GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 15, 2022

Connie Clauson
Leisure Living Mgt of Portage
Suite 203
3196 Kraft Ave SE
Grand Rapids, MI 49512

RE: License #: AL390007092
Investigation #: 2022A0581012
Fountain View Ret Vil of Port #1

Dear Mrs. Clauson:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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 #:	AL390007092
Investigation #:	2022A0581012
Complaint Receipt Date:	12/13/2021
Investigation Initiation Date:	12/13/2021
Report Due Date:	02/11/2022
Licensee Name:	Leisure Living Mgt of Portage
Licensee Address:	Suite 203 3196 Kraft Ave SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Kim Barber
Licensee Designee:	Connie Clauson
Name of Facility:	Fountain View Ret Vil of Port #1
Facility Address:	7818 Kenmure Drive Portage, MI 49024
Facility Telephone #:	(269) 327-9595
Original Issuance Date:	05/02/1989
License Status:	REGULAR
Effective Date:	12/25/2020
Expiration Date:	12/24/2022
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Residents were left without adequate supervision at approximately 6 am for 15 minutes due to facility staff evacuating a neighboring facility. Additionally, the facility is inadequately staffed.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/13/2021	Special Investigation Intake 2022A0581012
12/13/2021	APS Referral APS aware of allegations due to investigation at neighboring facility.
12/13/2021	Special Investigation Initiated - On Site Interviewed staff at facility.
12/13/2021	Contact - Telephone call made Interviewed staff.
12/20/2021	Inspection Completed On-site Interviewed staff and observed facility.
12/22/2021	Contact - Document Received Received resident documentation
01/19/2022	Contact - Document Received Received updated staffing schedule
02/04/2022	Inspection Completed-BCAL Sub. Non-Compliance
02/08/2022	Contact – Document Received Additional resident documentation.
02/08/2022	Exit conference with licensee designee, Connie Clauson.

ALLEGATION:

- **Residents were left without adequate supervision at approximately 6 am for 15 minutes due to facility staff evacuating a neighboring facility.**

- **The facility is inadequately staffed.**

INVESTIGATION:

On 12/13/2021, I discovered the facility, hereinafter referred to as "Assisted Living" facility, had been without supervision at approximately 6 am on 12/09/2021 for approximately 15 minutes when the sole direct care staff, Ashley Penny, went to the neighboring facility, hereinafter referred to as "Memory Care" facility, to assist the direct care staff with evacuating residents due to an emergency fire drill. The two facilities are operated by the licensee, are within walking distance of one another, and are approximately 40 feet apart.

On 12/13/2021, the facility's Administrator, Kim Barber, confirmed an emergency fire drill took place at the Memory Care facility on 12/09/2021. She stated the Memory Care's fire alarm had malfunctioned throughout 3rd shift and when the local fire department responded at approximately 3 am they informed direct care staff if the alarm went off again, they would need to evacuate the residents from the building. Ms. Barber stated the alarm malfunctioned again at approximately 6 am, which resulted in the Memory Care facility being evacuated. Ms. Barber indicated direct care staff member Ms. Penny had been working at the Assisted Living facility and assisted in the evacuation of the Memory Care facility's residents.

It should be noted the facility's licensed capacity is 20 residents. The facility is licensed to provide personal care, supervision, and protection to the aged populations and/or individuals diagnosed with Alzheimer's disease. I reviewed the facility's *Resident Register* which indicated there were 18 residents residing at Fountain View Retirement Village of Portage #1 or as it is referred to in this report, the Assisted Living facility, for the entire time during 11/21/2021 through 12/25/2021.

I interviewed multiple direct care staff via telephone including Ashley Penny, Jayla Kelly, and Jessica Kellogg. Ms. Penny confirmed she was the only direct care staff working at the Assisted Living facility on 12/09/2021 while direct care staff, Ms. Kelly, and Ms. Kellogg, were working at the Memory Care facility. Ms. Penny indicated at approximately 6 am, Ms. Kelly contacted her about the facility's fire alarm going off and requested assistance with evacuating the residents to the Assisted Living facility. Ms. Penny indicated she was gone from the Assisted Living facility for approximately "8-10 minutes." She indicated the residents of the Assisted Living facility had been sleeping and were not up at the time she was assisting in the evacuation. She denied any of the residents having any emergencies or requiring immediate care while she was not in the facility. Ms. Penny indicated there had multiple instances where there were only two direct care staff working between both

the Memory Care and Assisted Living facilities and indicated there was a floater or roaming staff that would go between the two buildings.

Ms. Kelly's and Ms. Kellogg's statements to me regarding Ms. Penny coming over to the facility to assist in evacuating the Memory Care facility residents were consistent with Ms. Penny's statement to me.

On 12/14/2021, I interviewed direct care staff Rachel Posthumus, via telephone. Ms. Posthumus stated on 12/13/2022 there were only two direct care staff working between both the Memory Care and Assisted Living facilities indicating both facilities were inadequately staffed from approximately 5 pm until 11 pm. Ms. Posthumus stated with only one direct care staff member with 18 residents it was not enough staff. Ms. Posthumus described numerous instances where only one direct care staff member was scheduled to work in the facility with a floating or roaming staff member available if needed. Ms. Posthumus indicated at least three residents, Resident I, J, and N, required two direct care staff members to assist in transferring and Resident I and J required two direct care staff members to rotate when providing incontinence assistance. She indicated all three of these residents require wheelchairs to ambulate.

On 12/20/2021, I interviewed direct care staff, Timora Moore, at the facility. Ms. Moore indicated there are approximately six residents in the facility who required assistance with transferring and/or utilized wheelchairs to be ambulatory. She indicated Resident C, D, and F utilized power wheelchairs, Resident G required a manual wheelchair for ambulating and required staff to propel her wheelchair, Resident D, E, and J required wheelchairs for ambulating and also required staff assistance in assisting with transferring into their wheelchairs.

I reviewed resident documentation for all 18 residents, which included documents titled "Assessment Report" (written assessment plan), "Resident Evaluation", *Assessment Plans for AFC Residents*, and *Health Care Appraisals*. Based on these documents, I determined the following:

- Two residents have a diagnosis of Dementia
- One resident is vision impaired/blind
- One resident is deaf and mute
- Two residents have a history of being non-compliant with assistance from staff in completing Activities of Daily Living (ADL's) such as grooming, dressing, and bathing.
- One resident is a two person assist (requires two direct care staff members) for toileting assistance and transferring
- Three residents have a history of falls within 3 months of their assessments being completed
- Five residents required "total assistance" or "total dependence" from staff in completing ADL's.
- Four residents required supervision and cuing from staff with bathing.

- Three residents required physical assistance from staff with ADL's.
- Seven residents are incontinent and/or require the assistance of staff with toileting
- Ten residents utilize a wheelchair to ambulate. Four out of these ten residents utilize both a wheelchair and walker. Three residents utilize a walker.
- One resident has a history of eloping.
- Three residents have behaviors or history of behaviors

I reviewed the facility's fire drill and Evacuation Records. According to these records, the Assisted Living facility had not completed any fire drills for 2021 until 10/26/2021 when there was one completed for 1st (10:30 am – 10:35 am), 2nd (4:00 pm – 4:06 pm), and 3rd (11:00 pm – 11:05 pm) shifts.

When I cross referenced the Evacuation Records between both the Memory Care and Assisted Living facilities, I discovered the same direct care staff, Latoya Howard, was involved in both 1st shift fire drills at both facilities, indicating this direct care staff was being used as a roaming or floating staff between the facilities. Additionally, I found the same direct care staff, Jasmine Muhammad, was listed on the evacuation records as being involved for both 2nd shift fire drills at both buildings and direct care staff, Tammy Ward, was also listed on both 3rd shift fire drill evacuation records indicating these direct care staff members were documented as working at both facilities at the same time.

I also reviewed the facility's staff schedule from 11/21/2021 through 12/25/2021, which was provided by Ms. Barber during my on-site investigation. Ms. Barber confirmed staff assigned to the Memory Care facility were indicated with an "M" and staff assigned to the Assisted Living facility were indicated with an "A". Ms. Barber indicated an asterisk located next to the M or A indicated the staff was assigned as the medication passer for that building. Upon my review of the facility's staff schedule, two staff were assigned to work at the Memory Care facility on 12/08/2021 for 3rd shift, which were Jayla Kelly and Dominique Thorne. The staff schedule also indicated there were two staff assigned to work the Assisted Living facility on 12/08/2021 for 3rd shift, which were Ashley Penny and Jessica Kellogg. Ms. Barber stated that contrary to what was indicated on the staffing schedule, Ms. Thorne hadn't worked 3rd shift on 12/08/2021 due to calling in. Ms. Barber indicated she had not updated the schedule to reflect these changes.

Upon my review of the schedule, from 11/21/2021 through 12/25/2021, there were 23 shifts where only one direct care staff was assigned to work at the Assisted Living facility and nine of these shifts indicated there was a staff assigned to work at both the Memory Care and Assisted Living facilities as indicated by the notation "M/A" on the schedule.

Ms. Barber provided me with an updated staff schedule on 01/19/2022 for 11/21/2021- 12/25/2021. Per the facility's *Resident Register* and my review of each resident's record, I determined the facility had 18 residents admitted to the facility

during this time frame and Resident I required two direct care staff to assist with transferring and personal care. Subsequently, upon my review of the updated staff schedule, I established the following information:

- On 11/21/2021, only one direct care staff was scheduled to work on the facility's first, second, and third shifts.
- On 11/22/2021, only one direct care staff was scheduled to work on the facility's second.
- On 11/24/2021, only one direct care staff was scheduled to work on the facility's third shift.
- On 11/25/2021, only one direct care staff was scheduled to work on the facility's second and third shifts.
- On 11/26/2021, only one direct care staff was scheduled to work on the facility's second and third shifts.
- On 11/27/2021, only one direct care staff was schedule to work on the facility's third shift.
- On 11/28/2021, only one direct care staff was scheduled to work on the facility's third shift.
- On 11/29/2021, only one direct care staff was scheduled to work on the facility's second and third shifts.
- On 11/30/2021, only one direct care staff was scheduled to work on the facility's second shift.
- On 12/01/2021, only one direct care staff was scheduled to work on the facility's third shift.
- On 12/02/2021, only one direct care staff was scheduled to work on the facility's third shift.
- On 12/03/2021, only one direct care staff was scheduled to work on the facility's third shift.
- On 12/05/2021, only one direct care staff was scheduled to work on the facility's first shift.
- On 12/06/2021, only one direct care staff was scheduled to work on the facility's third shift.
- On 12/08/2021, only one direct care staff was scheduled to work on the facility's third shift.
- On 12/09/2021, only one direct care staff was scheduled to work on the facility's third shift.
- On 12/10/2021, only one direct care staff was scheduled to work on the facility's third shift.
- On 12/11/2021, only one direct care staff was scheduled to work on the facility's third shift.
- On 12/13/2021, only one direct care staff was scheduled to work on the facility's third shift.
- On 12/14/2021, only one direct care staff was scheduled to work on the facility's third shift.

- On 12/16/2021, only one direct care staff was scheduled to work on the facility's third shift.
- On 12/17/2021, only one direct care staff was scheduled to work on the facility's third shift.
- On 12/18/2021, only one direct care staff was scheduled to work on the facility's first and third shifts.
- On 12/21/2021, only one direct care staff was scheduled to work on the facility's first shift.
- On 12/22/2021, only one direct care staff was scheduled to work on the facility's first shift.
- On 12/23/2021, only one direct care staff was scheduled to work on the facility's first shift.
- On 12/24/2021, only one direct care staff was scheduled to work on the facility's third shift.
- On 12/25/2021, only one direct care staff was scheduled to work on the facility's first and third shifts.

The updated schedule indicated there were 35 shifts where only direct care staff was assigned to work in the Assisted Living facility, with seven of these shifts being 1st shift, six of these shifts being 2nd shift, and 22 of these being 3rd shift. Additionally, 24 out of the 35 shifts had the notation "M/A", indicating a floater or roaming staff was assigned to work at both facilities as needed.

Again, I reviewed the facility's *Resident Register* which indicated there were 18 residents residing at the Assisted Living facility for the entire time during 11/21/2021 through 12/25/2021.

Upon review of the facility's file, this is a repeat finding for Adult Foster Care Licensing Rule 400.15206(1) and Rule 400.15206(2). According to Special Investigation Report 2019A0462028, dated 04/11/2019, the facility's census was 16, but it was confirmed only one direct care staff was occasionally working in the facility. According to the direct care staff schedule for 01/01/2019 through 02/02/2019 and 03/04/2019 through 03/11/2019 there were approximately 59 occasions when only one direct care staff was scheduled to work in the facility despite the facility having 16 residents during those time frames. Additionally, according to the direct care staff schedules, there were also six occasions when no direct care staff were scheduled to work in the facility.

A review of the resident assessment plans and facility *Incident Reports* indicated there had been a resident who eloped from the facility without staff being aware until the resident was discovered by a staff from the neighboring facility and returned. Additionally, the investigation determined another resident had frequent falls and required a two person assist to get off the floor after falling; however, the staff schedules indicated there were numerous instances where two direct care staff were not available to assist the resident.

The investigation indicated fire drills were not being completed when only one direct care staff was scheduled to work in the facility; therefore, the consultant completing the investigation was unable to establish if one direct care staff could safely evacuate the residents from the facility in a timely manner. The investigation determined; however, that based upon an assessment of the current residents' care needs and their ability to evacuate the facility independently, it had been established that more than one direct care staff was required to safely evacuate the residents from the facility in a timely manner.

The investigation also determined direct care staff from the neighboring facility were floating to the facility to assist direct care staff, as needed, and these staff were not to be considered in determining the correct ratio of direct care staff to residents as floating staff could not be in multiple locations at the same time. The investigation determined the facility was not consistently scheduling enough direct care staff to provide for the supervision, personal care, and protection of the facility's current residents.

The facility's corrective action plan (CAP), dated 04/25/2019, indicated that as of 03/18/2019, scheduling had been completed to ensure staffing of two direct care staff in each building 24 hours a day. The CAP indicated going forward, further measures would be evaluated if staffing ratios needed to be adjusted according to resident acuity. The facility's Administrator would be responsible for the implementation and for ensuring continued compliance with this rule.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours.

ANALYSIS:	On 12/09/2021, the facility was left unstaffed when direct care staff, Ashley Penny, left the facility to assist the neighboring facility (Memory Care) with evacuating residents due to an emergency fire drill. Additionally, based on my review of the facility's staffing schedules, the facility did not have the correct ratio of direct care staff to residents during waking hours for 13 total shifts between 11/21/2021 through 12/25/2021. During these waking hour shifts, there was only one direct care staff assigned to the 18 residents residing at the facility, which does not meet the requirement of 1 direct care staff to 15 residents during waking hours.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[SEE SIR 2019A0462028, DATED 04/11/2019, CAP DATED 04/25/2019].**

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:	The facility is licensed to provide Adult Foster Care services to the aged population and/or individuals with Alzheimer's disease. Based on my review of every resident's written assessment plan, it was determined 10 out of 18 residents residing at the facility required the use of a wheelchair, walker and/or cane to ambulate. According to Resident I's assessment plan and based on interviews with direct care, Ms. Penny, Ms. Kelly, Ms. Kellogg, Ms. Posthumus, and Ms. Moore, indicated multiple residents required two direct care staff with mobility transferring. Additionally, two out of the 16 residents had a diagnosis of Dementia and/or Alzheimer's, five residents required "total assistance" from staff in completing Activities of Daily Living such as grooming, bathing, dressing, seven residents were incontinent and/or required assistance of staff with toileting, and one resident is vision impaired/blind and one resident is deaf/mute. Documentation on the facility's fire drill evacuation records for both the Memory Care facility and the neighboring Assisted Living facility, dated 10/26/2021, indicated staff were being utilized from both facilities to complete the fire drills and thus did not have enough staff scheduled within the facility to complete the fire drill. The use of direct care staff members from another building to complete fire drills occurred again on 12/09/2021 when, during an unplanned fire drill direct care staff, Ms. Penny, came from the Assisted Living facility to assist two direct care staff, Ms. Kellogg, and Ms. Kelly, in evacuating the Memory Care facility residents. Additionally, my review of the facility's staffing schedules indicated the facility had 35 shifts between 11/21/2021 through 12/25/2021 where only direct care staff was assigned to work despite Resident I requiring the assistance from two direct care with transferring and personal care. Based upon the total care needs of the facility's population, a review of the facility's 2021 fire drill evacuation records, staffing schedules, and direct care staff interviews, there is substantial evidence indicating there is not a sufficient number of direct care staff members working to meet the needs of the residents admitted to the facility.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED**

	[SEE SIR 2019A0462028, DATED 04/11/2019, CAP DATED 04/25/2019].

APPLICABLE RULE	
R 400.15318	**Emergency preparedness; evacuation plan; emergency transportation.**
	(5) A licensee shall practice emergency and evacuation procedures during daytime, evening, and sleeping hours at least once per quarter. A record of the practices shall be maintained and be available for department review.
ANALYSIS:	The frequency of practicing emergency and evacuation procedures referenced in this subrule is one practice during daytime hours, one during evening hours, and one during sleeping hours, *each quarter*. A minimum of 3 practices must be completed every 3 months. Administrator Ms. Barber provided fire drill records and evacuation records which indicated only three fire drills were completed for the entire year of 2021, which took place on October 26, 2021, for 1st, 2nd, and 3rd shifts. Additionally, the Bureau of Fire Services also found in October 2021 that the facility had not been completing fire drills, as required, and requested a corrective action plan addressing this violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

During my investigation, I observed Resident D and Resident N in power wheelchairs on the second floor of the facility. I informed Ms. Barber during the on-site investigation residents with mobility issues cannot reside on the second floor of a facility even if the facility is equipped with elevators, which the facility does have.

Upon my review of resident documentation, Resident C, D, F, G, and N utilize wheelchairs to ambulate, while Resident O and P utilize walkers. The residents' documentation indicated all seven residents resided on the second floor of the facility.

I reviewed the facility's *Resident Register*, which had room numbers next to resident names. The facility's main floor room numbers were identified by being in the 100's while the second floor room numbers were identified by being in the 200's. The *Resident Register* confirmed Resident C, D, F, G, N, O, and P all had bedrooms on

the second floor as their room numbers were listed in the 200's rather than the 100's.

APPLICABLE RULE	
R 400.15408	**Bedrooms generally.**
	(9) A resident who has impaired mobility shall not sleep in or be assigned a bedroom that is located above the street floor of the home.
ANALYSIS:	Based on my review of the facility's *Resident Register* and my review of resident assessment plans, Resident C, D, F, G and N utilize wheelchairs to ambulate, while Resident O and P utilize walkers. Despite these seven residents having impaired mobility, they were residing on the second floor of the facility, which is not allowed.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Ms. Posthumus and Ms. Penny indicated they had been working at the facility for approximately one to one and a half months and denied participating in any type of fire drill making them familiar with what to do in the event of an emergency or actual fire.

Ms. Kelly and Ms. Kellogg both indicated they had participated in practice fire drills; however, they indicated the practice fire drill had been conducted when all the residents were all awake and residents were in the facility's "common area". Neither direct care staff indicated they had completed a practice fire drill at night or with just one staff.

Ms. Barber indicated an Employee Orientation Checklist is completed with every direct care staff, which indicates safety and fire prevention is addressed, as well as the facility's fire alarm response and evacuation procedures. Ms. Barber indicated an orientation was scheduled for new staff on 01/27/2022. Ms. Barber indicated four new direct care staff had been hired and provided signed copies of documents indicating they had read, received training, and understood safety and fire prevention at the facility; however, there was no indication these staff were familiar with the facility's evacuation and emergency procedures.

Ms. Barber was unable to provide confirmation Ms. Penny, Ms. Kellogg, or Ms. Kelly had received training and were competent in safety and fire prevention.

Ms. Barber provided documentation indicating practice fire drills had been conducted at the facility on 10/26/2021 for all shifts. The documentation indicated Ms. Kelly participated in the 2nd shift fire drill at 4:06 pm; however, none of these drills indicated Ms. Penny or Ms. Kellogg participated.

Ms. Barber also provided documentation indicating a "Mandatory In-Service" regarding fire drills procedures occurred on 07/22/2021. According to the sign in sheet Ms. Kellogg attended this in-service. Ms. Barber indicated the in-service addressed the facility's fire alarm response procedure and evacuation plan; however, the documentation indicated the procedure and evacuation plan were for a different facility based on the incorrect facility name and address.

APPLICABLE RULE	
R 400.15318	**Emergency preparedness; evacuation plan; emergency transportation.**
	(4) A licensee shall ensure that residents, all employees, volunteers under the direction of the licensee, and members of the household are familiar with emergency and evacuation procedures.
ANALYSIS:	Based on my interviews with direct care staff, they are not familiar with fire drills or evacuating residents in the event of an emergency.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 02/08/2022, I conducted my exit conference with the licensee designee, Connie Clauson, via telephone. Ms. Clauson acknowledged my findings. She also indicated she was addressing the violation of residents with impaired mobilities residing on the second floor.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of correction, I recommend a provisional license due to the severe and repeat quality of care violations cited in the report.

02/09/2022

Cathy Cushman Date
Licensing Consultant

Approved By:

02/15/2022

Dawn N. Timm Date
Area Manager