GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 14, 2022

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

RE: License #: AL780262260
Investigation #: 2022A0584027
Oliver Woods 2

Dear Mr./Ms. Shumaker:

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 (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 #:	AL780262260
Investigation #:	2022A0584027
Complaint Receipt Date:	07/15/2022
Investigation Initiation Date:	07/15/2022
Report Due Date:	09/13/2022
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:	Brandy Shumaker
Name of Facility:	Oliver Woods 2
Facility Address:	1312 W. Oliver St. Owosso, MI 48867
Facility Telephone #:	(989) 729-6060
Original Issuance Date:	04/16/2004
License **Status:**	REGULAR
Effective Date:	08/29/2021
Expiration Date:	08/28/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The facility is understaffed.	Yes
Resident care needs are not being met.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/15/2022	Special Investigation Intake 2022A0584027
07/15/2022	Special Investigation Initiated- Anonymous Complainant left email contact. Sent email to alert of investigation.
07/19/2022	Unannounced onsite investigation. Observation of residents. 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. Contact - Telephone call received. Received information from anonymous caller.
07/27/2022	Contact - Documents Received from administrator Dan Marchione
08/08/2022	Exit conference with former licensee designee Rochelle Lyon
09/08/2022	Exit conference with newly appointed licensee designee Brandy Shumaker.

ALLEGATIONS:

- **The facility is understaffed.**
- **Resident care needs are not being met**

INVESTIGATION:

On 07/15/2022, I received the above allegations via an email from an anonymous Complainant, Complainant A. Via email, I notified Complainant A I was assigned to investigate these allegations.

On 7/19/2022, I conducted an unannounced investigation at the facility and conducted interviews with direct care staff members Heather Farro, Lisa Madayag, Jessica Smith, Brenda Willings, Ellaura Strobridge, and care coordinator McKayla Gosselin. Ms. Farro, Ms. Madayag, and Ms. Gosselin who all denied the allegation the facility was understaffed. Ms. Madayag, Ms. Smith, Ms. Farro, Ms. Willings, Ms. Strobridge, and Ms. Gosselin stated they strive to provide the best care to all residents in accordance with their assessment plans and have witnessed other staff providing the same quality of care.

I observed six residents in the facility. Two residents were in the common area and four were resting in their rooms. All six residents appeared clean and well groomed.

On 7/19/2022, I received a telephone call from an anonymous individual, Complainant B, who identified as someone who is familiar with working at this facility. Complainant B stated at least two residents residing at the facility require personal care and transferring assistance by two direct care workers at the same time. However, there were occasions when only one direct care worker was scheduled to work in the facility by themselves. Complainant B stated direct care workers are mandated to stay and cover the next shift if the next shift's direct care workers "call into" work. Complainant B stated this creates a burden on those direct care staff members mandated to work additional shifts. Complainant B stated the direct care workers provide good care to the residents.

On 7/29/2022, I obtained the facility staff schedule for the months of June and July 2022. According to documentation on the facility staff schedules, the facility has two 12-hour shifts, one starting at 6:00 am to 6:00 pm (day) and another starting at 6:00 pm to 6:00 am (evening). According to documentation on the schedules provided, only one direct care worker was scheduled to work in the facility on the following dates/shifts:

6/30/2022 - Day shift
7/1/2022 – Day and evening shift
7/6/2022 – Evening shift
7/16/2022 – Day shift
7/22/2022 – Day shift and evening shift

I reviewed 16 residents' *Assessment Plans for AFC Residents* (assessment plans). Documentation on Resident D and Resident E's assessment plan confirmed they require "two-person" assistance with transferring.

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 residents and to provide the services specified in the residents resident care agreement and assessment plan.
ANALYSIS:	Based upon my investigation, which consisted of interviews with Complainant B and multiple facility staff members, an unannounced observation of six residents, and a review of facility documents relevant to this investigation, it has been established that for several days in June and July, only one direct care worker was scheduled to work in the facility. It was determined by review of 16 resident assessments, Residents D and E require “two-person” assistance with their care needs. Subsequently, it has been established that on 06/30/2022, 07/01/2022, 07/06/2022, and 07/22/2022 the facility was understaffed.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based upon my investigation, which consisted of an unannounced observation of six residents, interviews with multiple facility staff members, and a review of facility documents relevant to this investigation, it has been established that Residents D and E require transferring assistance by two direct care workers at the same time. However, according to documentation on the facility’s direct care worker schedules, there were occasions when only one direct care worker was scheduled to work in the facility. It has been established Residents D and E would not receive protection and personal care as specified in their assessment plans, if needed, on the occasions when only one direct care worker works in the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

I reviewed 16 resident medication administration records (MAR). As indicated by missing direct care staff workers' initials on Resident A, B, and C's MARs, it appeared there were occasions they did not receive their prescribed medications.

According to missing direct care staff initials on Resident A's June 2022 MAR, Resident A did not receive his 5:00PM dose of Cephalexin cap 500mg on 06/15/2022.

According to missing direct care staff initials on Resident B's June 2022 MAR Resident B did not receive her 4:00AM dose of Buspirone 7.5mg, Donepezil 10mg, Pravastatin 20mg, and Vitamin D 2000IU on 6/25/22, and 1:00 PM dose of Quetiapine 50mg on 6/25/22.

According to missing direct care staff initials on Resident C's June 2022 MAR, Resident C did not receive her 9:00AM dose of Escitalopram 20 mg, Furosemide 20mg, Bio freeze gel 4%, and Bupropion 100mg on 6/26/2022.

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 06/15/2022, 6/25/2022, and 6/26/22 Resident A, B, and C's MARs were missing the initials of the person who administered their medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 8/8/2022, I conducted an exit conference with licensee designee Rochelle Lyon via an email and shared with her the findings of this investigation.

On 9/8/2022, I emailed the newly appointed Licensee Designee, Brandy Shumaker, and shared with her the findings of this investigation.

IV. RECOMMENDATION

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

9/13/2022

Candace Coburn — Date
Licensing Consultant

Approved By:

9/14/2022

Michele Streeter — Date
Section Manager