

GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

ORLENE HAWKS DIRECTOR

June 28, 2022

Rebecca Nagey Rhema-Armada Village Operating, LLC 22600 W. Main Street Armada, MI 48005

> RE: License #: AL500382677 Investigation #: 2022A0617020

> > Meadow Ridge Assisted Living

Dear Ms. Nagey:

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.

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 (248) 975-5053.

Sincerely,

Eric Johnson, Licensing Consultant Bureau of Community and Health Systems Cadillac Place, Ste 9-100 Detroit, MI 48202

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL500382677
Investigation #	2022A0617020
Investigation #:	2022A0017020
Complaint Receipt Date:	05/03/2022
Investigation Initiation Date:	05/06/2022
Report Due Date:	07/02/2022
Report Due Date.	01702/2022
Licensee Name:	Rhema-Armada Village Operating, LLC
Licensee Address:	22600 W. Main Street Armada, MI 48005
	Amada, Wii 40000
Licensee Telephone #:	(586) 473-3227
Administrator:	Rebecca Nagey,
Licensee Designee:	Rebecca Nagey,
	rtoz coca rtagoj;
Name of Facility:	Meadow Ridge Assisted Living
Essility Address:	22590 W. Main Street
Facility Address:	Armada, MI 48005
Facility Telephone #:	(586) 473-3227
Original Issuence Date:	08/02/2016
Original Issuance Date:	06/02/2010
License Status:	REGULAR
Effective Date:	01/01/2021
Expiration Date:	12/31/2022
ZAPITACIONI DALON	12/01/2022
Capacity:	20
Dragger Tyras	DUVERCALLY HANDICARDED
Program Type:	PHYSICALLY HANDICAPPED AGED
	ALZHEIMERS

II. ALLEGATION(S)

Violation Established?

Facility is short staffed. Understaffing results in poor	Yes
supervision of residents.	

III. METHODOLOGY

05/03/2022	Special Investigation Intake 2022A0617017
05/03/2022	APS Referral Adult Protective Services (APS) referral denied
05/06/2022	Special Investigation Initiated - Letter Email sent to Licensee Designee Ms. Naggey
05/09/2022	Contact - Document Received Email rec from Ms. Nagey- I received the following: Staff schedule for April 2022, Resident A file, Resident Registry, Staff list with contact information, and Resident A's Mar
05/16/2022	Inspection Completed On-site On 05/16/22, I conducted an unannounced onsite investigation of the facility. During the onsite investigation I interviewed licensee designee Rebecca Nagey, staff Jeannie Wesley, Megan Misch, Rebecca Shewfelt, HR VB Heidi Nickel-Blommer, facility scheduler Megan Frazier, Resident A, Resident B, Resident C, and Resident D.
06/23/2022	Contact - Document Sent Email sent to LD Ms. Nagey
06/23/2022	Contact - Document Received Email received from Ms. Nagey
06/23/2022	Contact - Telephone call made TC made to Ms. Nagey
06/23/2022	Contact - Telephone call made I interviewed Business office Manager Diane Tomas

06/24/2022	Exit Conference
	I held an exit conference with licensee designee Rebecca Nagey
	to inform her of the results of the investigation.

ALLEGATION:

Facility is short staffed. Understaffing results in poor supervision of residents.

INVESTIGATION:

On 05/03/22, I received a complaint on the Pine View Assisted Living facility. The complaint indicated Resident A (age 73) resides at Advantage Living of Armada - Assisted living. Facility is left unattended at times. There is no medication technician on some shifts. There are 43 residents in the facility and 3 more coming. There are two staff on 3rd shift (10 pm-615 am) every weekend. There are two care managers and two medication technicians for three units on second shift. There are concerns of understaffing on every shift. Understaffing contributes to potential neglect of patients in the facility. Staff who are not certified to pass medication are required to pass medication.

On 05/16/22, I conducted an unannounced onsite investigation of the facility. During the onsite investigation, I interviewed licensee designee Rebecca Nagey, staff Jeannie Wesley, Megan Misch, Rebecca Shewfelt, HR VB Heidi Nickel-Blommer, facility scheduler Megan Frazier, Resident A, Resident B, Resident C, and Resident D.

This facility is one of three connected licensed AFC large facilities. The other two connected facilities are AL500382676 The Villages Community and AL500382675 Pine View Assisted Living.

During the onsite investigation, I interviewed facility's staff scheduler Megan Frazier. Ms. Frazier stated that there is one schedule for all three facilities. Staff are assigned to a building when they arrive to work. The facility, The Villages Community AL500382676 is operated as an independent care facility and staff do not provide those residents with 24-hour care and supervision. I received and reviewed the staff schedule for the week of 05/15/22-05/21/22. According to the schedule, direct care staff are scheduled from 6 am to 2:15pm, 2pm to 10:15pm, and 10pm to 6:15am. The medication passers are scheduled from 6 am to 2:30 pm and 2pm to 10:30pm.

I observed the following scheduling issues with regards to all three facilities:

- I observed that on 05/15/22, there was only one person scheduled from 10pm to 4am to cover all three facilities.
- On 05/16/22, there were only two people scheduled to work from 10pm to 6am to cover all three facilities.

- On 05/19/22, there were only two people scheduled to work from 10pm to 6am to cover all three facilities.
- On 05/21/22, there were only two people scheduled to work from 10pm to 6am to cover all three facilities.

On 06/23/22, I received and reviewed the staff schedule for June 2022. The facility continues to create one schedule for all three facilities. However, during the onsite investigation on 05/16/22, I informed facility scheduler Ms. Frazier that there must be at least one staff member always working in each building. According to the schedule on 06/06/22, the facility only had two people scheduled to work from 10pm to 6am to cover all three facilities. On 06/27/22, the facility has only two people scheduled to work from 11pm to 6am to cover all three facilities. According to the schedule, there are only two people scheduled to work from 10pm to 6am on 07/02/22.

APPLICABLE R	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:	According to Ms. Frazier, there is one schedule for all three facilities, the other two connected facilities are AL500382676 The Villages Community and AL500382675 Pine View Assisted Living. Staff are assigned to a building when they arrive to work. Each facility did not have at least one person working at all times.	
	On 05/15/22, I observed that there was only one person scheduled from 10pm to 4am to cover all three facilities. On 05/16/22, there were only two people scheduled to work from 10pm to 6am to cover all three facilities. On 05/19/22, there were only two people scheduled to work from 10pm to 6am to cover all three facilities. On 05/21/22, there were only two people scheduled to work from 10pm to 6am to cover all three facilities. On 06/23/22, I reviewed the staff schedule for June 2022 which demonstrates that the facility continues to create one schedule for all three facilities. According to the schedule on 06/06/22, the facility only had two people scheduled to work from 10pm to 6am to cover all three facilities. On 06/27/22, the facility only has two people scheduled to work from 11pm to 6am to cover all three facilities. According to the schedule there are only two people scheduled to work from 10pm to 6am on	

CONCLUSION:	VIOLATION ESTABLISHED
	07/02/22. This is a violation due to the facility not having at least 1 direct care staff member to 20 residents during normal sleeping hours per facility.

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:	According to Ms. Frazier, there is one schedule for all three facilities. Staff are assigned to a building when they arrive to work. According to the staff schedules, each facility did not have at least one person working at all times. The facility continues to create one schedule for all three facilities. This is a violation due to the facility not having at least 1 direct care staff member to 20 residents during normal sleeping hours per facility.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan (CAP) I recommend no change to the license.

Date Licensing Consultant

Approved By:

07/01/2022

Denise Y. Nunn Date Area Manager