GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 27, 2022

Christopher Trevathan
AH Holland Subtenant LLC
6755 Telegraph Rd Ste 330
Bloomfield Hills, MI 48301

RE: License #: AL700397726
Investigation #: 2022A0467016
AHSL Holland Bay Pointe

Dear Mr. Trevathan:

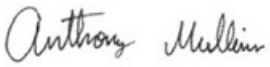
Attached is the Special Investigation Report for the above referenced facility. Due to the violation identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- Specific time frames for the 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 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,



Anthony Mullins, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL700397726
Investigation #:	2022A0467016
Complaint Receipt Date:	01/18/2022
Investigation Initiation Date:	01/18/2022
Report Due Date:	03/19/2022
Licensee Name:	AH Holland Subtenant LLC
Licensee Address:	One SeaGate, Suite 1500 Toledo, OH 43604
Licensee Telephone #:	(248) 203-1800
Administrator:	Christopher Trevathan
Licensee Designee:	Christopher Trevathan
Name of Facility:	AHSL Holland Bay Pointe
Facility Address:	11899 James Street Holland, MI 49423
Facility Telephone #:	(616) 393-2174
Original Issuance Date:	04/08/2019
License Status:	REGULAR
Effective Date:	10/08/2021
Expiration Date:	10/07/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The facility is not staffed appropriately as there are shifts with only one person working while some residents require a two-person assist/transfer.	Yes

III. METHODOLOGY

01/18/2022	Special Investigation Intake 2022A0467016
01/18/2022	Special Investigation Initiated - Telephone
01/19/2022	Inspection Completed On-site
01/27/2022	Exit conference conducted with licensee designee, Chris Trevathan.

ALLEGATION: The facility is not staffed appropriately as there are shifts with only one person working while some residents require a two-person assist/transfer.

INVESTIGATION: On 1/18/22, I received a telephone complaint stating that the facility has residents that require two-person assist and the facility is not appropriately staffed.

On 1/18/22, I spoke to the complainant via phone. The complainant stated that on Saturday, 1/15/22, staff member Vanessa Garza worked at the facility alone. During Ms. Garza's shift, she called the complainant to ask for assistance in helping a resident up from a fall. The complainant, as well as another staff member from a different facility were unable to assist due to providing care to their assigned residents. Per the complainant, the facility is a memory care unit and some residents require a two-person assist and the facility is not properly staffed. Due to being unable to assist Ms. Garza with the resident that fell, the complainant stated that she called an ambulance to assist Ms. Garza. Prior to the ambulance arriving, staff member Justin Lara arrived at the facility to obtain his cell phone that was left behind during his earlier shift and he was able to assist Ms. Garza with helping the resident that fell.

On 1/19/22. I made an unannounced onsite investigation to the facility. Upon arrival, I spoke with staff member Lori Rhoda. Ms. Rhoda has a consistent rotating schedule, working from 6:30 am to 3:00 pm. Ms. Rhoda confirmed that the facility has four residents that require a two-person assist or transfer. Ms. Rhoda acknowledged that she worked by herself this morning for "a little while," approximately one hour due to an agency staff member not showing up for work. Staff member Lekeysha Powell came to the facility around 9:00 am this morning to work with her. Except for today, Ms. Rhoda stated that she has never worked in the

facility by herself. Although Ms. Rhoda has only worked alone at the facility this morning, she stated that her colleague, Lydia Villegas works 3rd shift and complained about working alone. Ms. Rhoda provided names for Resident A, Resident B, and Resident C stating that they all require two-person assist and/or transfer. Ms. Rhoda was asked to provide copies of Resident A and B assessment plan, which she was unable to locate.

After speaking to Ms. Rhoda, I spoke to staff member Lekeysha Powell. Like Ms. Rhoda, Ms. Powell also has a consistent rotating schedule, working from 6:30 am until 3:00 pm. Ms. Powell confirmed that she started her shift working at Lakeshore this morning. Ms. Powell stated that she was sent to this facility because the 3rd shift staff member was mandated last minute and refused to stay. Ms. Powell and a lead resident assistant covered the gap in the schedule. Ms. Powell confirmed that American House Holland facilities all have staffing shortages, especially in Baypointe as it is a two-person assist facility. Ms. Powell stated that if I were to review the staff schedule, I would see the staffing issues throughout the facility. My interview with Ms. Powell was brief as she needed to go to Lighthouse facility to work while the on-call lead staff, Anna Khammanivong came to Baypointe to pass medication as Ms. Powell is unable to do so.

I spoke to Ms. Khammanivong and she stated that she is the on-call lead/med tech. Ms. Khammanivong works four times per month and stated she has to switch between facilities with other staff members to pass medication half of the shifts she works due to staffing issues.

After interviewing staff members, I spoke with the executive director/designee, Chris Trevathan and explained the allegations. Mr. Trevathan denied any knowledge of Baypointe having residents that require a two-person assist or transfer. Mr. Trevathan stated that some residents may get two-person assist but again, he is unaware of any of the residents requiring this. Mr. Trevathan stated that Baypointe is typically staffed with two people on 1st and 2nd shift due to the acuity of the residents. Mr. Trevathan stated that 3rd shift typically has one staff member and this has been ongoing for months. Mr. Trevathan provided me with copies of Resident A and B's "Uniform Evaluation Tool," which is the equivalent of their assessment plan. Resident A's assessment plan confirmed that he requires a two-person assist with the use of his mechanical or hoyer lift. Resident B's assessment plan confirmed that she requires two staff for transfer/bed safety. It also states that Resident B may also require the assistance of a mechanical lift/hoyer lift. Due to the residents requiring two-person assist, the facility needs to be staffed with two staff members 24/7. Mr. Trevathan acknowledged that 3rd shift has only had one staff member for months. The staffing schedule confirmed this as well.

On 1/20/22, I spoke to staff member Vanessa Garza via phone. Ms. Garza stated that she has been employed at the facility for approximately 3-4 weeks. On weekdays she typically works from 4:00 pm to 11:00 pm and weekends she works from 10:30 pm to 7:00 am at Baypointe. Ms. Garza reported that she worked at

Baypointe on Friday, 1/14/22. During this shift, there was another staff member present. Ms. Garza also worked 3rd shift at Baypointe on Saturday, 1/15/22. During this shift, Ms. Garza worked alone due to there being a no-call/no-show. During this shift, Ms. Garza stated that Resident C fell twice. Ms. Garza was unable to assist this resident by herself. During the first fall, Ms. Garza stated that her colleague just happened to come to the facility to find their phone and assisted her with picking up Resident C. During the second fall, Ms. Garza stated that she called the coordinator, Amy Simmon from Lighthouse to assist her. Ms. Garza stated that the American House facilities are always short staffed although she was told upon hire that it would always be two staff members.

Ms. Garza stated that there are a lot of residents in Baypointe that require a two-person assist or transfer and there is often only one staff member working there. This is concerning to Ms. Garza as Resident C is often combative and yesterday it took three staff members to contain him. Ms. Garza stated, “there is no way that building functions with one person.”

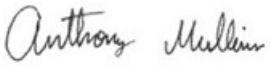
On 01/27/2022, I conducted an exit conference with licensee designee, Chris Trevathan. He was informed of the investigative findings and aware that a corrective action plan is required within 15 days of receipt of this report. Mr. Trevathan and all of management are actively working to address the staffing issues within American House.

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:	Ms. Rhoda, Ms. Powell and Ms. Garza each confirmed that there are residents in the facility who require a two-person assist and that the facility is short staffed. Resident A’s assessment plan confirmed that he requires a two-person assist with the use of his mechanical or hoyer lift. Resident B’s assessment plan confirmed that she requires two staff for transfer/bed safety. Mr. Trevathan confirmed that 3rd shift has only had one staff member working for months. The staff schedule was reviewed and confirmed this as well. Therefore, a preponderance of evidence does exist to support the allegation.

CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

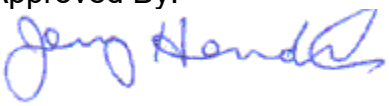
Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.



01/27/2022

Anthony Mullins Date
Licensing Consultant

Approved By:



01/27/2022

Jerry Hendrick Date
Area Manager