GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 18, 2021

Catherine Reese
Vibrant Life Senior Living Sterns Lodge
667 W. Sterns Road
Temperance, MI 48182

RE: License #: AH580353904
Investigation #: 2021A0585040
Vibrant Life Senior Living Sterns Lodge

Dear Ms. Reese:

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 (248) 975-5053.

Sincerely,

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
4th Floor, Suite 4B, 51111 Woodward Avenue
Pontiac, MI 48342
(313) 268-1788

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH580353904
Investigation #:	2021A0585040
Complaint Receipt Date:	07/14/2021
Investigation Initiation Date:	07/15/2021
Report Due Date:	09/13/2021
Licensee Name:	Vibrant Life Senior Living OC Temperance, LLC
Licensee Address:	5720 Williams Lake Road Waterford, MI 48329
Licensee Telephone #:	(734) 847-3217
Administrator:	Molly Bowman
Authorized Representative:	Catherine Reese
Name of Facility:	Vibrant Life Senior Living Sterns Lodge
Facility Address:	667 W. Sterns Road Temperance, MI 48182
Facility Telephone #:	(734) 847-3217
Original Issuance Date:	02/20/2014
License Status:	REGULAR
Effective Date:	02/20/2021
Expiration Date:	02/19/2022
Capacity:	46
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was issued a discharged notice.	No
Resident A was verbally abused by staff.	No
Additional Findings	Yes

III. METHODOLOGY

07/14/2021	Special Investigation Intake 2021A0585040
07/15/2021	Special Investigation Initiated - Telephone Attempted to contact complainant/resident by telephone. No contact established.
07/15/2021	APS Referral Made a referral to Adult Protective Services (APS).
07/19/2021	Inspection Completed On-site Completed with observation, interview and record review.
07/28/2021	Contact - Telephone call made Interviewed additional staff.
08/18/2021	Exit conference Conducted with authorized representative Catherine Reese.

ALLEGATION:

Resident A was discharged on 7/12/21 in retaliation.

INVESTIGATION:

On 7/14/21, the department received the allegations from the complaint via the BCAL Online complaint website.

On 7/15/21, the allegations in this report were sent to centralized intake at Adult Protective Services (APS).

On 7/19/21, during the onsite, I interviewed the complainant at the facility. She stated that the facility gave her a discharge letter. She stated that she believes the facility is retaliating against her for reporting to the State.

On 7/19/21, I interviewed the administrator Molly Bowman at the facility. She stated that the reason for the discharge is that Resident A has become increasingly violent toward staff. She stated that staff is receiving verbal threat from Resident A. She stated that this was not the first time that Resident A has been violent toward the staff. She stated that on two other occasions she has ran her mobilized chair into the staff causing injuries to them. Ms. Bowman shared copies of Resident A's discharge letter, service plan and progress notes.

The discharge letter dated 7/12/21 issued to Resident A read, facility issued a 30-day discharge notice due to numerous accounts of aggression and outburst toward staff members. The notice indicates that Resident A may file a complaint with the State and includes alternative facilities.

On 7/19/21, I interviewed Tajanika Rease at the facility. Ms. Rease stated that Resident A have run over several staff with her wheelchair.

On 7/28/21, I interviewed Latecia Crockett by telephone. Ms. Crockett stated that if things don't go Resident A's way, she gets angry. She stated that she can be verbally as well as physically aggressive. She stated that she is always rude to staff. She stated that when she gets angry, the first thing come out of her mouth is "Black Bitch".

The chart notes for Resident A read,

4/13/21 – Resident became very agitated demanding she get a shower right now. Resident is a 2 person assist for her showers and the second person wasn't available to help because they were in the middle of med pass and cannot be interrupted during that time. I explained to resident that her hospice shower was scheduled for today and her helper could wash her up once she was done using the toilet and when hospice came in and could be the second helper she would get her shower. Resident became irate and started yelling at the staff. (Jack Williams – Resident Care Coordinator)

5/3/21 – Spoke with hospice staff and she relayed some information regarding her conversation with [Resident A]……she threw her Depakote away and when they spoke of the incident where she ran over a staff member's foot, she smiled and laughed. She also relayed that [Resident A] was making some racist remarks, stating this is a "white facility" and doesn't know why "blacks" are working here. (Jack Williams- Resident Care Coordinator)

5/29/21 – Today shortly after dinner, [Resident A] became aggressive against the whole staff because another resident didn't have his utensils. She proceeded to tell another staff she was not doing her job then went on to call her deaf because [Resident A] supposedly asked her three times, this has been ongoing problem with [Resident A] since I have been at this job. She ran over one of my co-worker foot and still to this day shows no remorse, she has no manners, no patient, no respect and is just down right disrespectful and ignorant with everything she says and does. She is making it very difficult for me and my co-workers to come to work and enjoy our day at work. (Dantae O'niel)

5/29/21 – At and around 9 pm, [Resident A] decided to randomly disappear into another resident room so it took us some time to find her to get ready for bed after she disrespected staff this afternoon/evening around 5 pm. She called us out of our names and continued to act like she works here and demanded us to do this and that for not just her, other residents. This is only part of the problem with her. There is no respect. There is lack of guidance because others now don't want anything to do with her. She's very aggressive and this is a constant thing after we found her in the other resident's room because the other resident's call button fell off of her while changing and it wasn't noticed yet she had a terrible attitude toward us and told me and the other staff member involved that all we did or do is just stand there and we ignored her calling but we couldn't find her. (Ariana Read)

5/30/21 – Today at approximately 11:30 am, me and another staff were assisting [Resident A] using the bathroom, at first thing were okay and then [ResidentA] became verbally aggressive because the other staff accidentally threw the dirty rag in the bin that was supposed to be use to clean her bottom. The other staff replied telling her that it was an accident. [Resident A] escalated the situation by bringing up last night she was ringing her bell but she was not where to be found. Come to find out she was in another resident's room. She proceeded to tell us that the other resident's button was missing. [Resident A] told us to "kiss where the sun don't shine" then she went in her room, but as I was in the bathroom trying to explain to her how I felt she was wrong she says to me "You people need to come when you summoned." Her attitude toward staff and residents are becoming too much to deal with on a day-to-day basis. She is rude, disrespectful, unpleasant to deal with. She continuously makes racial remarks, she has no patient/respect to staff or the residents that are around her. (Dantae O'niel)

The discharge letter was issued to Resident A which included the date of discharge, the reason for discharge, and alternative facilities.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(13) A home shall provide a resident and his or her authorized representative, if any, and the agency responsible for the resident's placement, if any, with a 30-day written notice before discharge from the home. The written notice shall consist of all of the following: **(a) The reasons for discharge.** **(b) The effective date of the discharge.** **(c) A statement notifying the resident of the right to file a complaint with the department. The provisions of this subrule do not preclude a home from providing other legal notice as required by law.**
ANALYSIS:	The facility issued a discharge notice to Resident A due to accounts of aggression toward staff. Based on interview and record review, this claim of a wrongful discharge could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was verbally abused by staff.

INVESTIGATION:

The complainant stated that staff member Latrice Crockett verbally assaulted her. Complainant stated that Latrice Crockett mocked her condition and told her that she "would off herself". Complainant stated that Ms. Crockett refused to provide perineal care until the complainant apologized to her for talking rudely back to her. She stated that Ms. Crockett finally got her up but did not properly clean her and put her in the wheelchair correctly. Complainant stated Ms. Crockett refused to reposition her and called her a "fat ass". She stated that hit the staff member with her wheelchair. She stated that she has ran over a staff before because she gets angry when they don't do what they are supposed to do. She stated that she does say things when she mad, but she is not a racist and she like "black" people.

Ms. Bowman stated that complainant reported that staff member (Latrice Crockett) was verbally abusive to her. Ms. Bowman stated that she completed an investigation and did not find anything. She reviewed a video and she saw Resident A pushing her wheelchair into Ms. Crockett. She stated that all staff, including Ms. Crockett had abuse training as well as inservice on residents' rights.

A review of the video saw Resident A moving toward Ms. Crockett hitting her in the leg. Ms. Crockett was attempting to move out of the way from her. I saw Resident A saying something at the time of hitting Ms. Crockett with her wheelchair, but there was no audio and therefore I could not hear what was said.

On 7/19/21, I interviewed resident care coordinator Jack Williams. He stated that Resident A press the pendant. He stated that Ms. Crockett went to Resident A's room and told her that she would be back because she was helping another resident at that time. He stated that when Ms. Crockett went back to the room, Resident A was swearing at her and using racial slurs at her. He stated that she completed the care for Resident A. He said that once Ms. Crockett and Resident A was in the hall, Resident A hit her with the wheelchair.

On 7/19/21, I interviewed Resident B at the facility. She stated that she did witness the incident. She said she was in her room and came out to hear Resident A yelling at the staff. She stated that she have never had any problem with any staff and don't know anyone who does. She stated that staff always care for her needs.

On 7/19/21, I interviewed resident care aides Tajanika Rease at the facility. She stated that Resident A have attitudes all the time.

Ms. Crockett stated that on the day of the incident, Resident A press the call light. She stated that she was getting another resident ready for an appointment, so she went to Resident A's room to let her know that she will be back, and resident got mad. She stated that when she went back to care for Resident A, the resident started using profanity at her. She stated that she tried to explain to her, but she didn't want to hear it but continue to curse at her and called her a "black bitch". She stated that Resident A told her that she took too long and continued to "go off' on her. She stated that she took Resident A to the bathroom and stepped out to call the supervisor. Ms. Crockett stated that she felt that Resident A was having a bad morning. She stated that Resident A was very disrespectful. I did tell her that she needs to apologize, but I continued to do her care. She stated that as she exited Resident A's room, the resident hit her on the leg with her wheelchair. She stated that she has worked at the facility for five years and she have never had problems with a resident.

A review of the training revealed that Ms. Crockett had training consistent to Ms. Bowman's statement.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(2) The owner, operator, and governing body of a home shall do all the following:

	(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.
ANALYSIS:	Interviews with caregivers and review of Resident A's chart, revealed Resident A is known to be verbally aggressive as well as physical aggressive towards staff members. There is lack of evidence to support the allegation that Resident A was verbally abused by staff.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION

During an interview with Ms. Bowman, she stated that Resident A has become increasingly violent toward staff.

Mr. Williams and Ms. Crockett stated that Resident A is aggressive toward staff.

Service plan for Resident A read that she does not exhibit aggressive behavior.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	Service plan for Resident A notes that she does not exhibit aggressive behavior, but according to interviews and other documentation she has behaviors where she become abusive and aggressive toward staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 8/18/21 I conducted an exit conference with licensee authorized representative Catherine Reese by telephone.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

8/18/21

Brender Howard — Date
Licensing Staff

Approved By:

8/16/21

Russell B. Misiak — Date
Area Manager