GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 5, 2021

Alison Freed
White Lake Assisted Living
6827 Whitehall Road
Whitehall, MI 49461

RE: License #: AH610314487
Investigation #: 2022A1010009
White Lake Assisted Living

Dear Ms. Freed:

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 (616) 356-0183.

Sincerely,

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa NW Unit 13, 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH610314487
Investigation #:	2022A1010009
Complaint Receipt Date:	11/22/2021
Investigation Initiation Date:	11/29/2021
Report Due Date:	12/22/2021
Licensee Name:	White Lake Assisted Living, LLC
Licensee Address:	Suite 200 3196 Kraft Ave. Grand Rapids, MI 49512
Licensee Telephone #:	(616) 464-1564
Administrator:	Ami Moy
Authorized Representative:	Alison Freed
Name of Facility:	White Lake Assisted Living
Facility Address:	6827 Whitehall Road Whitehall, MI 49461
Facility Telephone #:	(231) 893-8730
Original Issuance Date:	09/05/2012
License Status:	REGULAR
Effective Date:	05/17/2021
Expiration Date:	05/16/2022
Capacity:	64
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident F received an improper 30-day discharge notice.	No
There are not enough staff at the facility.	No
Staff administered a deceased resident's insulin to Resident F.	Yes

III. METHODOLOGY

11/22/2021	Special Investigation Intake 2022A1010009
11/29/2021	Special Investigation Initiated - Telephone Spoke with administrator on 11/10 regarding this resident and the situation
11/29/2021	APS Referral APS referral emailed to Centralized Intake
12/01/2021	Contact – Document received Email from Ms. Moy received
12/09/2021	Contact - Telephone call made Interviewed the complainant by telephone
12/09/2021	Inspection Completed On-site
12/09/2021	Contact - Document Received Received Resident F's service plan, MARs, and staff notes
12/09/2021	Contact - Document Received Received facility documents regarding Resident F via email from the complainant
12/22/2021	Contact – Document Received Received staff schedule via email from Ms. Moy

ALLEGATION:

Resident F received an improper 30-day discharge notice.

INVESTIGATION:

On 11/10/21, I received a telephone call from administrator Ami Moy. Ms. Moy stated the facility identified Resident F required a higher level of care, however Resident F's responsible person was not in agreement. Ms. Moy explained Resident F was admitted as an "independent" resident, meaning she did not require assistance from staff for activities of daily living (ADLs). Ms. Moy said Resident F now required more assistance from staff.

Ms. Moy stated the facility would no longer be able to meet Resident F's care needs and ensure her safety consistent with the facility's program statement if she continued at her current level of care. Ms. Moy and I discussed the possibility of issuing Resident F a discharge notice if her responsible person did not agree to increase her level of care.

On 11/22/21, the bureau received the allegations from the online complaint system. The complaint read Resident F received a 30-day discharge notice "under very false pretenses." The complaint also read, "They are making things up to say that [Resident F] is more care than they can handle. The fact is, the care that she is receiving is not keeping her safe there, not to mention the emotional toll it is taking on her."

On 11/29/21, I emailed an Adult Protective Services (APS) complaint to Centralized Intake.

On 11/29/21, I reviewed the emails I received from Ms. Moy regarding Resident F. An email from Ms. Moy that I received on 11/18 read, "I met with [Relative F1] and offered 3 options for nsuring [sic] [Resident F's] care. Option 1 was for her to remain in IL but she would need to have home care take over her care and medication administration. Option 2 would be to move to AL and agree to the level of care that we recommend. Option 3 was a 30-day discharge notice. She tooke [sic] the 3 options with her and I am currently awaiting a response."

On 12/1/21, I received a follow up email from Ms. Moy. Ms. Moy stated, "I sat down with [Relative F1] and gave her 3 options and she was to sign one of them and let me know what option she wanted to pursue. She never got back to me and moved [Resident F] out without notice to me on 11.27.21.

On 12/9/21, I interviewed the complainant by telephone. The complainant reported Resident F's level of care did not increase since she was admitted to the facility. The complainant stated the facility gave Resident F a discharge notice "for no reason." The complainant said Ms. Moy claimed Resident F was incontinent, however she was not. The complainant explained there was an incident when Resident F was administered milk of magnesia so she "had an accident."

The complainant reported Ms. Moy also claimed staff found Resident F disoriented in the hallway and she was unable to find her room. The complainant stated Ms. Moy said Resident F also often used her pendant to summon staff for assistance with her ADLs. The complainant maintained Ms. Moy's statements were untrue because Resident F was independent.

The complainant stated staff accused Resident F of keeping moldy food in her room. The complainant reported Resident F is blind and staff were concerned she was going to eat it. The complainant explained Resident F had moldy apples in her room to feed the deer near the facility.

The complainant said Resident F was moved out of the facility because of disagreement with the three options Ms. Moy presented to keep Resident F as a resident at the facility.

I received an email from the complainant. The complainant provided me with a copy of Resident F's discharge notice for my review. The notice read, "[Resident F] is currently requiring an assisted living level of care a indicated by her current clinical evaluation, medication requirements, call light usage and need for stand by assist with ADL's related to her vision and unsteadiness." The notice also read, "[Resident F's] care needs are outside the scope of our independent living services. This letter is notifying you that we are no longer able to care for the needs of [Resident F] and we are issuing a 30-day notice to discharge [Resident F] from White Lake Assisted Living."

On 12/9/21, I interviewed wellness director Cindie Fluette at the facility. Ms. Fluette reported Resident F was given a discharge notice because her level of care did increase, however Relative F1 did not agree to increase her care. Ms. Fluette stated Resident F is legally blind and began to use her pendant more often for assistance from staff with ADLs such as dressing. Ms. Fluette said Resident F began to require assistance from staff getting to the dining room for meals. Ms. Fluette reported staff were no longer able to ensure Resident F's safety at the level of care in which she was admitted.

Ms. Fluette provided me with a copy of Resident F's service plan for my review. The *Lower Body Dressing* section of the plan read, "Fully dresses lower body independently. Fully dresses lower body independently. Resident is becoming more unsteady. Resident has a history of vertigo and currently has a wound on her foot in which she is utilizing home health for." The *Bathing* section of the plan read, "Bathes independently. Able to bathe self independently. Resident could benefit from a standby assist for safety related to unsteadiness. Family does not feel it is necessary at this time." The *Toileting Assistance* section of the plan read, "Incontinent of bowel and/or bladder an manages protective and/or assistive devices independently. Has occasional incontinence. Has required help from staff to manage."

The *Ambulation/Mobility* section of the plan read, “Ambulates or propels self with or without use of an assistive device. Ambulates self with walker. Occasionally requires staff to push her in a wheelchair due to fatigue and her foot wound.” Ms. Fluette provided me with a copy of Resident F’s staff notes for my review. A note dated 11/8 read, “resident came into mc around noon and asked for her inhaler for sob. When she walked in mc she was wheezing and said [Relative F1] seen [sic] her on camera in her room having a hard time breathing. I told her to push her pendant when she needs help. She said [Relative F1] told her to walk in there and not to use her pendent [sic]. This is a safety concern to me as if she having hard time breathing and walks she could end up falling.”

A note dated 11/19 read, “While in giving 5PM medications, resident informed staff that she had an accident in the bathroom. Resident stated that some feces got on the floor and she stepped in it. IT got tracked across the bathroom floor and is on her shoes. Staff cleaned up bathroom floor and shoes.”

On 12/9/21, I interviewed medication technician (med tech) Danielle Kitson at the facility. Ms. Kitson’s statements were consistent with Ms. Fluette. Ms. Kitson reported Resident F was unsteady on her feet and began to require stand by assistance from staff.

On 12/9/21, I interviewed med tech Kolynne Anderson at the facility. Ms. Anderson’s statements were consistent with Ms. Fluette and Ms. Kitson. Ms. Anderson reported Resident F did have moldy food in her room. Ms. Anderson explained during one incident, she observed moldy Crystal Light in Resident F’s cup in her room. Ms. Anderson said Resident F did not know the beverage had mold because she was blind. Ms. Anderson stated Resident F also tripped over the pedals on her wheelchair because she was blind.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(15) A home may discharge a resident before the 30-day notice if the home has determined and documented that either, or both, of the following exist: **(a) Substantial risk to the resident due to the inability of the home to meet the resident's needs or due to the inability of the home to assure the safety and well-being of the resident, other residents, visitors, or staff of the home.** **(b) A substantial risk or an occurrence of the destruction of property.**

ANALYSIS:	The emails I received from Ms. Moy, along with my interviews with Ms. Fluette, Ms. Kitson, and Ms. Anderson revealed resident F's care needs increased while she resided at the facility. The facility provided Relative F1 with the opportunity to increase Resident F's care services provided by staff. Relative F1 was not in agreeance with the increase in Resident F's care, therefore Resident F moved out of the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

There are not enough staff at the facility.

INVESTIGATION:

On 11/22/21, the complaint read the facility was "understaffed."

On 12/9/21, the complainant reported Resident F went several days with a clogged toilet in her bathroom because there are not enough staff available at the facility. The complainant stated Resident F's medications were administered hours late because the facility was understaffed. The complainant said there was one staff person administering resident medications from three medication carts.

On 12/9/21, Ms. Fluette stated the facility is adequately staffed to meet resident care needs. Ms. Fluette reported the facility is staffed as follows:

1st shift

- One med tech in the secured memory care
- One resident care aide in the secured memory care unit
- Two med techs in the general assisted living area
- One direct care aide in the general assisted living area

2nd shift

- One med tech in the secured memory care
- One resident care aide in the secured memory care unit
- One med tech in the general assisted living area
- One direct care aide in the general assisted living area

3rd shift

- One med tech in the secured memory care
- One resident care aide in the secured memory care unit

- One med tech in the general assisted living area
- One direct care aide in the general assisted living area

Ms. Fluette stated there are two residents in the secured memory care unit who required assistance from two staff persons to transfer. Ms. Fluette reported there were also two residents in the general assisted living area who required assistance from two staff persons to transfer. Ms. Fluette reported nursing and management staff are also available on first shift to assist staff as needed.

On 12/9/21, Ms. Kitson's statements regarding staffing at the facility were consistent with Ms. Fluette. Ms. Kitson explained staff use the iPods carried on their person during their shift to communicate with each other. Ms. Kitson stated the facility uses staff volunteers to cover shift vacancies. Ms. Kitson explained if there are no volunteers, staff mandates to stay over and cover the shift occur.

On 12/9/21, Ms. Anderson reported there were instances when one or two shift vacancies occurred, however staff were still able to complete care needs consistent with resident service plans. Ms. Anderson stated when the shift vacancies occurred, some resident cares, such as medication administration, occurred late. Ms. Anderson said the medications were still administered; they were just given later than normal.

On 12/9/21, I interviewed Resident G at the facility. Resident G reported staff met her care needs. Resident G stated she has used her pendant to summon staff for assistance. Resident G said staff responded timely when she used her pendant.

On 12/9/21, I interviewed Resident H at the facility. Resident H's statements were consistent with Resident G.

On 12/9/21, I interviewed Resident I at the facility. Resident I's statements were consistent with Resident G and Resident H.

On 12/9/21, I interviewed Resident J at the facility. Resident J stated there was high staff turnover at the facility, however it did not affect her care needs, they were still met.

On 12/22/21, Ms. Moy provided me with a copy of the staff schedule for 11/29 through 12/26 for my review. I observed the schedule was consistent with Ms. Fluette's statements.

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:	The interviews with Ms. Fluette, Ms. Kitson, Ms. Anderson, Resident G, Resident H, Resident I, and Resident J, along with review of the staff schedule, revealed there was sufficient staff to meet resident care needs consistent with their service plans.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff administered a deceased resident's insulin to Resident F.

INVESTIGATION:

On 11/22/21, the complaint read Resident F was administered a recently deceased resident's insulin because Resident F's insulin ran out and she did not have any available. The complainant wrote the insulin staff used to administer to Resident F belonged to Resident K who died "three days earlier." The complaint read the staff person "immediately began to cry and say she's so sorry." The complaint also read the staff person stated the facility's administrator Ami Moy told her to administer Resident K's insulin to Resident F.

On 12/9/21, Ms. Fluette initially reported denied knowledge regarding Resident F being administered Resident K's insulin. Ms. Fluette later stated Resident F was administered Resident K's insulin, however she was working with the pharmacy to get Resident K's insulin at the facility switched to Resident F. Ms. Fluette explained Resident F did not have insulin available because the pharmacy incorrectly delivered one insulin pen, not the three pens they were supposed to. Ms. Fluette said Resident F never went without insulin.

On 12/9/21, Ms. Anderson denied knowledge regarding Resident F getting another resident's insulin. Ms. Anderson reported she was aware there was an incident in which the pharmacy sent the incorrect number of Resident F's insulin pens. Ms. Anderson said to her knowledge, all resident medications were administered as prescribed. Ms. Anderson stated med techs were not trained to administer another resident's medication, even if it was the same, to another resident if theirs was unavailable.

On 12/9/21, Ms. Anderson admitted she administered Resident K's insulin to Resident F because Resident F did not have any available. Ms. Anderson reported Resident K's insulin was the same prescription as Resident F's, however it did belong to Resident K who was deceased.

Ms. Anderson stated before she administered Resident K's insulin to Resident F, she informed Ms. Fluette and Ms. Moy that Resident F did not have any insulin available due to a pharmacy error. Ms. Anderson said Ms. Fluette then asked if any other residents in the facility were prescribed the same insulin as Resident F. Ms. Anderson explained after Ms. Fluette was informed Resident K's insulin was the same, she directed her to administer Resident K's insulin to Resident F because it was available.

Ms. Anderson reported Resident F needed insulin the day of the incident because she was leaving the facility to spend time with her family. Ms. Anderson stated she knew it was wrong to administer Resident K's insulin to Resident F, however she was put in a difficult position. Ms. Anderson said Ms. Moy was present in the room when Ms. Fluette instructed her to administer Resident K's insulin.
Ms. Anderson said it was normally the facility's policy and procedure to destroy a deceased resident's medications if they had any left in the medication cart. Ms. Anderson reported Resident K's prescribed insulin was still in the medication cart after she died a few days prior to the incident in November.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	The interview with Ms. Anderson revealed she administered Resident K's insulin to Resident F in November because Resident F did not have any insulin pens available. Ms. Anderson reported she followed Ms. Fluette's instruction to administer Resident K's insulin to Resident F.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(5) A home shall take reasonable precautions to ensure or assure that prescription medication is not used by a person

	other than the resident for whom the medication is prescribed.
ANALYSIS:	The interview with Ms. Anderson revealed she administered Resident K's insulin to Resident F in November because Resident F did not have any insulin pens available. Ms. Anderson's actions were not consistent with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(6) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a licensed health care professional or a pharmacist.
ANALYSIS:	The interview with Ms. Anderson revealed Resident K's insulin was still present in the medication cart days after she had passed away. This medication should not have been available and was not properly disposed of after Resident K had passed.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

12/28/2021

_____

Lauren Wohlfert Date
Licensing Staff

Approved By:

12/28/2021

_____

Andrea Moore Date
Area Manager