GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 30, 2021

William Sowle
Stoneridge AFC, LLC
12200 North Ave
Bellevue, MI 49021

RE: License #: AL080387768
Investigation #: 2021A0577033
Stoneridge AFC

Dear Mr. Sowle:

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 (231) 922-5309.

Sincerely,

Bridget Vermeesch

Bridget Vermeesch, Licensing Consultant
Bureau of Community and Health Systems
1919 Parkland Drive
Mt. Pleasant, MI 48858-8010
(989) 948-0561

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL080387768
Investigation #:	2021A0577033
Complaint Receipt Date:	05/14/2021
Investigation Initiation Date:	05/17/2021
Report Due Date:	07/13/2021
Licensee Name:	Stoneridge AFC, LLC
Licensee Address:	4825 Fruin Rd Bellevue, MI 49021
Licensee Telephone #:	(269) 758-3388
Licensee Designee:	William Sowle
Administrator:	William Sowle
Name of Facility:	Stoneridge AFC
Facility Address:	4825 Fruin Rd Bellevue, MI 49021
Facility Telephone #:	(269) 758-3388
Original Issuance Date:	10/16/2018
License **Status:**	REGULAR
Effective Date:	04/16/2021
Expiration Date:	04/15/2023
Capacity:	20
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The facility has insufficient amount of direct care staff needed to provide the care the residents require, specifically residents who require two person assist and only one direct care staff is scheduled.	No
Third shift direct care staff are sleeping while working.	No
Additional Findings	Yes

III. METHODOLOGY

05/14/2021	Special Investigation Intake 2021A0577033
05/17/2021	Special Investigation Initiated - Telephone Interview with Complainant.
05/17/2021	APS Referral- Barry Co, Heather Townsend.
05/21/2021	Contact - Telephone call made- Interview with Complainant.
05/27/2021	Inspection Completed On-site Reviewed Resident Files, Interviewed Residents and Staff, Interviewed LD,
06/07/2021	Contact - Telephone call made-Interview with staff.
06/07/2021	Contact - Telephone call made- Dr. Veldt, VPA.
06/07/2021	Exit Conference with William Sowle, LD.
06/10/2021	Telephone call made- Left message for Relative A1.
06/11/2021	Exit Conference with William Sowle, LD, additional findings being cited in report.

ALLEGATION: The facility has insufficient amount of direct care staff needed to provide the care the residents require, specifically residents who require a two person lift assist and only one direct care staff is scheduled.

INVESTIGATION:

On May 14, 2021, a complaint was received alleging there are two residents who require two direct care staff members to assist with transferring but the facility only has one direct care staff member scheduled per shift. The complaint also alleged that five residents are being double briefed at night so third shift staff do not have to change them. The practice of double briefing is causing bed sores. The complaint reported third shift staff are sleeping during their shift.

On May 17, 2021, I spoke with Heather Townsend, Barry County Adult Protective Service (APS) Specialist who reported she spoke with Resident A on May 14, 2021. Ms. Townsend reported she witnessed staff in kitchen and two additional direct care staff providing direct care to residents. Ms. Townsend reported she spoke with Relative A1 who reported being "super happy" with the facility direct care staff members and had no complaints. Ms. Townsend reported she spoke with Brooklyn Herrera, home manager, who reported the facility currently does not have any residents in care who require two-direct care staff members to assist with any personal care tasks or transferring. Ms. Townsend reported Ms. Herrera explained they do double brief some residents at night due to the residents soaking a single brief while sleeping. Ms. Townsend reported Ms. Herrera reported bed checks are completed by direct care staff every few hours. Ms. Townsend reported she did not find any concerns while at the facility.

On May 21, 2021, I interviewed Complainant who reported the facility has a doctor who told licensee designee (LD) William Sowle and direct care staff that Resident A and Resident B need two direct care staff members to assist when transferring. Complainant reported Mr. Sowle told direct care staff he would pay more money per hour if direct care staff worked alone because he does not have the means to schedule and pay two direct care staff per shift. Complainant reported LD Mr. Sowle did not update either Resident A's or Resident B's *Assessment Plan for AFC Residents* with the physician ordered two-person assistance for transferring. Complainant reported there are 13 residents in care and first shift is from 7:00am-3:00pm with one kitchen staff and two direct care staff working. Complainant alleged second shift and third shift each has one direct care staff member working. Complainant alleged it is the second shifts responsibility to double brief the residents after supper and baths prior to third shift starting. Complainant alleged the direct care staff who works third shift gets mad if the residents are not double briefed because this causes this staff member to change residents more often. Complainant stated double briefing residents ensures residents will not soak through onto bedding. Complainant alleged third shift staff sleeps most of the shift.

Complainant reported Resident B sits in bed all day because there are not enough direct care staff members working to transfer Resident B. Complainant stated, "sometimes they will get her up for supper, but most of the times she stays in her room." Complainant reported Resident A is left to sit in his chair in the living room all day long because there is only one person working and Resident A has been dropped when one person tries to move Resident A. Complainant reported most direct care staff members wait until third shift direct care staff member arrives to transfer Resident A from the chair to his bed. Resident E often chooses to not leave her bedroom due to her disabilities. Resident E will come out for lunch and dinner but then wants to go back to her room.

On May 27, 2021, I conducted on unannounced onsite investigation and interviewed licensee designee William Sowle who reported the facility runs three shifts, 7:00am-3:00pm with two direct care staff (DCS) and a kitchen staff (who is trained as a DCS), 3:00pm-11:00pm with two direct care staff members scheduled and 11:00pm-7:00am with one DCS scheduled. I was able to review the staff schedule to confirm the staffing schedule. Mr. Sowle reported he has never heard of double briefing and asked what that was. Mr. Sowle reported they do not have any residents in care that require double briefing. Ms. Sowle reported when a brief is changed or checked the DCS is required to initial, date and time the brief of changes and checks. Mr. Sowle reported residents are checked every two hours for brief changes. Mr. Sowle reported there are no residents in care who require a two direct care staff members to assist with transferring or personal care tasks. Mr. Sowle denied the allegations of Resident A's physician requiring a two direct care staff members to assist with personal care tasks.

During my onsite investigation on May 27, 2021, I reviewed the *Resident Register* and found the facility currently has 14 residents in care. I reviewed the *Assessment Plans for AFC Residents and Health Care Appraisals* for the 14 residents in care and found 10 of the 14 residents use a form of assistive device for mobility and four residents were independent with mobility. None of the residents required two direct care staff members to assist with transferring, but two residents did require one direct care staff members to assist when transferring. There were no physician orders requiring any resident to have two direct care staff members assist with transferring.

On May 27, 2021, I interviewed direct care staff Angela Harper who reported there are no residents living at the facility that require two direct care staff members to assist when transferring. Ms. Harper reported she works the first shift from 7:00am-3:00pm and has not found any resident double briefed in the morning. Ms. Harper reported all residents who wear briefs are changed and/or checked every two hours. Ms. Harper reported there are no residents with bed sores or any type of wound at this time.

On May 27, 2021, I interviewed DCS McKenzie Laird who reported she was not aware of any residents having bed sores at this time and denied the allegation of

residents being double briefed at night. Ms. Laird reported there currently are not residents who require two direct care staff members to assist with transferring or mobility.

On May 27, 2021, DCS Seriena Harig and cook who reported residents are in and out of their bedrooms all day to sit in the living room or for meals. Ms. Harig reported there are no residents currently living at the facility who require two direct care staff members to assist with personal care tasks and/or transferring. Ms. Harig reported she has not seen or heard of residents being double briefed.

On May 27, 2021, I interviewed Resident I and Resident K who both denied the allegations of residents being double briefed at night and reported they are checked every couple of hours to see if they need assistance with going to the bathroom or having their briefs changed. Resident I and Resident K reported the staff take great care of the residents.

On June 07, 2021, I interviewed Brooklyn Herrera, Assistant Executive Director who reported there have been a couple of times when residents have been double briefed because the facility did not have the brief liner pads. Ms. Herrera reported even if residents are double briefed, they are still checked and taken to the bathrooms every two hours. Ms. Hawthorn reported Resident M often refuses to go to the bathroom during the night and so when the facility was out of the brief pad inserts, they would double brief Resident B to prevent Resident B from soaking through during those times. Ms. Herrera reported no residents are being double briefed on a continuous basis. Ms. Herrera reported no residents living in the facility require two direct care staff members to assist with personal care tasks and/or transferring. Ms. Herrera reported there are currently 14 residents in care with most residents using some form of assistive device to assist with mobility, such as a walker or wheelchair. Ms. Herrera reported DCS Connie Hawthorn works third shift and Ms. Herrera often looks at the camera to see if staff are sleeping or busy and had not seen her sleeping. Ms. Herrara reported she has not had any complaints from other staff or residents of Ms. Hawthorn sleeping.

On June 07, 2021, I interviewed Connie Hawthorn who reported she works third shift, from 11:00pm-7:00am six days a week. Ms. Hawthorn reported none of the residents living in the facility require two direct care staff members to assist with transferring or with personal care tasks. Ms. Hawthorn reported many of the residents use a walker or wheelchair for mobility, and one resident requires assistance from direct care staff when transferring. Ms. Hawthorn stated, “I feel one direct care staff is sufficient during third shift, I am able to provide the care that is needed by myself.” Ms. Hawthorn denied the allegations that she requires second shift direct care staff to double brief the residents. Ms. Hawthorn reported there are no residents who require to be double briefed.

On June 7, 2021, I contacted Dr. Veldt’s office with Visiting Physicians Association and left a message with no return call**.**

On June 10, 2021, I interviewed Relative A1 who reported she is not aware of a physician’s order, nor has Dr. Veldt reported to her, of Resident A requiring two direct care staff members to assist with transferring or personal care tasks. Relative A1 reported when she is at the facility, direct care staff will use two staff when transferring her husband due to his inability to participate in the transfer because he no longer can use his legs. Relative A1 reported she was not aware of the facility double briefing residents in place of staff providing care. Relative A1 reported she has no concerns regarding the care her husband receives.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services

	specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on the information gathered during the investigation, it has been found per the *Resident Register*, the facility currently has 14 residents in care. After reviewing each resident's *Assessment Plans for AFC Residents,* 10 residents were found to use a form of assistive device for mobility but no residents required two direct care staff members with transferring and/or personal care tasks. Two residents require one direct care staff member to assist with transferring and/or personal care tasks. Per the direct care staff schedule observed, there are two staff scheduled for first and second shift and one staff scheduled for third shift which is sufficient direct care staff on duty to provide supervision, protection and personal care to the residents as specified in the resident assessment plans. There was not enough evidence to determine residents were being 'double-briefed' during sleeping hours as direct care staff interviews were inconsistent.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Third shift direct care staff are sleeping while working.

INVESTIGATION:

On May 14, 2021, the complaint alleged third shift staff are sleeping during their shift.

On May 17, 2021, Complainant reported they have been told the third shift staff, Connie Hawthorn sleeps during her shift.

On May 27, 2021, I interviewed direct care staff Seriena Harig, Angela Harper, and McKenzie Laird, licensee designee William Sowle, Resident I and Resident K who all denied the allegation of Connie Hawthorn or any direct care staff sleeping during third shift.

On June 07, 2021, I interviewed Connie Hawthorns, DCS who denied sleeping during second shift.

On June 10, 2021, I interviewed Relative A1 who reported she is not aware of direct care staff sleeping during third shift, nor does she have concerns of this.

APPLICABLE RULE	
R400.15305	**Resident Protection**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	There was insufficient evidence found during the investigation to support the allegation of third shift staff sleeping during their shift. It has been found the residents are treated with dignity and their personal needs, including protection and safety are being provided at all times.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

During the onsite investigation on May 27, 2021, Resident A's *Assessment Plans for AFC Residents* was not in their resident record, nor could it be found. Resident B and Resident L did not have a completed *Health Care Appraisal* in their resident record.

APPLICABLE RULE	
R400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.

	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90 day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	Based on the information gathered during the investigation it has been found Resident A did not have a completed assessment plan for AFC residents in their resident record and Resident B and Resident L did not have a completed Health Care Appraisal in their resident record.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, it is recommended that the current status of the license remains unchanged.

Bridget Vermeesch 06/30/2021

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Bridget Vermeesch Date
Licensing Consultant

Approved By:

Dawn Timm 07/01/2021

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Dawn N. Timm Date
Area Manager