GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 12, 2022

Todd Dockerty
Dockerty Health Care Services, Inc.
8850 Red Arrow Hwy.
Bridgman, MI 49106

RE: License #: AL390381477
Investigation #: 2022A0581008
Beacon Pointe Memory Care

Dear Mr. Dockerty:

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 (517) 284-9730.

Sincerely,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL390381477
Investigation #:	2022A0581008
Complaint Receipt Date:	11/23/2021
Investigation Initiation Date:	11/23/2021
Report Due Date:	01/22/2022
Licensee Name:	Dockerty Health Care Services, Inc.
Licensee Address:	8850 Red Arrow Hwy. Bridgman, MI 49106
Licensee Telephone #:	(269) 465-7600
Administrator:	Todd Dockerty
Licensee Designee:	Todd Dockerty
Name of Facility:	Beacon Pointe Memory Care
Facility Address:	732 E. Centre Street Portage, MI 49002
Facility Telephone #:	(269) 775-1430
Original Issuance Date:	03/01/2018
License Status:	REGULAR
Effective Date:	08/30/2020
Expiration Date:	08/29/2022
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Facility doesn't have adequate staffing to safely evacuate residents out in the event of an emergency, specifically a fire.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/23/2021	Special Investigation Intake 2022A0581008
11/23/2021	Special Investigation Initiated - Telephone Interview with BFS inspector, Ken Howe.
11/23/2021	Referral - Office of Fire Safety
11/24/2021	APS Referral via email
11/29/2021	Inspection Completed On-site Interviewed staff, residents, and obtained documentation.
11/29/2021	Contact - Document Received Email from executive director, Kayla Davis.
11/30/2021	Contact - Telephone call made Interview with licensee designee, Todd Dockerty.
12/02/2021	Contact - Document Received Email from licensee designee, Todd Dockerty.
12/17/2021	Contact - Document Received Email from Ms. Davis.
12/17/2021	Contact - Document Sent Email to Ms. Davis and Mr. Dockerty.
01/05/2022	Inspection Completed-BCAL Sub. Compliance
01/06/2022	Contact – Document Sent Email correspondence with Ms. Davis.
01/06/2022	Contact – Document Received

	Email correspondence with Mr. Howe.
01/06/2022	Exit conference with licensee designee, Todd Dockerty, via telephone.

ALLEGATION:

Facility doesn't have adequate staffing to safely evacuate residents out in the event of an emergency, specifically a fire.

INVESTIGATION:

On 11/23/2021, Bureau of Fire Safety (BFS) inspector, Ken Howe, contacted Adult Foster Care Consultant, Michelle Streeter, to inform her he had conducted an inspection at the facility and discovered excessive fire drill evacuation times, which indicated the facility was not scheduling enough direct care staff to safely evacuate the residents from the facility in the event of an emergency, specifically a fire.

On 11/24/2021, Mr. Howe forwarded me a copy of the facility's fire drill records from 01/2021 through 10/2021, which he received from the facility's Executive Director, Kayla Davis. This document indicated the following:

Date of Drill	Number of Staff	Number of Residents	Drill time
01/27/2021	2	13	12 Minutes
03/03/2021	3	10	10 Minutes
03/29/2021	2	10	13 Minutes
04/28/2021	2	11	16 Minutes
05/26/2021	3	11	12 Minutes
06/30/2021	2	11	16 Minutes
07/28/2021	2	10	22 Minutes
08/25/2021	3	9	7 Minutes
09/29/2021	3	7	12 Minutes
10/27/2021	2	7	17 Minutes

The document also indicated if facility management was in the building, they would allow the direct care floor staff to run the fire drill to ensure staff from all shifts were familiar with the drills from beginning to end. Additionally, the document indicated "2-3 employees refers[*sic*] to one Medication Technician and 1-2 Caregivers."

Mr. Howe also forwarded me his fire drill documentation form, which provided the times of the facility's fire drills. This documentation indicated fire drill times between 3 and 8 minutes were "slow" while any fire drill times great than 8 minutes were "impractical." Based on this information, the facility's fire drill evacuation times were

impractical 9 out of 10 months from 01/2021 through 10/2021 despite having two or three direct care staff participating in the fire drills.

On 11/29/2021, I conducted an unannounced on-site inspection at the facility as part of my investigation. I interviewed the facility's Executive Director, Kayla Davis. Ms. Davis indicated there were seven residents currently residing in the facility and five out of the seven residents were unable to get themselves out of the bed in the event of an emergency. Ms. Davis acknowledged the evacuation times for fire drills were impractical; however, fire drills were being reviewed with direct care staff every two months to be in compliance with BFS's rules. Ms. Davis stated direct care staff complete training through CE solutions, which allows staff to complete training online. She stated staff had not been trained on emergency or fire situations at the time of hire, as indicated by not having any documentation verifying they had training, which included not having any checklist or signed document from staff indicating they had been trained. Ms. Davis indicated staff receive training on emergency situation, fire safety, and prevention through shadowing another staff; however, documentation verifying staff were competent in these areas was not available during the on-site inspection.

Ms. Davis indicated two direct care staff were working during my inspection, which were Shandra Morris and Lucy Cendejas. Ms. Davis also indicated Megan McMillan was also working but she was primarily the activities coordinator. Ms. Davis indicated Ms. Morris had been working at the facility for approximately three months while Ms. Cendejas had been working for approximately 4-5 months.

I interviewed both Ms. Morris and Ms. Cendejas. Ms. Morris stated she was hired in approximately June/July 2021 indicating she'd been at the facility for approximately 4-5 months. She indicated she primarily works 1st shift, which is 7 am until 3 pm. Ms. Morris stated she had never participated in a fire drill at the facility. She stated fire drills were discussed when she was hired; however, she never signed off on any document indicating she had been trained or was competent in completing a fire drill. Ms. Morris stated five out of the current seven residents at the facility require two person assistance indicating two direct care staff were needed to transfer the residents. Ms. Morris indicated one staff could use a Hoyer lift to transfer these residents; however, it was best if two staff could assist.

Ms. Cendejas stated she was hired the end of June 2021 and primarily works 1st shift. She also indicated five out of the seven residents in the facility require two person assistance for transferring. She indicated if only one staff was working then staff would have to use a Hoyer lift to transfer the residents requiring two person assistance. Ms. Cendejas stated she did not complete any training or sign off on any documents indicating she had been trained or was competent regarding fire safety, fire drills, or fire and safety prevention.

During my inspection, I asked Ms. Davis which residents were verbal and able to be interviewed. She stated all the residents were diagnosed with Dementia and had a

difficult time communicating, but Resident A and Resident B were verbal. I attempted to interview Resident A and Resident B; however, despite them being verbal they were unable to answer my questions or provide relevant information.

Ms. Davis provided me with several documents during my inspection, which included the fire drills record information she had provided to Mr. Howe. These records were consistent with what Mr. Howe provided me. She also provided me with a copy of a staff Training Checklist, which indicated it was to be completed with the staff's trainer and submitted to Ms. Davis upon completion. Upon my review of this document, there was no indication fire and safety prevention, or fire drill evacuations were on the training checklist. Ms. Davis also provided me the facility's "Fire Education" document, which addressed the protocol for evacuating the facility if a fire were to occur. She also provided me the facility's "CODE RED – FIRE PLAN". She indicated this document had recently been updated after Mr. Howe raised concerns; however, she indicated the updated revisions had not been reviewed with direct care staff yet. It was indicated in the fire plan, that its purpose is to "prepare for a potential fire, the procedures for operating during a potential fire situation, evacuation routes, and areas of congregation outside of Beacon Pointe." Ms. Davis also provided me with copies of two staff meeting sign in sheets, dated 07/28/2021 and 09/29/2021, indicating staff had attended a staff meeting where fire drills were discussed; however, there was no indication on the documents provided by Ms. Davis other than staff signatures and the dates.

Ms. Davis sent me via email all the resident's *Assessment Plans for AFC Residents* (assessment plans).

- Resident A's assessment plan, dated 04/01/2021, indicated Resident A requires one staff for assistance with Activities of Daily Living (ADLs) such as dressing, ambulating, transferring, and toileting.

- Resident B's assessment plan, dated 10/22/2021, indicated Resident B requires one staff for assistance with Activities of Daily Living (ADLs) such as dressing, ambulating, transferring, and toileting.

- Resident C's assessment plan, dated 02/19/2021, indicated Resident C "requires a mechanical lift or no mechanical lift but 2 person assist for all transfers. Mechanical lifts require the presence/assistance of 2 staff members". Additionally, it also indicated Resident C requires two staff for bathing and toileting.

- Resident D's assessment plan, dated 06/30/2021, indicated Resident D "Resident requires a mechanical lift or no mechanical lift but 2 person assist for all transfers. Mechanical lifts require the presence/assistance of 2 staff members". Additionally, it also indicated Resident D requires two staff for dressing and toileting.

- Resident E's assessment plan, dated 06/24/2021, indicated Resident E "…is unable to transfer self safely. Resident requires the assistance of 2 staff members using gait belt for transfers". Additionally, it also indicated Resident E requires two staff for toileting, dressing, and bathing.

- Resident F's assessment plan, dated 08/25/2021, indicated Resident F "…requires a mechanical lift or no mechanical lift but 2 person assist for all transfers. Mechanical lifts require the presence/assistance of 2 staff members". Additionally, it also indicated Resident F requires two staff for dressing.

- Resident G's assessment plan, dated 10/06/2021, indicated Resident G "…is unable to transfer self safely. Resident requires the assistance of 2 staff members using gait belt for transfers". Additionally, it also indicated Resident G requires two staff for toileting and dressing.

I also reviewed resident *Health Care Appraisals* (HCA), which indicated the following:

- Resident A's HCA, dated 03/29/2021, indicated Resident A uses a walker and cane to ambulate. It also indicated she has a diagnosis of "late onset Alzheimer's".

- Resident B's HCA, dated 10/20/2021, indicated Resident B is fully ambulatory, but requires the use of a walker, at times, to ambulate. It also indicated he experiences "intermittent confusion".

- Resident C's HCA, which had no date on it, indicted Resident C requires the use of a wheelchair or Geri chair to ambulate.

- Resident D's HCA, dated 10/04/2019, indicated Resident D requires the use of a walker to ambulate. It also indicated she has a diagnosis of dementia.

- Resident E's HCA, dated 06/25/2021, indicated Resident E requires the use of a wheelchair to ambulate.

- Resident F's HCA, dated 04/06/2018, did not indicate Resident F's mobility/ambulatory status.

- Resident G's HCA, dated 06/25/2021, indicated Resident G requires the use of a wheelchair to ambulate.

Ms. Davis also provided staff schedules for September and October 2021, which were consistent with the number of staff indicated on the fire drills.

On 11/30/2021, I interviewed the Licensee Designee and Administrator, Todd Dockerty. I informed Mr. Dockerty of my concerns of the long evacuation times for fire drills. I also informed him of my concerns staff were not receiving proper training on fire and safety prevention.

On 12/02/2021, I received an email correspondence from Mr. Dockerty indicating he had been working with facility staff over several days to run fire drills in a timelier manner. He also indicated he was communicating and working with BFS inspector, Mr. Howe, on how to get the facility's evacuation times out of the "impractical" timeframe for all three shifts.

On 01/06/2022, I received an email from Mr. Howe, which provided definitions for evacuation times. Mr. Howe indicated the following:

- Prompt: 3 minutes or less
- Slow: more than 3 minutes but less than 8 minutes
- Impractical: more than 8 minutes

A review of the facility's file indicates a repeat violation of Adult Foster Care licensing rule 400.14204(3)(f). According to renewal licensing study report, dated 08/28/2020, there had been no documentation on record in the facility verifying two direct care staff had been provided training in the areas of safety and fire prevention, as required. The licensee designee's corrective action plan (CAP), dated 09/11/2020, indicated compliance would be achieved effective 10/01/2020 by assigning this missed training to the employees through the facility's online training software (CE Solutions). The CAP indicated the certificates of completion would be printed and added to their employee charts. The CAP also indicated to maintain this compliance the facility's executive director would be responsible for ensuring all training certificates for completion of required training would be in the employee's charts.

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 my investigation, which included interviews with the facility's executive director, Kayla Davis, direct care staff, Shandra Morris and Lucy Cendejas, my interviews with Bureau of Fire Services inspector, Ken Howe, my review of the facility's fire drills, and my review of *Assessment Plans for AFC Residents* and *Health Care Appraisals* for all seven residents of the facility, there is evidence the facility does not have sufficient direct care staff in the facility, for all three working shifts, to provide adequate protection of the residents by promptly evacuating them out of the facility in the event of an emergency, specifically a fire. Based on my review of the resident's *Assessment Plans for AFC Residents*, Resident C, D, E, F, and G all require "two person assists" in transferring indicating they are unable to ambulate by themselves. Also, based on the *Health Care Appraisal* information, Resident A, B, D have either Alzheimer's disease, intermittent confusion, or Dementia, which can require more attention from staff in the event of an evacuation. Ms. Davis also indicated all seven of the residents have a diagnosis of Dementia. This information, in conjunction with having newer, or more inexperienced staff, like Ms. Morris and Ms. Cendejas, who only worked at the facility for approximately 5-6 months, could create more difficulty in evacuating residents from the facility. Subsequently, nine out of the 10 fire drills conducted between 01/2021 and 10/2021 took direct care staff longer than 10 minutes; therefore, creating impractical lengths of time to safely evacuate residents from the facility during fire drills. "Sufficient direct care staff" is defined to mean the number of staff necessary to implement the care needs as indicated in the resident's assessment plan, health care appraisal, and resident care agreements. Though the facility has been in communication with the Bureau of Fire Services inspector, Ken Howe, there is still indication the facility is not sufficiently staffed to safely get the residents out of the facility in the event of an emergency.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to

	direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(f) Safety and fire prevention.**
ANALYSIS:	There was no verification assuring direct care staff are competent in the area of safety and fire prevention appropriate to the needs of the facility's resident population, as required. Based on my interviews with the facility's executive director, Kayla Davis, and direct care staff, Shandra Morris and Lucy Cendejas, no such training verification was available for review and staff could not recall being trained on fire drills.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[SEE RENEWAL DATED 08/28/2020, CAP DATED 09/11/2020]**

ADDITIONAL FINDINGS

INVESTIGATION:

The *Assessment Plans for AFC Residents* submitted to me by Ms. Davis did not have signatures on them by any of the residents, their designated representatives, if applicable, or the licensee. On 01/06/2022, I informed Ms. Davis of my finding via email. Ms. Davis reported the assessments sent to me came directly from their ECP, online charting software system, so signatures wouldn't show up. I requested she send me Resident C's, D's, and E's assessment plans with signatures for my review, which she did via email on 01/07/2022. I reviewed these assessment plans and determined Ms. Davis was signing in the area designated for the Licensee's signature. Ms. Davis stated she was informed she could sign for the Licensee because her name had been added to the building. I informed Ms. Davis that Mr. Dockerty was still listed as the Administrator/Licensee Designee and would be required to sign all AFC documents unless he appointed another individual as the Administrator/Licensee Designee.

APPLICABLE RULE	
R 400.15301	**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.
ANALYSIS:	Based on my review of Resident C's, D's, and E's *Assessment Plans for AFC Residents*, there is no indication the licensee designee, Todd Dockerty, reviewed and/or participated in the development of the assessment plans, as required. Signatures of the licensee, resident and/or resident's representative and responsible agency, demonstrate all required persons have participated in the development of the written assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During my investigation, I requested to review all the resident's *Health Care Appraisals,* which Ms. Davis provided. Upon my review of these HCA's, I determined Resident C's HCA had no date of completion, Resident D's HCA was dated 10/04/2019 and Resident F's HCA was dated 04/06/2018, indicating these HCAs were not completed on an annual basis, as required.

A review of the facility's file indicates a repeat violation of Adult Foster Care licensing rule 400.14301(10). According to renewal licensing study report, dated 08/28/2020, two residents had expired HCAs. The licensee designee's corrective action plan (CAP), dated 09/11/2020, indicated compliance would be achieved effective 10/01/2020 by obtaining updated HCAs for the two residents. The CAP indicated the facility's executive director would be responsible for having HCAs completed by the time the annual funds and agreements were due. The CAP also indicated yearly appraisals would be tracked in the facility's ECP software and yearly binder. On 10/02/2021, the licensee designee, Mr. Dockerty, provided CAP compliance by submitting current HCAs for both residents.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(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 shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	Based on my review of resident *Health Care Appraisals*, Resident C, Resident D, and Resident F did not have their *Health Care Appraisals* completed on an annual basis, as required.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[SEE RENEWAL DATED 08/28/2020, CAP DATED 09/11/2020]**

On 01/07/2022, I conducted an exit conference with the licensee designee, Todd Dockerty, via telephone. I explained my findings to Mr. Dockerty, and he was in agreement with them. Mr. Dockerty indicated recently admitted residents were ambulatory making the evacuation times faster. He also indicated the facility was reviewing fire drill information with staff during meetings and having staff sign off acknowledging they received the training. Mr. Dockerty was informed information needed to be attached to the staff signatures indicating what was addressed during these meetings rather than just having a sign in sheet with signatures and a date. Additionally, Mr. Dockerty acknowledged the requirement of signing AFC paperwork whereas needed by Administrator/Licensee Designee. I informed Mr. Dockerty of the repeat findings, stressing the importance of submitting a CAP that would address the violations to prevent future repeat findings.

IV. RECOMMENDATION

Upon an acceptable plan of correction, I recommend no change in the current license status.

01/07/2022

Cathy Cushman Date
Licensing Consultant

Approved By:

01/12/2022

Dawn N. Timm Date
Area Manager