GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 10, 2022

Keristin Hetherington
KC Assisted Living Corporation
7884 Emery Rd
Portland, MI 48875

RE: License #: AM340410910
Investigation #: 2022A0783051
Country Living Senior Care

Dear Ms. Hetherington:

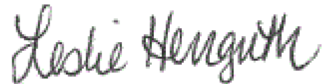
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (517) 284-9730.

Sincerely,



Leslie Herrguth, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 256-2181

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM340410910
Investigation #:	2022A0783051
Complaint Receipt Date:	06/20/2022
Investigation Initiation Date:	06/21/2022
Report Due Date:	08/19/2022
Licensee Name:	KC Assisted Living Corporation
Licensee Address:	7884 Emery Rd Portland, MI 48875
Licensee Telephone #:	(517) 647-4920
Administrator:	Keristin Hetherington
Licensee Designee:	Keristin Hetherington
Name of Facility:	Country Living Senior Care
Facility Address:	7884 Emery Rd Portland, MI 48875
Facility Telephone #:	(517) 647-4920
Original Issuance Date:	04/18/2022
License Status:	TEMPORARY
Effective Date:	04/18/2022
Expiration Date:	10/17/2022
Capacity:	12
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Residents A and C were assigned a shared bedroom on the lower level of the home and both residents' condition declined so that the residents were no longer able to go up and down stairs and their assigned bedroom remained on the lower level only accessible via stairs.	Yes
There are residents who require assistance from two staff members and there are times when only one staff member is scheduled to work at the facility.	No
Residents are given other residents' medications if they are out of a medication that another resident has.	No
Resident C was given more Ativan than prescribed and was given Resident A's prescribed Morphine on June 18, 2022.	No

III. METHODOLOGY

06/21/2022	Special Investigation Intake - 2022A0783051
06/21/2022	Special Investigation Initiated -Telephone call with Complainant
06/27/2022	Inspection Completed On-site
06/27/2022	Contact - Face to Face with administrator, licensee designee, and direct care staff member Keristin Hetherington
06/27/2022	Contact - Document Received - Resident A's resident record
06/27/2022	Contact - Document Received - Resident C's resident record
06/27/2022	Contact - Document Received - Resident B's resident record
06/29/2022	Contact - Telephone call made to direct care staff members Kelsie Meagher, Jenny Root, Sarah Headworth
07/06/2022	Contact - Telephone call made to Guardian B1, Relative A1, and Relative C1
08/09/2022	Exit Conference with Keristin Hetherington

ALLEGATION:

Residents A and C were assigned a shared bedroom on the lower level of the home and both residents' condition declined so that the residents were no longer able to go up and down stairs and their assigned bedroom remained on the lower level only accessible via stairs.

INVESTIGATION:

On June 21, 2022, I received a complaint via telephone wherein Complainant stated Resident A and Resident C were unable to walk up and down stairs and that they had bedrooms on the lower level of the home so they were no longer able to traverse freely about the facility. Complainant said both residents used walkers, and both could walk up and down stairs when they were admitted to the facility, but both have declined and can no longer get up and down the stairs. Complainant said Resident A stays in his bedroom all the time and Resident C sleeps on the couch upstairs and cannot access his bedroom. Complainant said a motorized chair lift was purchased but placed on the "other side" of the facility which is licensee designee Keristin Hetherington's personal residence.

On June 29, 2022, I spoke to direct care staff member Kelsie Meagher who said Resident A uses a walker to go up and down stairs so he can access his bedroom which is on the lower level of the facility and the common area which is on the upper level of the facility. Ms. Meagher said, "last week" Resident A could go up and down the stairs with help but that he recently began to "refuse" to go up and down stairs. Ms. Meagher said Resident A also refused to use the motorized stair lift in the licensee designee's personal quarters, so he has been spending 24/7 in his bedroom on the lower level of the facility. Ms. Meager said Resident A eats meals in his bedroom and "doesn't want to leave" his bedroom. Ms. Meagher said Resident C shared a bedroom with Resident A on the lower level of the home and that when he moved in, he went up and down stairs with assistance from one staff member and a walker. Ms. Meagher said over time Resident C's condition changed and he began refusing to sleep at night and one staff member could not adequately supervise Resident C during sleeping hours so Resident C began sleeping on the couch in the common area. Ms. Meagher said Resident C refused to go up and down the stairs and wanted to sleep on the couch.

On June 29, 2022, I spoke to direct care staff member Jenny Root who said Resident A always had a room in the lower level of the home and was able to walk up and down the stairs independently until recently when his condition declined and he began staying in his bedroom all the time. Ms. Root said Resident C walked down the stairs independently once when he first arrived and then refused to walk down the stairs again after that so Resident C slept on the couch in the living room.

On June 29, 2022, I spoke to direct care staff member Sarah Headworth who said Resident A was assigned a bedroom on the lower level of the home when he was

admitted to the facility and was able to walk up and down stairs with the assistance of his walker and one staff member. Ms. Headworth said Resident A recently began choosing to always stay in his bedroom, not because he is unable to traverse the stairs but because he does not want to leave his bedroom. Ms. Headworth said Resident C was assigned a shared bedroom with Resident A on the lower level of the facility and at the time of his admission Resident C could walk up and down the stairs with his walker and assistance from one staff member. Ms. Headworth said over time Resident C became physically weaker and could not walk up and down the stairs, so he slept on the couch until his condition deteriorated to the point that he stayed in his bedroom on the lower level of the home.

On July 6, 2022, I spoke to Relative C1 who said Resident C was assigned a bedroom on the lower level of the facility when he was admitted and that Resident C could walk up and down stairs at that time with the use of his walker and assistance from one staff member. Relative C1 stated it was her understanding that if Resident C could no longer walk up and down the stairs, he would have access to the motorized chair lift in the licensee designee's personal quarters attached to the facility. Relative C1 said after Resident C was hospitalized on May 17, 2022, he returned to the facility weak and began staying in his bedroom on the lower level all the time because he could not go up and down stairs. Relative C1 said prior to that Resident C slept in the common area on the couch or in the recliner because that was his preference.

On July 6, 2022, I spoke to Relative A1 who said when Resident A was admitted to the facility he could walk up and down stairs with the use of his walker but he was unsure if Resident A could walk up and down stairs at all at the time of the interview.

On June 27, 2022, I interviewed licensee designee and administrator Keristin Hetherington who said Resident C was admitted to the facility on May 2, 2022 and that upon admission he ambulated independently with a walker. Ms. Hetherington said upon admission Resident C could go up and down the stairs with his walker and assistant from one staff member which was necessary because his assigned bedroom was on the lower level of the home. Ms. Hetherington said Resident C had back pain and preferred to sleep on the couch on the recliner in the common area of the home for that reason. Ms. Hetherington said Resident C became "bed bound" for approximately one week before he passed away on June 24, 2022, and that he was no longer able to walk up and down the stairs so all meals, medications, etc. were brought to Resident C in his bedroom. Ms. Hetherington said Resident A has always been able to walk up and down the stairs with the use of his walker and assistance from one staff member but behaviorally refused for a short time upon returning from the hospital.

On June 27, 2022, I received and reviewed Resident A's *Health Care Appraisal* dated April 6, 2022, which stated Resident A used a walker, had gait abnormality, decreased strength in his extremities, and impaired mobility. There was no written *Assessment Plan for AFC Residents* available in Resident A's resident record. On

August 8, 2022, I once again requested Resident A's current *Assessment Plan for AFC Residents* and I received a written *Assessment Plan for AFC Residents* for Resident A completed on October 1, 2021, by the previous licensee.

On June 27, 2022, I received and reviewed Resident C's written *Assessment Plan for AFC Residents* (assessment plan) and *Health Care Appraisal* both completed in April 2022. Based on the written *Health Care Appraisal* Resident C used a walker for ambulation and had mild generalized weakness due to poor nutrition. The written assessment plan was not filled out completely as the assessments regarding walking/mobility, stair climbing, and physical limitations were left blank.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	Based on statements from Complainant, Ms. Meagher, Ms. Root, Ms. Headworth, Relative C1 and Ms. Hetherington I determined that both Resident A and Resident C were assigned a bedroom on the lower level of the facility and needed to traverse stairs to get from the common area to their bedroom. Resident A and Resident C declined physically and/or behaviorally and were unable or unwilling to walk up and down the stairs yet remained assigned to a bedroom on the lower level of the facility. Rather than moving each resident to another room or discharging each resident, each resident remained in his bedroom on the lower level of the home even though each resident lost the ability to traverse the stairs and were unable to leave the bedroom. This bedroom arrangement did not provide for the well-being of Residents A and C.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan

	on file in the home.
ANALYSIS:	After reviewing Resident A's resident record and requesting his written *Assessment Plan for AFC Residents* on more than one occasion, I determined a written *Assessment Plan for AFC Residents* was not completed by the current licensee designee along with Resident A's designated representative. Upon reviewing Resident C's record, I determined that while a written *Assessment Plan for AFC Residents* was started with Resident C's designated representative, however it was not completed as areas pertinent to this investigation including walking/mobility, stair climbing, and physical limitations were not assessed and filled in on the written assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

There are residents who require assistance from two staff members and there are times when only one staff member is scheduled to work at the facility.

INVESTIGATION:

On June 21, 2022, I received a complaint via telephone wherein Complainant stated from 1:00 pm to 6:00 pm and from 11:00 pm to 7:00 am one staff member is scheduled to work alone at the facility when Resident A, Resident B, and Resident C require assistance from two direct care staff members to meet their care needs. Complainant said Resident A needs two staff members to reposition him, Resident B needs two staff members to assist her with toileting, and Resident C needs two direct care staff members to help him with ambulating down the stairs to his bedroom. Complainant said if two staff members are not working the residents must wait until shift change to have their needs met.

On June 29, 2022, I spoke to direct care staff member Kelsie Meagher who said one staff member works from 11:00 pm until 7:00 am and from 1:00 pm to 6:00pm. Ms. Meagher denied that any resident, including Residents A, B, and C, require assistance from two staff members for any reason. Ms. Meagher denied that any resident had to wait for any care need to be met due to having one staff member at the facility. Ms. Meagher said she worked alone at the facility and cared for each resident including Residents A, B, and C with no problems.

On June 29, 2022, I spoke to direct care staff member Jenny Root who said at times Resident B requires two staff members to assist her with toileting. Ms. Root denied that Residents A and C nor any other resident besides Resident C require assistance from two staff members or must wait until shift change to have their care

needs met. Ms. Root said Resident B typically requires assistance from one staff member but if she is working alone and needs assistance, she can telephone facility administrator and licensee designee Keristin Hetherington who resides in the private living quarters attached to the facility. Ms. Root denied that Resident B is only toileted at shift change when there are two staff members present. Ms. Root stated she worked alone at the facility and had no problems.

On June 29, 2022, I spoke to direct care staff member Sarah Headworth who said during the afternoon and overnight hours there is one staff member scheduled to work. Ms. Headworth said there are no residents who require assistance from two staff members for any reason including Resident A, Resident B, and Resident C. Ms. Headworth said, “occasionally on a bad day” Resident B “might” require assistance from two staff members in which case Ms. Hetherington can assist as she resides in the living quarters attached to the facility. Ms. Headworth said she worked alone and had no problems caring for each resident including Residents A, B, and C.

On June 27, 2022, I spoke to facility co-owner and direct care staff member Courtney Shafer who said during the afternoon and overnight hours one staff member is scheduled to work and care for each resident admitted to the facility. Ms. Shafer said she worked alone and had no problems completing all the required resident care related tasks. Ms. Shafer said there are no residents who require assistance from two staff members including Resident A, Resident B, and Resident C.

On June 27, 2022, I spoke to facility administrator, licensee designee, and direct care staff member Keristin Hetherington who said from 1:00 pm to 6:00 pm and from 11:00 pm to 7:00 there is one staff member scheduled to work at the facility. Ms. Hetherington denied that any resident, including Residents A, B, nor C require assistance from two staff members for any reason. Ms. Hetherington said if Resident B is “having a super bad day” she may require assistance from two people with toileting. Ms. Hetherington said if one staff member needs assistance with Resident B she can assist because she resides in the living quarters attached to the facility.

On July 6, 2022, I spoke to Relative A1, Guardian B1, and Relative C1 who all said the residents for whom they are responsible (Resident A, Resident B, and Resident C) did not require assistance from two staff members for any reason that they were aware of.

On June 27, 2022 and August 8, 2022, I requested a copy of Resident A’s written *Assessment Plan for AFC Residents* and received an outdated assessment plan dated October 1, 2021 and completed by the previous facility owner and licensee designee. The assessment plan did not indicate that Resident A required assistance from two staff members with anything. On June 15, 2022, I received and reviewed Resident A’s *Health Care Appraisal* dated April 6, 2022, which stated Resident A was diagnosed with obesity, mood disorder, gait abnormality, hypertension, dysphasia, chronic pain and paresthesia. The *Health Care Appraisal* stated Resident

A used a walker and did not indicate that he required assistance from two staff members for any reason.

On June 27, 2022, I received and reviewed Resident B’s *Assessment Plan for AFC Residents* dated February 14, 2022. Resident B’s assessment plan stated that Resident B requires standby assistance for toileting. Resident B’s assessment plan did not indicate she required assistance from two staff members for any reason. On June 15, 2022, I received and reviewed Resident B’s *Health Care Appraisal* dated April 11, 2022. Resident B’s *Health Care Appraisal* indicated she used a walker and a wheelchair and stated she had impaired mobility, but it did not indicate she needed assistance from two staff members for anything.

On June 27, 2022, I received and reviewed Resident C’s written *Assessment Plan for AFC Residents* dated April 27, 2022, which stated Resident C used a walker and required standby assistance with most activities of daily living it did not indicate that Resident C requires assistance from two staff members for any reason. On the same day I reviewed Resident C’s written *Health Care Appraisal* dated April 24, 2022, which stated Resident C used a walker and had mild generalized weakness but did not indicate he required assistance from two staff members for any reason.

APPLICABLE RULE	
R 400.14206	**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 statements from Complainant, Ms. Meagher, Ms. Root, Ms. Headworth, Ms. Shafer, Ms. Hetherington, Relatives A1, and C1 and Guardian B1 along with written documentation in the named residents’ resident records, there is lack of evidence to prove that Resident A, Resident B, nor Resident C require assistance from two staff members for any reason nor that the facility is not adequately staffed when one staff member is working alone.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents are given other residents' medications if they are out of a medication that another resident has.

INVESTIGATION:

On June 17, 2022, I received a complaint via telephone wherein Complainant stated she worked at the facility administering medication and when any given resident is out of medication, that resident is given another resident's medication if it is the same medication. Complainant stated this occurs "all the time" but was unable to name any specific residents or dates that one resident was given another resident's medication. Complainant said she was directed to give one resident another resident's prescribed Tylenol but could not provide any additional details. Complainant said that was the one and only time she was directed to give one resident another resident's medication. Complainant stated this is done per the directions of facility administrator and licensee designee Keristin Hetherington.

On June 27, 2022, I spoke to direct care staff member Kelsie Meagher who stated she administers medication as part of her job responsibilities at the facility and has never given any resident another resident's medication nor has she ever been directed to do so. Ms. Meagher said if a resident needs medication it is ordered from the pharmacy and delivered within 24 hours and there would be no need to use another resident's medication.

On June 27, 2022, I spoke to direct care staff member Jenny Root who stated she administers medication as part of her job responsibilities at the facility and has never given any resident another resident's medication nor has she ever been directed to do so. Ms. Root said the pharmacy used by all residents at the facility delivers medications the same or next day and there would be no need to give any resident another resident's medication.

On June 27, 2022, I spoke to direct care staff member Sarah Headworth who said she administers medication at the facility as part of her job responsibilities and has never given any resident another resident's medication.

On June 27, 2022, I interviewed facility co-owner and direct care staff member Courtney Shafer who said she administers medication and orders medication as needed as part of her job responsibilities at the facility. Ms. Shafer said every staff member is responsible for notifying both her and licensee designee Keristin Hetherington if a resident needs medication refills so they can notify the pharmacy who has a representative deliver the medication the same day or the next day at the latest. Ms. Shafer said the medication cart is examined monthly so that residents in need of as – needed (PRN) medication will have the medication ordered via the pharmacy. Ms. Shafer said she has never given one resident another resident's medication, nor has she instructed any other staff member to do that.

On June 27, 2022, I interviewed facility administrator, licensee designee, and direct care staff member Keristin Hetherington who said she administers and orders medication as needed as part of her job responsibilities at the facility. Ms. Hetherington said every staff member is responsible for notifying Ms. Shafer and Ms. Hetherington if a resident medication is needed so they can ensure the medication is ordered and delivered by the pharmacy. Ms. Hetherington said every resident uses the same pharmacy which delivers medications the same day or the day after the medications are ordered. Ms. Hetherington said she has never given one resident another resident's medication, nor has she directed any direct care staff member to do that.

On June 27, 2022, I completed an unannounced onsite investigation at the facility and reviewed all the medication in the medication cart and did not see any medication that appeared to be missing or unaccounted for due to being given to another resident. I specifically compared the medication to the medication administration record in detail for approximately one third of the residents admitted to the facility and did not note any errors or anomalies.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on statements from Complainant, Ms. Meagher, Ms. Root, Ms. Headworth, Ms. Shafer and Ms. Hetherington as well as my observations at the unannounced onsite investigation there is lack of evidence to indicate that any resident was given another resident's medication.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident C was given more Ativan than prescribed and was given Resident A's prescribed Morphine on June 18, 2022.

INVESTIGATION:

On June 21, 2022, I received a complaint via telephone wherein Complainant said on June 18, 2022, she gave Resident C more of his prescribed Ativan (lorazepam) than ordered by his physician per the instructions of facility co-owner and direct care staff member Courtney Shafer. Complainant said the Ativan was ordered to be administered every four hours to Resident C and she have it to him at 1:00 am on

June 18, 2022 and because Resident C was still combative, Ms. Shafer told her to give Resident A more Ativan at 1:30 am and 3:00 am which she did and documented on Resident C's written medication administration record (MAR). Complainant said after she gave Resident A more Ativan at 3:00 am he remained restless and combative, so she telephoned facility administrator and licensee designee Keristin Hetherington who came to the facility at approximately 5:00 am and gave Resident A's prescribed Morphine to Resident C. Complainant said Ms. Hetherington did not document that she gave Resident A's medication to Resident C.

On June 27, 2022, I interviewed facility co-owner and direct care staff member Courtney Shafer who said on June 18, 2022, at approximately 3:00 am direct care staff member Kim Bunce telephoned her and said Resident C was "talking to people who weren't there," so she inquired how long it had been since Resident C last received a dose of his prescribed Ativan and was told "it had been hours." Ms. Shafer said she advised Ms. Bunce that if it had been more than four hours since Resident C last received a dose of Ativan, she should administer the medication at that time, which she stated she did. Ms. Shafer said an hour later Ms. Bunce telephoned her a second time and said Resident C punched her in the face. Ms. Shafer said at that time she spoke with facility administrator and licensee designee Keristin Hetherington who told her she was going to the facility to assist Ms. Bunce and Ms. Shafer estimated that was at approximately 4:30 am. Ms. Shafer denied that she instructed Ms. Bunce to administer more Ativan to Resident A than prescribed.

On June 27, 2022, I interviewed facility administrator and licensee designee Keristin Hetherington who said she was notified Resident C was demonstrating combative behavior during the early morning hours of June 18, 2022, so she went to the facility to check on Resident C at approximately 5:00 am. Ms. Hetherington said when she arrived Resident C was "irritated," and he attempted to "raise his arm at" Ms. Hetherington but did not hit her. Ms. Hetherington said she telephoned Resident C's hospice provider and was advised to increase Resident C's PRN dose of Ativan from every four hours to every hour as needed. Ms. Hetherington said Resident C also had a physician's order for Morphine, but she did not administer the medication on June 18, 2022. Ms. Hetherington said she was certain she did not administer Resident A's prescribed Morphine to Resident C.

On June 29, 2022, I spoke to direct care staff member Kelsie Meagher who said Resident C was prescribed a scheduled dose of Ativan every four hours as well as a PRN dose to be given hourly for agitation. Ms. Meagher said she never gave Resident C more Ativan than prescribed nor did anyone ever direct her to do so.

On June 29, 2022, I interviewed direct care staff member Jenny Root and Sarah Headworth who both stated they administered medications as part of their job responsibilities at the facility. Both staff members stated they have administered

every resident's medication as prescribed and have never given Resident C more Ativan than prescribed nor were they ever directed to do so.

On August 9, 2022, I received and reviewed Resident A's written physician's orders for Ativan. The written order dated June 18, 2022, stated the Ativan (lorazepam) 0.5 mg should be administered once every hour for anxiety and restlessness.

On June 27, 2022, I received and reviewed Resident C's written medication administration record (MAR) for June 18, 2022. I observed that Resident C's prescribed Ativan was administered by direct care staff member Kim Bunce at 1:00 am, 3:30 am, and 4:30 am. I noted that Resident C's prescribed Morphine was not administered on June 18, 2022.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the written documentation at the facility and statements from Ms. Shafer, Ms. Hetherington, Ms. Meagher, Ms. Root, and Ms. Headworth I determined that Resident C was prescribed Ativan and Morphine to be taken hourly as – needed (PRN) for agitation and restlessness and the Ativan was administered as prescribed on June 18, 2022 and the Morphine was not administered at all.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

08/09/2022

Leslie Herrguth — Date
Licensing Consultant

Approved By:

08/10/2022

Dawn N. Timm — Date
Area Manager