GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 30, 2024

Erin Gust
Dignitas Inc
P.O. Box 3460
Farmington Hills, MI 48333-3460

RE: License #: AS630315897
Investigation #: 2024A0612032
Dignitas, Inc/Orchard Lake House 2

Dear Ms. Gust:

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 #:	AS630315897
Investigation #:	2024A0612032
Complaint Receipt Date:	07/05/2024
Investigation Initiation Date:	07/08/2024
Report Due Date:	09/03/2024
Licensee Name:	Dignitas Inc
Licensee Address:	Suite 112 24380 Orchard Lake Road Farmington Hills, MI 48336-3460
Licensee Telephone #:	(248) 442-1170
Administrator:	Erin Gust
Licensee Designee:	Erin Gust
Name of Facility:	Dignitas, Inc/Orchard Lake House 2
Facility Address:	24485 Orchard Lake Road Farmington Hills, MI 48336
Facility Telephone #:	(248) 442-1170
Original Issuance Date:	04/05/2012
License **Status:**	REGULAR
Effective Date:	10/05/2022
Expiration Date:	10/04/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A had a fall and suffered bruising all over her body.	Yes
Resident A is on a pureed diet due to not having teeth. While at the hospital direct care staff from the group home brought Resident A hamburger and onion rings.	Yes

III. METHODOLOGY

07/05/2024	Special Investigation Intake 2024A0612032
07/05/2024	APS Referral Referral received from Adult Protective Services (APS). The complaint was not assigned for APS investigation.
07/08/2024	Special Investigation Initiated - Telephone Telephone call to the complainant. There was no answer. The mailbox was full, and I was unable to leave a voicemail message.
07/08/2024	Inspection Completed On-site I completed an unscheduled onsite investigation. I interviewed direct care staff Saykeiya Cook, Clinical Director Krisanne George, Resident A and Resident B.
07/08/2024	Contact - Telephone call made Telephone interview completed with Resident A's guardian.
07/09/2024	Contact - Telephone call received Telephone interview completed with Clinical Director Krisanne George.
07/10/2024	Contact – Document Received Facility documentation received via email.
07/15/2024	Contact - Telephone call made Telephone interview completed with direct care staff, Vera Reeves.
07/15/2024	Contact - Telephone call made Telephone call to the complainant. There was no answer. The mailbox was full, and I was unable to leave a voicemail message.

07/17/2024	Contact - Telephone call made Telephone interview completed with direct care staff, Sandra Hall.
07/18/2024	Exit Conference Telephone call placed to licensee designee Erin Gust to conduct an exit conference.

ALLEGATION:

Resident A had a fall and suffered bruising all over her body.

INVESTIGATION:

On 07/05/24, I received a referral from Adult Protective Service (APS). APS denied the referral for investigation. The referral indicated Resident A had a previous transient ischemic attack (TIA) and has difficulty speaking, she is frail. Resident A is not able to complete her own activities of daily living. Resident A resides at Dignitas Inc group home. Resident A was scared to go back to her group home. This is due to the group home feeling like prison. While at the group home Resident A was previously in a fall and had bruising all over her body. It is unknown how Resident A fell. It is unknown how Resident A sustained the bruises. Resident A is on a pureed diet due to not having teeth. While at the hospital Resident A's caregiver from the group home brought her a hamburger and onion rings. This was given to Resident A during her discharge. It is unknown why the food was brought to Resident A as she was being fed at the hospital. It is unknown why the food was provided to Resident A. I initiated my investigation with a call to the complainant on 07/08/24, and 07/15/24. There was no answer. The mailbox was full, and I was unable to leave a voicemail message.

On 07/08/24, I completed an unscheduled onsite investigation. I interviewed direct care staff Saykeiya Cook, Clinical Director Krisanne George, Resident A, and Resident B. While onsite I observed Resident A had bruising around her right eye. The bruise was dark purple and green.

On 07/08/24, I interviewed direct care staff Saykeiya Cook. Ms. Cook stated she has worked for this company since January 2024. Ms. Cook works the morning shift from 8:00 am – 4:00 pm and the afternoon shift from 4:00 pm – 12:00 am. Ms. Cook stated on 07/01/24, she was informed that Resident A fell out of her bed during the midnight shift. When she arrived to work Resident A had a bruise on her eye. She took Resident A to urgent care; she was later referred to the hospital. Ms. Cook took Resident A to Corewell Hospital. Resident A was admitted, and she remained in the hospital for two to three days. Ms. Cook stated Resident A had to stay in the hospital due to her kidney levels being low not because of the injuries she sustained when she fell. Ms. Cook stated she does not suspect Resident A's injuries were caused by any of the staff who work at the home.

On 07/08/24, I interviewed Resident B. Resident B stated she has lived at this home for five years. She has no issues or complaints. Resident B said the staff treat her well.

On 07/08/24, I interviewed Resident A. Resident A stated three or four days ago, she fell out of bed and hit her head on the floor. Resident A stated she was trying to get herself out of bed and into her wheelchair when she fell. Resident A denies that any staff caused the injury.

On 07/08/24, I interviewed Clinical Director Krisanne George. Ms. George stated on 07/01/24, at 4:00 am Resident A fell out of her bed during the midnight shift. The staff on shift, Sondra Hall heard her fall but did not witness it happen. In the morning, when Resident A woke up her face was bruised. At 10:30 am, Resident A's primary care doctor was notified. Resident A was not experiencing a mental status change and she was eating and drinking normally. As such, her physician said that she did not require medical attention and recommended that they continue to monitor her. Resident A's guardian was also made aware of the incident. Later that afternoon, Resident A complained of back pain. As a result, she was taken to the hospital. Ms. George stated Resident A was admitted to the hospital because her kidney enzymes were elevated. While in the hospital the facility provided one on one staffing to Resident A because she can become agitated and confused. Resident A was discharged back home on 07/03/24.

On 07/09/24, I completed a second interview with Clinical Director Krisanne George via telephone. Ms. George stated Resident A completed an occupational therapy (OT) assessment in March 2024. She did not receive a copy of the report or hear any follow up regarding the recommendations. Last week, Ms. George followed up and found out that the OT assessment recommended Resident A obtain a different bed (a bed with rails or a lower bed) and a fall mat. Ms. George stated she should have followed up on the OT assessment much quicker, the guardian should have been consulted, and the recommended equipment should have been ordered.

On 07/08/24, I interviewed Resident A's guardian via telephone. Resident A's guardian stated Resident A has a history of trying to get herself out of bed. Resident A has an unsteady gait. She was informed that Resident A fell out of her bed on 07/01/24. Resident A's primary care doctor was also contacted. Resident A's guardian stated Resident A completed an OT assessment in March 2024 however she did not receive a copy of the assessment. The OT recommended a fall mat be placed near Resident A's bed, A bed with a rail, or lowering Resident A's bed to the floor. Resident A's guardian stated she spoke to Ms. George about following up on the OT recommendations and Ms. Georged stated that she had not received a copy of the OT assessment either. Resident A's guardian stated Ms. George informed her that she would contact the DME supplier and see when the recommended equipment would be delivered. Resident A's guardian stated she was not present when Resident A fell however, she wonders if staff did not move Resident A's wheelchair away from her bed and when she fell, she hit her head on the wheelchair. Resident A's guardian remarked, Resident A has thin skin, she is frail, and she has osteoporosis. It is not uncommon for Resident A to get frustrated

and want to walk. Resident A's guardian stated at baseline Resident A can be feisty and combative. She commonly says, "just let me die." Despite living in this facility for many years and doing well, Resident A expresses interest in moving.

On 07/17/24, I completed a telephone interview with direct care staff Sandra Hall. Ms. Hall stated she has worked for this company for seven years. She works midnights from 12:00 am – 8:00 am. Ms. Hall stated she completes hourly checks on Resident A throughout the night. On 07/01/24, she heard a noise in Resident A's bedroom she went into the room and observed Resident A on the floor. Resident A feel out of her bed and onto the floor. Ms. Hall stated Resident A did not have any injuries at the time of the incident. She got Resident A up in the morning, assisted her with a shower, got her dressed, did her hair, and Resident A went to work. Later in the day, Resident A developed bruising above her eye. Ms. Hall stated Resident A's primary care doctor was contacted and Resident A was taken to the hospital where she was admitted. Ms. Hall stated it is common for Resident A to toss and turn during the night. Resident A does not have bedrails or a fall mat however, she suspects that she should as this is not the first time Resident A has fallen out of her bed.

I reviewed the following relevant documentation:

- Resident A's Occupational Therapy Evaluation report dated 03/25/24. The report indicates "The 36" full electric low bed with half rails and Geo-Mattress UltraMax mattress is recommended to decrease fall risk, promote skin integrity and safety for client and care providers during transfers. Additional safety features including Infinity floor mat and bed alarm are recommended to alert staff if (Resident A) attempts to transfer out of bed and to decrease risk of injury."
- Incident Report (IR) written by direct care staff, Sandra Hall dated 07/01/24. In summary, the IR indicates at 4:30 am Ms. Hall heard a noise from Resident A's bedroom. Ms. Hall entered the room and found Resident A on the floor. Resident A indicated pain in her neck and back. There was no mental status change observed. Primary care doctor was notified when a bruise formed on Resident A's forehead. Resident A was taken to urgent care then admitted into Beaumont Farmington Hills.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	Based on the information gathered through this investigation, there is sufficient information to determine that the instructions and recommendations of Resident A's OT assessment were not

	followed. Resident A competed an OT assessment on 03/25/24. A 36” full electric low bed with half rails and Geo-Mattress UltraMax mattress was recommended to decrease fall risk, promote skin integrity, and safety for Resident A and staff during transfers. An Infinity floor mat and bed alarm was also recommended to alert staff if Resident A attempts to transfer out of bed and to decrease risk of injury. Clinical Director Krisanne stated she did not receive a copy of the OT report or hear any follow up regarding the recommendations and therefore the equipment was not ordered. Ms. George stated she should have followed up on the OT assessment much quicker, the guardian should have been consulted, and the recommended equipment should have been ordered. Failure to follow the recommendations of Resident A's OT assessment resulted in her falling out of bed and sustaining an injury on 07/01/24.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A is on a pureed diet due to not having teeth. While at the hospital direct care staff from the group home brought Resident A hamburger and onion rings.

INVESTIGATION:

On 07/08/24, I completed an unscheduled onsite investigation. I interviewed direct care staff Saykeiya Cook, Clinical Director Krisanne George, Resident A, and Resident B. While onsite I observed a posted menu on the refrigerator stating Resident A is on a mechanically soft diet.

On 07/08/24, I interviewed direct care staff Saykeiya Cook. Ms. Cook stated Resident A is a diabetic, she has no teeth, and it is difficult for her to swallow. Ms. Cook stated some of Resident A’s food is pureed, other foods are cut up finely or mashed. Ms. Cook stated Resident A will eat pureed oatmeal for breakfast, but she will not eat pureed dinner. Resident A enjoys soup, grilled cheese sandwiches, and cookies. Resident A does not like when her meals are pureed, she will refuse to eat it. When asked if Resident A would typically eat a hamburger and onion rings Ms. Cook stated she would only feed Resident A a hamburger if it was cut up.

On 07/08/24, I interviewed Resident B. Resident B stated she has lived at this home for five years. She has no issues or complaints. Resident B said the staff treat her well. Resident B stated they eat a lot of chicken with their meals.

On 07/08/24, I interviewed Resident A. Resident A stated she does not like pureed food. Resident A stated she hates hospital food. She enjoys eating fish and A&W. Resident A stated direct care staff, Victoria brought her something to eat while she was in the

hospital. Resident A was unwilling/unable to confirm if she was given a hamburger and/or onion rings.

On 07/08/24, I interviewed Clinical Director Krisanne George. Ms. George stated Resident A is on a mechanically soft diet. Her food is cut into small pieces. Ms. George stated she does not have a prescription on site and available for review for Resident A's special diet. Ms. George remarked, Resident A eats well. Ms. George stated staff should not have given Resident A a hamburger whole as all her food should be cut into small pieces. Ms. George stated while Resident A was in the hospital the facility provided one on one staffing. At the time of this interview, she was unsure which staff was present at the time of her discharge.

On 07/09/24, I completed a second interview with Clinical Director Krisanne George via telephone. Ms. George stated direct care staff, Vera Reeves informed her that Resident A was not eating well when she was in the hospital. On the day she was discharged Ms. Reeves took Resident A A&W (hamburger, onion rings and a small diet coke). Ms. Reeves cut up Resident A's food and was with her while she was eating. Resident A finished eating at the hospital prior to being transferred home via EMS. Ms. George stated Resident A enjoys A&W and KFC these are foods she eats normally. It is important that Resident A eats.

On 07/08/24, I interviewed Resident A's guardian via telephone. Resident A's guardian stated Resident A is on a mechanically soft diet. Resident A has trouble swallowing, she has dry mouth, and not teeth. Some of her food gets processed however, other foods can be cut up into small pieces. Resident A has a history of hospitalization and when she is hospitalized staff have brought her in food because Resident A does not like hospital food. Staff monitor Resident A while she eats. Resident A does not have a history of choking or aspirating while eating. Resident A enjoys eating spaghetti, KFC chicken, sandwiches, and French fries. Resident A's guardian stated she has taken Resident A out for lunch, and she can sit in a restaurant and eat food if she is supervised. Resident A's guardian does not have any information regarding Resident A being given a hamburger while in the hospital. Resident A's guardian stated she received a call at 3:16 pm on 07/03/24, informing her that Resident A was going to be discharged from the hospital. Resident A was transferred home via EMS. She arrived home between 6:00 pm – 7:00 pm, which is after dinner time. Resident A's guardian remarked, maybe a staff brought Resident A dinner because she was not going to arrive home until after dinner time.

On 07/15/24, I interviewed direct care staff Vera Reeves via telephone. Ms. Reeves stated she has worked for this company for one year, she works afternoons and midnights. Ms. Reeves stated the day before Resident A was discharged from the hospital she asked her for a hamburger. Resident A was not eating the food she was served at the hospital because she does not like pureed food, she said it is dog food. Ms. Reeves stated on the day Resident A was discharged she worked 4:00 pm – 12:00 am. Ms. Reeves brought Resident A a hamburger and onion rings from A&W. The staff at the hospital observed Resident A eating and said they were so happy she was finally

eating because she had not been cooperating or eating well. Ms. Reeves stated she did not cut up the hamburger or onion rings, Resident A can eat them whole. Resident A finished her food prior to being transported home via EMS. Ms. Reeves stated Resident A loves to eat hamburgers, KFC, and fish. She can eat these foods whole, not cut up. Ms. Reeves stated if Resident A eats meat that is tough such as sausage, steak, or pork chops they must be cut up. Resident A will eat pureed oatmeal for breakfast but does not prefer her other foods to be pureed.

On 07/17/24, I completed a telephone interview with direct care staff Sandra Hall. Ms. Hall stated she works the midnight shift; she usually makes Resident A breakfast and sometimes lunch. Ms. Hall stated she purees Resident A's breakfast. She typically eats oatmeal and eggs. For lunch Resident A enjoys soup, pudding, and cheese puffs. Ms. Hall remarked she has heard that Resident eats KFC however, she has never fed it to her. Ms. Hall stated she would not feed Resident A a hamburger as she would be unable to eat it.

I reviewed Resident A's Health Care Appraisal dated 12/10/23. It is recommended that Resident A follow a diabetic diet.

On 07/18/24, I placed a telephone call to licensee designee Erin Gust to conduct an exit conference and review my findings. There was no answer. I left a detailed message regarding my findings and informed Ms. Gust that a corrective action plan would be required.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet.
ANALYSIS:	Based on the information gathered through this investigation there is sufficient information to concluded that Resident A is prescribed a mechanically soft diet. Although there is a menu posted Clinical Director Krisanne George stated there was no prescription onsite and observed for review. Direct care staff Vera Reeves stated she took Resident A a hamburger and onion rings from A&W on the day she was discharged from the hospital. It was consistently reported that Resident A's food should be cut up however, Ms. Reeves stated she gave Resident A the hamburger and onion rings whole. She did not cut the food into bite sized pieces. Although it as consistently reported that Resident A enjoys eating foods such as A&W and KFC as there is no prescription

	that outlines Resident A's dietary needs it cannot be determined if this is an acceptable/appropriate meal for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

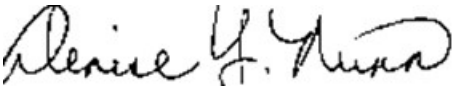
IV. RECOMMENDATION

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

07/18/2024

Johnna Cade — Date
Licensing Consultant

Approved By:



07/30/2024

Denise Y. Nunn — Date
Area Manager