GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 19, 2022

Mike Dykstra
Golden Life AFC, LLC
4386 14 Mile Rd, NE
Rockford, MI 49341

RE: License #: AL410393675
Investigation #: 2022A0357022
Golden Life AFC # 4

Dear Mr. Dykstra:

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 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 (616) 356-0100.

Sincerely,

Arlene B. Smith, MSW, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4213

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410393675
Investigation #:	2022A0357022
Complaint Receipt Date:	06/21/2022
Investigation Initiation Date:	06/21/2022
Report Due Date:	08/20/2022
Licensee Name:	Golden Life AFC, LLC
Licensee Address:	4386 14 Mile Rd, NE Rockford, MI 49341
Licensee Telephone #:	(616) 307-7719
Administrator:	Mike Dykstra
Licensee Designee:	Mike Dykstra
Name of Facility:	Golden Life AFC # 4
Facility Address:	10860 Northland Dr. Rockford, MI 49341
Facility Telephone #:	(616) 884-0022
Original Issuance Date:	12/07/2020
License **Status:**	REGULAR
Effective Date:	07/14/2021
Expiration Date:	07/13/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED, DEVELOPMENTALLY DISABLED, MENTALLY ILL, AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The home is insufficiently staffed.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/21/2022	Special Investigation Intake 2022A0357022
06/21/2022	APS made the referral to our department, and they denied the complaint.
06/21/2022	Contact – telephone call made to APS Senia Eckelbarger and left a message.
06/21/2022	Special Investigation Initiated - Telephone Spoke with complainant.
06/24/2022	Contact - Telephone call made To Joanne Wright, Director of Operations
06/30/2022	Contact - Document Received From Joanne Wright
07/05/2022	Contact - Document Received Email from Joanne Wright. Attached were resident assessment plans, their schedule and hours and their work report sheet.
08/16/2022	Inspection Completed On-site Unannounced inspection at the facility.
08/16/2022	Contact - Face to Face I conducted a face-to-face interview with Direct Care Staff, Tandy Grannis. Conducted face-to-face interviews with 11 residents.
08/18/2022	Contact - Telephone call made I conducted a telephone interview with the new Home Manager, Sarah Crawford, former Direct Care staff, Diviana Zisuertes, Direct Dare Staff Kelly Austin, Justice Kimble, Keshia Ackley, Ashley VanEck, Bryce Robach, and Mary Jo Peterson. I also spoke by telephone with Tandy Grannis.
08/19/2022	Exit conference by telephone with Licensee Designee, Mike Dykstra.

ALLEGATION: The home is insufficiently staffed.

INVESTIGATION: On 06/21/2022, our office received a complaint from Department of Health and Human Services, Kent County. Adult Protective Services denied the complaint. The complaint alleged that there were 18 residents and there should be three staff per shift. The home was understaffed and there were concerns for safety and wellbeing of residents.

On 06/21/2022, I conducted a telephone interview with the complainant. This individual did not have direct knowledge of the staffing ratios of the home. They reported they had been talking to a staff (unnamed) on the telephone, who was complaining about the lack of staffing.

On 06/24/2022, I spoke by telephone with Joanne Wright, Director of Operations. She explained that they have had challenges to securing direct care staff. She explained that the Home Manager had employed several of her immediate family members. She stated that the Home Manager chose to leave because she found another job and therefore her family members who were employed by the home also left. Ms. Wright reported that they had to find staff immediately and that takes some time. I explained that I needed to review the residents' assessment plans and the facility staff schedule. She explained that there were several residents that had COVID. I requested that she send me the residents' assessment plans and the staffing schedule which she agreed she could do but it would take her some time to pull all this information together.

On 06/26/2022, Ms. Wright sent me an Incident Report (IR) for Resident O who passed away on 06/26/2022. There were 17 residents until he passed away. Now there are 16 residents.

On 06/30/2022, Ms. Wright sent me an email. She explained that they use software called "QuickBooks time tracker." She wrote that when an employee leaves, they will not show up in the past schedule for the hours they have worked. She reported that she will message their accountant to see if he could do anything on his end to help her show proof. She explained that their Home Manger Jennifer Mullins, had hired members of her family and friends so when she chose to leave, they all left with her. She reported that they had lost six staff. They had hired three new staff that also did not work out and left. When I reviewed the staff schedules with the names of staff who no longer work in the home not being on the schedule, it was difficult to determine if they had met the staffing ratios.

On 07/05/2022, Ms. Wright sent me an email. Attached to the email were resident assessment plans, which I reviewed. Also included in the email was their staff schedule and their work report sheet. She reported that she found resident assessment plans that were not completely signed so she mailed them to the appropriate parties. She stated that they are using QuickBooks for their work schedule and "*the print off of the hours report sheet*." She sent their staff names and

telephone numbers. Again, she wrote that once a staff leaves employment their name does not show up the previous hours they worked in the home.

On 07/05/2022, I reviewed Resident M's Assessment Plan. The word "yes" was checked for all self-care skills, indicating that staff assistance is needed. He needed his food warmed up (because he chooses to eat later after the meal has been served) and his food has to be cut up, due to poor teeth, toileting encourage to wear Depends, bathing daily reminders, grooming daily reminders, dressing, encourage and daily reminders, personal hygiene daily reminders and for walking encourage to use walker.

On 07/18/2022 Ms. Wright sent me an email with an attachment of one resident's assessment plan, but it only had page 1 and was missing pages 2, 3, and 4.

On 08/16/2022, I made an unannounced inspection at the facility. The staff reported that no one had COVID. I conducted a face-to-face interview with Direct Care Staff, Tandy Grannis, and we discussed the residents' needs and staffing levels. I met three staff and a staff that was training. I conducted face-to-face interviews with 11 residents.

On 08/16/2022, Ms. Grannis reported that they currently have 16 residents. She showed me her work schedule on her telephone and on every other weekend she works 7:00am to 7:00pm and she is the only staff during her 12-hour shift. Ms. Grannis stated she passes all the residents' medications which takes from 7:00 am to 9:30 am. She also fixes breakfast, cleans up after the meal and does personal care to residents who need help. She stated that she additionally answers all of the call lights, does residents' laundry which is downstairs, does her charting, fixes lunch and passes any noon medications. As the day progresses Ms. Grannis reportedly fixes dinner, cleans up and passes any scheduled medications. I asked her about the resident's care needs and she spoke about Resident R, who uses a wheelchair all the time. She reported that when he moved in on 03/10/2022, he required a two-person assist because he is paralyzed from the waist down, but now they can care for him with a one-person assist. She stated Resident B has dementia and moved in on 03/29/2022. She reportedly frequently removes her clothes throughout the day. She reported Resident L requires help in the shower. She said Resident P defecates in the bathroom, and he gets the fecal materials all over the place and under his fingernails. She stated he refuses help even after they ask him multiple times. She reported that they have to clean the entire bathroom. She said when this happens, they have to give him a shower. I asked who answers call lights and supervises other residents when she is showering Resident P and she is the only staff on duty. She stated she does the best she can. She also reported that most of the other residents can do most of their own personal care and some need reminders or cueing. She stated that Sarah Crawford is the home manager, and she works during the week, but she does not work on the weekends. She reported that direct care staff, Mary Jo Paterson works every other weekend, and she also works the 7:00am to 7:00pm shift alone.

On 08/16/2022, I observed Resident P, Resident D, Resident L, Resident F, Resident A, and Resident B were using walkers in the home. Resident R uses a wheelchair. Resident M has a walker, and he is encouraged by staff to use it, but he usually refuses to use it.

On 08/16/2022, I conducted interviews with residents. Resident P denied that he needed any personal care assistance from staff, which is different than what Ms. Grannis reported. Resident E, Resident N, Resident I, Resident F, Resident G, Resident K, Resident D, Resident M, and Resident J (which is nine of the 16 residents not counting Resident P) all denied that they require any help from staff with personal care. Upon review of their assessment plans they matched what these residents reported. Upon review of the other four residents (Resident's A, Resident C, Resident H, Resident L), their needs were recorded as requiring "cueing" with personal care, stand-by assistance with showers (as needed), and encouragement to shower or to change their clothes with staff help when needed. The residents who required total care were Resident R and Resident B. Resident M does not take direction well and he is reminded by staff to put on clean clothes and to take showers, to wear adult protection and to care for his personal hygiene, use his walker, but he is resistant to staff's directions. When I interviewed him, he had a dirty T shirt on. None of the residents I interviewed stated that they had any needs that were not met. They stated they sometimes have to wait a bit, but their needs are always met.

On 08/18/2022, I conducted a telephone interview with the Sarah Crawford (home manager). She acknowledged that they are "short staffed". She reported that Resident B has just gone on hospice and the hospice staff help with her showers. She reported that she worked first shift on 08/17/2022 and then third shift from 08/17/22 into 08/18/2022. I asked her how many staff she has, and she provided the names of six individuals. One of the six was part time and one had just started on Monday 08/22/2022. She reported they do not have a second shift because staff are scheduled 7:00am to 7:00pm and some staff are assigned four hours at the time the residents need the most care. She said she just hired two new staff. She reported that there are a few staff from their other licensed homes that come and fill in. She acknowledged that Resident C and Resident D had recently fallen. She said they had to call "Lift Assist" for Resident D who had slid from her bedside onto the floor. She reported that the staff are EMT's and they do help lift residents. She expressed concern for Resident M and his not complying with personal care needs. She explained they have sought help from his guardian and his case manager, and they have only suggested to encourage him to shower and change his clothes.

On 08/18/2022, I conducted a telephone interview with Bryce Robach. Direct Care Staff who works third shift which is 7:00pm to 7:00am. He stated that he usually woks alone but occasionally there is an extra staff for a short shift. He stated that he does his best to meet all the residents' needs.

On 08/18/2022, I conducted a telephone interview with Direct Care Staff, Mary Jo Peterson. She stated that she works every other weekend, and she works alone from 7:00am to 7:00pm. She reported it is very difficult to give showers when only one staff is working. She said she meets all the residents needs but at times some have to wait for her to get to them. She also reported that she did work third shift and she worked alone. Just recently she moved to the 7:00am to 7:00pm shift. She stated that Resident R and B require “total care” and that she administered all the residents’ medications, fixed three meals and cleaned up, did laundry, did personal care for those who needed it and did her charting.

On 08/19/2022, I conducted a telephone exit conference with the Licensee Designee Mike Dykstra, and he said he was not aware that the staffing on the weekends was with only one staff. He said their plan was to have two staff on during the day from 8:00am to 8:00pm. He said it has been difficult to find staff since COVID began. He agreed with my findings.

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:	Two Direct Care Staff, Tandy Gannis and Mary Jo Peterson both stated they work every other weekend from 7:00am to 7:00pm alone and the facility has 16 residents. They reported that two residents, Resident B and Resident R, require “total care”. They stated that they administer all of the resident’s medications, fix three meals with clean up, answer all the call lights, do laundry, and help with personal care for all the residents who require care. During this investigation there was evidence found that the Licensee Designee has not provided the required 1 direct care worker to 15 residents during waking hours. The department has determined that the ratio of direct care staff is not adequate to carry out the responsibilities defined in the act and in these rules. Therefore, a violation is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 08/16/2022, I conducted an interview with Resident J and he reported on several occasions that he helped lift a resident off the ground after the resident fell. He stated that one night (he thought it was 8/6), a resident had fallen outside in the dark and he picked her up from the ground. He was able to say her name (Resident C). He said she falls a lot. He said Ms. Crawford the home manager thanked him the next day for helping. He reported that he has helped pick up other residents who have fallen but he was unable to provide dates or names. He reported that a staff named “Keyna” had trouble getting Resident R into bed and he had to help her, but he was unsure of the date.

On 08/19/2022, I spoke with Ms. Crawford by telephone. Ms. Crawford stated she does not remember thanking Resident J for him helping a resident up from the ground. She did acknowledge that direct care staff Keyna Norvell had difficulty getting Resident R into bed. Ms. Crawford told her not to ask any resident to help care for another residents, but she said it was possible that it happened. Ms. Norvell no longer works at the home.

On 08/19/2022, I conducted a telephone exit conference with the Licensee Designee Mike Dykstra, and he said he did not know this happened. He said they have taught all of their staff to do the care and that no resident is to provide any type of care for another resident. He stated he agreed with my findings.

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 resident’s and to provide the services specified in the resident’s care agreement and assessment plan.
ANALYSIS:	Resident J acknowledged that he helped a Resident C get up after she had fallen to the ground. He also reported he helped a direct staff get Resident R into his bed. The Home Manager, Sarah Crawford said this was possible that he did help staff get Resident R into bed because she was so small in stature. The home is required to have sufficient direct care staff on duty at all times for the protection of the residents. Resident J is not responsible for the care of Resident C or Resident R. Therefore, there is a rule violation established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: I was at the home on 08/16/2022. I was interviewing direct care staff, Tandy Grannis, who had begun the process of preparing a meal for residents. I asked Ms. Grannis if she had any experience or training to prepare the meals of the residents. She said no, and reported that when she started in the home a roast was on the menu and she had never prepared a roast before. While speaking with Ms. Grannis, direct care staff Keshia Ackley came into the kitchen and said she would "plate the food". I observed the food, Swiss Steak, baked potatoes and green beans, had been plated and had sat for a period of time. There were only a few residents in the kitchen/dining area. I explained to Ms. Grannis that hot foods are to be served hot and cold foods are to be served cold. She instructed Ms. Ackey to heat each plate for each resident in the microwave before she served each resident, which she did. Ms. Grannis reported that she prepares three meals for the residents, breakfast, lunch and dinner and does the best she can do.

On 08/18/2022 I asked Ms. Ackley if she had training in food service and she stated she has experience as being a cook in several restaurants, but she has not been trained in food safety.

On 08/18/2022, I conducted a telephone interview with direct care staff, Mary Jo Peterson. She stated that she works every other weekend alone and prepares breakfast, lunch and supper for 16 residents by herself. She explained that for breakfast the residents have a choice of cold cereal, hot cereal or eggs and they choose how they want their eggs prepared. She stated that she has worked in other facilities but does not have any training in the area of food service.

On 08/19/2022, I conducted a telephone exit conference with the Licensee Designee Mike Dykstra, and he said he cannot agree or disagree with my findings. He said that they have one staff who takes the food safety class and then teaches the other staff. He stated that he would provide an acceptable plan of correction for this rule.

APPLICABLE RULE	
R 400.15201	**Qualifications of administrator, direct care staff, licensee, and members of the household; provision of names of employee, volunteer, or member of the household on parole or probation or convicted of felony; food service staff.**
	(14) A licensee shall employ at least one individual who is qualified by training, experience, and performance to be responsible for food preparation. Additional food service staff shall be employed as necessary to endure regular and timely meals.
ANALYSIS:	Three direct care staff, Ms. Grannis, Ms. Peterson and Ms. Ackley all acknowledged that they have not had any training in food service.

	During this investigation there was evidence found that the licensee does not employ at least one individual who is qualified by training, experience and performance to be responsible for food preparations. Therefore, a violation is established to this rule
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend the licensee provide an acceptable plan of correction and the license remain the same.

08/19/2022

Arlene B. Smith, MSW
Licensing Consultant

Date

Approved By:

08/19/2022

Jerry Hendrick
Area Manager

Date