GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 28, 2022

Aubrey Bogdon
The Legacy at the Oaks
706 North Avenue
Battle Creek, MI 49017-3251

RE: License #: AH130297466
Investigation #: 2022A1028041
The Legacy at the Oaks

Dear Ms. Bogdon:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
Cell (616) 204-4300

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AH130297466 |
| | |
| **Investigation #:** | 2022A1028041 |
| | |
| **Complaint Receipt Date:** | 05/10/2022 |
| | |
| **Investigation Initiation Date:** | 05/12/2022 |
| | |
| **Report Due Date:** | 07/09/2022 |
| | |
| **Licensee Name:** | Trilogy Healthcare of Battle Creek, LLC |
| | |
| **Licensee Address:** | Suite 200<br>303 N.Hurstbourne Pkwy #2<br>Louisville, KY 40222 |
| | |
| **Licensee Telephone #:** | (502) 213-1710 |
| | |
| **Authorized Representative/Administrator:** | Aubrey Bogdon |
| | |
| **Name of Facility:** | The Legacy at the Oaks |
| | |
| **Facility Address:** | 706 North Avenue<br>Battle Creek, MI 49017-3251 |
| | |
| **Facility Telephone #:** | (269) 964-4655 |
| | |
| **Original Issuance Date:** | 11/21/2008 |
| | |
| License **Status:** | REGULAR |
| | |
| **Effective Date:** | 08/26/2021 |
| | |
| **Expiration Date:** | 08/25/2022 |
| | |
| **Capacity:** | 30 |
| | |
| **Program Type:** | ALZHEIMERS<br>AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Staff member left early, abandoning residents during shift. | No |
| Additional Findings | No |

## III. METHODOLOGY

| | |
|---|---|
| 05/10/2022 | Special Investigation Intake<br>2022A1028041 |
| 05/12/2022 | Special Investigation Initiated - Letter<br>2022A1028041 |
| 05/12/2022 | APS Referral<br>APS denied |
| 05/18/2022 | Contact - Face to Face<br>Interviewed AR/Admin/Aubrey Bogdon at the facility. |
| 05/18/2022 | Contact - Face to Face<br>Interviewed Employee B at the facility. |
| 05/18/2022 | Contact - Face to Face<br>Interviewed Employee C at the facility. |
| 05/18/2022 | Contact<br>Interviewed the complainant. |
| 09/28/2022 | Exit Interview |

**ALLEGATION:**

**Staff member left early, abandoning residents during shift.**

**INVESTIGATION:**

On 5/10/2022, the Bureau received the allegations from the online complaint system.

On 5/12/2022, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 5/18/2022, I interviewed facility authorized representative/administrator, Aubrey Bogdon, at the facility. Ms. Bogdon reported Employee A did leave the second shift early in the memory care unit on 5/5/2022. However, Employee A was in training and did not have residents assigned to [them]. Ms. Bogdon reported Employee A notified the supervisor on duty on 5/5/2022 about leaving early but did not notify the shift trainer. Ms. Bogdon reported there are currently 10 residents in memory care with one to two care staff and a supervisor as well during first, second, and third shifts. There are also float staff in assisted living that can assist if needed. Ms. Bogdon reported no resident care was affected by Employee A leaving the shift early on 5/5/2022. Ms. Bogdon reported Employee A was counseled along with the shift trainer concerning the incident. Ms. Bogdon reported due to other circumstances, Employee A is no longer at the facility. Ms. Bogdon provided me a copy of the working staff schedule for April 2022 to May 2022 for my review.

On 5/18/2022, I interviewed Employee B at the facility. Employee B reported Employee A did leave second shift early on 5/5/2022, but while the shift supervisor was notified, the shift trainer was not notified. Employee A clocked out 27 minutes prior to the end of second shift. Employee B reported no resident care was disrupted due to Employee A leaving early because Employee A was in training and did not have residents assigned to [their] care. Employee B's statements are consistent with Ms. Bogdon's statement about resident to staff ratio in the memory care unit. Employee B reported the shift trainer and Employee A received counseling due to the incident. Employee B confirmed Employee A is no longer at the facility due to other circumstances.

On 5/18/2022, I interviewed Employee C at the facility. Employee C's statements are consistent with Ms. Bogdon's and Employee B's statements concerning Employee A leaving second shift early on 5/5/2022 and resident care being unaffected by this leave of absence prior to the end of second shift. Employee C reported Employee A and the shift trainer received counseling on appropriate communication and procedures due to the incident. Employee C's statements are consistent with Ms. Bogdon's and Employee B's statements about resident to staff ratio in the memory care unit. Employee C also confirmed Employee A is no longer at the facility.

On 5/18/2022, I interviewed the complainant. The complainant reported being unaware Employee A notified the supervisor prior to leaving second shift early on 5/5/2022 due to transportation issues. The complainant reported this incident "was a misunderstanding between [the shift trainer] and [Employee A], but I thought it should be reported just to be safe". The complainant had no further concerns.

On 5/18/2022, I completed an on-site inspection and noted appropriate facility staff to resident ratios in the memory care unit.

On 5/19/2022, I completed a review of the working staff schedule for April 2022 and May 2022 which revealed appropriate staffing levels for the number of residents in memory care.

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1931** | **Employees; general provisions.** |
| | **(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.** |
| **ANALYSIS:** | Interviews along with review of documentation reveal no resident care was affected by Employee A exiting the second shift 27 minutes early on 5/5/2022. Employee A was in training and had no residents assigned to [their] care.<br><br>The facility also provided appropriate counseling to Employee A and other facility staff that were involved in the incident. No violation found. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

## IV. RECOMMENDATION

I recommend the status of this license remain unchanged.

Julie Viviano

5/19/2022

_____

Julie Viviano Date
Licensing Staff

Approved By:

09/27/2022

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