GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 14, 2021

Melissa Peebles
Park Village Pines
2920 Crystal Lane
Kalamazoo, MI 49009

RE: License #: AH390236863
Investigation #: 2022A1028008
Park Village Pines

Dear Ms. Peebles:

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 on 12/29/21 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 (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
Cell (616) 204-4300

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

I. IDENTIFYING INFORMATION

License #:	AH390236863
Investigation #:	2022A1028008
Complaint Receipt Date:	11/02/2021
Investigation Initiation Date:	11/04/2021
Report Due Date:	12/14/2021
Licensee Name:	The Kalamazoo Area Christian Retirement Assoc. Inc.
Licensee Address:	2920 Crystal Lane Kalamazoo, MI 49009
Licensee Telephone #:	(269) 372-1928
Authorized Representative/Administrator:	Melissa Peebles
Name of Facility:	Park Village Pines
Facility Address:	2920 Crystal Lane Kalamazoo, MI 49009
Facility Telephone #:	(269) 372-1928
Original Issuance Date:	03/01/1975
License **Status:**	REGULAR
Effective Date:	03/31/2021
Expiration Date:	03/30/2022
Capacity:	215
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Care staff are disrespectful to Resident A.	No
Facility is understaffed to meet the needs of residents.	No
Care staff did not administer Resident A medications in a timely manner.	Yes

III. METHODOLOGY

11/02/2021	Special Investigation Intake 2022A1028008
11/04/2021	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
11/04/2021	APS Referral APS referral emailed to Centralized Intake
11/22/2021	Contact - Face to Face Interviewed Resident A at the facility
11/22/2021	Contact - Face to Face Interviewed director of compliance, David Murray, at the facility
11/22/2021	Contact - Face to Face Interviewed care staff person, Lisa Horton, at facility
11/22/2021	Contact - Face to Face Interviewed care staff person, Stephanie Junker, at the facility
11/22/2021	Contact - Face to Face Interviewed care staff person, Jamie Rosselott, at the facility

12/3/2021	Contact – Telephone call made Interviewed Resident A's authorized representative by telephone
12/3/2021	Contact – Telephone call made Interviewed care staff person, Michelle Bogema, by telephone
12/14/2021	Exit Interview

ALLEGATION:

Care staff are disrespectful to Resident A.

INVESTIGATION:

On 11/3//21, the Bureau received the allegations from the online complaint system.

On 11/3/21, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 11/22/21, I interviewed Resident A at the facility. Resident A reported their spouse passed away a while ago and the care person (Michelle) that took care of the spouse came over from another building to assist one day. Resident A asked care staff person, Michelle, why she was passing medications on the floor. Resident A reported Michelle said, "I am over to help out because Stephanie said no one wants to pass meds on your floor because they hate you". Resident A reported being very upset by this comment and reported this conversation to management, care staff person, Stephanie, and family.

On 11/22/21, I interviewed director of compliance, David Murray, at the facility. Mr. Murray reported Resident A has resided at the facility for 10 years and is "very much independent for care". Mr. Murray reported Resident A's spouse passed a while back and Resident A still struggles emotionally with this at times. Mr. Murray reported a conversation was brought to his attention by Resident A in which a care staff member, Michelle, said to Resident A "*Stephanie said no one wants to work on [Resident A's] floor because staff hate [Resident A]".* Mr. Murray reported he interviewed the care staff persons, Michelle and Stephanie, that were involved in this conversation, and both denied saying that. Mr. Murray reported he does not believe it was said that to Resident A, but something could have been taken out of context or misunderstood. Mr. Murray reported there are some staff Resident A prefers over other staff, but "generally there are no issues between staff and Resident A". Mr.

Murray reported he spoke with Resident A about this alleged conversation and reported disrespect of any kind is not tolerated at the facility.

On 11/22/21, I interviewed care staff person (CSP), Stephanie Junker, at the facility. Ms. Junker reported Resident has resided at the facility a very long time and is "pretty independent with care". Ms. Junker reported Resident A still seems to be struggling with some emotions since Resident A's spouse passed and "just does not seem happy anymore". Ms. Junker reported other care staff have reported to her that Resident A has been difficult and will say mean things to care staff or yell at care staff. Ms. Junker reported Resident A can be demanding and vocal if Resident A sees something they do not like or want. Ms. Junker reported care staff person "Michelle Bogema and Resident A have a good relationship. Michelle may have been joking with [Resident A] during a medication pass one day and [Resident A] may have taken it the wrong way". Ms. Junker reported she did not say "*no one wants to work on [Resident A's] floor because staff hate Resident A*." Ms. Junker denied saying those words and reported "there was never a conversation between Michelle and I about [Resident A]". Ms. Junker reported she questioned care staff person, Ms. Bogema, about this incident and Ms. Bogema reported she did not say anything like that to Resident A. Ms. Junker reported Resident A was upset due to what was allegedly said and left several voicemails on her work phone about this incident. Ms. Junker reported Mr. Murray and management further discussed this incident with Resident A. Ms. Junker reported to her knowledge there have no issues reported about care staff being disrespectful to Resident A or any resident. Ms. Junker reported that disrespect of residents is not allowed or tolerated at the facility.

On 11/22/21, I interviewed CSP, Jamie Rosselott, at the facility. Ms. Rosselott reported Resident A is independent with almost all care. Ms. Rosselott reported she has had no issues with Resident A and has no knowledge of any care staff person disrespecting Resident A or speaking ill about Resident A. Ms. Rosselott reported disrespect to anyone in the facility would not be tolerated. Ms. Rosselott reported Resident A "can be demanding sometimes but I wouldn't say difficult. Resident A just likes to stick to [their] schedule for the day and for things to be on time". Ms. Rosselott reported no knowledge that Resident A had been told care staff do not want to work the floor because they do not like Resident A.

On 11/22/21, I interviewed CSP, Lisa Horton, at the facility. Ms. Horton reported she has never had any issues with Resident A. Ms. Horton reported Resident A has seemed more down lately due to Covid and the passing of her husband awhile back. Ms. Horton reported Resident A "is known to yell at other staff if staff members do not move as fast as [Resident A] wants them to or if [Resident A] thinks staff is being mean". Ms. Horton reported no knowledge that Resident A had been told care staff do not want to work the floor because they do not like Resident A. Ms. Horton reported "comments like that to anyone would not be tolerated here".

On 12/3/21, I interviewed Resident A's authorized representative. The authorized representative reported Resident A informed [them] that the comment "*no one wants*

to work on [Resident A's] floor because staff hate you" was made to them by a care staff person. The authorized representative reported Resident A was very upset by this comment. The authorized representative reported it may have been a misunderstanding and it was very unprofessional. The authorized representative reported when [they] visit the facility, staff are helpful and kind. The authorized representative reported Resident A is very independent and despite being so independent, care staff might overlook Resident A at times to focus attention on others who require more help. The authorized representative reported Resident A has reported various things to management and the board over the years and "Resident A has felt pushed aside or ignored". The authorized representative reported Resident A thrives on structure and the facility has been able to provide that for Resident A, so if something is different with Resident A's regimen, Resident A may be vocal about it.

On 12/3/21, I interviewed CSP, Michelle Bogema, by telephone. Ms.Bogema reported she and Resident A have a very good working relationship. Ms. Bogema reported she took care of Resident A's spouse for a long time and she and Resident A because close during this time. Ms. Bogema reported she did come over from another building to assist with medication administration one day and administered Resident A's medications. Ms. Bogema reported Resident A asked why she was there that day and Ms. Bogema reported she "just came over to help out so they wouldn't be shorthanded". Ms. Bogema reported she and Resident A had a short conversation and were joking back and forth, but she never said "*no one wants to work on [Resident A's] floor because staff hate [Resident A]".* Ms. Bogema reported she never said anything about Stephanie saying those words either. Ms. Bogema reported she did not talk to Resident A about Stephanie or any other care staff during their conversation and that the conversation was short and light-hearted.

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:	Interviews reveal that Resident A reported a conversation to management and [their] authorized representative in which Resident A was allegedly told "*no one wants to work on [Resident A's] floor because staff hate [Resident A].*" Management took appropriate steps to address Resident A's concerns, to ensure [their] dignity was respected, and to investigate this alleged incident because it does not align with the values and rights of residents at the facility. While it is unfortunate that Resident A felt their dignity was compromised by facility staff, there is no evidence to substantiate these alleged words were said to Resident A by care staff.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Facility is understaffed to meet the needs of residents.

INVESTIGATION:

On 11/22/21, Resident A reported help with care has been late because the facility is understaffed. Resident A reported there are not enough staff to help residents with care in a timely manner. Resident A reported it takes staff longer to respond to resident requests.

On 11/22/21, Mr. Murray reported the facility has faced difficulty with staffing due to the pandemic, but no shift goes uncovered. Mr. Murray reported staff from other buildings fill, there is mandation, overtime, agency staff, on-call staff, and management will assist as well to make sure any shift shortage is covered.

On 11/22/21, Ms. Junker reported there are times when call-ins occur shorting a shift, but the facility will either call in care staff, use mandation, use agency staff, have care staff from other buildings if available fill the vacancy, or management will assist on the floor as well. Ms. Junker reported staffing is beginning to improve as well and the facility is continually hiring. Ms. Junker reported the facility "makes it work" despite to the call-ins to make sure no shift is shorthanded.

On 11/22/21, Ms. Rosselott reported the pandemic affected staffing, but it has recently been improving. Ms. Rosselott reported the facility continues to hire, use

agency staff, use call-in care staff or care staff from other buildings, or implements mandation to make sure no shift is short. Ms. Rosselott reported management often helps with care as well. Ms. Rosselott reported the facility is doing the best they can to hire and retain good care staff.

On 11/22/21, Ms. Horton reported call-ins occur, but the facility uses agency, on-call care staff, care staff from other buildings, mandation, and management assists as well to prevent shift shortages. Ms. Horton's statements are consistent with Mr. Murray's, Ms. Junker's, and Ms. Rosselott's statements.

On 11/22/21, I reviewed the working staff schedules at the facility. The review revealed utilization of agency staff, call-in care staff, mandation, and management assisting to prevent shift shortages.

I completed an inspection of the facility and observed adequate care staff on the floor to meet the needs of residents. Residents observed in common areas and in the hallway were clean, groomed, and content.

On 12/3/21, Resident A's authorized representative reported Resident A has complained of care staff not being as prompt as [they] would like care staff to be in responding to requests. The authorized representative reported when visiting the facility, care staff have been helpful and kind. The authorized representative reported [they] are not aware if the facility is shorthanded or not, as there have been care staff available when [they] visited the facility.

On 12/3/2021, Ms. Bogema statements are consistent with Mr. Murray's, Ms. Junker's, Ms. Rosselott's, and Ms. Horton's statements about call-ins, facility hiring, and covering shifts to prevent shortages. Ms. Bogema reported the facility is doing a good job to ensure all shifts are covered despite call-ins and unexpected shift vacancies.

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 plan.

ANALYSIS:	Interviews and review of the working staff schedules reveal a normalization of care staff to appropriately meet the needs of residents at the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Care staff did not administer Resident A medications in a timely manner.

INVESTIGATION:

On 11/22/21, Resident A reported there are not enough care staff to administer medications on time. Resident A reported care staff have administered medications up to an hour late. Resident A also reported [they] had not received their 1:00pm Seroquel medication yet. (The time was 2:11pm when Resident A reported this to me at the facility).

On 11/22/21, Mr. Murray reported no knowledge of Resident A not receiving [their] 1:00pm Seroquel medication or any resident medications being up to an hour late when care staff are administering. Mr. Murray reported "[Resident A] should have been given [their] 1:00pm med". I requested Mr. Murray pull Resident A's medication record for that day to confirm the medication administration. Mr. Murray also provided me a copy of the medication policy for my review.

I reviewed Resident A's medication record with Mr. Murray present. The medication record was blank for Resident A's Seroquel medication for 1:00pm on 11/22.

On 11/22/21, Ms. Junker reported that residents receive medications on time at the facility and the medication administration record is to be completed as soon as the medication administration is completed. Ms. Junker reported no knowledge of late or missed medication administration for residents. Ms. Junker reported Resident A is very knowledgeable about [their] medication administration and will often come to the medication cart to have medications administered. Ms. Junker reported Resident A should have been administered their 1:00pm Seroquel medication. Ms. Junker provided Resident A's medication listing report for 11/22 for my review.

Resident A's medication listing report shows one tablet of Seroquel 50mg to be given by mouth three times daily. Care staff initials LSH and time 12:25pm are on shown on the report.

On 11/22/21, Ms. Rosselett reported no knowledge of residents not receiving medications in a timely manner. Ms. Rosselett reported Resident A will often come to the medication cart to receive [their] medications but to her knowledge “there have been no issues with [Resident A’s] medication.”

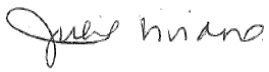
On 11/22/21, Ms. Horton reported she administered Resident A’s medication today. Ms. Horton reported Resident A is very knowledgeable about [their] medications and will often come to the medication cart at the time medications are due to be administered. Ms. Horton reported there were a lot of residents today at the medication cart, but Resident A was given [their] “1:00pm Seroquel medication around 12:30pm”. When questioned further and shown the blank medication administration record for Resident A’s 1:00pm Seroquel medication, Ms. Horton reported she did not record it on the medication administration record yet for the day because “I just wanted get to lunch and would come back and finish it”.

On 12/3/21, I interviewed Resident A’s authorized representative. The authorized representative reported Resident A has reported to [them] that medications were being administered late, but never a missed medication. The authorized representative Resident is very functional and knowledgeable [their] medications and there would be “concerns if [Resident A] were in need of more care”.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.
ANALYSIS:	Interviews with care staff and Resident A reveal it cannot be determined if Resident A received the 1:00pm Seroquel medication because Resident A’s medication administration record was not completed appropriately or in a timely manner when reviewed at the facility on 11/22. Resident A denies receiving the 1:00pm dose of Seroquel on 11/22 and care staff reports Resident A was given the medication at 12:30pm on 11/22. However, Resident A’s medication record was not completed by assigned care staff demonstrating correct and appropriate medication administration. Therefore, the facility is in violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

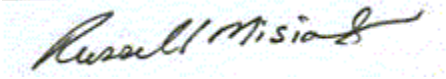
Contingent upon an approved corrective action plan, I recommend the license remain unchanged.



12/3/2021

Julie Viviano Date
Licensing Staff

Approved By:



12/10/21

Russell B. Misiak Date
Area Manager