GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 20, 2024

Sunil Bhattad
Memory Mission, LLC
415 N Chippewa St.
Shepherd, MI 48883

RE: License #: AL370377901
Investigation #: 2024A1029058
Stone Lodge Supportive Senior Living

Dear Mr. Bhattad:

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 licensee designee 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 (231) 922-5309.

Sincerely,

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
browningj1@michigan.gov - 989-444-9614

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL370377901
Investigation #:	2024A1029058
Complaint Receipt Date:	08/05/2024
Investigation Initiation Date:	08/06/2024
Report Due Date:	10/04/2024
Licensee Name:	Memory Mission, LLC
Licensee Address:	415 N Chippewa St., Shepherd, MI 48883
Licensee Telephone #:	(989) 828-5683
Administrator:	Sunil Bhattad
Licensee Designee:	Sunil Bhattad
Name of Facility:	Stone Lodge Supportive Senior Living
Facility Address:	415 N. Chippewa Street, Shepherd, MI 48883
Facility Telephone #:	(989) 828-5683
Original Issuance Date:	04/01/2016
License Status:	REGULAR
Effective Date:	10/01/2022
Expiration Date:	09/30/2024
Capacity:	14
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Direct care staff members are not providing regular care to Resident A because she is sitting in a chair all day and is not being repositioned. Direct care staff members are not providing personal care to Resident B because she is sitting in urine-soaked briefs from 6 AM – 2 PM.	No
Resident D has a rash in her vaginal area which itches her all day and direct care staff members are not doing anything to treat her.	No
Resident A is not being fed regularly because direct care staff members will give her one bite of food and then walk away, come back in 30 minutes to feed her more, and walk away again.	No
Additional Findings	Yes

III. METHODOLOGY

08/05/2024	Special Investigation Intake 2024A1029058
08/06/2024	APS Referral -Referral was sent from denied APS from Centralized Intake.
08/06/2024	Special Investigation Initiated – Telephone to RN Adam Burggraf Hospice
08/06/2024	Contact - Telephone call made to direct care staff member Natalie Ward
08/06/2024	Contact - Telephone call made to Guardian A1
08/06/2024	Contact - Telephone call made Guardian B1, wrong number and text message from direct care staff member Marissa Leon
08/23/2024	Inspection Completed On-site - Face to Face with direct care staff member Debra James, Resident B, Resident C, Aubrey Groat at Stone Lodge Supportive Senior Living
09/13/2024	Contact – Telephone call to direct care staff member / home manager Melissa Baker, licensee designee Sunil Bhattad

09/18/2024	Contact – Email sent to Sunil Bhattad requesting documentation.
09/19/2024	Contact – Document received from Mr. Bhattad and Ms. Baker
09/20/2024	Exit conference with licensee designee Sunil Bhattad.

ALLEGATION:

Direct care staff members are not providing regular care to Resident A because she is sitting in a chair all day and is not being repositioned.

Direct care staff members are not providing personal care to Resident B because she is sitting in urine-soaked briefs from 6 AM – 2 PM.

INVESTIGATION:

On August 5, 2024, a complaint was received via a denied Adult Protective Services (APS) referral with concerns that direct care staff members are not providing proper personal care to Resident A and Resident B. According to the complaint information, Resident A was sitting in a chair all day and not being repositioned by the direct care staff members. There were also concerns direct care staff members were not providing personal care to Resident B because she is sitting in urine-soaked briefs from 6:00 AM to 2:00 PM each day.

On August 6, 2024, I contacted RN Adam Burggraf Hospice. RN Burggraf stated Resident A and Resident B are both on hospice and he provides hospice care to them twice per week. RN Burggraf stated he has never had concerns Resident A was sitting in the chair too much and not being repositioned however, since she is on hospice and her condition has worsened, she does spend a lot of time in her chair or bed. RN Burggraf stated Resident A does not eat well and has weak skin which does not help because she has a sore on the inside of her left foot. RN Burggraf stated he does not believe any of these wounds are a result of neglect.

RN Burggraf stated Resident B is incontinent with urine which has worsened with her advancing dementia. RN Burggraf stated he has observed Resident B release urine while sitting in the lobby in a chair and it flooded the floor immediately right after direct care staff members changed her brief. RN Burggraf stated he has never observed her to be sitting in her own urine for prolonged periods of time.

On August 23, 2024, I completed an unannounced on-site investigation at Stone Lodge Supportive Senior Living and interviewed direct care staff member Debra James. Ms. James stated Resident A needs full assistance with all tasks. Ms. James stated she

has never had concerns direct care staff members were not repositioning Resident A when she is in her chair or bed. Ms. James stated Resident B needs help in the bathroom and they take her every hour instead of every two hours because she urinates a large volume so she wears briefs during day and overnight ones at night. Ms. James stated she has used two briefs on her at once because even in an hour, she can flood the seat she is in. Ms. James stated Resident B will sometimes communicate verbally. Ms. James stated there is no way Resident B would sit in urine from 6 AM – 2 PM because if that was the case, there would be urine all over the floor under where she is sitting and that would be uncomfortable for her.

I observed many of the residents at Stone Lodge Supportive Senior Living sitting in chairs in the living room. I attempted to interview Resident B and Resident C however, due to their dementia diagnosis they were unable to complete a detailed interview. Resident C did say he always can get help when he needs it and said the direct care staff members were "good to him". Resident B was in the shower when I arrived and when I sat down with her, she showed me her new clothes and told me she had help with her bath.

On August 23, 2024 I interviewed direct care staff member Aubrey Groat. Ms. Groat stated she has never noticed a time when Resident A or Resident B did not receive personal care as required. Ms. Groat stated both residents need a lot of assistance but Resident B needs to be changed often because she urinates a lot and will wet through her brief easily.

I reviewed the following documents:

1. Resident A's *Health Care Appraisal* includes she has a diagnosis of vascular dementia, mixed hyperlipidemia, HTN, Osteoporosis, GERD, and MDD and she is nonverbal.
2. Resident A's *Assessment Plan for AFC Residents* which states she has a hoyer lift and broda chair, has minimum movement but likes watching television in a group setting, and she requires total assistance for all activities of daily living.
3. Resident A's *Personalized Service Plan* states that she is checked and changed every two hours and she is repositioned every two hours.
4. Resident B's *Health Care Appraisal* includes a diagnosis of dementia and HTN and that she relies on a walker for her assistive device. Under health-related information: Unable to dress or bathe herself and at times requires assistance with feeding.
5. Resident B's *Personalized Service Plan* states that briefs are checked and changed every two hours.
6. Resident B's *Assessment Plan for AFC Residents* includes documentation she requires total assistance for all activities of daily living and Under Toileting: *Wears briefs taken to the bathroom every two hours*.

Ms. Ward stated she has not had concerns direct care staff members were not toileting Resident B regularly because sometimes they toilet her 10 times in a shift and within a short time, she will fill her brief and they toilet her often to try to prevent this from occurring.

On September 13, 2024, I interviewed direct care staff member Sunil Bhattad. Mr. Bhattad stated he has no concerns regarding the direct care staff members failing to reposition Resident A when she is in her chair and they do this every couple of hours. Mr. Bhattad stated she does not have any pressure sores on her. Mr. Bhattad stated Resident B does wear briefs and they are supposed to change or at least check her every two hours..

On September 13, 2024, I interviewed direct care staff member whose current role is home manager, Melissa Baker. Ms. Baker stated Resident A is nonverbal, non-ambulatory, and requires full care from the direct care staff members for feeding, dressing, and providing all personal care. Ms. Baker stated Resident A is supposed to be repositioned every two hours when she is in bed. Ms. Baker states Resident A gets up for meals and they lay her down after lunch to take a nap. Ms. Baker stated she feels Resident A has declined recently and she is on hospice. Ms. Baker stated she had no concerns regarding Resident B not being changed on a regular basis.

APPLICABLE RULE	
R 400.15303	**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:	There was no indication Resident A and Resident B have not been cared for according to their *Assessment Plan for AFC Residents* because Resident A is repositioned on a regular basis and Resident B is not left in urine-soaked briefs. Based on the interviews with Ms. Baker, Mr. Bhattad, Ms. Groat, and Hospice RN Burggraf, Resident B urinates a large volume and they are providing personal care assistance to her more often than every two hours because she will regularly urinate through her briefs. During the on-site, I observed Resident A and Resident B at Stone Lodge Supportive Senior Living and both residents appeared to be clean and in good spirits and the direct care staff members seemed to be attentive to their needs.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident D has a rash in her vaginal area which itches her all day and direct care staff members are not doing anything to treat her.

INVESTIGATION:

On August 5, 2024 a complaint was received via a denied Adult Protective Services (APS) referral with concerns that direct care staff members are not doing anything for Resident D to help her because she has a rash in her vaginal area which itches her all day and they are not doing anything to treat her.

On August 23, 2024, I completed an unannounced on-site investigation at Stone Lodge Supportive Senior Living and interviewed direct care staff member Debra James. Ms. James stated she is not aware of Resident D having a rash on her vaginal area now but she has had one there in the past. Ms. James stated Resident D has a yeast rash currently under her left breast. Ms. James stated she does have a Peri-guard Powder that she uses. Ms. James stated she believes there is an order for this however, she is not sure because Relative D1 brings this to the facility. Ms. James stated Resident D is not receiving Hospice services currently.

On August 23, 2024, I interviewed direct care staff member Aubrey Groat. Ms. Groat stated Resident D sometimes has a rash on her but Resident D's family will provide them with a powder they can use to assist in clearing this up. Ms. Groat stated Resident D does not have a rash in her vaginal area currently.

I reviewed the following documentation:

1. Resident D's *Health Care Appraisal* includes a diagnosis of HTN, Anxiety, Alzheimer's, Hyperlipidemia.
2. Resident D's resident record included *Stone Lodge Standing Orders* which included Remedy cleaning foam for skin care and a remedy protectant paste barrier (Calamine) to be used topically on the area and then reapply after incontinent episodes.
3. I reviewed Resident D's eMAR which showed she had a Nystatin Powder to be used as a PRN.
4. I reviewed a prescription for Lotrimin AF 2% topical powder, however there is a note from the pharmacy which states the family will provide the medication and I reviewed the *Care History* documentation provided by Mr. Bhattad showing Resident D has the Lotrimin applied to her two times per day.
5. Resident D's resident record included an intake form with family expectations and one of them is that she does not wear a bra because she has had too many sores in the past, that she is very resistant to taking baths.
6. Resident D's *Assessment Plan for AFC Residents* includes documentation she should shower twice a week and uses briefs which are changed every two hours.

On September 13, 2024, I interviewed direct care staff member Sunil Bhattad. Mr. Bhattad stated he is not aware of any rashes on her currently. Mr. Bhattad stated the direct care staff members are supposed to document when they are putting the barrier creams or powders on to assist Resident D.

On September 13, 2024, I interviewed direct care staff member whose current role is home manager, Melissa Baker. Ms. Baker stated Resident D did have a rash on her breast even though she was not wearing a bra but there was skin to skin which can cause a breakdown. Ms. Baker will scratch in her vaginal area throughout the day which does not help a rash. Ms. Baker stated sometimes Resident D will refuse to be toileted which can contribute to this however Resident D does have a powder she uses when there is a rash.

APPLICABLE RULE	
R 400.15310	**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:	There is no indication Resident D has a rash in her vaginal area that is not being treated. According to Ms. Groat, Ms. Baker, and Ms. James, Resident D did have a rash under her left breast which was treated with powder on as needed. According to Resident D's eMAR she has a Nystatin Powder to be used as a PRN. In her resident record there is an intake form with family expectations and one of them is that she does not wear a bra because she has had too many sores in the past, that she is very resistant to taking baths which may contribute to some of the soreness. I reviewed a prescription for Lotrimin AF 2% topical powder and I reviewed the *Care History* documentation provided by Mr. Bhattad which verified Resident D received the Lotrimin two times per day. At this time there is no indication direct care staff members are not addressing the concerns when Resident D does get a rash.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A is not being fed regularly because direct care staff members will give her one bite of food and then walk away, come back in 30 minutes to feed her more, and walk away again.

INVESTIGATION:

On August 5, 2024 a complaint was received via a denied Adult Protective Services (APS) referral with concerns that direct care staff members are not feeding Resident A regularly because she will get a bite of food and direct care staff members will walk away because she eats slowly and will not come back until 30 minutes has passed to give her more food.

On August 6, 2024, I contacted RN Adam Burggraf Hospice. RN Burggraf stated he charts that she only eats between 0-25% of meals. RN Burggraf stated there are several patients that need to be fed but not enough staff to sit one on one with each resident so they do have to alternate between residents when they are feeding them, however, he has never seen them left alone while she is being fed.

On August 6, 2024, I contacted Guardian A1. Guardian A1 stated Resident A has resided at Stone Lodge Supportive Senior Living for about 2.5 years and she has visited Resident A every day since May during the evening hours. Guardian A1 stated once in a while Resident A is able to take a bite of food on her own but 95% of the time Resident A must be fed by others. Guardian A1 stated there have been a lot of staffing changes and she knows there were two times when Resident A did not get dinner in the last week and the first time Guardian A1 stated she gave Resident A a protein shake but she did not appear to be hungry. Guardian A1 stated the second time she was told by an unknown direct care staff member it was “hectic” and another resident took her meal and they did not give her another one. Guardian A1 stated when she found out, Guardian A1 stated she went to the fridge and made her a plate from the fridge to feed Resident A. Guardian A1 stated some time she will feed her some strawberries and yogurt. Guardian A1 stated some residents need encouragement to eat and some need hands on assistance, but Resident A requires the most assistance at mealtimes. Guardian A1 stated if she shows up during dinner time, the direct care staff members will leave and she will feed Resident A which she does not mind doing because she does take a long time to chew and will not eat a lot of food. Guardian A1 stated she has never observed the direct care staff members give a resident one bite of food and then walk away.

On August 23, 2024, I completed an unannounced on-site investigation at Stone Lodge Supportive Senior Living and interviewed direct care staff member Debra James. Ms. James stated she has never had concerns regarding Resident A not being fed but a lot of times they will need to wake her to see if she is hungry. Ms. James stated she also has Ensure Resident A can have when she is not able to eat. Ms. James stated they

also assist Resident E with eating so they sit them together at lunch and dinner so they can assist both at the same time.

On August 23, 2024 I interviewed direct care staff member Aubrey Groat. Ms. Groat stated she has never observed a time when Resident A was not fed because direct care staff members take turns feeding her since it takes time to feed Resident A. Ms. Groat stated Resident A is fed regularly but sometimes doesn't have much of an appetite so they will give her an Ensure to drink. Ms. Groat stated if a resident refuses to eat, then they will offer the meal again.

I reviewed the following documentation:

1. Resident A's *Resident Weight Record* does not have a weight listed since July 13, 2022 because each month is documented as "no weight – hoyer lift" since that time.
2. Resident A's *Assessment Plan for AFC Residents* includes documentation Resident A needs assistance with Eating / Feeding and has had difficulties with weight loss in the past.

On September 13, 2024, I interviewed direct care staff member Sunil Bhattad. Mr. Bhattad stated he has not had any complaints that Resident A is not getting fed properly. Mr. Bhattad stated he has not heard anything about Resident A missing meals but he will look into this.

On September 13, 2024, I interviewed direct care staff member whose current role is home manager, Melissa Baker. Ms. Baker stated there are times Resident A falls asleep during a meal, so direct care staff will return after Resident A wakes up. As long as she is awake they will stay with her and keep feeding her. Ms. Baker stated Nancy White will also assist with mealtimes if needed because she is there as well. Ms. Baker stated Resident A eats okay, somedays she eats better than others. She's maybe 100 pounds and has lost weight during her time on Hospice. Ms. Baker stated she does not know anything about her missing a meal.

APPLICABLE RULE	
R 400.15313	**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:	There was no indication Resident A is not receiving three meals per day. There was one occasion when she did not receive a meal timely because another resident ate her meal and the direct care staff members did not prepare her another one until Guardian A1 came to visit. Guardian A1 prepared Resident A a meal and assisted her by feeding this meal to her. Based on the interviews with licensee designee Mr. Bhattad, Ms. Baker, Ms. James, and Ms. Groat, Resident A has not missed other meals as that was an isolated incident. Resident A is on hospice, has a low appetite, and chews slowly while often falling asleep at mealtimes, but the direct care staff members interviewed all state they assist her in feeding her meals.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Shortly before receiving this special investigation, on July 30, 2024, I completed the licensing renewal inspection and facility documentation was reviewed in an end bedroom with a fish tank. This room did have a bed set up but there was also a long table and it appeared to be used as an office space. At no time did Mr. Bhattad state there was a resident staying in this room and I did ask during the renewal if the resident in the room passed away because there was a bed set up in the office area, and Mr. Bhattad stated no.

On August 7, 2024, I interviewed former direct care staff member Marissa Leon. Ms. Leon stated Mr. Bhattad moved Resident C out of his regular bedroom during the renewal inspection because the room did not have a window and the next day moved him back into his fish tank room because that is what he is used to and his television is in there. Ms. Leon stated Resident C resides in the room at the end of the hallway that has a cutout with a built-in fish tank with curtains over it.

On August 23, 2024, I completed an unannounced on-site investigation at Stone Lodge Supportive Senior Living and interviewed direct care staff member Debra James. Ms. James stated Resident C was residing in the room with the fish tank but the previous manager, Ms. Schoen had Resident C move to a room down the hall for the renewal because there is no window in his bedroom but he was moved back afterward because he prefers the other room.

During the on-site investigation, I observed Resident C was residing in the bedroom with the fish tank which has no window. I attempted to interview Resident C and he stated he was moved temporarily to another bedroom but he likes the “fish tank” room better and that is where he is staying again. In this bedroom, the fish tank looks through to the living room area and there is a curtain on the bedroom side

providing privacy for Resident C but there is no window which could be used for an evacuation in the case of a fire in that room.

APPLICABLE RULE	
R 400.15408	**Bedrooms generally.**
	(7) Bedrooms shall have at least 1 easily openable window.
ANALYSIS:	Resident C's resident bedroom does not have any openable window in his room rather Resident C's bedroom has a cutout with a large fish tank showing through to the living room. Although there are curtains for privacy on the room side of the fish tank, there is no window which could be used for evacuation in case of an emergency.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change in the license status.

Jennifer Browning _____09/20/2024_____

Jennifer Browning
Licensing Consultant
Date

Approved By:

Dawn Timm 09/20/2024

_____

Dawn N. Timm
Area Manager
Date