GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 30, 2024

Deborah Hampton
Church of Christ Assisted Living
23621 15 Mile Road
Clinton Township, MI 48035

RE: License #: AH500243182
Investigation #: 2025A0585018
Church of Christ Assisted Living

Dear Ms. Hampton:

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) 284-9730.

Sincerely,

Brender L. Howard

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street, P.O. Box 30664
Lansing, MI 48909
(313) 268-1788

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500243182
Investigation #:	2025A0585018
Complaint Receipt Date:	12/09/2024
Investigation Initiation Date:	12/12/2024
Report Due Date:	02/08/2025
Licensee Name:	Church of Christ Assisted Living
Licensee Address:	23575 15 Mile Rd. Clinton Township, MI 48035
Licensee Telephone #:	(586) 791-2470
Authorized Representative/Administrator:	Deborah Hampton
Name of Facility:	Church of Christ Assisted Living
Facility Address:	23621 15 Mile Road Clinton Township, MI 48035
Facility Telephone #:	(586) 285-6230
Original Issuance Date:	04/26/2002
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	138
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's catheter was not emptied, night shift turned on the light in Resident A's room and waking him, Funeral director was instructed to take the deceased through the front door.	No
Poor and negligent medication management.	Yes
Regular housekeeping was not done. Paper towels dispenser empty for 24 hours. Refrigerator defrosted and soaked carpet from sink to hall entry door. Bathroom ceiling tiles were wet.	Yes
Additional Findings	No

III. METHODOLOGY

12/09/2024	Special Investigation Intake 2025A0585018
12/12/2024	Special Investigation Initiated - On Site
12/12/2024	Inspection Completed On-site Completed with observation, interview and record review.
12/12/2024	Inspection Completed – BCAL Sub. Compliance.
12/12/2024	APS Referral A referral was made to Adult Protective Services (APS).
01/02/2025	Exit Conducted via email to authorized representative Deborah Hampton.

ALLEGATION:

Resident A's catheter was not emptied, night shift turned on the light in Resident A's room and waking him, Funeral director was instructed to take the deceased through the front door.

INVESTIGATION:

On 12/9/2024, a complaint was received via BCHS complaint online. The complaint read in part that on 11/5/2024, the midnight shift entered the room of Resident A and turned on the bright light, speaking loudly and waking the resident. The complaint alleged that Resident A's catheter was emptied twice a week. The complaint alleged that the funeral director was instructed to exit the body through the main entrance past residents while they were eating lunch.

On 12/12/2024, a referral was made to Adult Protective Service (APS).

On 12/12/2024, an onsite was completed. I interviewed the administrator, Deborah Hampton. The administrator stated that Resident A was on hospice. She said that Resident A's catheter is emptied every day. The administrator stated that she had no knowledge of a staff going into Resident A's room and turning on a bright light. She said that residents are treated with respect and dignity. The administrator stated that the funeral director only uses the front door to exit and there really was no other choice but to go through the front door.

On 12/2024, I interviewed Employee #1 whose statements were consistent with the administrator regarding Resident A.

Service plan for Resident A read, "Currently bed bound. Has a foley catheter and incontinent of bowels.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(a) Assume full legal responsibility for the overall conduct and operation of the home.**
ANALYSIS:	There is no evidence to support these claims. Therefore, this claim could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Poor and negligent medication management.

INVESTIGATION:

The complaint alleged in part, that the medication technician ran out of the ordered medication hychrosamin four times in seven days, facility is not dispensing medication as prescribed by hospice, and that she had to request overdue medication when it had not been provided within one hour of scheduled dose. The complaint alleged that staff was attempting to give Resident A medication that was discontinued by hospice.

The administrator stated that hospice was not calling the orders in and sometimes they would change the orders but would not tell them. She said that this was causing problem with Resident A's medication. She said that hospice would put the order in Resident A's chart and not tell them. The administrator said that hospice is supposed to let her, or the nurse know about new orders for them to process. She said that there is a two-hour window to administer medication. She said they can give medication a hour before or a hour afterwards. She said that hospice did not discontinue medication but once it was brought to their attention, they corrected it right away. She said that when medication is discontinued (D/C), they send it to the pharmacy, and it takes 24 hours to get out of the system. She said that hospice forgot to call in Resident A's Ativan which was to be scheduled but they did not call it in and Resident A missed three doses. She said that hospice usually call in the narcotics. The administrator stated that on the 12th, Resident A did not get his Ativan because hospice had not called it in.

Doctor's order for Resident A showed in part the following:

11/4/2024 – D/C current Ativa and morphine sulfate orders. Start Ativan 0.5 mg po/sL every 2 hours ATC. Start morphine sulfate 0.5 ml. Equals two syringes of 0.25 every two hours ATC po/sL. Albuterol updrafts vial every 6 hours ATC. – No signature of nurse receiving order.

11/6/2024 – Hycosamine 0.125 mg. Please mix with morphine and Ativan every 4 hours. No nurse signature for receiving order.

11/7/2024 – Morphine concentrate (20 mg/ML) give 0.5 ml every 2 hours ATC. Ativan 0.5 mg, give 1 Tab (crushed with morphine every 2 hours ATC. Signed by nurse as receiving order.

No date – change order in system to reflect giving only one syringe. Amounts were updated to 0.5 mL. No signature of nurse receiving order.

11/10/2024 – Ativan 0.5 mg to 2 tabs po/sL every 2 hours. No signature of nurse receiving order.

A review of the November 2024 medication administration record (MAR) showed the following:

Acetaminophen 650 mg suppository insert 1 every 8 hours for pain/fever. D/C 11/12/2024. On 11/7 and 11/10, the 6:00 a.m. medication was not given. On 11/10 the 12:00 p.m. medication was not given.

Albuterol Sul 2.5 MG/3 ML S 1 vial inhale orally every 6 hour for dyspnea. DC date: 11/11/2024. On 11/7, this medication was not administered at 6 a.m.

Hyoscyamine 0.125 mg Tab SL. Give 1 tablet sublingually every 4 hours for secretions. D/C date 11/12/2024. On 11/10 the 12:00 p.m. medication was not given.

IPRAT – ALBUT 0.5-3 (2.5) MG/3 1 vial inhale orally every 4 hours for sob. D/C 11/12/36 0851. On 11/12 the 4:00 a.m. dose was not given.

Lorazepam 0.5 MG tablet give 1 tablet orally every 2 hours every Mon. Tues. Wed. Thurs. Fri, Sat. Sun for agitation. Missed doses 4:00 a.m., 6:00 a.m., and 8:00 a.m. D/C date 11/12/2024 12:36. On 11/11 at 2:00 p.m. the dose was not given.

Morphine Sulf 100 MG/5 ML C. Give 1 syringe orally every 2 hours every day for pain/sob give 2 syringes if they are 0.25 ML. D/C 11/12/2024. On 11/10 at 10:00 and 2:00 the medication was not administered.

Morphine Sulf 100 MG/5 ML C. Give 1 syringe orally two times a day for low 02/pain. D/C 11/04/2024. On 11/2 the medication was not administered at 9:00 p.m.

Service plan for Resident A read in part, “Hospice transition care plan 11/6/2024. Currently not alert 11/6/2024. Currently bed bound.”

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.

ANALYSIS:	Resident A was not always administered his medication as prescribed. Although, Resident A was in hospice, he was still the responsibility of the facility to ensure that he receive his medication. Therefore, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Regular housekeeping was not done. Paper towels dispenser empty for 24 hours. Refrigerator defrosted and soaked carpet from sink to hall entry door. Bathroom ceiling tile was wet.

INVESTIGATION:

The complaint alleged that regular housekeeping was not done, and cob wells were all in the window corners. The complaint alleged that paper towels dispenser was empty for 24 hours and the refrigerator defrosted and left the carpet soaked from the sink to hall entry door. The complaint alleged that the bathroom ceiling tile was wet.

The administrator stated that she did not know that the ceiling tile was like that. She said that there was nothing reported to her regarding the tile or a leak.

During the onsite, I inspected several residents' rooms as well as the common areas. The rooms and common areas appeared to be clean at that time. Paper towels dispenser was stocked at that time. There were no issues with the refrigerators. However, the bathroom ceiling that was previously occupied by Resident A had brown water marks that was from a leak. Two of the ceiling tiles had water damage on it. She said that all residents' rooms are cleaned once a week and as needed for emergencies. The administrator stated that the cleaning of residents' rooms includes vacuuming, and dusting. She explained that there are two full time housekeepers and one part time housekeeper as well as two contingent housekeepers.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.

ANALYSIS:	During the onsite, the facility was clean, and no issues noted with the cleanliness of the facility. There were no issues with the inspected refrigerators. Paper towels dispenser inspected had paper towels. The room that was occupied by Resident A had a ceiling that contained water damage. Therefore, the facility did not comply with this rule for keeping the building in good repair.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no changes in The status of this license.

12/30/2024

Brender Howard Date
Licensing Staff

Approved By:

12/30/2024

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