GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 16, 2020

Lauren Gowman
Linden Square Assisted Living
650 Woodland Drive East
Saline, MI 48176

RE: License #: AH810334704
Investigation #: 2020A1021035
Linden Square Assisted Living

Dear Ms. Gowman:

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) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH810334704
Investigation #:	2020A1021035
Complaint Receipt Date:	02/25/2020
Investigation Initiation Date:	02/26/2020
Report Due Date:	04/26/2020
Licensee Name:	Linden Square Assisted Living, LLC
Licensee Address:	950 Taylor Avenue Grand Haven, MI 49417
Licensee Telephone #:	(616) 846-4700
Administrator:	Robert Boyd
Authorized Representative:	Lauren Gowman
Name of Facility:	Linden Square Assisted Living
Facility Address:	650 Woodland Drive East Saline, MI 48176
Facility Telephone #:	(734) 429-7600
Original Issuance Date:	06/21/2013
License Status:	REGULAR
Effective Date:	01/10/2020
Expiration Date:	01/09/2021
Capacity:	187
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Employees take pictures of residents.	Yes
Employees are under the influence of drugs.	No
Facility has insufficient staff.	Yes
Additional Findings	No

III. METHODOLOGY

02/25/2020	Special Investigation Intake 2020A1021035
02/26/2020	Special Investigation Initiated - Telephone interviewed complainant
02/26/2020	APS Referral allegations sent to centralized intake at APS
03/02/2020	Inspection Completed On-site
03/10/2020	Inspection Completed On-Site
03/16/2020	Exit Conference Exit Conference with authorized representative Lauren Gowman

ALLEGATION:
Employees take pictures of the residents.

INVESTIGATION:
On 2/25/20, the licensing department received an intake with allegations employees are taking pictures and videos of the residents to make fun of them.

On 2/26/20, the allegations in this report were sent to centralized intake at Adult Protective Services (APS).

On 2/26/20, I interviewed the complainant by telephone. The complainant reported employees take pictures and videos of residents, especially in the memory care unit, to make fun of the residents. The complainant reported employee Jordan Fouty and employee Tayler Babik are known to take photos and videos.

On 2/26/20, I received photos and videos obtained by the complainant. The photos revealed caregivers sitting in resident rooms and interacting with residents. In some of the photos it did not appear that the resident was aware the photo was being taken. The complainant did not provide dates and the person that sent the photos.

On 3/2/20, I interviewed administrator Robert Boyd at the facility. Mr. Boyd reported the facility does not allow personal cell phones to be used while working. Mr. Boyd reported employees can use cell phones in break areas but not in resident care areas.

On 3/2/20, I interviewed employee Tayler Babik at the facility. Ms. Babik reported a family member requested her to take a photo of a resident with the resident, herself, and her son as the resident enjoyed hearing about Ms. Babik's son. Ms. Babik denied taking photos of residents to mock them. Ms. Babik reported cell phones are only to be used in break areas and not in resident common areas.

On 3/2/20, I interviewed employee Jordan Fouty at the facility. Ms Fouty denied taking photos or videos of residents at the facility. Ms. Fouty reported caregivers are not to use their personal cell phones in resident care areas.

On 3/3/20, I contacted the complainant to inquire dates and how the photos and videos were obtained. The complainant was not able to be reached and therefore I was unable to obtain additional information on the photos and videos.

On 3/10/20, I interviewed resource manager Jaime Deal at the facility. I showed Ms. Deal the pictures of the staff members and the residents. Ms. Deal confirmed the staff member in the pictures were Ms. Fouty. Ms. Deal confirmed Ms. Fouty was working as Ms. Fouty was wearing a company issued uniform and was wearing a facility pendent.

I reviewed the cell phone policy of the facility in the *Assisted Living Center Handbook*. The policy read,

> "text messages are not encrypted and are not HIPPA secure. Text messages with (protected health information) PHI are NOT allowed. Texting PHI will result in disciplinary action including termination of employment. Cell phone photographs are not permitted. Resident ECP/EMAR photos are not permitted to be transmitted via cell phone messaging or text or email."

I reviewed the employee record for Ms. Fouty. The record revealed Ms. Fouty received training on the employee handbook on 5/23/19. Ms. Fouty received training on resident rights on 3/15/19.

The picture of Ms. Fouty showed Ms. Fouty smiling at the camera with Resident A. Another picture showed Ms. Fouty in Resident B's bathroom standing behind her and taking a picture. Resident B does not appear to be aware the picture was taken.

The video showed Resident C attempting to put lipstick on and a caregiver laughing in the background.

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: **(d) A patient or resident is entitled to privacy, to the extent feasible, in treatment and in caring for personal needs with consideration, respect, and full recognition of his or her dignity and individuality.**
ANALYSIS:	Ms. Fouty took pictures and videos of Resident A, B and C while working at the facility. Resident A, B and C's respect and dignity were violated when these photos and video were taken and distributed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:
Employees are under the influence of drugs.

INVESTIGATION:
The complainant reported employees at the facility are under the influence of drugs. The complainant reported the care the employees provide is not adequate as they are using drugs and then go to work. The complainant reported Ms. Fouty and Ms Babik are known to use drugs.

Mr. Boyd reported no employees have been disciplined or fired due to allegations of drug abuse. Mr. Boyd reported before an employee is hired at the facility, the employee completes a drug screen. Mr. Boyd reported if there are concerns about an employee using drugs, they are to complete another drug screen. Mr. Boyd reported the facility has a no drug use policy for all employees.

Ms. Deal reported there has been no allegations of employee drug use. Ms. Deal reported no employees have been asked to complete another drug screen due to concerns of using drugs.

I interviewed medication technician Dominique Clifton at the facility. Ms. Clifton reported there have been no concerns or allegations of employee drug use at the facility.

I interviewed resident service associate Christine Inman at the facility. Ms. Inman reported there have been no concerns or allegations of employee drug use at the facility.

I interviewed shift supervisor Julie Nickerson at the facility. Ms. Nickerson reported there have been no concerns or allegations of employee drug use at the facility.

I reviewed Ms. Fouty employee record. Ms. Fouty completed drug screening upon hiring. Ms. Fouty had no discipline action against her regarding drug use.

I reviewed Ms. Babik employee record. Ms. Babik completed drug screening upon hiring. Ms. Babik had no discipline action against her regarding drug use.

I interviewed Ms. Fouty at the facility. Ms. Fouty denied allegations of drug abuse.

I interviewed Ms. Babik at the facility. Ms. Babik denied allegations of drug abuse.

I reviewed *HPM Assisted Living Center Handbook*. The handbook read,

"Drug Free Workplace. The purpose of this policy is to ensure a safe work environment. Drug and alcohol abuse pose a serious threat to the safety and welfare of the user and of all employees. Abuse also interferes with efficiency and productivity, on which all of our jobs depend. Therefore, if an employee test positive for alcohol or drugs, disciplinary action will take place with immediate dismissal. Policy Implementation: Our Living Center reserves the right to require an employee to submit to drug/alcohol screening if there is any reason to believe an employee is under the influence of drugs or alcohol."

APPLICABLE RULE	
R 325.1923	**Employee's health.**
	(1) A person on duty in the home shall be in good health. Files shall be maintained containing evidence of adequate health, such as results of examinations by a qualified health care professional and tuberculosis screening which consists of an intradermal skin test or chest x-rays, or other methods recommended by the local health authority. Records of accidents or illnesses occurring while on duty that place others at risk shall be maintained in the employee's file.
ANALYSIS:	The facility conducts drug screening on all new employees and has a drug use policy. The policy allows the facility to drug screen employees if there are concerns about drug use. Ms. Babik and Ms. Fouty completed an initial drug screen and have had no concerns or discipline action regarding drug use. There is lack of evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:
Facility has insufficient staff.

INVESTIGATION:
The complainant reported the facility has insufficient staff to care for the residents.

Mr. Boyd reported the facility is working through staff turnover and is currently hiring. Mr. Boyd reported the facility recently hired more caregivers which is helping with staffing.

Ms. Deal reported the facility is currently hiring and is looking to fill positions on second and third shifts. Ms. Deal reported caregivers have a set schedule and then

part time and contingent workers fill in as needed. Ms. Deal reported when the schedule is developed there are sometimes open shifts that need to be filled. Ms. Deal reported caregivers will usually pick up additional shifts. Ms. Deal reported the facility uses an online scheduling application and will send out alerts if the facility needs additional staff. Ms. Deal reported the facility does not have a mandation policy. Ms. Deal reported the facility has a reward program to reward caregivers that pick up additional shifts. Ms. Deal reported the facility has 74 residents. Ms. Deal reported on first and second shift there will be at least 11 caregivers, but the facility tries to schedule 13 caregivers. Ms. Deal reported on third shift there are five caregivers, but the facility tries to schedule seven caregivers. Ms. Deal reported employees work together to ensure the care needs are met.

Ms. Clifton reported she works first, second, and third shifts. Ms. Clifton reported there is insufficient staff at the facility. Ms. Clifton reported medications are late, call lights take increased time to answer, and there are increased falls at the facility. Ms. Clifton reported a caregiver and herself are responsible for 12 residents and two residents are a two person assist, 10 residents require assistance with toileting, and four residents have behavior issues. Ms. Clifton reported residents do not receive the care they deserve.

Ms. Inman reported she typically works first shift in assisted living. Ms. Inman reported the facility could use additional staff. Ms. Inman reported caregivers use walkie-talkies to communicate with each other. Ms. Inman reported if she goes into a resident's room that requires another caregiver, she will walkie for another caregiver and hope someone can come and assist her. Ms. Inman reported residents have increased falls and delayed caregiver response time because there is lack of staff.

Ms. Nickerson reported some days the facility has enough staff and other days there is insufficient staff. Ms. Nickerson reported she is a shift supervisor but will work the floor as needed. Ms. Nickerson reported on 3/3, she worked as a medication technician because multiple caregivers called in for their shift. Ms. Nickerson reported a caregiver and herself are responsible for 17 residents and three residents are a two person assist and four residents require assistance with toileting. Ms. Nickerson reported she can walkie-talkie for additional assistance from another caregiver and hope someone can assist her. Ms. Nickerson reported she is unable to meet the needs of the residents and at times medications are administered late because there is lack of staff.

Ms. Babik reported she typically works first shift in memory care. Ms. Babik reported a caregiver and herself are responsible for 16 residents. Ms. Babik reported three residents are a two person assist, two residents can be a two-person assist depending on the day, 16 residents require assistance with toileting, and 15 residents have behavior issues. Ms. Babik reported the facility is short staffed two-three times a week. Ms. Babik reported she is unable to meet the needs of the residents by medications are administered late and there are increased falls at the facility.

Ms. Fouty reported she typically works first shift in memory care. Ms. Fouty reported the facility needs more staff at the facility especially in the memory care unit. Ms. Fouty reported she is unable to meet the needs of the residents by residents must wait to be toileted, some residents do not receive showers when they should, and there are increased falls at the facility. Ms. Fouty reported family members have voiced concerns to her regarding lack of staff. Ms. Fouty reported a medication technician and herself are responsible for 16 residents. Ms. Fouty reported four residents are a two person assist, 15 residents require assistance with toileting, 15 residents have behavior issues, one resident is on oxygen, one resident has a catheter, and 16 residents require assistance with dressing and bathing.

At the facility I observed the general layout. The facility is a U-shaped facility with multiple hallways. The facility has courtyard unit, which is secure memory care unit, C/D/E unit, F/G unit, and H/I/J/K unit, and terrace unit, which is a secure memory care unit. The secure memory care units are in the back of the facility and are not near common areas. The caregivers carry walkie-talkies to communicate but the facility is very large, and it takes time to get to the various units at the facility.

I reviewed incident reports sent to the licensing department. The incident reports revealed the facility had eight residents fall between 2/1/20-3/11/20. Seven of the eight falls were unwitnessed and six of the falls happened in the memory care unit.

I reviewed Resident C, D, E, F, G, and H service plan. Resident C, D, E, F, G, and H reside in the courtyard memory care unit. The service plans revealed six residents require assistance with ambulation, six residents exhibit behaviors that require additional staff interventions, six residents require assistance with dressing and bathing, four residents require assistance with toileting, one resident require assistance of two staff persons for toileting, three residents require assistance of two staff persons for transferring, and one resident require eyes on him while in common areas.

I reviewed the staff schedule for the courtyard memory care unit. The schedule revealed on 3/1, 3/2, and 3/6 there was one caregiver and medication technician for first shift. On 3/1, 3/3, 3/6, and 3/7 for second shift there was only one medication technician and one caregiver.

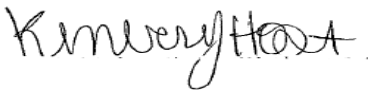
APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.

ANALYSIS:	Interviews with staff, consideration of care needs as identified in their plans of care, along with schedule review revealed the facility has lack of staff to provide care to the residents especially in the memory care unit. There are three residents that require two staff persons to assist, yet there are only two caregivers in that unit, indicating other residents that require supervision or assistance are without it during that time. The utilization of others from other areas of the facility would leave those areas understaffed if not already understaffed.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 3/16/20, I conducted an exit conference with authorized representative Lauren Gowman by telephone.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.



3/12/20

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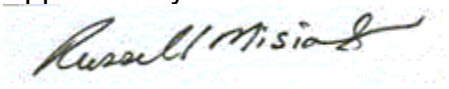
Kimberly Horst — Date
Licensing Staff

Approved By:



3/12/20

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Russell B. Misiak — Date
Area Manager