GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 9th, 2022

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

RE: License #:	AH410236832
Investigation #:	2022A1021046
	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 #:	2022A1021046
Complaint Receipt Date:	04/26/2022
Investigation Initiation Date:	04/26/2022
Report Due Date:	06/26/2022
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?
Facility has insufficient staff.	Yes
Additional Findings	No

III. METHODOLOGY

04/26/2022	Special Investigation Intake 2022A1021046
04/26/2022	Special Investigation Initiated - Letter Allegations sent to APS
04/29/2022	Inspection Completed On-site
05/04/2022	Contact - Telephone call made Interviewed manager David Gasirabo
05/04/2022	Contact - Telephone call made Interviewed SP1
05/04/2022	Contact - Telephone call made Interviewed SP3
05/06/2022	Contact - Telephone call made Interviewed administrator Michelle Dubridge
05/06/2022	Contact - Telephone call made Interviewed SP4
08/09/2022	Exit Conference Exit Conference with authorized representative Beth Covault by telephone.

ALLEGATION:

Facility has insufficient staff.

INVESTIGATION:

On 4/26/22, the licensing unit received a complaint with allegations the facility had insufficient staff on first shift on 4/24/22. The complainant alleged there was only one resident care associate to care for the 32 residents. The complaint was anonymous and therefore I was unable to contact the complainant for additional information.

On 4/26/22, the allegations in this report were sent to centralized intake at Adult Protective Services (APS).

On 4/29/22, I interviewed wellness director Mary Mazurek at the facility. Ms. Mazurek reported on first shift two medication technicians and three resident care associates are to work. Ms. Mazurek reported on 4/26/22, there was three resident care associates that were scheduled but only one reported for their shift and two medication technicians that were scheduled and worked first shift. Ms. Mazurek reported first shift starts at 6:30am and ends at 3:00pm. Ms. Mazurek reported the facility was able to find one replacement resident care associate that worked 9:00am-3:00pm. Ms. Mazurek reported when the facility has an employee that does not report for their shift, an on-call manager is contacted. Ms. Mazurek reproted the on-call manager is responsible for contacting employees and finding a replacement. Ms. Mazurek reported if a replacement worker cannot be found, the manager is responsible for working the floor. Ms. Mazurek reported this policy was recently started and the facility is working out the logistics of the new policy. Ms. Mazurek reported the facility has no mandation for employees to stay over their scheduled end shift time nor a policy for on call. Ms. Mazurek typically employees will pick up extra shifts or will come in when contacted. Ms. Mazurek reported the facility is actively hiring and is still using agency workers to fill shift shortages.

On 5/4/22, I interviewed management team member David Gasirabo by telephone. Mr. Gasirabo reported he was the manager on duty on 4/24/22. Mr. Gasirabo reported he was contacted by an employee at the facility reporting two workers did not report for their shift. Mr. Gasirabo reported he was able to secure a worker from the Terrace building, an independent living unit, to come over to the facility. Mr. Gasirabo reported the worker came over around 9:00am. Mr. Gasirabo reported he contacted all the employees, and no one was able to come into the facility to work. Mr. Gasirabo reported he contacted staffing agency companies and the staffing agencies were also unable to provide a worker.

On 5/4/22, I interviewed staff person 1 (SP1) by telephone. SP1 reported she worked on 4/24/22. SP1 reported the employees at the building contacted the one call worker requesting assistance on finding a replacement worker as two resident care associates did not report for their scheduled shift. SP1 reported at 9:00am, which was two hours after the start of the shift, a worker from the Terrace unit came over. SP1 reported from 6:30-9:00am there was only one resident care associate for 32 residents. SP1 reported residents were left in bed, were not dressed, did not receive a shower, nor came to breakfast due to lack of staff in the building. SP1 reported the medication technicians attempted to assist with resident care but were also trying to pass medications.

On 5/4/22, I interviewed SP3 by telephone. SP3 reported she worked the first shift on 4/24. SP2 reported there was lack of resident care associates on this day. SP3 reported resident care suffered by residents were not dressed, showered, nor up for breakfast. SP3 reported the medication technicians provided resident care the best they could but they were also responsible for passing medications.

On 5/6/22, I interviewed administrator Michelle DuBridge by telephone. Ms. DuBridge reported if the facility has employees that do not report for their scheduled shift, the on-call worker is notified and is responsible for finding a replacement worker. Ms. DuBridge reported on 4/24/22, the facility was short two resident care associates in the beginning of the shift but then was able to find one additional resident care associate. Ms. DuBridge reported medication technicians are trained in resident care and are expected to assist with resident care. Ms. DuBridge reported the facility has no mandation nor on-call policy for the employees. Ms. DuBridge reproted the facility recently enacted the on-call policy for managers. Ms. DuBridge reproted this is not a written policy, but she would expect a manager to come in and work the floor if an employee cannot be found within one hour.

On 5/6/22, I interviewed SP4 by telephone. SP4 reported she was working at the Terrace Unit and then transferred to the Woods. SP4 reported she arrived at the facility around 9:00am and there were residents still in bed and had not ate breakfast. SP4 reported the employees worked together to ensure resident needs were met for the remainder of the shift but that the beginning of the shift was very rough. SP4 reported medication technicians were attempting to provide resident care as they were able to do so.

I reviewed the staff schedule for 4/24/22. The scheduled revealed there was two resident care associates scheduled for first shift. The schedule revealed one resident care associate called in for their shift and a replacement worker was found at 9:00.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
For Reference: R 325.1901	**Definitions.**

	(22) "Supervision" means guidance of a resident in the activities of daily living, and includes all of the following: **(a) Reminding a resident to maintain his or her medication schedule in accordance with the instructions of the resident's licensed health care professional as authorized by section 17708(2) of the act, MCL 333.17708(2).** **(b) Reminding a resident of important activities to be carried out.** **(c) Assisting a resident in keeping appointments.** **(d) Being aware of a resident's general whereabouts as indicated in the resident's service plan, even though the resident may travel independently about the community.** **(e) Supporting a resident's personal and social skills.**
ANALYSIS:	Interviews with employees revealed on 4/24/22, there was only one resident care associate. The facility has implemented a policy for management to assist in finding replacement workers and/or working the floor. However, there is no organized program with this policy such as when the on-call worker is expected to come into the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 8/9/22, I conducted an exit conference with authorized representative Beth Covault by telephone.

IV. RECOMMENDATION

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

F

Kimberly Horst 5/25/22

Kimberly Horst Date
Licensing Staff

Approved By:

Andrea L. Moore 08/08/2022

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