GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 4, 2024

Madiha Zeeshan
Grand Blanc Assisted Living, LLC
219 Church St.
Auburn, MI 48611

RE: License #: AL250390289
Investigation #: 2024A0580050
Grand Blanc Fields Assisted Living

Dear Madiha Zeeshan:

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) 643-7690.

Sincerely,

Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 835-1019

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL250390289
Investigation #:	2024A0580050
Complaint Receipt Date:	09/06/2024
Investigation Initiation Date:	09/06/2024
Report Due Date:	11/05/2024
Licensee Name:	Grand Blanc Assisted Living, LLC
Licensee Address:	12628 Pagels Drive Grand Blanc, MI 48439
Licensee Telephone #:	(810) 606-0823
Administrator:	Madiha Zeeshan
Licensee Designee:	Madiha Zeeshan
Name of Facility:	Grand Blanc Fields Assisted Living
Facility Address:	12628 Pagels Drive Grand Blanc, MI 48439
Facility Telephone #:	(810) 606-0823
Original Issuance Date:	08/03/2018
License Status:	REGULAR
Effective Date:	02/03/2023
Expiration Date:	02/02/2025
Capacity:	20
Program Type:	DEVELOPMENTALLY DISABLED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A never received the basics in personal care.	No
Resident A's family was harassed to use hospice.	No
• Resident A was handled in a rough manner that caused Resident A many skin tears on Resident A's skin. • Staff was witnessed taking very harshly to Resident A.	No
Another resident's medication was found in Resident A's room.	No
Medications were set in front of Resident A and then staff would walk away.	No
Water in private shower did not get hot.	Yes
Facility/showers are dirty with feces.	No
Resident A slept with only a fitted sheet and throw blanket.	No

III. METHODOLOGY

09/06/2024	Special Investigation Intake 2024A0580050
09/06/2024	Special Investigation Initiated - Letter A referral was made to APS.
09/06/2024	APS Referral A referral was made to APS sharing the allegations.
09/17/2024	Inspection Completed On-site Unannounced onsite inspection. Contact with Manager, Jennifer.
09/17/2024	Contact - Face to Face Interview with staff, Toni Ferrero.
10/07/2024	Contact – Document Received Copy of Photos received.
10/23/2024	Inspection Completed On-site Interview with Resident B.
10/23/2024	Contact - Face to Face Interview with Resident C.
10/23/2024	Contact - Face to Face

	Interview with Relative D1 and D2.
10/23/2024	Contact - Face to Face Interview with Resident E.
10/23/2024	Contact - Face to Face Interview with staff, Shacoya Sykes.
10/23/2024	Contact - Face to Face Interview with staff, Joyce Wilson.
10/28/2024	Contact – Telephone call made Call to Jennifer Wojt, Home Manager.
10/28/2024	Contact - Telephone call made Call to Relative A.
10/29/2024	Contact - Telephone call made Call to Mid-Michigan Hospice.
11/04/2024	Contact – Telephone call made Call to Jennifer Wojt, Home Manager.
11/04/2024	Exit Conference Exit with Licensee Designee, Madiha Zeeshan.

ALLEGATION:

Resident A never received the basics in personal hygiene.

INVESTIGATION:

On 09/06/2024, I received a complaint via BCAL Online Complaints.

On 09/06/2024, A referral was made to Adult Protective Services (APS) sharing the allegations.

On 09/17/2024, I conducted an onsite inspection at Grand Blanc Fields Assisted Living. Contact was made with the Jennifer Wojt, Home Manager (HM). HM Wojt denied the allegations that Resident A was not provided with basic personal care while residing in the facility. HM Wojt added that via her family, Resident A was provided with a private caregiver who came in and gave Resident A showers 3 times, and attended to Resident A's personal hygiene, 2-3 days a week. Resident A also received showers via Mid-Michigan Hospice Services. HM Wojt denied that Resident A was not provided with

routine oral care and hygiene. While the relationship with the private caregiver began well, it ended with her being banned from the building. HM Wojt went on to share that she had multiple issues with the private caregiver, from arguing with the staff, to giving the staff directives even though she is not an employee.

HM Wojt stated that staff are to conduct 2-hour checks and changes for incontinent residents. There was one incident in which Resident A was found soaked in urine. The staff responsible was terminated on the same day.

The Assessment Plan for Resident A states that Resident A requires assistance to the bathroom. Resident A requires full assistance with personal hygiene, bathing and dressing. Resident A requires stand to assist mobility and uses both a walker and a wheelchair.

On 09/17/2024, while onsite, I interviewed direct staff, Toni Ferrero, who denied not providing Resident A with personal hygiene care, indicating that she assisted Resident A with washing her face, getting her dressed, brushing her teeth, etc. Hospice typically provided Resident A with her showers. Staff Ferrero also recalled that Resident A slept a lot.

On 10/28/2024, I spoke with Relative A, who identified herself as the assigned Power of Attorney for Resident A. Relative A stated that while a resident at Grand Blanc Fields, Resident A often had dry skin and her teeth were not brushed. Relative A stated that a caregiver was hired, in addition to the rate being charged by the facility, to assist Resident A with showering and daily hygiene 2 times a week. Due to the lack of personal care being provided, an additional day for the caregiver was added. Mid-Michigan Hospice did provide personal care as well. Relative A added that Resident A expressed that she preferred to receive assistance from the caregiver, stating that staff at Grand Blanc Fields were too rough with Resident A.

Relative A also recalled that Resident A was found soaked in urine in more than one occasion. Relative A recalled specifically on the day that Resident A was moving from the home she had to request that staff clean Resident A up prior to departing. When staff removed Resident A from her wheelchair, the pillow under Resident A was soaked. Staff would often put the soiled clothes on the floor of the bathroom or the carpet, leaving them there to cause a smell. Relative A shared that Resident A moved out of Grand Blanc Fields Assisted Living on 08/06/2024. Resident A passed away on 09/04/2024.

On 10/29/2024, I placed a call to Mic-Michigan Hospice, Nurse Kim Avery, previously assigned to Resident A, is no longer employed by the company. Resident A received their hospice services beginning 05/16/2024-08/06/2024.

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:	It was alleged that Resident A never received the basics in personal hygiene. Jennifer Wojt, Home Manager, denied the allegations that Resident A was not provided with basic personal care while residing in the facility. The Assessment Plan for Resident A states that Resident A requires assistance to the bathroom. Resident A requires full assistance with personal hygiene, bathing and dressing. Resident A requires stand to assist mobility and uses both a walker and a wheelchair. Direct staff, Toni Ferrero, denied not providing Resident A with personal hygiene care, indicating that she assisted Resident A with washing her face, getting her dressed, brushing her teeth, etc. Relative A stated that while a resident at Grand Blanc Fields, Resident A often had dry skin and her teeth were not brushed. Relative A stated that a caregiver was hired, in addition to the rate being charged by the facility, to assist Resident A with showering and daily hygiene 2 times a week. Mid-Michigan Hospice did provide personal care as well. Relative A also recalls that Resident A was found soaked in urine in more than one occasion. Based on the interviews conducted and a review of the AFC Assessment Plan for Resident A, there is not enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A’s family was harassed to use hospice.

INVESTIGATION:

On 10/28/2024, while speaking with Relative A, she expressed that family was harassed until they allowed Resident A to use Mid-Michigan Hospice Services, which is owned by the licensee designee's husband. Relative A stated that she always felt like it was 2 against 1 when dealing with Mid-Michigan Hospice.

On 11/04/2024, I spoke with HM Jennifer Wojt who denied the allegations that residents are required to use Mid-Michigan Hospice. HM Wojt stated that Residents are allowed to choose their own provider. Heart to Heart and Asension Genesys are a few examples of other hospice providers that have worked with the home.

On 11/04/2024, I spoke with LD Zeeshan who denied the allegations, indicating that depending on the needs of the resident, they have worked with Kindred, The Care Team, Heart to Heart and other hospice provides in the area.

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: **(l) The right to employ the services of a physician, psychiatrist, or dentist of his or her choice for obtaining medical, psychiatric, or dental services.**
ANALYSIS:	It was alleged that the family was harassed to use Mid-Michigan Hospice Services, owned by the licensee designee's husband. .
	HM Jennifer Wojt denied the allegations, stating that Residents are allowed to choose their own provider. LD Zeeshan denied the allegations, indicating that depending on the needs of the resident, they have worked with Kindred, The Care Team, Heart to Heart Hospice, as well as other providers in the area. Based on the interviews conducted, there is enough evidence to support this rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

- Resident A was handled in a rough manner that caused Resident A many skin tears on Resident A's skin.
- Staff was witnessed talking very harshly to Resident A.

INVESTIGATION:

On 09/17/2024, while onsite, HM Wojt denied any mistreatment of residents. HM Wojt stated that Resident A was receiving wound care via Mid-Michigan Hospice. On the day in question the caregiver approached staff Toni Ferrero and requested that she remove the bandage. Staff Ferrero should not have removed the bandage, however, as staff, she did what was asked of her. Staff Ferrero denied that she ripped the bandage off as alleged.

On 09/17/2024, while onsite, I interviewed staff Ferrero, who denied Staff Ferrero denied speaking harshly or being rude to Resident A. Staff Ferrero also denied the allegations that she ripped the bandage off Resident A's arm as alleged. Staff Ferrero stated that she took the bandage off when asked by Resident AA's private caregiver. As she pulled the band-aid up, it began to bleed. She then went to get a new bandage. Staff Ferrero denied ripping the bandage off as alleged.

On 10/23/2024, I conducted a follow-up onsite at Grand Blanc Fields. While onsite I interviewed Resident B, who currently resides in Resident A's old room. Resident B stated that he likes living in the home. Resident B stated that the staff treat him well.

On 10/23/2024, while onsite, Resident C denied any mistreatment in the home.

On 10/23/2024, while onsite, I spoke with Relative D1 and Relative D2, who were visiting with Resident D. Resident D is receiving hospice care and currently in the active stages of dying. Relative's D1 and Relative D2 both deny that the staff are rude and disrespectful. Both relatives commended the facility for the care provided to their loved one.

On 10/23/2024, while onsite, I interviewed Resident E who stated that the staff are not mean to her. Resident E denied any mistreatment by staff.

On 10/28/2024, while speaking with Relative A, she recalled receiving a call from the facility requesting that she speak with Resident A to get her to calm down for bed. The next day Relative A shared that Resident A informed her that staff, Toni Ferrero, was rough taking her clothes off, yanking them and messing up her hair. Relative A stated that she did address staff Ferrero's behavior with HM Wojt.

Relative A also added that although Resident A was a fall risk, she constantly had scratches and wounds from bumping into things. Relative A stated that she was

informed by the caregiver that staff, Toni Ferrero ripped the bandage off Resident A's arm causing it to bleed.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	It was alleged that staff spoke very harshly to Resident A and handled her in a rough manner that caused her many skin tears on her skin. HM Wojt denied any mistreatment of residents. HM Wojt stated that Resident A was receiving wound care via Mid-Michigan Hospice. Staff Ferrero denied speaking harshly or being rude to Resident A. Resident B stated that he likes living in the home and the staff treat him well. Resident C denied any mistreatment in the home. Relative's D1 and Relative D2 both deny that the staff are rude and disrespectful, commending the facility for the care provided to their loved one. Resident E denied any mistreatment, stating that staff are not mean to her. Relative A shared that Resident A informed her that staff, Toni Ferrero, was rough taking her clothes off, yanking them and messing up her hair. Relative A also added that although Resident A was a fall risk, she constantly had scratches and wounds from bumping into things Based on the interviews conducted, there is not enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Another resident's medication was found in Resident A's room.

INVESTIGATION:

On 10/07/2024, I received a text message from the complainant with a photo of a prescription for throat lozenges for Resident F. The complainant stated that these lozenges were found in Resident A's room.

On 10/23/2024, I conducted an unannounced onsite inspection at Grand Blanc Fields Assisted Living. While onsite I did not observe any medication in any of the resident rooms, nor lying on the floor.

On 10/23/2024, staff members Joyce Wilson and Shacoya Sykes both stated that medication is stored and locked in the medication cart, in the medication room. Both deny leaving medication in any resident's room.

On 10/28/2024, HM Jennifer Wojt stated that Resident F is a resident at the facility. HM Wojt stated that she has no idea how the lozenges would have been in Resident A's room and it was never brought to her attention. All medication in the facility is locked and stored in the medication cart.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	It was alleged that another resident's medication was found in Resident A's room. I observed a photo of a prescription for throat lozenges for Resident F. The complainant stated that these lozenges were found in Resident A's room. On 10/23/2024, while onsite I did not observe any medication in any of the resident rooms, nor lying on the floor. Staff members Joyce Wilson and Shacoya Sykes both stated that medication is stored and locked in the medication cart, in

	the medication room. Both deny leaving medication in any resident's room. HM Jennifer Wojt stated that Resident F is a resident at the facility and she has no idea how the lozenges would have been in Resident A's room. All medication in the facility is locked and stored in the medication cart. Based on my observation of the prescription belonging to Resident A and the interviews conducted, there is not enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Medications were set in front of Resident A and then staff would walk away.

INVESTIGATION:

On 09/17/2024, HM Wojt denied that the staff are not observing residents take their medication.

On 09/17/2024, staff Ferrero denied that the residents are given their medication without observation, stating that she stands and waits to confirm that the medication was taken.

On 10/23/2024, Resident B denied that staff do not supervise/observe while administering medication.

On 10/23/2024, Resident C stated that staff stay and watch to ensure that she swallows when giving medication.

On 10/23/2024, Relative's D1 and Relative D2 stated that there were no concerns with the medication administration.

On 10/23/2024, Resident E denied that staff drop the medication off without watching that she takes them.

On 10/23/2024, while onsite, I interviewed direct staff member Shacoya Skyes, while in the medication room. Staff Sykes denied that that she places the medication in front of residents and walk away, stating that she waits to verify that the residents have taken their medication, before returning to the computer to mark that it has been administered.

On 10/23/2024, while onsite, I interviewed direct staff members Joyce Wilson while in the medication room. Staff Wilson denied that she sets the medication in front of residents and walk away, stating that she waits until the residents swallow, before returning to the computer to mark that it has been administered.

On 10/28/2024. Relative A stated that one evening when Resident A had just returned from the hospital and having missed dinner, staff brought Resident A a sandwich and her medication, sitting it in front of her.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(3) Unless a resident's physician specifically states otherwise in writing, the giving, taking, or applying of prescription medications shall be supervised by the licensee, administrator, or direct care staff.
ANALYSIS:	It was alleged that medications were set in front of Resident A and then staff would walk away. HM Wojt denied that the staff are not observing residents as they take their medication. Staff Ferrero denied that the residents are given their medication without observation, stating that she stands and waits to confirm that the medication was taken. Resident B denied that staff do not supervise/observe while administering medication. Resident C stated that staff stay and watch to ensure she swallows when giving medication. Resident E denied that staff drop the medication off without watching that she takes them. Staff Sykes and Joyce Wilson both denied that they the medication in front of residents and walk away. Relative A stated that she observed staff bring Resident A her medication and set it down in front of her.

	Staff Sykes and Joyce Wilson both denied that they the medication in front of residents and walk away. Relative A stated that she observed staff bring Resident A her medication and set it down in front of her. Base on the interviews conducted, there is not enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Water in Resident A's private shower did not get hot.

INVESTIGATION:

On 10/23/2024, while onsite, I tested the hot water in the room formerly occupied by Resident A. The water in the sink tested at 110 degrees. The water in the sink is the same bathroom where Resident A's shower is located. The water in the shower tested at 95 degrees. The water did not reach full pressure.

On 10/28/2024, Relative A stated that Resident A's shower was not hot enough, which is why Resident A began using the community shower.

On 11/04/2024, I conducted an exit conference with Licensee Designee (LD), Madiha Zeeshan. LD Zeeshan was informed of the finding of this investigation. LD Zeeshan stated that she will get someone to address the lack of hot water in Resident A's former room.

APPLICABLE RULE	
R 400.15401	**Environmental health.**
	(2) Hot and cold running water that is under pressure shall be provided. A licensee shall maintain the hot water temperature for a resident's use at a range of 105 degrees Fahrenheit to 120 degrees Fahrenheit at the faucet.
ANALYSIS:	It was alleged that the water in Resident A's private shower did not get hot. Water in the shower tested at 95 degrees. The water did not reach full pressure. Relative A stated that Resident A's shower was not hot enough, which is why Resident A began using the community shower. There is enough evidence to support this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Facility/showers are dirty with feces.

INVESTIGATION:

On 09/17/2024, while onsite, HM Wojt recalled on the day in question, hospice staff had just finished showering a resident in the community shower. The caregiver did not allow staff time to clean the shower prior to going in the shower room, therefore yes there was feces in that instance, however the bathroom is cleaned regularly. In addition, each resident has a private shower in their room available for use.

While onsite, I observed the shower in the room that formerly belonged to Resident A. The shower was observed clean. I also observed both community showers located in the facility. The showers were clean. No feces were observed.

On 10/23/2024 while onsite, I again observed both community showers located in the facility, and the shower in the room that formerly belonged to Resident A. The showers were clean. No feces were observed.

On 10/23/2024, Resident B stated that his shower is cleaned regularly. Resident B stated that he does not use the community showers.

On 10/23/2024, Resident C stated that her shower is cleaned regularly. Resident C denied seeing any feces in the shower.

On 10/23/2024, Resident E denied that the showers are dirty, stating that her shower is cleaned regularly.

On 10/28/2024, Relative A stated that while she did not observe feces in the community shower, she did receive photos of feces in the bathroom shower, on the wall and on the shower chair, sent to her by the caregiver.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	It was alleged that the facility/showers are dirty with feces. HM Wojt stated that hospice staff had just finished showering a resident in the community shower. The caregiver did not allow staff time to clean the shower prior to going in the shower room, therefore yes there was feces in that instance. HM Wojt denied the allegations, stating that the showers are regularly cleaned.

	On 09/17/2024 and 10/23/204, I observed both community showers located in the facility and the shower in the room formerly belonging to Resident A. The showers were clean. No feces were observed. Residents B, C and E all denied their showers being dirty or containing feces. Relative A stated that while she did not observe feces in the community shower, she did receive photos of feces on the bathroom shower, on the wall and on the shower chair. There is not enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

At times Resident A slept with only a fitted sheet and throw blanket.

INVESTIGATION:

On 10/23/2024, while onsite, I randomly observed the bedding on beds located in bedrooms # 15, 16, 20, and 21. The beds were properly fitted with 2 sheets, a pillowcase, a blanket, and a bedspread for each bed.

On 10/28/2024, Relative A stated most of the times that she visited, Resident A only had a blanket and a fitted sheet. Resident A constantly had to ask where Resident A's favorite blankets were, which was usually in another resident's room.

On 11/04/2024, I conducted an exit conference with Licensee Designee (LD), Madiha Zeeshan. LD Zeeshan was informed of the finding of this investigation. LD Zeeshan stated that she will get someone to address the lack of hot water in Resident A's former room.

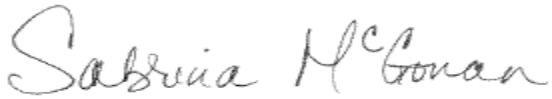
APPLICABLE RULE	
R 400.15411	**Linens.**
	(1) A licensee shall provide clean bedding that is in good condition. The bedding shall include 2 sheets, a pillowcase, a minimum of 1 blanket, and a bedspread for each bed. Bed linens shall be changed and laundered at least once a week or more often if soiled.

ANALYSIS:	It was alleged that at times, Resident A slept with only a fitted sheet and throw blanket. Relative A stated most of the times that she visited, Resident A only had a blanket and a fitted sheet. Beds located in bedrooms # 15, 16, 20, and 21 were properly fitted with 2 sheets, a pillowcase, a blanket, and a bedspread for each bed. There is not enough evidence to support this rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 11/04/2024, I conducted an exit conference with Licensee Designee (LD), Madiha Zeeshan. LD Zeeshan was informed of the finding of this investigation.

IV. RECOMMENDATION

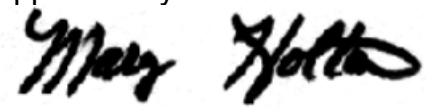
Upon the receipt of an approved corrective action plan, no change to the status of the license is recommended.



November 4, 2024

Sabrina McGowan — Date
Licensing Consultant

Approved By:



November 4, 2024

Mary E. Holton — Date
Area Manager