GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 10, 2024

Ellen Byrne
Commonwealth Senior Living at East Paris
3956 Whispering Way, SE
Grand Rapids, MI 49546

RE: License #: AH410407276
Investigation #: 2025A1010004
Commonwealth Senior Living at East Paris

Dear Licensee:

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 authorized representative 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) 241-1970.

Sincerely,
Lauren Wohlfert

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa NW Unit 13, 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410407276
Investigation #:	2025A1010004
Complaint Receipt Date:	10/14/2024
Investigation Initiation Date:	10/15/2024
Report Due Date:	12/13/2024
Licensee Name:	MCAP East Paris Opco, LLC
Licensee Address:	Suite 301 915 E. High Street Charlottesville, VA 22902
Licensee Telephone #:	(434) 963-2421
Administrator:	Amy Simmon
Authorized Representative:	Ellen Byrne
Name of Facility:	Commonwealth Senior Living at East Paris
Facility Address:	3956 Whispering Way, SE Grand Rapids, MI 49546
Facility Telephone #:	(616) 949-9500
Original Issuance Date:	08/16/2023
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	90
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff Peron 1 (SP1) was physically and verbally aggressive towards Resident A on 10/1/24.	No
Residents are left soiled, and their needs are not met consistent with their service plans.	No
Additional Findings	Yes

III. METHODOLOGY

10/14/2024	Special Investigation Intake 2025A1010004
10/15/2024	Special Investigation Initiated – Letter APS referral emailed to Centralized Intake
10/15/2024	APS Referral APS referral emailed to Centralized Intake
10/22/2024	Inspection Completed On-site
10/22/2024	Contact - Document Received Received facility internal investigation documents, resident service plan, and staff training documents
10/24/2024	Contact - Document Received Email received from assigned Kent Co APS worker Steve Conrad
11/01/2024	Contact - Telephone call made Interviewed SP1 by telephone
11/01/2024	Contact - Telephone call made Interviewed SP2 by telephone
12/10/2024	Exit Conference

ALLEGATION:

Staff Peron 1 (SP1) was physically and verbally aggressive towards Resident A on 10/1/24.

INVESTIGATION:

On 10/14/24, the Bureau received the allegations from the online complaint system. The complainant was anonymous; therefore, I was unable to gather additional information. The complaint read, “A resident was hit by [SP1]. [SP1] continued to threaten the resident after hitting her. The incident occurred on 10/1 in the resident’s bedroom. The resident was being changed. The resident look [sic] like she was chewing, and [SP1] grabbed the residents [sic] cheeks aggressively and yelled at her to open her mouth. Staff is still working there and nothing has been done.”

On 10/15/24, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 10/22/24, I interviewed the administrator at the facility. The administrator reported she was not aware of the incident until APS was at the facility to investigate the allegations as staff did not report it to her. The administrator stated after she met with the APS staff person, she initiated an internal investigation into the incident. The administrator said she interviewed SP1 and SP2 who was also present during the incident on 10/1/24.

The administrator explained part of her internal investigation included watching video footage of the hallway outside of Resident A’s room in the secured memory care unit in the facility. The administrator said SP1 was observed walking into Resident A’s room at 9:21 pm, then she came out at 9:25 pm to ask for additional staff assistance. The administrator explained SP1 then went back into Resident A’s room at 9:26 pm. The administrator reported SP2 is not seen entering Resident A’s room until 9:34 pm, then she exits at 9:35 pm and immediately got her cell phone and started texting.

The administrator reported when she interviewed SP1, SP1 stated she had to ask SP2 for assistance to change Resident A while Resident A was in her bed during second shift on 10/1/24. The administrator explained Resident A has a history of being physically aggressive and non-compliant with staff during the provision of her care. The administrator said SP1 told her Resident A “kept grabbing” her and was “hitting her hands.” The administrator reported SP1 denied hitting Resident A or being physically aggressive towards her.

The administrator stated SP1 reported she noticed it appeared as if Resident A “was chewing something” while she and SP2 were changing her. The administrator said SP1 reported she could not get Resident A to open her mouth, so she used her fingers and pressed on Resident A’s cheeks to attempt to get her to open her mouth. The administrator reported SP1 denied hurting or forcing Resident A to open her mouth. The administrator stated SP1 was concerned Resident A would choke if she had something in her mouth because she was laying down in her bed during the incident.

The administrator reported she interviewed SP2 regarding the incident. The administrator stated SP2 said Resident A became combative when she and SP1

were turning Resident A in bed to change her. The administrator said SP2 reported Resident A was trying to hit her and SP1. The administrator stated SP2 said SP1 “swatted” Resident A back on her hand. The administrator reported SP2 stated she heard SP1 say, “I told you I hit back.” The administrator said SP2 reported she also heard SP1 ask Resident A “what’s in you mouth?” The administrator reported SP2 said SP1 then “forcefully” tried to open Resident A’s mouth.

The administrator reported SP1 was placed on suspension while she completed the internal investigation into the incident. The administrator stated Resident A did not have any visible injuries after the alleged incident. The administrator said she concluded her internal investigation with no findings and SP1 has returned to work.

The administrator stated SP1 has not had any formal or informal reprimands regarding her job performance or her treatment of residents since she was hired at the facility. The administrator reported SP1 does not have any disciplinary actions in her employee record. The administrator said SP1 received resident rights training when she started at the facility.

The administrator provided me with copies of SP1 training documents for my review. SP1’s *Resident Rights & Protection* document read she received and read it on 7/27/23. The document was signed by SP1. SP1 received, reviewed, and signed the facility’s *Abuse and Neglect Prohibition Policy* on 7/27/24. SP1’s *New Orientation Checklist* document read she received “Resident Rights and Responsibilities training on 7/18/24.

On 10/22/24, I attempted to interview Resident A in the secured memory care unit in the facility. I was unable to engage Resident A in meaningful conversation. I did not observe any marks or bruises on the visible parts of Resident A’s body, such as her arms and face.

On 11/1/24, I interviewed SP1 by telephone. SP1 denied ever being physically aggressive towards Resident A, or any other resident in the facility. SP1 said she did not hit or “swat” Resident A’s hand on 10/1/24 when she and SP1 were changing her in bed. SP1 denied ever saying, “I told you I hit back.” SP1 reported it did appear that Resident A had something in her mouth that she was concerned about her choking on. SP1 stated she did not force Resident A’s mouth open.

SP1 said she received resident rights training when she started at the facility. SP1 reported she also received training on working with residents with memory loss.

On 11/1/24, I interviewed SP2 by telephone. SP2’s statements regarding the incident were consistent with the administrator.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(l) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician or physician's assistant. In case of a chemical restraint, a physician shall be consulted within 24 hours after the commencement of the chemical restraint.**
ANALYSIS:	The interview with the administrator, SP1, and SP2, revealed Resident A became physically combative during the provision of her care on 10/1/24. SP1 denied "swatting at" Resident A's hand in return and forcing Resident A's mouth open when she was observed chewing. Resident A did not present with any injuries after the incident. The interview with the administrator and SP1, along with review of SP1's training documents revealed she received resident rights training upon hire at the facility. There is insufficient evidence to suggest the facility was not in compliance with this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents are left soiled, and their needs are not met consistent with their service plans.

INVESTIGATION:

On 10/14/24, the complaint read “Residents are not being changed and washed before bed. Residents are being left in dirty briefs and dirty clothes.”

On 10/22/24, the administrator reported residents are not intentionally left soiled for extended periods of time. The administrator stated individual resident toileting needs are outlined in their service plans. The administrator said resident care needs are met by staff in accordance with their service plans. The administrator denied receiving complaints regarding resident care from visitors or resident family members.

The administrator reported there have been instances of staff “infighting” and not getting along. The administrator stated these issues are being addressed as they are either observed or reported to management staff.

The administrator explained one of the facility’s washer and dryer units broke down. The administrator stated when this occurred, resident laundry was still completed in the second washer and dryer units within the facility. The administrator said no residents went without their laundry being done during this time. The administrator reported the issues with the washer and dryer were fixed timely and they are both running now. The administrator explained the washer and dryer units broke down and were fixed approximately two or three weeks ago.

On 10/22/24, I interviewed SP3 at the facility. SP3’s statements were consistent with the administrator. SP3 reported staff are trained to change a resident’s soiled brief immediately upon its discovery.

On 10/22/24, I interviewed SP4 at the facility. SP4’s statements were consistent with the administrator and SP3.

On 10/22/24, I interviewed Resident B at the facility. Resident B reported all his care needs are met by staff. Resident B denied any concerns regarding staff at the facility. Resident B said his laundry is done timely and on his scheduled shower days that are twice a week. I observed Resident B was wearing clean clothing and was adequately groomed. I did not detect any foul odors coming from Resident B, or in Resident B’s room.

On 10/22/24, I interviewed Resident C at the facility. Resident C’s statements were consistent with Resident B. I observed Resident C was wearing clean clothing and was adequately groomed. I did not detect any foul odors coming from Resident C, or in Resident C’s room.

On 10/22/24, I interviewed Relative C1 at the facility. Relative C1 denied concerns regarding the care Resident C receives from staff. Relative C1 stated Resident C is

always in clean clothing and is well groomed when she visits Resident C at the facility. Relative C1 denied concerns regarding Resident C's laundry not being done.

On 10/22/24, I inspected the facility, including the secured memory care unit. I did not detect any foul odors anywhere in the facility. I observed several residents in the common areas in the general assisted living area and in the secured memory care unit. The residents were all adequately groomed and wore clean clothing. I did not observe any dirty or soiled clothing left in resident rooms or common areas.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	The interviews with the administrator, SP3, SP4, Resident B, Resident C, Relative C1, along with my inspection of the facility revealed residents are not intentionally left soiled for long periods of time. I observed several residents throughout the facility. The residents were adequately groomed and wore clean clothing. I did not detect any foul odors anywhere in the facility. There is insufficient evidence to suggest the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 10/22/24, the administrator reported she had no prior knowledge regarding the incident on 10/1/24 because it was not reported to management staff.

On 11/1/24, SP2 reported she did report the incident to SP5 immediately on 10/1/24 via text message. SP2 provided me with the text message she sent to SP5. I observed the message was sent on 10/1/24 at 9:36 pm. SP2's text messages explained the incident consistent with her statements to the administrator and I. I observed SP5 acknowledged the information and thanked SP2 for informing her. An incident report or internal investigation was not initiated until approximately two weeks after SP2 informed SP5.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, quality review program.**
	(7) The facility must have a policy and procedure to ensure that an incident, once known by facility staff, is reported as soon as possible, but not later than 48 hours after the incident, to a resident's authorized representative or designated health care professional, as appropriate. Verbal or written notification must be documented in the resident's record to reflect the date, time, name of staff who made the notification, and name of the representative or professional who was notified.
ANALYSIS:	The interview with SP2 revealed SP5 was informed of the incident on 10/1/24 between SP1 and Resident A. The administrator reported she was not aware of the incident until she was informed by APS approximately two weeks later. SP5 did not report the incident to the administrator or initiate an internal investigation after she was informed of the incident on 10/1/24.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Ellen Byrne on 12/10/24.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

12/04/2024

Lauren Wohlfert Date
Licensing Staff

Approved By:

12/09/2024

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Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section