GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 26, 2021

Melissa Peebles
Park Village Pines
2920 Crystal Lane
Kalamazoo, MI 49009

RE: License #:	AH390236863
Investigation #:	2021A1021052
	Park Village Pines

Dear Ms. Peebles:

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 #:	AH390236863
Investigation #:	2021A1021052
Complaint Receipt Date:	09/29/2021
Investigation Initiation Date:	09/30/2021
Report Due Date:	11/29/2021
Licensee Name:	The Kalamazoo Area Christian Retirement Assoc Inc
Licensee Address:	2920 Crystal Lane Kalamazoo, MI 49009
Licensee Telephone #:	(269) 372-1928
Administrator/ Authorized Representative:	Melissa Peebles
Name of Facility:	Park Village Pines
Facility Address:	2920 Crystal Lane Kalamazoo, MI 49009
Facility Telephone #:	(269) 372-1928
Original Issuance Date:	03/01/1975
License Status:	REGULAR
Effective Date:	03/31/2021
Expiration Date:	03/30/2022
Capacity:	215
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Facility is not following Covid-19 protocols.	Yes
Call lights are not answered.	No
Resident A transferred incorrectly.	Yes
Additional Findings	Yes

III. METHODOLOGY

09/29/2021	Special Investigation Intake 2021A1021052
09/30/2021	Special Investigation Initiated - Telephone interviewed complainant
09/30/2021	APS Referral referral sent to APS
10/07/2021	Inspection Completed On-site
10/08/2021	Contact-Document Received Received call light response times
10/19/2021	Contact-Documents Received Received Covid-19 policies
10/19/2021	Contact-Telephone call made Interviewed caregiver Greshena Howlett
10/26/2021	Exit Conference Exit Conference with authorized representative Melissa Peebles

ALLEGATION:

Facility is not following Covid-19 protocols.

INVESTIGATION:

On 9/29/21, the licensing department received a complaint with allegations the facility is not following Covid-19 protocols.

On 9/30/21, the allegations in this report were sent to Adult Protective Services (APS).

On 9/30/21, I interviewed the complainant by telephone. The complainant alleged the facility had Covid-19 positive residents and staff members were not wearing appropriate personal protective equipment (PPE). The complainant alleged Resident B was diagnosed with Covid-19 and was not separated from her roommate.

On 10/7/21, I interviewed administrator Melissa Peebles at the facility. Ms. Peebles reported the facility had no positive Covid-19 residents. Ms. Peebles reported the last positive case was with Resident B on 9/20. Ms. Peebles reported Resident B had a roommate, Resident C, and the residents were not separated because Resident C was already exposed to Covid-19 by Resident B. Ms. Peebles reported Resident B had a very minor case of Covid-19 with no respiratory distress. Ms. Peebles reported if Resident B had a more severe case than the residents would have been separated. Ms. Peebles reported both residents are vaccinated. Ms. Peebles reported when there is a positive resident the facility places PPE outside the room for the caregivers to use. Ms. Peebles reported the facility assigns one or two specific caregivers to care for that resident to decrease additional cases. Ms. Peebles reported if a transfer device is needed for the resident than the transfer device is placed in the room to protect the other residents. Ms. Peebles reported the resident is placed on precautions and does not leave their room for 10 days. Ms. Peebles reported staff members are to always wear a mask while inside the facility.

On 10/7/21, I interviewed caregiver Erica Wilke at the facility. Ms. Wilke reported when a resident is diagnosed with Covid-19 they are quarantined to their room. Ms. Wilke reported the positive resident is cared by one or two caregivers to decrease the spread of Covid-19. Ms. Wilke reported PPE is placed outside the room and staff members wear the PPE when caring for the positive Covid-19 resident.

On 10/7/21, I interviewed caregiver Stephanie Junker at the facility. Ms. Junker statements were consistent with those made by Ms. Peebles and Ms. Wilke.

At the facility I observed all caregivers wearing masks in public and private areas.

I reviewed executive order *Requirements for Residential Care Facilities.* The order read,

> *“Residential care facilities (hereafter referred to as "facilities" in this order) shall comply with the Center for Medicare and Medicaid Services guidance included in QSO-20-39-NH.*

I reviewed *Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes*. The order read,

> *"Place a patient with suspected or confirmed SARS-CoV-2 infection in a single-person room.*
>
> *Ideally, a resident with suspected SARS-CoV-2 infection should be moved to a single-person room with a private bathroom while test results are pending.*
>
> *In general, it is recommended that the door to the room remain closed to reduce transmission of SARS-CoV-2. This is especially important for residents with suspected or confirmed SARS-CoV-2 infection being cared for outside of the COVID-19 care unit. However, in some circumstances (e.g., memory care units), keeping the door closed may pose resident safety risks and the door might need to remain open. If doors must remain open, work with facility engineers to implement strategies to minimize airflow into the hallway.*
>
> *If limited single rooms are available, or if numerous residents are simultaneously identified to have known SARS-CoV-2 exposures or symptoms concerning for COVID-19, residents should remain in their current location pending return of test results.*
>
> *Residents should only be placed in a COVID-19 care unit if they have confirmed SARS-CoV-2 infection.*
>
> *Fully vaccinated residents who have had close contact with someone with SARS-CoV-2 infection should wear source control and be tested as described in the testing section. Fully vaccinated residents and residents with SARS-CoV-2 infection in the last 90 days do not need to be quarantined, restricted to their room, or cared for by HCP using the full PPE recommended for the care of a resident with SARS-CoV-2 infection unless they develop symptoms of COVID-19, are diagnosed with SARS-CoV-2 infection, or the facility is directed to do so by the jurisdiction's public health authority. Additional potential exceptions are described here.*

APPLICABLE RULE	
R 325.1917	**Compliance with other laws, codes, and ordinances.**
	(1) A home shall comply with all applicable laws and shall furnish such evidence as the director shall require to show compliance with all local laws, codes, and ordinances.

ANALYSIS:	Review of current Center for Disease Control and Prevention Order revealed if a resident tests positive for Covid-19 than they should be placed in a private room. In addition, if a resident has close contact with Covid-19 but is fully vaccinated, they do not have to quarantined, be restricted to their room, or cared for by staff with full PPE. Interviews with staff revealed Resident C was exposed to Covid-19 by her roommate, Resident B. Resident C was fully vaccinated and never tested positive for Covid-19. The facility did not act in accordance with the current orders by they did not separate Resident C and instead placed Resident C in quarantine.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Call lights are not answered.

INVESTIGATION:

The complainant alleged on 9/24 within the Oakview Terrace unit call lights were not answered in a timely manner. The complainant alleged caregivers do not answer call lights and do not respond to resident needs. The complainant alleged on 9/29 she was not able to access the system to answer call lights which resulted in residents not receiving assistance.

Ms. Peebles reported residents have pendants or have a pull cord within their room. Ms. Peebles reported when a resident calls for assistance, the alarm goes to an iPod the caregiver carries. Ms. Peebles reported the call lights are reviewed by the care staff on the unit and management. Ms. Peebles reported if a call light is not answered in a timely manner than a manager will respond. Ms. Peebles reported no concerns have been brought to her attention from caregivers, residents or family members regarding call lights not answered. Ms. Peebles reported she has not been made aware of caregivers unable to access the call light system. Ms. Peebles reported if an iPod is not working than there is extra iPods to use. Ms. Peebles reported temp staff have their own unique login and the login information is at the nurse station. Ms. Peebles reported if a caregiver is unable to access the system, then the caregivers will work together to ensure call lights are answered appropriately. Ms. Peebles reported the facility expectation is to answer call lights in under 17 minutes.

Ms. Wilke reported caregivers carry an iPod to answer resident call lights. Ms. Wilke reported caregivers work together to ensure the call lights are answered appropriately. Ms. Wilke denied allegation that call lights are not answered.

Ms. Junker reported call lights are answered very quickly. Ms. Junker reported if a caregiver has an issue with logging into the system, a manager can reset their login to ensure they are able to login. Ms. Junker reported caregivers work together to ensure call lights are answered appropriately. Ms. Junker denied allegations call lights are not answered.

On 10/19/21, I interviewed caregiver Greshena Howlett by telephone. Ms. Howlett reported it is common for temporary staff to have problems logging into the system. Ms. Howlett reported if this occurs staff members will try to assist them. Ms. Howlett reported caregivers will work together to let staff members know what call lights need to be addressed.

While on Oakview Terrace unit I observed three staff members working. All staff members had working iPods. The caregivers were responding to call lights as soon as the iPod alerted them.

I reviewed call light response times for 9/24. The average call light response time was 14 minutes. I reviewed call light response times for 9/29. The average call light response time was 2 minutes. The call light response time for 9/29 revealed the complainant responded to call lights throughout the shift.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(1) Personal care and services that are provided to a resident by the home shall be designed to encourage residents to function physically and intellectually with independence at the highest practical level.
ANALYSIS:	Interviews with management and caregivers revealed call lights are answered in an appropriate timeframe. Review of call light response times for 9/24 and 9/29 revealed call lights were answered within the expected timeframes.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A transferred incorrectly.

INVESTIGATION:

The complainant alleged on 9/29 she was providing care to Resident A on Oakview Terrace unit. The complainant alleged Resident A requires a sit-stand device for transfers. The complainant alleged Staff Person 1 (SP1) came and took the device. The complaint alleged she had to leave Resident A alone on the toilet while she found another device to transfer Resident A off the toilet. The complainant alleged the facility had broken equipment and incorrect pads to use on the devices. The complainant alleged Resident A was left on the toilet for one hour while she attempted to find a device to transfer Resident A. The complainant alleged caregivers told her to transfer Resident A without a device.

Ms. Peebles reported Resident A does not require a device to transfer. Ms. Peebles reported Resident A can stand and pivot by herself to transfer. Ms. Peebles reported every month caregivers are to demonstrate how to correctly use the sit-stand device and the Hoyer device. Ms. Peebles reported the facility inspects the devices monthly to make sure they are in good working condition. Ms. Peebles reported no knowledge of broken equipment or lack of equipment on the unit.

Ms. Wilke reported Resident A does not require a sit-stand device to transfer and is able to transfer herself.

Ms. Junker reported Resident A did require a sit-stand device but now does not require the device to transfer.

I attempted to interview Resident A. Resident A was a poor historian and unable to provide details on the events that occurred on 9/29.

While on the unit I observed four Hoyer's and three sit-stand devices. Upon inspection, the devices were in good working condition.

Ms. Howlett reported during the morning hours and after lunch there are multiple residents that require a device to transfer. Ms. Howlett reported when this occurs, it can take increased time to find a device. Ms. Howlett reported no knowledge of Resident A being left on the toilet on 9/29.

I reviewed Resident A's service plan. The service plan read,
"Resident requires a sit to stand lift for all transfers."

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:	While it is uncertain if Resident A was left on the toilet for increased time on 9/29, multiple interviews with management and caregivers revealed Resident A is a stand-pivot transfer and a sit-stand device is not needed. However, review of Resident A's service plan states Resident A does require a sit-stand device. Resident A is not provided care that is consistent with her service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Ms. Peebles reported the facility is using multiple staffing agencies to fill open shifts. Ms. Peebles reported when the worker reports to the facility she escorts them to their unit and the employee is mentored by another employee. Ms. Peebles reported the facility does not complete training as they are already trained.

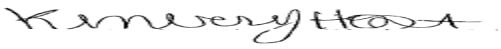
APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following: **(a) Reporting requirements and documentation.** **(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 10/26/21, I conducted an exit conference with authorized representative Melissa Peebles by telephone. Ms. Peebles reported it is an unrealistic expectation that temporary agency to be trained on site. Ms. Peebles requested a telephone call with HFA area manager Russ Misiak.

IV. RECOMMENDATION

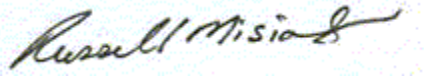
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.



10/21/21

Kimberly Horst — Date
Licensing Staff

Approved By:



10/21/21

Russell B. Misiak — Date
Area Manager