GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 11, 2022

Beth Covault
Samaritas Senior Living Grand Rapids Woods
1900-32nd Street, SE
Grand Rapids, MI 49508-1583

RE: License #:	AH410236832
Investigation #:	2022A1021030
	Samaritas Senior Living Grand Rapids Woods

Dear Ms. Covault:

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 (517) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410236832
Investigation #:	2022A1021030
Complaint Receipt Date:	02/22/2022
Investigation Initiation Date:	02/23/2022
Report Due Date:	04/24/2022
Licensee Name:	Samaritas
Licensee Address:	8131 East Jefferson Avenu Detroit, MI 48214-2691
Licensee Telephone #:	(231) 936-1012
Administrator/Authorized Representative:	Beth Covault
Name of Facility:	Samaritas Senior Living Grand Rapids Woods
Facility Address:	1900-32nd Street, SE Grand Rapids, MI 49508-1583
Facility Telephone #:	(616) 452-4470
Original Issuance Date:	02/15/1994
License Status:	REGULAR
Effective Date:	02/28/2022
Expiration Date:	02/27/2023
Capacity:	61
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was locked in a hallway.	No
Additional Findings	Yes

III. METHODOLOGY

02/22/2022	Special Investigation Intake 2022A1021030
02/23/2022	Special Investigation Initiated - Letter referral sent to APS
02/28/2022	Inspection Completed On-site
03/11/2022	Exit Conference Exit Conference with authorized representative Beth Covault

ALLEGATION:

Resident A was locked in a hallway.

INVESTIGATION:

On 2/22/22, the licensing department received a complaint with allegations Resident A is locked in a hallway. The complainant alleged that Resident A wanders and therefore is locked in a hallway that she cannot get out of. The complainant alleged multiple staff members have locked Resident A and other residents in this hallway.

On 2/23/22, the allegations in this report were sent to centralized intake at Adult Protective Services (APS).

On 2/28/22, I interviewed administrator Michelle DuBridge at the facility. Ms. DuBridge reported the facility has one main dining area for the residents. Ms. DuBridge reported there are four or five residents that require additional assistance during mealtimes. Ms. DuBridge reported these residents are placed in a separate area to allow them more supervision and assistance. Ms. DuBridge reported there is one door that is closed but it is not locked, and the residents are able to access the main dining room. Ms. DuBridge reported there is always a staff member with the

residents during this time. Ms. DuBridge reported the door is a fire door and cannot be locked.

On 2/28/22, I attempted to interview Resident A at the facility. Due to Resident A's cognitive impairment, I was unable to gather additional information from Resident A.

On 2/28/22, I interviewed caregiver Makbule Vodollari at the facility. Ms. Vodollari reported Resident A will take other residents' food and bother other residents during mealtimes. Ms. Vodollari reported she is placed in the dining area that is adjacent to the main area so that she does not bother other residents. Ms. Vodollari reported there is always a caregiver present during mealtimes.

On 2/28/22, I interviewed caregiver Agatha Doe at the facility. Ms. Doe reported the facility separates residents that require additional assistance and supervision during mealtimes. Ms. Doe reported the residents are never locked in the area and can leave the area. Ms. Doe reported residents are never forced to an area and she has never observed any caregivers forcing a resident to a specific area.

On 2/28/22, I interviewed medication technician Heather Simon at the facility. Ms. Simon reported residents are not locked in the area as the doors do not lock. Ms. Simon reported the facility does not force residents but do re-direct if they are bothering other residents. Ms. Simon reported during mealtimes there is always a caregiver present in both dining areas. Ms. Simon reported she has never observed any concerning interactions with residents and caregivers.

On 2/28/22, I interviewed kitchen staff Michelle Barry at the facility. Ms. Barry reported kitchen staff do not interact with the residents. Ms. Barry reported she has never observed any concerning interactions between kitchen staff and residents.

On 2/28/22, I reviewed the dining area. I observed a main dining area with many tables and chairs. I observed a separate area adjacent to the dining area. This area had two tables with chairs. I observed the doors that was described by Ms. DuBridge. The doors were a double door that did not have the capacity to lock.

I reviewed employee record for Ms. Simon, Ms. Doe, and Ms. Vodollari. The records revealed all employees were trained on resident rights, code of conduct, dementia training, and abuse upon hire at the facility.

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 with caregivers and observations at the facility, revealed residents are separated into two separate areas during mealtimes to allow for increased supervision. There is lack of evidence to support the allegation Resident A is locked in a hallway.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Ms. DuBridge reported the facility utilizes agency staff to fill vacant staff positions. Ms. DuBridge reported the facility scheduling office ensures the temporary worker has a tuberculous test, background check, and drug screening. Ms. DuBridge reported it is the expectation that the company provides training for the worker and no training is provided on site.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following: **(a) Reporting requirements and documentation.** **(b) First aid and/or medication, if any.** **(c) Personal care.** **(d) Resident rights and responsibilities.** **(e) Safety and fire prevention.** **(f) Containment of infectious disease and standard precautions.** **(g) Medication administration, if applicable.**
ANALYSIS:	The facility utilizes temporary staffing agencies to supply workers to fill otherwise vacant scheduled positions. Interview with administrator revealed temporary agency staff are not trained at the facility. There is no training or competency evaluation documentation maintained for agency staff workers that demonstrates the temporary staff are competent on facility program statement, resident service plans, reporting requirements and documentation, first aid and/or medications, personal care, resident rights and responsibilities, safety and

	disaster plans, containment of infectious disease and standard precaution, and medication administration, if applicable.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 3/11/22, I conducted an exit conference with authorized representative Beth Covault by telephone. Ms. Covault reproted the agency staff workers are trained within their agency. Ms. Covault reported the agency staff participate in huddles and receive education.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

Kimberly Horst 3/4/22

Kimberly Horst Date
Licensing Staff

Approved By:

Andrea L. Moore 03/11/2022

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section