GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 11, 2024

Achal Patel & Vivek Thakore
Divine Nest of Williamston INC
2045 Birch Bluff Dr
Okemos, MI 48864

RE: License #: AL330413975
Investigation #: 2024A0466058
Divine Nest of Williamston INC

Dear Mr. Patel and Mr. Thakore:

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 (517) 284-9727.

Sincerely,

Julie Elkins

Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AL330413975
Investigation #:	2024A0466058
Complaint Receipt Date:	08/20/2024
Investigation Initiation Date:	08/20/2024
Report Due Date:	10/19/2024
Licensee Name:	Divine Nest of Williamston INC
Licensee Address:	2045 Birch Bluff Dr Okemos, MI 48864
Licensee Telephone #:	(517) 898-2431
Administrator:	Achal Patel
Licensee Designee:	Achal Patel and Vivek Thakore
Name of Facility:	Divine Nest of Williamston INC
Facility Address:	241 McCormick St WILLIAMSTON, MI 48895
Facility Telephone #:	(517) 655-5800
Original Issuance Date:	08/25/2023
License Status:	REGULAR
Effective Date:	02/24/2024
Expiration Date:	02/23/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATIONS:

	Violation Established?
Direct care worker (DCW) Tabitha Harris yelled at Resident A for eating her chips.	No
Resident A is being administered morphine even though she is allergic to it.	No
Additional Findings	Yes

III. METHODOLOGY

08/20/2024	Special Investigation Intake 2024A0466058.
08/20/2024	APS Referral-Referral denied.
08/20/2024	Special Investigation Initiated – Telephone call with licensing consultant Jana Lipps interviewed after she interviewed Relative A1.
08/22/2024	Inspection Completed On-site.
09/09/2024	Contact- telephone call to Relative A2 with licensing consultant Jana Lipps.
10/09/2024	Contact- telephone call to DCW Tabitha Harris, message left.
10/09/2024	Contact- telephone call to DCW Sally Doxtader interviewed.
10/10/2024	Contact- telephone call to DCW Tabitha Harris interviewed.
10/10/2024	Exit conference with licensee designee Achal Patel.

ALLEGATION: Direct care worker (DCW) Tabitha Harris yelled at Resident A for eating her chips.

INVESTIGATION:
On 08/20/2024, the department received a denied adult protective service (APS) referral which stated that DCW Tabitha Harris yelled at Resident A for eating her chips.

On 08/20/2024, I interviewed Complainant who reported that on an unknown date DCW Harris became very upset with Resident A because she left her personal chips

and pop on the counter and Resident A ate the chips and took a drink of the pop. Complainant reported DCW Harris stated she was so upset with Resident A that she wanted to punch her.

On 08/20/2024, Relative A1 reported that on a date unknown another DCW (name unknown) told her that Resident A was being yelled at by DCW Harris. Relative A1 reported that another DCW told her that Resident A ate DCW Harris's chips and that upset DCW Harris. Relative A1 reported that when she brought this concern up to manager Ziza Gashi she reported that Resident A hit DCW Harris.

On 08/22/2024, I conducted an unannounced investigation and I reviewed the *Resident Register* which documented that Resident A was admitted on 7/16/2024 and discharged on 8/12/2024.

I interviewed DCW KaResha Pearson who reported that she has worked with DCW Harris before and she has observed DCW Harris giving/sharing with the residents her personal food. DCW Pearson reported that she never heard that DCW Harris was upset with Resident A for eating her chips and drinking her pop but reported that Resident A does pick up everything that she sees. DCW Pearson reported that DCW Harris is very bubbly, nice and funny. DCW Pearson reported that none of the DCWs including DCW Harris yell at the residents. DCW Pearson reported that all the DCWs have a positive attitude and that DCW Harris even brings her dog in for the residents to play with.

I interviewed Ms. Gashi, who denied that DCW Harris was upset with Resident A for eating her chips and drinking her pop. Ms. Gashi reported that none of the DCWs yell at the residents and they all have a positive attitude even while addressing some difficult behaviors. Ms. Gashi reported that Resident A had been having increased behavioral concerns which was why she was discharged on 08/12/2024.

Resident A was discharged on 08/12/2024 and therefore was not at able to be interviewed.

On 9/9/24 adult foster care licensing consultant, Jana Lipps, and I interviewed Relative A2 via telephone. Relative A2 reported that Resident A did not tell her that DCW Harris or any DCW was yelling at her.

On 10/09/2024, I interviewed DCW Sally Doxtader who reported that she was working with DCW Harris when she yelled at Resident A for taking a handful of her chips. DCW Doxtader reported that Resident A found an almost empty bag of Doritos and was eating them. DCW Doxtader reported that DCW Harris told her she couldn't eat those as those were hers, so she took them from Resident A and threw the empty bag away. DCW Doxtader reported that DCW Harris opened another bag of Doritos and found Resident A eating them again. DCW Doxtader reported that she yelled at Resident A for taking her chips and said, "you can't have these" and threw that bag away also. DCW Doxtader reported that DCW Harris was very upset

and told her she had to get out of here for minute, so she walked outside and took a break. DCW Doxtader did not recall DCW Harris saying that she wanted to hit Resident A nor did she recall Resident A hitting DCW Harris. DCW Doxtader did recall Resident A calling DCW Harris a “bitch.” DCW Doxtader reported that DCW Harris is rude and never nice to any of the residents. DCW Doxtader reported DCW Harris’s behavior on several occasions to Ms. Gashi and nothing was ever done.

On 10/10/2024, I interviewed DCW Harris who denied that she ever yelled at Resident A for taking a handful of her chips, DCW Harris reported that she shares all her food with residents and she would never take any food away from them nor tell them “you can’t have these.” DCW Haris reported that she even brings her dog in to interact with the residents. DCW Harris denied ever being rude or mean to any resident. DCW Harris denied ever becoming frustrated with Resident A. DCW Harris denied saying that she wanted to hit Resident A, DCW Harris reported that she liked Resident A and would never harm her.

APPLICABLE RULE	
R 400.15304	**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: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Complainant and DCW Doxtader reported that DCW Harris yelled at Resident A for taking her chips, said “you can’t have these” and threw that bag away. DCW Pearson, Ms. Gashi and DCW Harris all denied that DCW Harris yells at the residents therefore there is not enough corroborating evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A is being administered morphine even though she is allergic to it.

INVESTIGATION:
On 8/20/24, the department received a denied APS referral which documented that Resident A is being administered morphine that she has been prescribed when she is allergic to this medication.

On 08/22/2024, I conducted an unannounced investigation and I reviewed Resident A's July 2024 and August 2024 medication administration records (MAR)s. Resident A's July 2024 MAR documented that her physician is Senior Community Care of Michigan (Program of All-Inclusive Care for the Elderly-PACE) and she was prescribed "Morphine SUL SOL 100/5ML take .25ML between the gum and cheek every 4 hours as needed for pain and shortness of breath." This was prescribed on 07/25/2024 and administered on 07/25/2024 (trouble breathing), 07/27/2024 (shortness of breath), 07/30/2024 (shortness of breath) and 07/31/2024 (low oxygen).

Resident A's August 2024 MAR documented that her physician is Senior Community Care of Michigan (PACE) and she was prescribed "Morphine SUL SOL 100/5ML take .25ML between the gum and cheek every 4 hours as needed for pain and shortness of breath." This was prescribed on 07/25/2024 and administered on 08/02/2024 (shortness of breath), 08/03/2024 (shortness of breath), 08/07/2024 (shortness of breath) and 08/09/2024 (shortness of breath). Resident A was discharged on 08/12/2024 and therefore there was no medication administration since that date.

Resident A had been admitted to the facility on 7/16/2024 and discharged on 8/12/2024 therefore she could not be interviewed nor could her medications in the physician prescribed containers be reviewed.

I interviewed DCW Pearson who reported that she was aware that Resident A's record noted that she was allergic to morphine. DCW Pearson reported that she contacted a PACE nurse (name unknown) who reported that Resident A "grew out of the morphine allergy" and that it was ok to administer morphine to her. DCW Pearson reported that Resident A needed the morphine as she would have labored breathing and that would help as Resident A refused to keep on her prescribed oxygen. DCW Pearson reported that she did not notice any signs of Resident A having an allergic reaction to the morphine. DCW Pearson reported that she did not notice Resident A having any change of behavior with the morphine. DCW Pearson reported that the morphine would help the labored breathing and then Resident A would agree to keep the oxygen on.

I interviewed Ms. Gashi who reported that she contacted PACE (name of who she talked to unknown) the same day that the morphine was delivered to discuss Resident A's Morphine allergy. Ms. Gashi reported that PACE stated that the

morphine allergy was from 20 years ago and they have no current evidence to verify this allergy. Ms. Gashi reported that the facility was instructed by PACE to administer the morphine as prescribed.

On 9/9/24 adult foster care licensing consultant, Jana Lipps, and I interviewed Relative A2 via telephone. Relative A2 reported that she is the Durable Power of Attorney (DPOA) for Healthcare for Resident A. She reported that she had been told by Relative A2's PACE care team that Resident A was having increased behavioral issues and required increased supervision and medication management for these behaviors. Relative A2 reported that she spoke with the PACE care team regarding Resident A's morphine allergy and was told that because Resident A was receiving comfort care that morphine would be the medication used. Relative A2 reported that she was not sure if Resident A did, in fact, have a morphine allergy. She reported that there was speculation that Resident A had stated to a physician quite some time ago that she was allergic to morphine because she did not want to take it, and then this information was placed in her medical record. Relative A2 reported that she did not instruct the PACE care team to remove morphine from Resident A's medications and she was aware Resident A was being administered morphine.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Complainant reported that Resident A is being administered Morphine even though she is allergic to it**.** Resident A's July 2024 and August 2024 medication administration records documented that she was prescribed "Morphine SUL SOL 100/5ML take .25ML between the gum and cheek every 4 hours as needed for pain and shortness of breath." Relative A2 reported that she is the Durable Power of Attorney (DPOA) for Healthcare for Resident A. Relative A2 was aware that Resident A may be allergic to morphine and also aware that morphine was prescribed/being administered. Relative A2 did not request for these medication instructions to change or for the PACE care team to remove morphine from Resident A's medications. Resident A's morphine was being administered as prescribed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 08/22/2024, I conducted an unannounced investigation and I reviewed Resident A's written *Assessment Plan for AFC Residents* which was dated 7/16/2024 and documented in the "use of assistive devices" section of the report that Resident A uses a "walker."

I reviewed Resident A's entire record page by page and the record did not contain a physician order for the therapeutic use of a walker which was documented in the written *Assessment Plan for AFC Residents*.

I interviewed Ms. Gashi who confirmed that the facility did not have a physician order for Resident A's walker. Ms. Gashi reported that the walker was provided by PACE.

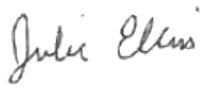
On 09/09/2024, Relative A2 reported that Resident A began to use a seated walker after being admitted to the adult foster care placement. Relative A2 reported that Resident A was ambulatory prior to the admission to the facility and that she had previously walked several miles a day unassisted. Relative A2 reported that she did not have a physician order for the walker for Resident A.

APPLICABLE RULE	
R 400.15306	**Use of assistive devices.**
	(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization.
ANALYSIS:	Resident A's written *Assessment Plan for AFC Residents* documented in the "use of assistive devices" section of the report that Resident A uses a "walker" however the resident record did not contain a physician order that stated the reason for the therapeutic support and the term of the authorization therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/10/2024 an exit conference was conducted with licensee designee Achal Patel who understood the findings of the investigation.

IV. RECOMMENDATION

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



10/10/2024

Julie Elkins — Date
Licensing Consultant

Approved By:

10/11/2024

Dawn N. Timm — Date
Area Manager