GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 2, 2022

Rochelle Lyons
Oliver Woods Retirement Village LLC
Suite 200
3196 Kraft Ave SE
Grand Rapids, MI 49512

RE: License #: AL780282845
Investigation #: 2022A0584022
Oliver Woods 3

Dear Ms. Lyons:

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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Candace Coburn, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL780282845
Investigation #:	2022A0584022
Complaint Receipt Date:	05/11/2022
Investigation Initiation Date:	05/17/2022
Report Due Date:	07/10/2022
Licensee Name:	Oliver Woods Retirement Village LLC
Licensee Address:	Suite 200 3196 Kraft Ave SE Grand Rapids, MI 49512
Licensee Telephone #:	(810) 334-8809
Administrator:	Daniel Marchione
Licensee Designee:	Rochelle Lyons
Name of Facility:	Oliver Woods 3
Facility Address:	1330 W. Oliver St. Owosso, MI 48867
Facility Telephone #:	(989) 729-6060
Original Issuance Date:	10/26/2006
License Status:	REGULAR
Effective Date:	08/29/2021
Expiration Date:	08/28/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Masks and gloves not worn and handwashing not done when working with residents.	No
An unidentified resident in the facility was coughing and was not isolated from other residents.	No
There are not enough facility staff members scheduled to provide care to the residents.	No
New direct care staff members are not properly trained	No
Additional findings.	Yes

The written complaint included several other allegations that were not Adult Foster Care rule violations. Subsequently, these allegations were not investigated by the department.

III. METHODOLOGY

05/11/2022	Special Investigation Intake 2022A0584022
05/17/2022	Special Investigation Initiated – Telephone interview with Administrator Daniel Marchione
06/27/2022	Inspection Completed On-site. Contact – Separate face to face interviews with administrator Daniel Marchione, director of client services Litha Hatmaker-Adams and direct care staff members Briana Hunt, Jasmine Kinsey, and Ellaura Strobridge.
07/06/2022	Exit Conference via email with Licensee designee, Rochelle Lyons
07/11/2022	Contact – Separate telephone interviews with direct care staff members Shyanne Parker, Trinda Strobridge, Makayla Dick, and Breanna Hunt. Left a voicemail message for direct care staff members Taylor Reetz and Lola Beardon.
07/19/2022	Contact – Separate face to face interviews with care coordinator McKayla Gosselin, and direct care staff members Heather Farro, Lisa Madayag, Jessica Smith, and Brenda Willing.
08/29/2022	Contact – Separate face to face interviews with direct care staff

	members Heather Farro, China Williams, Ellaura Strobridge and Arielle Radick, human resources manager.

ALLEGATIONS:

- **Masks and gloves not worn and handwashing not done when working with the residents.**
- **An unidentified resident in the facility was coughing and was not isolated from other residents.**
- **There are not enough facility staff members scheduled to provide adequate care for the residents.**
- **New direct care staff members are not trained appropriately**

INVESTIGATION:

On 05/10/2022, Adult Protective Services dismissed the above allegations received by an unidentified Complainant for investigation and forwarded them to the Bureau of Community and Health Systems (BCHS) via the BCHS online complaint system. The written complaint did not identify the name of the resident who was allegedly sick and subsequently not isolated from the other residents. According to the written complaint, the facility is “very short-staffed” and there are not enough facility staff members scheduled to assist residents when using mechanical lifts. The written complaint also indicated new direct care staff members are not trained adequately and direct care staff members do not have access to residents’ *Assessment Plans for AFC Residents* (assessment plans).

Via telephone, I attempted to call the phone number left by the unidentified complainant. I was not able to make contact and left a voicemail message. As of the date of this report, no call back has been received.

On 6/27/2022, I conducted an unannounced investigation onsite and observed five residents in the facility’s common area, enjoying a presentation and three direct care staff members working in the facility. All five residents appeared well groomed and well cared for. The facility appeared to be adequately staffed and all staff members were wearing face masks.

Upon inspection, I established the facility was equipped with plenty of masks and hand sanitizer units were located at the doorways, and in hallways and common areas for use. I inspected the facility’s storage room and observed an adequate amount of masks and gloves.

Facility administrator Daniel Marchione, who was present at the time of my onsite investigation, provided me with the resident register which indicated that 13 total residents resided at the facility during the months of May and most of June 2022. At the end of June 2022, two more residents were added to the resident register, making the total resident census 15.

I conducted separate face-to face interviews with direct care staff members Briana Hunt, Jasmine Kinsey, and Ellaura Strobridge, who all reported working full time at this facility. Ms. Hunt, Ms. Kinsey, and Ms. Strobridge each stated the facility has an adequate supply of masks and gloves to use. Ms. Hunt, Ms. Kinsey, and Ms. Strobridge each stated that they use masks and gloves when providing care to residents, as well as wash their hands frequently. Ms. Hunt, Ms. Kinsey, and Ms. Strobridge denied the allegation the facility was not staffing adequately.

According to Ms. Hunt, Ms. Kinsey, and Ms. Strobridge, Resident A was the only resident who was sick and had a cough in the month of May. Ms. Hunt, Ms. Kinsey, and Ms. Strobridge stated Resident A has congestive heart failure. Ms. Hunt, Ms. Kinsey, and Ms. Strobridge each stated that during this time, they monitored Resident A's vital signs and documented any and all associated symptoms in "direct care staff notes". According to Ms. Hunt, Ms. Kinsey, and Ms. Strobridge, Resident A did stay in her room and was ultimately sent to the emergency room for treatment when her symptoms did not improve. The facility has a policy that when it is determined a resident has a contagious illness, that they are quarantined in their room before and during treatment.

I conducted a face-to face interview with Litha Hatmaker-Adams, whose title is director of client services. Ms. Hatmaker-Adams statements regarding Resident A were consistent with the statements Ms. Hunt, Ms. Kinsey, and Ms. Strobridge provided to me. Ms. Hatmaker-Adams provided me with Resident A's Medical Administration Record. The medical documentation reviewed indicated prompt intervention for Resident A, including assessing for COVID to determine if isolation was necessary and notifying Resident A's physician and family members of Resident A's condition. Ms. Litha-Hatmaker-Adams informed me Resident A did not have COVID. Documentation on Resident A's hospital discharge summary indicated Resident A was diagnosed with bacterial pneumonia. Ms. Hatmaker-Adams informed me Resident A was treated twice in the hospital for pneumonia during the month of May 2022.

I conducted a search of bacterial pneumonia using the internet search engine Google. According to the article "Is bacterial pneumonia contagious? – Patient Education MD", located via Google, bacterial pneumonia is not considered contagious to others.

On 7/11/2022, I conducted separate telephone interviews with Ms. Hunt and direct care staff members Shyanne Parker, Trinda Strobridge and Makayla Dick who all stated the facility provides an adequate amount of masks and gloves, which they use

when caring for residents. Ms. Hunt, Ms. Parker, Ms. Trinda Strobridge, and Ms. Dick all denied the allegation the facility was not staffed adequately. According to Ms. Hunt, Ms. Parker, Ms. Strobridge, and Ms. Dick, there were no residents at the facility who required assistance from more than one direct care staff at a time.

I requested and reviewed documentation on all 15 residents' *Assessment Plans for AFC Residents* (assessment plans), which confirmed there are no residents who require assistance from more than one direct care staff or required transferring assistance with a mechanical lift, as indicated in the written complaint.

I attempted to make telephone contact with direct care staff members Taylor Reetz and Lola Beardon. I left voicemails and requested they contact me. However, Ms. Reetz and Ms. Beardon did not return my telephone call.

On 7/19/2022, I conducted a second unannounced investigation at the facility and conducted interviews with direct care staff members Heather Farro, Lisa Madayag, Jessica Smith, Brenda Willings, and care coordinator McKayla Gosselin, who all stated they have access to and use masks and gloves when providing care to the residents. Ms. Farro, Ms. Madayag, and Ms. Gosselin all stated there was at least one direct care staff member working in the facility at all times, and this was adequate to meet the needs of the residents.

I obtained the facility staff schedule for the months of June and July 2022. According to documentation on the facility staff schedules, the facility is staffed with two 12-hour shifts. Both shifts had at least one direct care staff and one medication passer assigned to this facility, on each shift, in all of June and July.

I reviewed the fire drill records from January through July 2022. Documentation on the facility's fire drill records indicated that during the practice drills, facility staff members evacuated all residents from the facility in a timely manner.

On 8/29/2022, I conducted a third unannounced investigation onsite and reviewed the personnel records of direct care staff members Ellaura Strobridge and Ms. Kinsey. Documentation located in Ms. Strobridge and Ms. Kinsey employee records verified that they had received adequate training in all in required areas within a week of their hire date. Also located in their personnel records was written verification of staff observations, confirming Ellaura Strobridge and Ms. Kinsey satisfactorily demonstrated tasks when providing direct care.

I reviewed the training records of Ms. Ferro and direct care worker China Williams, who were newly hired, and confirmed they were also adequately trained.

I conducted in person interviews with Ellaura Strobridge and Ms. Ferro and Ms. Williams, who both worked for a local temporary employment agency and were assigned to cover last minute facility staff members absences. All three direct care workers stated they have been tested and adequately trained to provide direct care

to the residents. All three direct care workers stated they have been observed in person providing care to the residents and received satisfactory assessment. Ellaura Strobridge, Ms. Ferro, and Ms. Williams all stated direct care workers had access to the resident assessment plans, which were located in resident records inside the facility's main office

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	The written complaint did not identify the name of the resident who was allegedly sick and subsequently not isolated from the other residents. According to facility staff members Briana Hunt, Jasmine Kinsey, and Ellaura Strobridge, Resident A was the only resident who was sick and had a cough in the month of May. Resident A was separated from others to recuperate in her bedroom after returning from the hospital. Based upon my investigation, which consisted of interviews with multiple facility staff members, an observation of residents, and a review of facility documents relevant to this investigation, it has been established Resident A tested negative for COVID and was diagnosed with bacterial pneumonia twice in May 2022. Bacterial pneumonia is not considered contagious. Other than what was indicated in the written complaint, there was also no evidence to substantiate the allegations facility staff members did not use masks and gloves when caring for residents and/or did not wash their hands when working with residents and did not have access to residents' assessment plans.
CONCLUSION:	**VIOLATIONS NOT ESTABLISHED**

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:	Based upon my investigation, which consisted of interviews with multiple facility staff members and a review of facility documents relevant to this investigation, other than what was indicated in the written complaint, there is no evidence to substantiate there was not enough facility staff members assigned to this facility to provide adequate care to the residents and to assist with transferring residents using a mechanical lift.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(a)Reporting requirements.** **(b)First aid.** **(c)Cardiopulmonary resuscitation.** **(d)Personal care, supervision, and protection.** **(e)Resident rights.** **(f)Safety and fire prevention.** **(g)Prevention and containment of communicable diseases.**
ANALYSIS:	Based upon my investigation, which consisted of interviews with direct care workers and a review of employee records, there is no evidence to substantiate the allegation newly hired direct care workers are not trained adequately.
CONCLUSION:	**VIOLATIONS NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

I reviewed 13 resident medication administration records (MAR). As indicated by missing direct care staff members' initials on Resident B and Resident C's MARs, it appeared they did not get their doses of their prescribed medication on several occasions.

According to missing direct care staff initials on Resident B's June 2022 MAR, it appeared Resident B did not receive her Acetaminophen on 06/23/2022.

According to missing direct care staff initials on Resident C's June 2022 MAR, it appeared Resident C did not receive her 5:00AM and noon dose of Acetaminophen 500 on 06/01/2022 and her 5:00AM dose of Acetaminophen on 06/03/2022.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administers the mediation, which shall be entered at the time the medication is given.**
ANALYSIS:	Based upon my investigation, which consisted of a review of facility documents relevant to this investigation, it has been established that on 06/1/2022 and 06/03/2022, Resident C's MAR was missing the initials of the person who administered Resident C's Acetaminophen. On 06/23/2022, Resident B was missing the initials of the person who administered her Acetaminophen
CONCLUSION:	**VIOLATIONS ESTABLISHED**

IV. RECOMMENDATION

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

9/2/2022

Candace Coburn Date
Licensing Consultant

Approved By:

9/2/2022

Section Manager Date