GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 24, 2025

Vasha Patel
Collaborative Care Partners Inc
10900 James Way
Portage, MI 49002

RE: License #: AL030406376
Investigation #: 2025A0357009
Stanford Lodge

Dear Ms. Patel:

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 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 (616) 356-0100.

Sincerely,

Arlene B. Smith

Arlene B. Smith, MSW, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4213

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL030406376
Investigation #:	2025A0357009
Complaint Receipt Date:	12/02/2024
Investigation Initiation Date:	12/03/2024
Report Due Date:	01/31/2025
Licensee Name:	Collaborative Care Partners Inc
Licensee Address:	10900 James Way Portage, MI 49002
Licensee Telephone #:	(269) 718-9040
Administrator:	Keyur Patel
Licensee Designee:	Vasha Patel
Name of Facility:	Stanford Lodge
Facility Address:	409 Naomi Street Plainwell, MI 49080
Facility Telephone #:	(269) 718-2745
Original Issuance Date:	01/21/2021
License Status:	REGULAR
Effective Date:	07/21/2023
Expiration Date:	07/20/2025
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Family members of Resident A have found pills on Resident A's side table and on the floor.	Yes
Resident A's living area is unkept and there was stool lining the toilet and the bathroom was not properly cleaned.	No
Resident A's catheter bag was completely filled, and urine was backing up in the tube.	Yes

III. METHODOLOGY

12/02/2024	Special Investigation Intake 2025A0357009
12/03/2024	Special Investigation Initiated - Telephone
12/12/2024	Contact - Document Received Email received from Kristin Campbell, Area Agency on Aging, Supports Coordinator.
12/12/2024	Contact - Document Received Received email from Kristin Campbell, with an attached picture.
12/12/2024	Contact - Telephone call made To Kristin Campbell to discuss her concerns.
12/12/2024	Contact - Document Received Received pictures from Kristin Campbell.
01/03/2025	Contact - Document Received Email from Kristin Campbell.
01/13/2025	Inspection Completed On-site Unannounced inspection at the facility.
01/13/2025	Contact - Face to Face With Resident A.
01/13/2025	Contact - Face to Face Met with Assisted Living Manager, Sierra Easter.
01/14/2025	Contact - Telephone call received From Licensee Designee, Vashu Patel.
01/16/2025	Contact - Telephone call made

	To Resident A's Family Member 1 and Family Member 2.
01/16/2025	Contact - Document Received Resident A Family Member 2 sent me a picture.
01/22/2025	Contact – Telephone to the Assisted Living Manager, Sierra Easter. Telephone interview with Direct Care Staff, Arian Eaves.
01/22/2025	Contact Document Received an Incident Report from Ms. Easter.
01/24/2025	I conducted a telephone exit conference with the Licensee Designee, Vasha Pantel.

ALLEGATION: Family members of Resident A have found pills on Resident A's side table and on the floor.

INVESTIGATION: On 11/25/2024, we received a complaint from LARA-BCHS-Complaints@michigan.gov. The complaint noted that Resident A's family members were finding pills on the floor. Family members were unsure what these pills are for and when staff were informed, they reportedly said they would just give them to her, without knowing exactly what it is. It was also reported that the living area is unkept with stool lining the toilet and the bathroom not properly cleaned. On 12/12/2024, I received a picture from Resident A's Supports Coordinator, Kristin Campbell, of Resident A's catheter bag completely filled with urine and the urine was backing up into the tube.

On 12/12/2024, I received an email with attachments from Kristin Campbell, LMSW from Area Agency on Aging. She explained that Resident A's family members had contacted her as she is the Supports Coordinator for Resident A about finding pills in Resident A's room. Ms. Campbell said they sent her the pictures of the pills laying where they found them. Ms. Campbell sent me the same pictures. There were no dates or times on these pictures, and they were black and white. Ms. Campbell stated the family members had told her they had reported the discovered pills with the staff and the staff had told them "We'll just give them to her." There was no name of the staff provided.

On 01/13/2025, I made an unannounced inspection to the facility. Upon entering the facility, I met the Assisted Living Manager, Sierra Easter and I asked to meet with Resident A. She took me to her room. I attempted to interview Resident A, but it was obvious that she had cognitive deficits. I asked her about receiving her pills and she said she takes her pills. I asked if any had fallen onto the floor, and she said, "No." She could answer very simple questions and suddenly she said: "I am not answering any more questions." I observed her room was clean and neat. I did not see any pills on her floor or on her stand that was next to her. I asked if I could look at the

bathroom and she agreed. The bathroom and the toilet were clean. I thanked for her time, and I left the room.

On 01/13/2024, I conducted an interview with Assisted Living Manager, Sierra Easter. I asked her about Resident A's missing pills. She explained that Resident A's family members had spoken to her about their concern of finding her pills on the floor and other places. She reported that they provided pictures of the pills in various places in Resident A's room. Ms. Easter stated that she has instructed her staff to make sure Resident A swallows all of her pills when they administer them and to make sure doesn't "cheek" them or spit them out. She explained that one of her staff, Arian Eaves, had found a pill in Resident A's chair and brought the pill to her and then Ms. Eaves completed an Incident/Accident report. She was uncertain of the date but would find the IR and scan it to me later. She added that they audit the medication cart often and have weekly medication trainings. She said she has retrained two new staff and recently hired two new housekeepers.

On 01/13/2025, I reviewed Resident A's file with Ms. Easter. Resident A has Alzheimer's type of dementia, urinary retention, and wears adult protection. Ms. Easter reported that Resident A came to the facility with a catheter. Resident A can eliminate for a bowel movement in the bathroom. Her assessment stated that she needs to have her medications administered to her by staff.

On 01/16/2025, I telephoned Resident A's Family Member 1 and Family Member 2. I was able to interview them together on the telephone. They explained that Resident A had a heart attack in September and had been living in a facility for rehabilitation. They reported that she was admitted on 11/07/2024. They reported that they want Resident A to be in a memory care facility but have not been able to find one. Family Member 1 (FM1) stated that she took a pill she had found on the floor (no date provided) in Resident A's bedroom to Ms. Easter and Ms. Easter told her she would give it to Resident A later. Later on, Ms. Easter apologized to her that she should not have said that, and she would not be giving Resident A the pill later. FM1 and FM2, both explained that they are very upset about how the facility is run and have many concerns that they want me to know about.

FM1 reported that Resident A's shower day is also her laundry day, and staff left Resident A's clothes in the dryer all day, and they were damp and not folded. She said the staff left someone else's clothes in Resident A's room. She reported that Resident A is to drink a lot of water, because she is on Lasix, and they don't even have an ice maker. They have to use ice trays and put them in an empty bucket, and they have seen staff reach in with their hands to get the ice into the cups. She said Ms. Easter has since purchased a small ice maker. She said they purchased Resident A a water cup and when they come it does not have water in it, and they found the cup behind her chair one day. They reported that Resident A needed to go to the bathroom and so they pressed her button and waited 20 minutes. FM 1 reported that she went into the halls looking for staff. She reported that there are individuals who require a two-person assist and the two staff were in with another

resident. She said she pushed her call light again and still no staff came to help Resident A for another 20 minutes so Resident A had an accident in her pants (no date provided). FM1 stated that Resident A wears a pendent around her neck and she pushes it when she needs help. FM1 stated that one time they pushed it, and no one came, and they pushed it again and still no one came. She said she found that the pendent was not working. She reported that Ms. Easter gave Resident A, a watch and every time they came to visit the watch was not on Resident A but on the floor or elsewhere. FM1 reported that she found a male staff outside of the facility (date unknown) and she asked if Resident A could have the pendent around her neck again and not the watch. She said the male staff said yes and provided it for her.

I asked FM1 and FM2 about finding her pills on the floor and they stated the first time was on 11/10/2024 and there was a blue pill by her feet and one pill by her comb on her stand that sits next to her. The second time was on 11/14/2024, at 12:53 and they found an oblong pill on the floor and FM1 took the pill to Ms. Easter. The third time was on 11/21/2024, at 2:01 where they found two pills by Resident A's feet on the floor. Then they found a pill on the floor on 12/22/2024, and FM1 took the pill to Ms. Easter and gave it to her. FM2 stated they take pictures every time they are visiting Resident A. The pictures I had matched what they reported when they found Resident A's pills on the floor or on the side table. This was a total of six pills found by the family. I asked them if they had seen any improvements lately and they reported "some." They had no other recent dates where they found Resident A's pills on the floor or in other places. Both FM1 and FM2 stated they have witnessed the pills on the floor or on the stand. FM2 stated she took the pictures of the pills where she saw them. Resident A was unable to contribute to the investigation.

On 01/22/2025, I telephoned the facility and spoke with Ms. Easter. I asked if I could speak with the staff that found the pill and had completed an IR. Ms. Easter reported her name was Arian Eaves. I conducted a telephone interview with Ms. Eaves. She reported she was filling-in for half of a shift for another staff when she was in Resident A's room standing next to her in her recliner when she saw a pill between Resident A's leg and the side of the chair. She reported that the took the pill to Ms. Easter and completed an IR. She said this was the only time that she found a pill. She reported that she is a CNA, and she educates other staff members concerning medication administration. She reported she has worked in the facility for four to five months but has worked in the field for over four years.

On 01/22/ 2025, Ms. Easter sent me a copy of the IR completed by Ms. Eaves. It was dated 11/21/2024, at 3:12pm. The report read that she along with FM1 found the medication on the floor by Resident A's chair. The report read that staff was able to ID which med it was and then took it to Ms. Easter. The report read that the medication was destroyed in the **"**drug buster**"**, and she completed the IR. The corrective measures read that they should retrain on the propter administration of medications. The name of the medication was not recorded on the IR.

On 01/24/2025, I conducted a telephone exit conference with the Licensee Designee, Vashu Patel and she agreed with my findings.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	It was alleged that family members of Resident A have found pills on Resident A's side table and on the floor during visits. FM1 and FM2 both reported that they discovered pills in Resident A's room. They took pictures of the pills where they found them. On 11/10/2024, two pills were found. On 11/14/2024 1 pill was found. On 11/21/2024 two pills were found. On 12/22/2024 1 pill was found for a total of 6 pills found on the floor or side table. Assisted Living Manager**,** Sierra Easter, acknowledged that Resident A's family members had found pills on the floor in her room and other places. She acknowledged that Direct Care Staff, Arian Eaves had brought a pill she had found in Resident A's room, and she had completed an Incident/Accident report on finding of the pill. Direct Care Staff Arian Eaves acknowledged that she and FM1 had found a pill in Resident A's room, and she completed an Incident/Report. During this investigation there was evidence found that Resident A did not properly receive six prescribed medications over a period of time because they were found on the floor or on the side table. Therefore, there is a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A's living area is unkept and there was stool lining the toilet and the bathroom was not properly cleaned.

INVESTIGATION: On 12/12/2024, Kristin Campbell, LMSW, Supports Coordinator for Resident A sent me eleven pictures she had received from FM2 of Resident A's living area, her toilet, her bathroom, and the floor of her room. None of these pictures were dated, and they all were in black and white. One of the pictures showed a water bottle, with pieces of paper or paper towels on the floor in front of

the heater vent along the wall. Another picture was a shower chair with a wadded-up washcloth laying on the chair. On another picture was the top a wooden cabinet with two tubes of some kind and a pump container laying on its side. A picture showed what appeared to be to be dried fecal material on the outside of the toilet tank and some on the seat. There was a picture of what looked like a plastic liner over the toilet seat with dried fecal material on it. One picture was of a straw laying on the floor. There was a picture of a water bottle on the floor along with pieces of papers or Kleenex lying with the water bottle. In another picture was a white cord encircled with the phone cord. There were several pictures that were indecipherable.

On 01/13/2024, I made an unannounced inspection to the facility and upon entering I asked to go to Resident A's room immediately. I found nothing on the floor. The bathroom along with the toilet was clean. The entire room was neat and orderly.

On 01/16/2025, I spoke with FM1 and FM2 by telephone and I explained what I had observed on 01/13/2025 that her room was clean and neat. I found Resident A's bathroom and toilet to be clean. They said I had picked a good day to come, because other days it was not good. They expressed their concern for the home not having housekeeping staff until just recently. They did not believe that the home was maintained adequately and needed much more in the way of daily maintenance.

On 01/24/2025 I conducted a telephone exit conference with the Licensee Designee, Vashu Patel and she agreed with my findings.

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 Resident A's room was no being adequately cleaned and there was stool lining the toilet and the bathroom was not properly cleaned. On 12/12/2024, the pictures sent to me were in black and white and were not dated nor was the time stamped on them. On 01/13/2025, when I observed Resident A's room, bathroom and toilet, all were very clean. There were no items observed on the floor and no trip hazards. During this investigation the pictures demonstrated items left on the floor that could be a trip hazard but when I observed the room it was clean and neat. The toilet and the bathroom were clean. Therefore, there is not a violation the rule.

CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A's catheter bag was completely filled, and urine was backing up in the tube.

INVESTIGATION: On 12/12/2024, I received an email from Kristin Campbell, Supports Coordinator for Resident A. I called Ms. Campbell, and we discussed the picture she had sent me of Resident A's catheter bag totally filled with urine and the urine was backing up in the descending tube. She expressed concern for the health and safety of Resident A. She reported that FM1 and FM2 had found Resident A's catheter bag this way and sent her the picture.

On 01/13/2025, I conducted an unannounced inspection and met Resident A in her bedroom. She was unable to speak about her catheter bag due to her dementia. She would not let me look at her catheter bag. She said I could not ask her any more questions.

On 01/13/2025, I interviewed Assisted Living Manager, Sierra Easter. She explained that Resident A came into their facility with the catheter bag. She reported that FM1 told her what they had found with Resident A's catheter bag on 12/12/2024 and showed her the picture. She told me that she had the staff empty the bag and then had the staff check the bag every two hours. She said she taught the staff how to move the bag inside of Resident A's pant leg. She said since the reported incident occurred, no one has reported that the bag has filled again.

On 01/13/2025, I reviewed Resident A's assessment plan. There was very little listed on the document. I asked Ms. Easter who had completed the assessment plan, and she reported that the staff from the nursing home had completed it. There was no mention of Resident A having a catheter. I showed Ms. Easter on the assessment plan who is to complete the document and the intent of the document along with the importance of its content. I advised her to complete a new assessment plan with the family.

On 01/16/2025 I conducted a telephone interview with Resident A's family members, FM1 and FM2. They told me they had found her catheter bag full of urine and the urine was backing up into the descending tube. FM1 said she took a picture of it on 12/12/2024 at 11:56 am and sent it to Ms. Campbell. Both FM1 and FM2 said that Resident A could get a bladder infection from the urine going back up into the tube. FM1 said she immediately told Ms. Easter about it. They both questioned how the staff could ignore the catheter bag for so long to let it get so full.

On 01/24/2025, I conducted a telephone exit conference with the Licensee Designee, Vasha Patel and agreed with my findings.

APPLICABLE RULE	
R 400.15305	**Resident Protection**
	(3) A resident shall be treated with dignity and his personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	It was alleged that Resident A's catheter bag was completely filled, and the urine was backing up in the tube. Resident A was admitted to the facility with a catheter bag. On 12/12/2024, Family Member 1 and Family Member 2 stated that they found the bag totally filled with urine and the urine was backing up into the descending tube. It had not been emptied for a long time. Family Member 2 took a picture of it and sent it to Kristin Campbell, Resident A Supports Coordinator. This picture was subsequently sent to me. During this investigation evidence was found that Resident A's catheter bag was found to be extremely full of urine and the urine was backing up into the descending tube. Therefore, there is a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend the Licensee Designee provide an acceptable plan of correction and the license remain the same.

Arlene B. Smith 01/24/2025

Arlene B. Smith Date
Licensing Consultant

Approved By:

Jerry Hendrick 01/24/2025

Jerry Hendrick Date
Area Manager