**<br>**(j) The right of reasonable access to and use of his or her personal clothing and belongings.** |
| **ANALYSIS:** | Based on the information gathered through this investigation there is insufficient information to conclude that Resident A did not have reasonable access to her personal belongings. I reviewed photos of Resident A sitting in the wheelchair while she lived at Prime Residential Care and photos of the wheelchair provided by Resident A's guardian after Resident A moved out of Prime Residential Care. The wheelchair in all of the photos appears to be the same wheelchair. Although it can |

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| | be confirmed in the pictures provided by Resident A's guardian that the wheelchair is missing an arm, this complaint was received by the department two months after Resident A was discharged from the home. Therefore, it cannot be confirmed that Prime Residential Care is responsible for the damage. Resident A's guardian confirmed that she did not notice that the arm was missing from the wheelchair when she discharged Resident A from the home. Moreover, although Resident A's guardian stated the serial number of the wheelchair Resident A has currently does not match the serial number of the wheelchair she was issued over a year ago, there is not enough information to determine that Prime Residential Care is responsible. Resident A lived in the home from September 2023 - February 2024. It was consistently reported by all staff that Resident A was discharged from the home with the wheelchair she moved in with. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

## IV. RECOMMENDATION

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

05/31/2024

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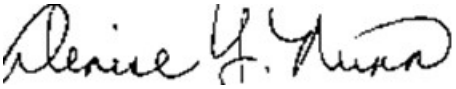
Johnna Cade Date
Licensing Consultant

Approved By:



06/11/2024

_____

Denise Y. Nunn Date
Area Manager