GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 7, 2022

Achal Patel
Divine Life Assisted Living Center 3 LLC
2045 Birch Bluff Drive
Okemos, MI 48864

RE: License #: AL330404952
Investigation #: 2022A0577021
Divine Life Assisted Living Center 3 LLC

Dear Mr. Patel:

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 (231) 922-5309.

Sincerely,

Bridget Vermeesch

Bridget Vermeesch, Licensing Consultant
Bureau of Community and Health Systems
1919 Parkland Drive
Mt. Pleasant, MI 48858-8010
(989) 948-0561

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL330404952
Investigation #:	2022A0577021
Complaint Receipt Date:	01/26/2022
Investigation Initiation Date:	01/28/2022
Report Due Date:	03/27/2022
Licensee Name:	Divine Life Assisted Living Center 3 LLC
Licensee Address:	2045 Birch Bluff Drive Okemos, MI 48864
Licensee Telephone #:	(517) 339-2390
Administrator/Licensee Designee:	Achal Patel, Designee
Name of Facility:	Divine Life Assisted Living Center 3 LLC
Facility Address:	2077 Haslett Road Haslett, MI 48840
Facility Telephone #:	(517) 339-2390
Original Issuance Date:	11/09/2020
License **Status:**	REGULAR
Effective Date:	05/09/2021
Expiration Date:	05/08/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS

	AGED

II. ALLEGATION(S)

	Violation Established?
There is not adequate staff scheduled to properly care for the resident and meet their needs.	Yes

III. METHODOLOGY

01/26/2022	Special Investigation Intake 2022A0577021
01/28/2022	Special Investigation Initiated - Telephone Interview with Complainant.
02/08/2022	Inspection Completed On-site Interviewed residents, relatives, home manager. Reviewed records, staff schedule.
02/09/2022	Contact-Document Received Staff Schedule and IR.
02/16/2022	Contact - Telephone call made Interview with staff.
02/16/2022	Exit Conference with licensee designee Achel Patel.

ALLEGATION: There is not adequate staff scheduled to properly care for the resident and meet their needs.

INVESTIGATION:

On January 26, 2022, a complaint was received with concerns that there is not adequate staffing to provide proper care for residents. The complaint reported there is only one direct care staff at night. The complaint reported due to lack of staffing Resident B fell at the facility.

On January 28, 2022, I interviewed Complainant who reported around December 06, 2021, Resident B fell and broke her femur. Complainant reported there is not enough staff scheduled to meet the needs of the residents and this is what caused Resident B to fall. Complainant reported she was speaking with a direct care staff in December 2021 through social media and the direct care staff reported working third shift from

6:00am-6:00pm by themselves at times. Complainant was not able to provide me with the social media documentation.

On February 08, 2022, I completed an unannounced onsite investigation at the facility and reviewed the facility *Resident Register* documenting the facility currently has 18 residents admitted to the facility. I reviewed the *Assessment Plan for AFC Residents* of the 18 residents and found three residents who require two direct care staff members assistance when transferring, toileting and bathing. The additional 15 residents require some variety of direct care staff supervision while bathing, toileting, and dressing. My review of each *Assessment Plan for AFC Residents* also found that 16 residents require an assistive device such as walker or wheelchair to assist with mobility. I reviewed and received copies of the staff schedule for December 2021-January 2022 and found that in December 2021 and half of January 2022 the schedule reflected the use of three eight-hour shifts, 6:00am-2:00pm, 2:00pm-10:00pm, and 10:00pm-6:00am. During the week of January 16, 2022, the schedule changed to twelve-hour shifts, from 6:00am-6:00pm and 6:00pm-6:00am with the staff schedule documenting each shift having two direct care staff members per shift, plus an additional direct care staff member from 8:00am-8:00pm. The staff schedule for December 15, 2021, documented a staff member was a no call/no show for the 10:00pm-6:00am shift and on December 16, 2021, a staff left their shift early from 10:00pm-6:00am leaving one direct care staff working both days. The week of December 19, 2021, during the 2:00pm-10:00pm shift on December 19, 21, 22, and 24, there was only one direct care staff scheduled to work. The week of January 02, 2022, during the 2:00pm-10:00pm shift on January 2, 3, 5, 6, and 7, there was one direct care staff scheduled and working the floor. On January 11, 12, and 15th from 6:00pm-10:00pm there was one direct care staff working. Based on my review from January 16, 2022, through January 31, 2022, there are no shifts being left unscheduled, no call in/no shows, or staff leaving early. The staff schedule starting on January 16, 2022, documented two staff scheduled per shift with no shifts being left unstaffed.

During my onsite investigation on February 08, 2022, I interviewed Resident C, Resident D, Resident A, Resident E, and Relative A1 who all reported there is adequate staffing, the direct care staff are very attentive, and if there is an emergency such as a fall, they hit their emergency button and direct care staff are there immediately. Relative A1 stated, “the care and staff are amazing, terrific and over the top accommodating.” Relative A1 reported being at the facility a couple of times a week and it is always unannounced. Relative A1 reported the facility is always clean, the residents are very well cared for and has no concerns regarding the amount of staffing. Relative A1 reported there have always been two staff working during her visits. Relative A1 stated, “I cannot say enough good things about the staff and care that is provided.” I attempted to interview Resident B, but Resident B not at the facility during the time of my onsite investigation.

On February 08, 2022, I interviewed direct care staff member Rose Benavidez who reported there is supposed to be two direct care staff at the facility at all times. Ms. Benavidez reported the facility recently went from three eight hour shifts to two twelve-

hour shifts, plus an additional person from 8:00am-8:00pm. Ms. Benavidez reported this switch has made it easier to schedule staff and cover shifts to ensure two staff are on the floor at all times. Ms. Benavidez reported her normal hours are Monday-Friday, 6:00am-6:00pm, but she often will cover shifts when there are call-ins and assist on the weekends when needed. Ms. Benavidez reported she is not aware of a shift when there was only one direct care staff working.

On February 09, 2022, Achel Patel, Licensee Designee, emailed me copies of the December 2021 direct care staff schedules and *AFC Licensing Division-Incident/Accident (IR) Report* involving Resident B's fall. The IR for December 08, 2022, documented the staff involved were Jada Wall, Elara Home Care Nurse Zachary Jarvis, and Resident B. The IR reported Ms. Wall was passing medication and heard a loud thud, went into the kitchen, saw RN Jarvis rushing over to Resident B, and they picked Resident B up, asked Resident B if they were okay, checked for obvious injuries, called the ambulance, notified sister and doctor's office. IR documented time as PM-no specific time.

On February 16, 2022, I interviewed direct care staff member Jada Wall who reported she started work at 2:00pm on December 08, 2021 and feels the fall occurred between 2:00pm and 3:00pm. The direct care staff schedule for December 08, 2022, documented from 2:00pm-10:00pm Jada Wall was working and Rose Benavidez from 6:00am-6:00pm, and then from 4:00pm-10:00pm another staff came in. Ms. Wall reported Zachary Jarvis, wound care nurse with Elara Home Care, was at the facility completing rounds with his patient and was sitting in the chair by Resident B's bedroom when Resident B fell coming out of her bedroom. Ms. Wall reported she mostly works first shift and there is usually two people working that shift.

On February 16, 2022, I interviewed direct care staff member Rose Benavidez who reported there have been times, prior to the new schedule of 12-hour shifts, when staff have had to leave a shift leaving only one direct care staff member working. Ms. Benavidez reported they would try and get other staff to cover the shift, but sometimes are unsuccessful. Ms. Benavidez reported she normally arrives to work around 6:00am but on some days will come in around 4:00am to assist during a shortage. Ms. Benavidez reported on December 08, 2021, when Resident B fell, she was working the floor until 6:00pm with Jada Wall who came to work at 2:00pm.

On February 16, 2022, I interviewed direct care staff member Arren Hart who reported she started in October 2021 and works third shift. Ms. Hart reported there have been shifts, about seven or eight in total, where she worked by herself due to a no call/no show or the other staff had to leave due to being ill. Ms. Hart reported she contacted management immediately and was told they contacted other staff to come in to cover the shift but no one ever showed up. Ms. Hart reported there have been times when home manager Rose Benavidez came in early for her shift to assist. Ms. Hart reported she does not remember the specific dates of the shifts she worked by herself and again said it was about seven or eight since October 2021. Ms. Hart reported the facility has

recently changed the staff schedule from eight hour shifts to 12-hour shifts and there have been two people working per shift so she has not worked alone since the change.

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 the information gathered during the investigation, the facility had 18 residents admitted to the facility and three residents required two direct care staff to assist with transfers, bathing, and toileting. Per the staff schedules reviewed and direct care staff interviewed, on December 15, 16, 19, 21, 22, 24 and January 2, 5, 6, 7, 11, 12, and 15 there was only one direct care staff working despite having three residents who required two direct care staff members to assist with transferring and personal care tasks. Therefore, there was not sufficient direct care staff scheduled to meet the needs of the residents during those dates.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, it is recommended that the current status of the license remains unchanged.

Bridget Vermeesch

02/16/2022

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Bridget Vermeesch Date
Licensing Consultant

Approved By:

Dawn Timm

03/07/2022

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Dawn N. Timm Date
Area Manager