GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 13, 2023

Khurram Shahzad
New Hope White Lake, LLC
3678 Prairie Creek Lane
Saginaw, MI 48603

RE: License #: AH630406127
Investigation #: 2023A1027092
New Hope White Lake Senior Living Community

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed the authorized representative and dated.

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. 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 877-458-2757.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630406127
Investigation #:	2023A1027092
Complaint Receipt Date:	09/08/2023
Investigation Initiation Date:	09/11/2023
Report Due Date:	11/08/2023
Licensee Name:	New Hope White Lake, LLC
Licensee Address:	450 S Williams Lake Rd White Lake, MI 48386
Licensee Telephone #:	(551) 998-1221
Administrator:	Alan Ford
Authorized Representative:	Khurram Shahzad
Name of Facility:	New Hope White Lake Senior Living Community
Facility Address:	450 S Williams Lake Rd White Lake, MI 48386
Facility Telephone #:	(248) 886-6700
Original Issuance Date:	01/27/2023
License Status:	REGULAR
Effective Date:	07/27/2023
Expiration Date:	07/26/2024
Capacity:	117
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility violated HIPPA (Health Insurance Portability and Accountability Act).	Yes
Resident A lacked care and had bruises on his hand.	No
Medications were not administered per the physician's order.	Yes
The memory care staff were alone.	No
The building lacked maintenance.	No
Additional Findings	No

III. METHODOLOGY

09/08/2023	Special Investigation Intake 2023A1027092
09/11/2023	Contact - Document Received Email correspondence from complainant forwarded from licensing staff Ms. Gregory-Weil
09/11/2023	Special Investigation Initiated - Telephone Voicemail left with complainant
09/11/2023	Contact - Document Sent Follow-up email sent to complainant
09/12/2023	Contact - Document Received Two emails received from complainant with investigation information and pictures
09/12/2023	Contact - Document Received Email received from complainant
09/13/2023	Contact - Document Received Email received from complainant
09/13/2023	Contact - Document Received Email received from complainant

10/03/2023	Inspection Completed On-site
10/13/2023	Contact - Telephone call made Telephone interview conducted with Employee #6
10/13/2023	Inspection Completed-BCAL Sub. Compliance
10/23/2023	Exit Conference Conducted by telephone with authorized representative Khurram Shahzad

ALLEGATION:

The facility violated HIPPA (Health Insurance Portability and Accountability Act).

INVESTIGATION:

On 9/8/2023, the Department received allegations initially by telephone then by email in which alleged staff's laptops were left opened with residents' private health information. The allegations read the narcotic logs were left on the medication carts. The allegations read residents' binders with medical information were in the copy room and accessible to housekeepers and maintenance staff.

On 9/12/2023 and 9/13/2023, the complainant emailed pictures of facility laptops open in public areas with residents' information, laptops left in public areas, and residents' binders with medical information accessible.

On 10/3/2023, I conducted an on-site inspection at the facility. I interviewed Employee #3 who stated staff were trained in new hire orientation regarding confidentiality. Employee #3 stated she conducted she conducted an in-service regarding HIPPA compliance on 9/6/2023 for all staff.

While on-site, I reviewed the HIPPA compliance training dated 9/6/2023 which read consistent with Employee #3's statements.

While on-site, I observed medication carts, along with the narcotic count logs, were in locked medication rooms located on each hallway. I observed the laptop computers utilized to document the administration of residents' medications were locked in the medication rooms as well.

While on-site, I observed a laptop computer in the medication room in which a medication technician on duty opened the computer. I observed that the computer had the facility's login information written on it. I observed the medication technician

login using that login information which opened to a main screen and read New Hope White Lake. I observed the medication technician utilized a specific login assigned to her to access residents' medical records for medication administration.

While on-site, I observed the residents' binders with medical record information were in the "copy room" behind the receptionist's desk. I observed the copy room door had a keypad lock and was left open. I observed the opened copy room door was located a short distance from front entrance doors in which anyone could access the room since the receptionist was not at the desk.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(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: **(c) A patient or resident is entitled to confidential treatment of personal and medical records, and may refuse their release to a person outside the health facility or agency except as required because of a transfer to another health care facility, as required by law or third party payment contract, or as permitted or required under the health insurance portability and accountability act of 1996, Public Law 104-191, or regulations promulgated under that act, 45 CFR parts 160 and 164.**
ANALYSIS:	Observations revealed although the facility's laptops had login information located on them, each staff member had an assigned login to access residents' medical records. Observations of residents' medical record binders revealed although the copy room door maintained a keypad lock, it was left open and records were accessible, therefore the facility was in violation of this law.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A lacked care and had bruises on his hand.

INVESTIGATION:

On 9/8/2023, the Department received allegations initially by telephone then by email which alleged Resident A lacked care.

On 9/12/2023 and 9/13/2023, the complainant emailed pictures of bruising on Resident A's right hand, Resident A sitting in wet sweatpants, wet sweatpants, his fingernails, and Resident A sitting on his bed with his pants pulled down past his knees and bed not made.

On 10/3/2023, I conducted an on-site inspection at the facility. I interviewed Employee #3 who stated Resident A admitted to the facility on 3/27/2023 and discharged on 9/7/2023. Employee #3 stated Resident A had behaviors of agitation and combativeness frequently in which staff provided redirection, as well as re-attempted care after he refused. Employee #3 stated Resident A's physician was notified of the behaviors in which he changed his medication regimen however, they continued until he discharged. Employee #3 stated Resident A required two-person assistance for transfers to his wheelchair.

While on-site, I interviewed Employee #5 whose statements were consistent with Employee #3.

I reviewed Resident A's face sheet which read consistent with staff interviews. Resident A's face sheet read in part he had diagnoses of anemia, hyperlipidemia, dementia, major depressive disorder, Alzheimer's, other seizures, sleep related hypoventilation, other sleep apnea, essential hypertension, paroxysmal atrial fibrillation, cardiac arrhythmia, gastro-esophageal reflux disease with esophagitis, diverticulitis, polyp of colon, unspecified hemorrhoids, other muscle spasm, other abnormalities of gait and mobility and presence of cardiac pacemaker.

I reviewed Resident A's service plan which read consistent with staff interviews. The plan read in part he required assistance with grooming tasks, bathing/showering, oral hygiene, toileting needs, two-hour and as needed toilet checks and changes, dressing/undressing, and eating. The plan read in part he required two-person assistance for transfers and mobility. The plan read in part Resident A had behavior patterns/aggressive/combative and to provide a distraction item. The plan read in part in part Resident A placed himself on the floor. The plan read in part for staff to frequently round on Resident A throughout the shift. The plan read in part Resident A was not able or willing to follow staff instructions and unable to communicate his needs.

I reviewed Resident A's observation notes dated March 27, 2023, through September 7, 2023, which read consistent with staff attestations and his service plan.

The notes read in part Resident A had behaviors such as but not limited to combativeness, agitation, and declining care from staff on the following dates 3/28/2023, 3/30/2023, 4/24/2023, 4/27/2023, 5/1/2023, 5/11/2023, 5/22/2023, 6/5/2023, 6/6/2023, 6/8/2023, 6/13/2023, 6/29/2023, 7/14/2023, 7/19/2023, 7/21/2023, 7/24/2023, 7/25/2023, 7/29/2023, 8/12/2023, 8/21/2023, 8/22/2023, 8/23/2023, 8/24/2023, 8/25/2023, 8/27/2023, 8/29/2023, 9/2/2023, and 9/5/2023. The notes read in part staff attempted three times when Resident A resisted care and tried redirection with playing ball, magazines, or coloring books.

For example, note dated 8/29/2023 read in part Resident A's physician did not have any additional recommendations for medication changes for his behaviors and Resident A required special evaluation, as well as input beyond his expertise.

For example, note dated 8/15/2023 read in part during staff's two-hour checks, Resident A was observed sitting at the edge of his bed with a wet brief in his hands. The note read in part staff cleaned Resident A and applied a new brief.

For example, note dated 8/13/2023 read in part a small light purple bruise on Resident A's right palm area was observed by staff. The note read in part Resident A was unable to communicate to staff how the bruise occurred due to his dementia. The note read in part Resident A attempted to self-transfer from the chair to the wheelchair. The note read in part Resident A's durable power of attorney was notified.

I reviewed Resident A's medication administration records (MARs) from 3/27/2023 through 9/7/2023 which read consistent with statements from Employee #3.

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:	Review of Resident A's medical records revealed he had a diagnosis of Alzheimer's dementia. Review of Resident A's service plan read consistent with his medical records and staff attestations. Review of Resident A's observations notes, along with staff attestations, revealed he demonstrated combative, agitated behaviors, and was resistant to care in which methods were implemented to provide care consistent with his personal needs. Additionally, the notes read staff communicated with Resident A's licensed healthcare professional and spouse. Review of Resident A's MARs revealed medication changes were implemented by his physician. It could not be determined the cause of Resident A's bruise on his right hand. Furthermore, given Resident A's behaviors of removing his clothing and briefs, as well as declining care from staff, there was insufficient evidence to support he lacked care.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Medications were not administered per the physician's order.

INVESTIGATION:

On 9/8/2023, the Department received allegations initially by telephone then by email in which alleged residents' medications were not given on time. The allegations read staff were not initialing MARs when they administered medications and were having the next shift document it. Additionally, the allegations read on 7/27/2023, Resident A was administered an as needed medication for no reason.

On 9/12/2023 and 9/13/2023, the complainant emailed pictures of text correspondences between staff regarding early medication administration, text correspondences between the complainant and staff regarding administration of as needed medication, and Resident A's Rivastigmine patch box on top of a bag of briefs.

On 10/3/2023, I conducted an on-site inspection at the facility. I interviewed Employee #4 who stated the facility utilized the program "*ECP*" to administer

residents' medications. Employee #4 stated staff documented residents' medication administration on a facility laptop in which they clicked to verify the medication to be administered, then clicked after it was administered. Employee #4 stated staff were expected to attempt to administer medications three times and document it if a resident refused.

While on-site, I interviewed Employee #5 who stated medications were permitted to be administered one hour before or after the time in "*ECP*." Employee #5 stated staff documented medications when they were administered. Employee #5 stated she was not aware of staff administering residents' medications early. Employee #5 stated possibly in the event of an emergency, staff would not document medications at the time they were administered, but there had not been any recent emergency situations.

While on-site, I interviewed Employee #3 whose statements were consistent with Employees #4 and #5. Employee #3 stated some medications were prescribed to be administered early in the morning before breakfast, such as a thyroid medication. Employee #3 stated all residents' prescribed medications were locked in the bathroom cupboard of their apartment. Employee #3 stated all narcotics were locked in a medication cart located in the medication room. Employee #3 stated staff carried a laptop computer to each apartment in which they would administer each residents' medications. Employee #3 stated only shift supervisors were permitted to administer as needed narcotic medications.

Additionally, Employee #3 stated staff administered Resident A's medications per the physician's orders which were crushed. Employee #3 stated sometimes Resident A was "*very aggressive and combative*" in which staff would contact his spouse first to assist with redirection, then provide as needed medication if applicable. Furthermore, Employee #3 stated Resident A's Rivastigmine patches were located with his other medications in the locked cupboard in his bathroom. Employee #3 stated Resident A's spouse had a medication key for her apartment which was the same for all residents' apartments so she could not confirm if medications were out of the locked cupboard from staff or after her going through his medications.

While on-site, I observed the memory care unit and residents' rooms in which I observed medications were in the locked cupboards and the medication carts with the narcotics were in the medication rooms.

I reviewed Resident A's medication administration records (MARs) dated March 27, 2023, through September 7, 2023.

> The March 2023 MARs read there were two as needed orders prescribed for Lorazepam. The MARs read Lorazepam 0.5 mg, take one tablet by mouth two times a day as needed (anxiety) and Lorazepam 0.5 mg, take two tablets (1 mg) by mouth every day as needed for muscle spasms. On 3/28/2023, staff

documented the Lorazepam as administered for the order that read it was for muscle spasms, but documented it was administered for anxiety.

The April 2023 MARs read Lorazepam, take one tablet by mouth three times day and on 4/3/2023 at 8:00 AM, that dose was left blank. Additionally, the MARs read he had two prescribed orders for as needed Lorazepam. For example, the MARs read Lorazepam 0.5 mg, take one tablet by mouth two times day as needed for anxiety and Lorazepam 1 mg, take one tablet by mouth two times a day as needed for anxiety/agitation.

The May 2023 MARs read consistent with the April 2023 MARs in which there were two prescribed as needed orders for Lorazepam. For example, the MARs read Lorazepam 0.5 mg, take one tablet by mouth every day as needed for anxiety/agitation and Lorazepam 1 mg, take one table by mouth two times a day as needed for anxiety/agitation.

The June 2023 MARs read Lorazepam, take one tablet by mouth two times day and on 6/18/2023 at 8:00 AM, that dose was left blank.

The July 2023 MARs read consistent with the April and May 2023 MARs in which there were two prescribed as needed orders for Lorazepam. The MARs read on 7/27/2023, staff documented the reason for administration of as needed Lorazepam was "*agitation*" and the effectiveness of it was "*some relief*."

I reviewed the facility's medication training for staff titled "*Medication Competency Evaluation*" which read in part that medication was marked when pulled and then documented as given before it was administered.

On 10/13/2023, I conducted a telephone interview with Employee #6 who stated she previously worked third shift at the facility. Employee #6 stated in May 2023, the facility was short staffed on first shift. Employee #6 stated she was instructed by Employee #3 to administer all residents' morning medications early, around 6:00 AM, and not document it at that time. Employee #6 stated the laptop computer permitted staff to review all medications for each resident, so she could see what medications were due for first shift and administer them. Employee #6 stated first shift staff documented the residents' medications as administered on their shift.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.
For Reference:	

R 325.1932	**Resident's medications.**
	(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following: **(b) Complete an individual medication log that contains all of the following information:** **(iv) The time when the prescribed medication is to be administered and when the medication was administered.** **(v) The initials of the individual who administered the prescribed medication.**
ANALYSIS:	Review of Resident A's MARs revealed there were two instances where staff did not initial his medications as administered, thus it could not be confirmed if he received them or not. Resident A's MARs read he was prescribed Lorazepam as needed for anxiety and agitation in which staff documented the reasons for administration were consistent with the orders, as well as on the specified date of 7/27/2023. However, Resident A's MARs read there were duplicate as needed Lorazepam orders in which lacked sufficient information to determine which dose of the medication was to be given. Staff attestations and observations revealed medications were in each residents' locked cupboard and the narcotics were in the locked medication cart. Telephone interview with Employee #6 revealed residents' medications were not always administered per the facility's medication administration policy or the physician's orders. Therefore, a violation was substantiated for these allegations.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The memory care staff were alone.

INVESTIGATION:

On 9/8/2023, the Department received allegations initially by telephone then by email which alleged staff were alone in memory care.

On 10/3/2023, I conducted an on-site inspection at the facility. I interviewed Employee #3 who stated there were nine or ten residents in memory care while Resident A was there. Employee #3 stated Resident A required two-person assist and all other residents were one person assist.

Employee #3 stated staff worked three shifts both in the assisted living and memory care. Employee #3 stated in memory care, two staff members were assigned to work first and second shifts, and one staff member was assigned worked third shift. Employee #3 stated there were approximately 12 residents in the assisted living which had the same staffing assignment as memory care. Employee #3 stated there were all assisted living residents were independent or required one-person assist, so the assisted living staff were available to assist in memory care when needed.

While on-site, I reviewed the staff schedules dated 5/28/2023 through 9/7/2023 which read consistent with statements from Employee #3.

While on-site, I observed the memory care unit. I observed ten memory care residents and two staff members.

APPLICABLE RULE	
R 325. 1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	Review of staff schedules revealed they read consistent with staff attestations; thus, this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The building lacked maintenance.

INVESTIGATION:

On 9/8/2023, the Department received allegations initially by telephone then by email in which alleged there was black mold under the sink in the juice room. The allegations read there were roof leaks in the conference room, director of resident care office, the 700-hall laundry, and the assisted living dining room on the side near

the courtyard. The allegations read the public bathroom in the lobby near the receptionist's desk had sewer issues.

On 9/12/2023 and 9/13/2023, the complainant emailed pictures of black mold and a wet floor.

On 10/3/2023, I conducted an on-site inspection of the facility. I interviewed Employee #1 stated although the facility was new, there were areas of the facility that required repairs. Employee #1 stated there was a leak in the piping that caused the black mold under the sink in the juice room; however, a professional company was hired to remove it. Employee #1 stated the hired company removed the black mold, treated the area after removal, then repaired it.

Also, Employee #1 stated there was a leak near an exhaust vent located on the roof where the flashing and shingles had not prevented the water from coming through. Employee #1 stated the exhaust vent was sealed and the roof no longer leaked and all areas within the facility were fixed.

Additionally, Employee #1 stated he connected pipes to the gutters to drain the water away from building to prevent any water seeping through the floor. Employee #1 stated he sealed an area outside of the assisted living dining area to prevent water from coming through onto the floor.

Furthermore, Employee #1 stated a plumbing company inspected the public bathroom by the lobby and a low spot was identified in the plumbing which was backing up and needed to be repaired.

While on-site, I interviewed Employee #2 who stated the public restroom smelled of sewer intermittently.

While on-site, I interviewed administrator Alan Ford who stated they had identified flaws in the facility's construction work and contacted the contracted companies who completed the work, but they did not return for the repairs. Mr. Alan stated A-1 Painting & Decorating was the company who performed the mold removal and repair. Also, Mr. Alan stated although he obtained a quote for plumbing repairs in the public restroom, the work was extensive in which they would need to remove concrete, so he was looking to obtain two additional quotes from plumbing companies prior to completing repairs.

While on-site, I observed under the sink in the juice room in which lacked mold and had been repaired. I observed the alleged ceiling areas within the facility which were repaired. I observed the outside exhaust vent which appeared sealed. I observed the outside gutters which had drains attached to move the water away from the facility. I observed the facility's floors including the assisted living dining area which appeared dry. The facility lacked odors specifically near the public restroom in the lobby.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	Observations of the building revealed the roof leaks and mold under sink were repaired. Staff attestations revealed there was plan in plan place to correct the sewer in the public bathroom after additional estimates were obtained. Based on this information, this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the license remain unchanged.

Jessica Rogers 10/16/2023

Jessica Rogers Date
Licensing Staff

Approved By:

Andrea L. Moore 10/22/2023

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