GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 26, 2022

Mark Walker
The Pines Of Burton Memory - South
5340 Davison Road
Burton, MI 48509

RE: License #: AH250382918
Investigation #: 2022A1027048
The Pines Of Burton Memory - South

Dear Mr. Walker:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed by the authorized representative and dated.

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. 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) 241-1970.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 241-1970

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH250382918
Investigation #:	2022A1027048
Complaint Receipt Date:	04/13/2022
Investigation Initiation Date:	04/13/2022
Report Due Date:	06/13/2022
Licensee Name:	Premier Operating Burton MC South, LLC
Licensee Address:	299 Park Ave - 6 Fl New York, NY 10171
Licensee Telephone #:	(212) 739-0794
Administrator:	Matt Brawner
Authorized Representative:	Mark Walker
Name of Facility:	The Pines Of Burton Memory - South
Facility Address:	5340 Davison Road Burton, MI 48509
Facility Telephone #:	(810) 743-8520
Original Issuance Date:	10/05/2017
License Status:	REGULAR
Effective Date:	04/05/2022
Expiration Date:	04/04/2023
Capacity:	23
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The facility's third shift is understaffed resulting in resident falls.	No
Additional Findings	Yes

III. METHODOLOGY

04/13/2022	Special Investigation Intake 2022A1027048
04/13/2022	Special Investigation Initiated - Letter Email sent to administrator Matt Brawner requesting an employee list
04/13/2022	Contact - Document Received Requested documentation received from Mr. Brawner
04/18/2022	Inspection Completed On-site
04/19/2022	Contact - Telephone call made Telephone interview conducted with Employee #1
04/19/2022	Contact - Telephone call made Telephone interview conducted with Employee #2
04/21/2022	Contact - Document Sent Email sent to administrator Mr. Brawner requesting clarification regarding staff schedule as well as Resident A's facesheet and service plan
04/21/2022	Contact - Document Received Requested documentation received from Mr. Brawner
04/21/2022	Contact - Document Sent Email sent to Mr. Brawner requested employee clock-in reports
04/25/2022	Contact - Document Received Requested documentation received from Mr. Brawner
04/26/2022	Inspection Completed-BCAL Sub. Compliance
05/12/2022	Exit Conference

	Conducted with authorized representative Mark Walker by email

ALLEGATION:

The facility's third shift is understaffed resulting in resident falls.

INVESTIGATION:

On 4/13/2022, the department received an anonymous complaint which alleged the third shift was understaffed resulting in residents having falls. Due to the anonymous nature of the complaint, I was unable to obtain additional information from the complainant.

On 4/18/2022, I conducted an on-site inspection at the facility. I interviewed administrator Matt Brawner. Mr. Brawner stated the facility had 14 residents last month and currently has 17 residents all with a dementia diagnosis. Mr. Brawner stated the facility is licensed for 22 beds. Mr. Brawner stated last month all residents in the facility were a one person assist. Mr. Brawner stated the facility admitted a resident on 4/8/2022 requiring a two person assist. Mr. Brawner stated the facility always has two staff members on third shift. Mr. Brawner stated the facility usually has two staff assigned to the facility and a supervisor. Mr. Brawner stated sometimes the facility has two staff and a supervisor of shift split between two buildings on the facility's campus. Mr. Brawner stated if a staff member calls-in for their shift, then the shift supervisor will work the floor or another staff member from second shift will be mandated. Mr. Brawner stated the facility has sufficient staffing at this time. Mr. Brawner stated Resident A fell last month on third shift and there has not been any other falls to report. Mr. Brawner stated Resident A had been declining and trying to ambulate without her walker.

On 4/19/2022, I conducted a telephone interview with Employee #1 who stated there were two caregivers assigned to the third shift. Employee #1 stated there were usually two staff assigned to the third shift.

On 4/19/2022, I conducted a telephone interview with third shift Employee #2 who stated there were shifts in which one staff member was assigned. Employee #2 stated Resident B required a two person assist since her move in three years ago as well as other residents who require two staff to assist with turning in bed and care.

I reviewed a list of staff which read there 18 caregivers for the facility in which six were third shift staff.

I reviewed the facility's staff schedule for March and April 2022 for third shift. The March 2022 staff schedule read there were six shifts 3/3/2022, 3/7/2022, 3/11/2022, 3/21/2022, 3/22/2022, and 3/24/2022 in which one caregiver was assigned. I reviewed the clock-in reports for the dates corresponding to the six shifts with one

caregiver assigned which read on 3/3/2022 two staff worked, on 3/7/2022, 3/11/2022, 3/21/2022, 3/22/2022 and 3/24/2022 three staff worked. The April 2022 staff schedule read on 4/19/2022 there was one caregiver assigned to work. I reviewed the staff clock-in report for 4/19/2022 which read two staff worked.

I reviewed Resident B's service plan which read she required one person assist for transfers, toileting, morning, and evening care.

I reviewed the incident reports in the facility's file which read consistent with Mr. Brawner's interview.

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:	Staff interviews revealed there were residents in the facility who required a two person assist. Review of the staff schedule and staff clock-in reports revealed there was a minimum of two staff persons assigned per shift to provide care. Based on this information, this allegation cannot be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

Review of the March staff schedule revealed there were six shifts 3/3/2022, 3/7/2022, 3/11/2022, 3/21/2022, 3/22/2022, and 3/24/2022 in which one staff member assigned. Review of the April 2022 schedule read on 4/19/2022 there was one caregiver assigned to work.

Review of the staff clock-in reports revealed on 3/3/2022 two staff worked and on 3/7/2022, 3/11/2022, 3/21/2022, 3/22/2022 and 3/24/2022 three staff worked. Review of the clock-in report for 4/19/2022 read two staff worked.

APPLICABLE RULE	
R 325.1944	**Employee records and work schedules.**
	(2) The home shall prepare a work schedule showing the number and type of personnel scheduled to be on duty on a

	daily basis. The home shall make changes to the planned work schedule to show the staff who actually worked.
ANALYSIS:	Review of the staffing schedule along with the clock-in reports revealed the schedule did not reflect the staff who actually worked each shift. For example, the schedule read on 3/22/2022, Employee #3 worked the third shift, however the clock-in report revealed Employee #4, #5, #6 worked that shift on 3/22/2022. Based on this information, the facility was in violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, the status of the license remains unchanged.

4/26/2022

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Jessica Rogers Date
Licensing Staff

Approved By:

05/10/2022

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