GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 23, 2021

Cheryl Peters
Carveth Village of Middleville
690 W Main Street
Middleville, MI 49333

RE: License #: AH080236758
Investigation #: 2021A1028014
Carveth Village of Middleville

Dear Ms. Peters:

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.

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,

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 204-4300

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

I. IDENTIFYING INFORMATION

License #:	AH080236758
Investigation #:	2021A1028014
Complaint Receipt Date:	02/25/2021
Investigation Initiation Date:	02/25/2021
Report Due Date:	03/27/2021
Licensee Name:	Carveth Village Assisted Living
Licensee Address:	690 W Main St. Middleville, MI 49333
Licensee Telephone #:	(269) 795-4972
Administrator:	Cheryl Peters
Authorized Representative:	Steven Peters
Name of Facility:	Carveth Village of Middleville
Facility Address:	690 W Main Street Middleville, MI 49333
Facility Telephone #:	(269) 795-4972
Original Issuance Date:	04/30/1999
License **Status:**	REGULAR
Effective Date:	07/25/2020
Expiration Date:	07/24/2021
Capacity:	68
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident falls are not being reported in an appropriate amount of time.	Yes
There is not enough staff to meet the needs of the residents.	Yes

III. METHODOLOGY

02/25/2021	Special Investigation Intake 2021A1028014
02/25/2021	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
02/25/2021	APS Referral APS referral emailed to Centralized Intake
03/03/2021	Contact - Face to Face Interviewed Administrator, authorized representative, and staff in person
03/03/2021	Contact - Document Received Received staff schedule, staff contact information, staff time sheets and Resident A, B, C, D, E, F, G, H, I, and J's care plans with record notes from care staff supervisor, Karen Carpenter
03/09/2021	Contact - Telephone call made Interviewed care staff Anna Ramey by telephone
03/09/2021	Contact - Telephone call made Interviewed Catherine Dunkelberger by telephone
03/09/21	Contact – Telephone call made

	Interviewed care staff person Tracie Teague by telephone
03/10/21	Contact – Telephone call made Interviewed Interim Hospice manager, Jim LaFroge and Hospice care staff Kristin Pajot by telephone

ALLEGATION:

Resident falls are not being reported in an appropriate amount of time.

INVESTIGATION:

On 2/25/21, the Bureau received the allegations from the online compliant system. The complainant wished to remain anonymous. Therefore, I was unable to contact them to clarify their concerns or gather additional information.

On 02/25/21, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 3/3/21, I interviewed authorized representative, Cheryl Peters at the facility. Ms. Peters reported that to her knowledge the former administrator was completing the incident reporting to the department of LARA. Ms. Peters stated that care staff manager, Karen Carpenter, is completing and submitting the reports now.

On 3/3/21, I interviewed care staff manager, Karen Carpenter, at the facility. Ms. Carpenter reported that prior to 1/27/21, the former administrator was completing the reporting. Ms. Carpenter reported that she has been submitting incident reports since the former administrator's departure. Ms. Carpenter provided Resident A, B, C, D, E, F, G, H, I, and J's care plans with record notes for my review.

On 3/3/21, I interviewed care staff person (CSP) Chanda King at the facility. Ms. King reported that falls are documented in "the resident's charts by staff when they happen".

On 3/3/21, I interviewed CSP Amanda Becker at the facility. Ms. Becker's statements are consistent with Ms. King's statements.

On 3/9/21, I interviewed Catherine Dunkelberger by telephone. Ms. Dunkelberger reported that to her knowledge, all falls are documented in resident records. Ms. Dunkelberger explained that "Ms. Carpenter reviews the reports and then submits them to the state".

On 3/9/21, I interviewed CSP Anna Ramey by telephone. Ms. Ramey's statements are consistent with Ms. Dunkelberger's.

On 3/10/21, I reviewed Resident A, B, C, D, E, F, G, H, I, and J's care plans with the resident record notes. The review revealed Resident G incurred a fall on 1/29/21. There is no evidence that an incident report was submitted by the facility to the department of LARA. Resident I incurred a fall on 2/5/21. There is no evidence that an incident report was submitted by the facility to the department of LARA.

Review of the facility incident report file also revealed that no incident reports prior to 2/1/21 were submitted to the department of LARA. The last incident report submitted occurred in October 2020.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.
ANALYSIS:	Interviews with the authorized representative and staff demonstrate an understanding of fall reporting to the department of LARA. However, a review of resident records along with the facility file of incident reports revealed that Resident G and Resident I incurred falls that were not reported to the department of LARA. It also cannot be determined if Resident G and Resident I's residents authorized representatives or the resident's physicians were notified of the falls. The review of the facility incident report file also revealed that the department of LARA has not received any incidents reports from October 2020 to 2/1/21. An incident/accident must be reported within 48 hours of the occurrence to the resident's authorized representative, physician, and to the department of LARA.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

There is not enough staff to meet the needs of the residents.

INVESTIGATION:

Ms. Peters reported that six new employees were recently hired and that staff "is almost at full capacity for the facility now". Ms. Peters reported that second and third shift have more call-ins than first shift, but that call-ins are infrequent. Ms. Peters reported that the facility was short staffed in fall and early winter due to Covid-19, but that there were enough facility and agency staff available to fill the vacancies. There are currently 44 residents in the facility and there are currently ten care staff with three additional facility staff in non-clinical roles that are also trained as care staff. This total does not include the six new hires. Ms. Peters reported "first shift has three aides scheduled, second shift has three aids scheduled, and third shift has two to three aides scheduled". Ms. Peters also reported that "since the employee shifts overlap, there are actually three to four aides for each shift". Ms. Peter provided care staff time punch sheets and the working staff schedule from December 1, 2021 to February 27, 2021 for my review.

Ms. Carpenter reported that the facility was short-staffed due to Covid-19, but that facility staff would come in early or stay later to fill any vacancies. Ms. Carpenter reported that some care staff are working 12-hour or 16-hour shifts to avoid the facility being short staffed. Ms. Carpenter reported that "staffing has been much better within the last month and half" and that six new employees were in orientation for second and third shifts.

On 03/03/21, I interviewed CSP Kina Vandenburg at the facility. Ms. Vandenburg has worked first, second, and third shifts and reported working between 12 to 16 hours to cover staffing shortage. Ms. Vandenburg's statements are consistent with Ms. Carpenter's statements.

CSP Chanda King reported she works various shifts in the facility. Ms. King reported that she thinks "there is enough staffing for first, second, and third now". She reported that while there have been call-ins on all shifts, it is rare. She reported that staff "have made it work when there is a call-in or shortage, even if it means working 12-hour or 16-hour shifts".

CSP Amanda Becker's statements are consistent with Ms. King's statements.

CSP Anna Ramey works third shift and reported "third shift has more people now than in the past." Ms. Ramey reported she is not aware of call-ins on third shift. Ms. Ramey also reported that staff will either come in early or stay late to cover a staffing shortage.

CSP Catherine Dunkelberger works various shifts and her statements are consistent with Ms. Ramey's statements.

On 3/9/21, I interviewed facility hairdresser Tracie Teague. Ms. Teague reported that her current role within the facility is hairdresser. However, Ms. Teague reported she is trained as a care staff person and has assisted with resident care in the past when there is a staffing shortage.

On 3/10/21, I interviewed Interim Hospice care staff Kristin Pajot by telephone. Ms. Pajot reported that she has no concerns with Resident A or Resident B's care provided by the facility.

On 3/15/21, I reviewed the working staff schedule from December 1, 2021 to February 27, 2021. The schedule designates first shift from 7am to 3pm, second shift from 3pm to 11pm, and third shift from 11pm to 7am. On 12/14/20, there was one call-in on third shift, leaving two care staff persons only from 3am to 7am for resident care. No coverage was obtained for the vacancy. On 12/28/20, there was a note on the working staff schedule that read '*short from 11p to 3a and 3a to 7a*'. There does not appear to be any additional coverage obtained to fill those vacancies. There was one call-in on second shift on 1/11/21. No coverage occurred to fill the vacancy, leaving two care staff for second shift resident care. On 1/13/21, one call-in occurred on second shift. There was staff coverage until 7pm, but from 7pm to 3am, there were only two care staff persons for second shift resident care. On 2/2/21, a care staff person on first shift left fours early, but there were enough staff already scheduled to cover the vacancy. On 2/10/21, there was a call-in for second and third shift, but there was enough staff already scheduled to fill the vacancies. On 2/12/21, a care staff person left early between the hours of 3am to 7am, leaving third shift with one care staff person for third shift resident care until 7am.

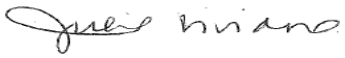
Further review of the working staff schedule revealed that agency staff was used on 2/22/21 on third shift and again on 2/24/21 for third shift, but not for any of the vacancies in December 2020, January 2021, or for February 12, 2021. Further review also revealed only one care staff person worked from 11:30pm to 3am on 1/22/21 due to improper scheduling; and only one care staff person worked from 3am to 5am on 1/23/21 due to improper scheduling. On 1/24/21, only one care staff person worked third shift from 3am to 5am due to improper scheduling. The review also revealed that care staff working hours often overlap between first, second, and third shifts, but there is a consistent pattern from December 1, 2020 to February 27, 2021 of only two care staff available between the hours of 3am to 7am for third shift resident care.

Review of Resident B's and Resident F's service plan reveal both residents are two person assist with all transfers. Both residents are one to two person assist with mobility and care routines. Resident A's and Resident D's service plans reveal that both residents are one to two person assist with all transfers. Also, both residents are one to person assist with mobility and care routines as well.

APPLICABLE RULE	
R 325.1931 (5)	**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 the authorized representative and care staff reveal that the facility was short staffed in the fall and at the beginning of winter. Additional staff have recently been hired to relieve staff that have been working between 12 and 16 hour shifts to avoid staffing shortage and to have more staff available for overall resident care across all shifts. However, review of the working staff schedules revealed that while care staff working hours often overlap between first, second, and third shifts, there is a pattern of only two care staff available between the hours of 3am to 7am for third shift resident care. The review revealed several call-ins from 12/14/20 to 2/12/21 with no coverage obtained to fill the vacancies. Also, only care staff person worked from 11:30pm to 3am on 1/22/21 due to improper scheduling. Only one care staff person worked from 3am to 5am on 1/23/21 due to improper scheduling. Also, on 1/24/21, only one care staff person worked third shift from 3am to 5am due to improper scheduling. Of the service plans reviewed, Resident B's and Resident F's service plan reveal both residents are two person assist with all transfers. Both residents are one to two person assist with mobility and cares as well. Resident A's and Resident D's service plans reveal that both residents require one to two person assist with all transfers. Both residents require one to person assist with mobility and cares. Due to the consistent pattern of only having two care staff available and at times only one care staff person available between the hours of 3am to 7am, the residents reviewed are at potential risk of harm or injury because there is not enough staff available to adequately or safely meet the resident's needs.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

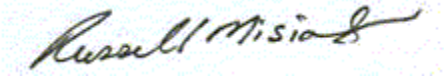
Contingent upon an acceptable corrective action plan, I recommend the status of the license remain unchanged.



3/15/21

Julie Viviano — Date
Licensing Staff

Approved By:



3/23/21

Russell B. Misiak — Date
Area Manager