GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 15, 2022

Karen Barry
Bay Valley Adult Foster Care Inc.
5113 Reinhardt Lane
Bay City, MI 48706

RE: License #:	AL090084487
Investigation #:	2022A0123059
	Bay Valley AFC Inc.

Dear Ms. Barry:

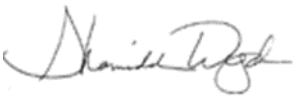
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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. 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) 643-7960.

Sincerely,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL090084487
Investigation #:	2022A0123059
Complaint Receipt Date:	09/21/2022
Investigation Initiation Date:	09/22/2022
Report Due Date:	11/20/2022
Licensee Name:	Bay Valley Adult Foster Care Inc.
Licensee Address:	5113 Reinhardt Lane Bay City, MI 48706
Licensee Telephone #:	(989) 450-8769
Administrator:	Karen Barry
Licensee Designee:	Karen Barry
Name of Facility:	Bay Valley AFC Inc.
Facility Address:	5113 Reinhardt Lane Bay City, MI 48706
Facility Telephone #:	(989) 450-8769
Original Issuance Date:	01/07/1999
License Status:	REGULAR
Effective Date:	05/09/2021
Expiration Date:	05/08/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A is not safe at the assisted living facility. Resident A has left the facility three times in the last 20 days without supervision. She has not been injured during her three escapes. Other residents have also left the facility without permission or escort.	No
The facility is short staffed and is need of more safety precautions to ensure Resident A and others do not leave unaccompanied.	Yes

III. METHODOLOGY

09/21/2022	Special Investigation Intake 2022A0123059
09/22/2022	APS Referral Information received regarding APS referral.
09/22/2022	Special Investigation Initiated - On Site I conducted an unannounced on-site visit at the facility.
10/11/2022	Contact - Telephone call made I spoke with Resident A's Relative 1 via phone.
10/11/2022	Contact - Telephone call made I spoke with Resident A's Relative 2 via phone.
10/24/2022	Contact - Telephone call made I left a voicemail requesting a return call from Resident B's Relative 3 via phone.
10/24/2022	Contact - Telephone call made I spoke with Resident C's Relative 4 via phone.
10/24/2022	Contact - Telephone call made I interviewed staff Kimberly Ayala via phone.
10/24/2022	Contact - Telephone call received I spoke with Resident B's Relative 3 via phone.
11/01/2022	Contact- Documents Received I received requested documentation via fax.
11/07/2022	Contact- Telephone call made I spoke with licensee designee Karen Barry via phone.

11/07/2022	Exit Conference I spoke with licensee designee Karen Barry via phone.
11/09/2022	Exit Conference I spoke with licensee designee Karen Barry via phone.
11/09/2022	Contact- Telephone call made I left a voicemail requesting a return call from third shift staff Margaret Kowalski.
11/09/2022	Contact- Telephone call made I interviewed third shift staff Florence White via phone.
11/15/2022	Contact-Telephone call made I attempted to contact staff Margaret Kowalski via phone. I left a message requesting a return call.
11/15/2022	Contact- Telephone call received I received a voicemail from Staff Kowalski.
11/15/2022	Contact- Telephone call made I interviewed Staff Kowalski via phone.

ALLEGATION: Resident A is not safe at the assisted living facility. Resident A has left the facility three times in the last 20 days without supervision. She has not been injured during her three escapes. Other residents have also left the facility without permission or escort.

INVESTIGATION: On 09/22/2022, I conducted an unannounced on-site visit at the facility. Upon entry into the home and during the course of the visit, I notice the home has an active door alarm system that alerts staff every time an exit door is opened. I spoke with licensee designee Karen Barry. She denied the allegations. She stated that Resident A got out of the facility one time, and she herself went and retrieved Resident A. She stated that she informed the family that Resident A needed to be tested for a UTI at that time due to her aggression and taking off out of the door. She stated that Resident A did have a UTI, was treated, and that the family visits daily. She denied that Resident A has eloped three times in the last 20 days. She stated that Resident A has a bed alarm. She stated that Resident B's wife has told the facility that he could go out, and that he was found one time on the next-door neighbor's back deck, and Resident C likes to go for long walks. She stated that Resident C got out one time, and she, Ms. Barry called 911. She stated that staff know right away if a resident leaves. She stated that the time Resident A got out, there was a lot going on at the facility due to having a contractor present making repairs to the home.

On 09/22/2022, I interviewed staff Sarah Fauver at the facility. She stated that she has worked here for seven years. She denied the allegations. She stated that none of them have eloped during any of her shifts.

On 09/22/2022, I interviewed staff Amber Ellison at the facility. She denied the allegations. She stated that she has worked in the facility for about a month, and in this time, Resident A has not eloped. She stated that Ms. Barry told her that Resident A eloped about a couple months before Staff Ellison began working. She denied having any knowledge of Resident B or Resident C eloping.

On 09/22/2022, I interviewed Resident A at the facility. Resident A stated that she does not remember walking away from the facility and stated that she feels safe.

On 09/22/2022, I observed Resident B sitting in a recliner chair during my unannounced on-site visit. Resident B appeared to be clean and appropriately dressed. She was not interviewed due to lack of verbal skills.

I observed Resident C as well. He appeared clean and appropriately dressed. He was not interviewed during this on-site as he was in a meeting with a visitor.

During this on-site I observed multiple residents in the dining room and living room area of the home, and they appeared clean and appropriately dressed.

On 10/03/2022, I received requested documentation via fax. An incident reported dated 08/04/2022 states that Resident C went for a walk in the neighborhood. Staff canceled a 911 call and checked the door alarms.

An *AFC- Licensing Division- Incident/Accident Report* dated for 05/26/2022 states that Resident A walked out of the door and was found walking down the street. She was brought back to the facility by vehicle. She was safe, and staff checked the door alarms.

On 11/09/2022, I made a call to licensee designee Karen Barry via phone. She stated that the measures staff took to rectify the situation of the residents getting out of the facility were to re-Velcro (re-secure) the door alarms and change out the batteries. She stated that there is more increased monitoring and head counts going on as well. She stated that staff were not alerted to Resident A getting out because of either the Velcro strap was not secure, or due to a dead battery in the alarm.

On 10/03/2022, I received requested documentation via fax. A copy of Resident C's *Assessment Plan for AFC Residents* dated 03/13/2022 indicates she can move independently in the community and does not need assistance with walking. Resident C's *Health Care Appraisal* dated for 04/18/2022 states that she is diagnosed with dementia.

A copy of Resident A's *Assessment Plan for AFC Residents* dated 07/02/2022 has yes checked for moving independently in the community, and does not need assistance with walking, but uses a walker. A copy of Resident A's *Health Care Appraisal* dated for 09/16/2022 notes that she has dementia

I reviewed a copy of Resident B's *Assessment Plan for AFC Residents* dated for 04/13/2022 which states he can move independently in the community and can walk independently. It is noted that staff should keep an eye on him to make sure he is safe. A copy of Resident B's Health Care dated for 05/02/2022 states that he has Parkinson's disease and memory loss.

On 11/09/2022, I made a call to licensee designee Karen Barry via phone. She stated that she was not clear on what "*moves independently in the community*" on the *Assessment Plan for AFC Residents* meant, and that she thought it referred to within the facility. She stated that she would correct the assessment plan in regard to Resident A, Resident B, and Resident C being able to move independently in the community. She stated that Resident B can go out in the community and do what he wants per his doctor and his wife, however he could get lost, have a fall, or get agitated if you don't let him do what he wants to do. She stated that this could lead to physical aggression because Resident B does not like to be told what to do. She stated that they have to do what is best for Resident B and that she tries to reason with him. She stated that she thinks he has short term memory loss because he recalls old memories.

On 10/11/2022, I spoke with Resident A's Relative 1 via phone. Relative 1 is Resident A's durable power of attorney. She denied having any concerns regarding Resident A's care. She stated that Resident A did elope once, but the facility took steps to prevent this. She denied that Resident A has eloped three times in the last 20 days, and that any concerns the family has, they are addressed on an as needed basis. Relative 1 stated that they visit daily, Resident A's personal care needs are met, and it would be catastrophic to move Resident A from the facility. She stated that Resident A will get "hyper" and when she decides to walk, she does. She stated that now staff take her on walks.

On 10/11/2022, I spoke with Resident A's Relative 2 via phone. Relative 2 stated that last time Resident A eloped was on 09/01/2022, and since then, staff have intercepted Resident A. She stated that one-time, Resident A made it down the street a few blocks. She stated that another time occurred a few months prior, and one-time, Resident A made it to the porch. Relative 2 stated that Resident A is well cared for, and that the facility has door alarms. Relative 2 stated that Resident A also has a bed alarm. Relative 2 stated that she has heard rumor that other residents have gotten out.

On 10/24/2022, I spoke with Resident C's son Relative 4 via phone. Resident C stated that the situation with Resident C was handled well by staff. He denied having any concerns regarding Resident C's care

On 10/24/2022, I spoke with Resident B's wife, Relative 3 via phone. Relative 3 denied having any concerns regarding Resident B's care. She stated that she knows about the incident, and that staff knew right away. She stated that the facility has door alarms. She stated that Resident B has been in the facility since April 2022.

On 10/24/2022, I interviewed staff Kim Ayala via phone. She stated that one time, one of the door alarms fell off of the door due to the Velcro being loose. She stated that this was the time Resident C walked out of the facility. She stated that she was working that shift, giving another resident a shower at the time of the incident. She stated that the other staff were right on top of the situation, and she does not think Resident C got far. She stated that she was not working the shift where Resident A got out. She stated that Resident B's wife lets him go outside, and there was one time where he was sitting on the next-door neighbor's deck. She stated that Resident B has his mind, and also has a call button.

On 11/15/2022, I interviewed third shift staff Margaret Kowalski via phone. She stated that she has worked at the facility for a little over a year. She stated that there have been no elopements during any of her shifts. She stated that she checks the door alarms nightly. She stated that she heard about Resident A eloping and confirmed that Resident A does have a bed alarm.

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:	Licensee designee Karen Barry, Staff Fauver, Staff Ellison, and Staff Ayala denied the allegations. Relative 1, Relative 3, and Relative 4 did not express any concerns. Relative 1 denied that Resident A eloped three times in 20 days, and that she eloped once but the facility took steps to prevent it from happening again. Relative 2 stated that staff have intercepted Resident A since her last attempt at eloping from the facility. An incident report dated for 08/04/2022 documents that Resident C was intercepted by staff in the neighborhood after taking off for a walk. An incident reported dated for 05/26/2022, stated that Resident A took off for a walk and was brought back to the facility.

	The facility is equipped with door alarms, and Relative 2, Ms. Barry, and Staff Kowalski reported that Resident A has a bed alarm. There is no preponderance of evidence to substantiate a rule violation in regard to staff not providing protection and safety.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The facility is short staffed and is need of more safety precautions to ensure Resident A and others do not leave unaccompanied.

INVESTIGATION: On 09/22/2022, I conducted an unannounced on-site visit at the facility. Upon entry into the home and during the course of the visit, I notice the home has an active door alarm system that alerts staff every time an exit door is opened. I spoke with licensee designee Karen Barry. She denied the allegations.

On 09/22/2022, I interviewed staff Sarah Fauver at the facility. She stated that she has worked here for seven years. She denied the allegations. She stated that there are two staff per shift, and one staff at night. She stated that there are 20 residents, no one in wheelchairs, but staff may walk with some and help them sit down. She stated that each resident does walk independently. She stated that for fire drills staff get the residents out quickly and that none of them have eloped during any of her shifts.

On 09/22/2022, I interviewed staff Amber Ellison at the facility. She denied the allegations. She stated that there are two to three staff per shift. She stated that the facility is sufficiently staffed, and they have a great team.

On 09/22/2022, I interviewed Resident A at the facility. Resident A stated that she does not remember walking away from the facility and stated that she feels safe. She stated that she does not know how long she has to wait for staff assistance and does not know if staffing is adequate.

On 09/22/2022, I observed Resident B sitting in a recliner chair during my unannounced on-site visit. Resident B appeared to be clean and appropriately dressed. She was not interviewed due to lack of verbal skills.

I observed Resident C as well. He appeared clean and appropriately dressed. He was not interviewed during this on-site as he was in a meeting with a visitor.

During this on-site I observed multiple residents in the dining room and living room area of the home, and they appeared clean and appropriately dressed.

On 10/03/2022, I received requested documentation via fax. A copy of Resident C's *Assessment Plan for AFC Residents* dated 03/13/2022 indicates she can move

independently in the community and does not need assistance with walking. Resident C's *Health Care Appraisal* dated for 04/18/2022 states that she is diagnosed with dementia.

A copy of Resident A's *Assessment Plan for AFC Residents* dated 07/02/2022 has yes checked for moving independently in the community, and does not need assistance with walking, but uses a walker. A copy of Resident A's *Health Care Appraisal* dated for 09/16/2022 notes that she has dementia.

I reviewed a copy of Resident B's *Assessment Plan for AFC Residents* dated for 04/13/2022 which states he can move independently in the community and can walk independently. It is noted that staff should keep an eye on him to make sure he is safe. A copy of Resident B's Health Care dated for 05/02/2022 states that he has Parkinson's disease and memory loss.

On 10/12/2022, I received copies of the facility's fire drills. February 2022 through September 2022 fire drills for the facility were reviewed. The fire drill evacuation times were four minutes or less for each drill. There were no issues noted regarding the drills. Three third shift fire drills were reviewed. The drills are date 03/25/2022, 06/21/2022, and 09/19/2022, and each drill noted that one staff was present during the drill.

On 10/24/2022, I spoke with Resident C's son Relative 4 via phone. He denied having any concerns regarding Resident C's care. He stated that during his visits, there are about three to four staff present on shift. He stated that Resident C is always clean and showered.

On 10/24/2022, I spoke with Resident B's wife, Relative 3 via phone. Relative 3 denied having any concerns regarding Resident B's care. She stated that the facility has door alarms. She stated that Resident B has been in the facility since April 2022. She stated that she thinks the facility is sufficiently staffed, and that she has not gotten the sense that the facility is understaffed.

On 10/24/2022, I interviewed staff Kim Ayala via phone. Staff Ayala stated that she thinks the facility is sufficiently staffed. She stated that there are just a handful of residents staff have to keep tabs on.

On 10/31/2022, I received copies of the staff schedule for August and September 2022. The staff schedule shows that there are two to three staff on first and second shift, and one staff on third shift.

On 11/07/2022, I spoke with licensee designee Karen Barry via phone. She reported that she has two to three staff that work during the day, and one staff on shift at night. She stated that there are no residents in the facility that are a two person assist, each resident is mobile, and there are none that require a Hoyer lift. She

stated that there are currently 19 residents in the facility, and that she would add more staffing if it were actually needed.

On 11/09/2022, I made a call to licensee designee Karen Barry via phone. She stated that she was not clear on what "*moves independently in the community*" meant on the *Assessment Plan for AFC Residents*, and that she thought it referred to within the facility. She stated that Resident C has a neurologist appointment next week to see if she really has dementia and stated that Resident C is limited verbally. She stated that there are only about four residents who can actually go out into the community independently, and there are about ten residents diagnosed with dementia. She stated that each resident can get out of their bed independently, and in the morning, staff will wake residents and instruct them to go use the restroom as part of their routine. She stated that Resident B can go out in the community and do what he wants per his doctor and his wife, however he could get lost, have a fall, or get agitated if you don't let him do what he wants to do. She stated that this could lead to physical aggression because Resident B does not like to be told what to do. She stated that they have to do what is best for Resident B and that she tries to reason with him. She stated that she thinks he has short term memory loss because he recalls old memories. She stated that when some residents whether they have dementia or not, when they get a UTI, they get agitated and want to take off out of the facility, and that they stay on top of it when they suspect a UTI. She stated that there are one to two residents who, to get them out faster during an evacuation she has them sit in wheeled kitchen chairs to get them moving faster. She stated that none of the residents would try to go back in the facility in case of a fire, and that they have a sprinkler system. She stated that second shift leaves at 11:00 pm and first shift comes in at 6:00 am, so there is only seven hours where there is one staff, and that other staff and herself are available by phone and can respond to the home if needed during the night. She stated that she has always operated with one staff on at night.

On 11/09/2022, I interviewed third shift staff person Florence White via phone. Staff White stated that she has worked at the facility since February 2022 and works three to four days a week. She stated that she works third shift alone, and thinks staffing is sufficient. When asked if she has conducted any fire drills, she reported that she hasn't. (It should be noted that on the fire drills that I observed during the course of this investigation, Staff White's name was not noted on any of the drills.) She stated that she would have to assist some residents with waking up so they can get out of bed and estimated that it would probably take 10-15 minutes to do a fire drill. She stated that each resident can walk independently. She stated that no resident has tried to walk out of the facility during her shifts. She stated that there are only about two or three residents who can be out in the community on their own without staff assistance. She stated that a while ago, she had to call an ambulance during her shift for a resident to be transported to the hospital but could not recall when or which resident it was.

On 11/15/2022, I interviewed third shift staff Margaret Kowalski via phone. She stated that she has received fire drill training, and that confirmed that she conducted two fire drills, one in March 2022 and one in June 2022. She stated that she thinks third shift should have two staff on shift, because it would make it easier to get the bigger residents out of bed if there are two staff are present. She stated that most residents sleep throughout the night. She stated that during a fire drill, it takes a lot to get all of the residents out of the house with one staff. She stated that there are at least five residents with dementia, and one new resident she just learned is legally blind. She stated that Resident B has Parkinson's disease, is a fall risk, and is shaky even when using his walker.

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 resident's resident care agreement and assessment plan.
ANALYSIS:	On 10/31/2022, I received copies of the staff schedule for August and September 2022. The staff schedule shows that there are two to three staff on first and second shift, and one staff on third shift. Fire drills documentation was reviewed, and no issues were noted. Resident A, Resident B, and Resident C's assessment plans were reviewed and notes they are independent with walking. Staff Fauver and Ms. Barry both reported that the residents are all independently mobile. However, Resident A and Resident C are diagnosed with dementia per their health care appraisal. Ms. Barry reported that there are about 10 residents in the facility who have dementia. Licensee Designee Karen Barry, Staff Fauver, Staff Ellison, and Staff Ayala denied the allegations. Staff White was interviewed and reported that she thinks the facility is sufficiently staffed with one staff on third shift but has not conducted a fire drill on third shift and estimated that it would take 10-15 minutes to conduct a fire drill. Staff Kowalski was interviewed and reported that she thinks third shift should have two staff as it takes a lot to evacuate all of the residents. Relative 1, Relative 2, Relative 3, and Relative 4 were interviewed and did not express any concerns regarding the facility being short staffed.

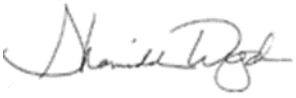
	There is a preponderance of evidence to substantiate a rule violation in regard to insufficient staffing on third shift due to residents diagnoses and care needs (i.e., supervision).
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/07/2022, I conducted an exit conference with licensee designee Karen Barry. I informed her of the findings and conclusion.

On 11/09/2022, I conducted a follow-up exit conference call with licensee designee Karen Barry. I informed her of the findings and conclusions.

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC large group home license (capacity 20).



11/15/2022

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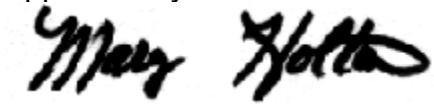
Shamidah Wyden Date
Licensing Consultant

Approved By:



11/15/2022

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Mary E. Holton Date
Area Manager