GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 1, 2022

Daniel Stevens
Plainview Assisted Living, LLC
202 Plainview Drive
Auburn, MI 48611

RE: License #:	AL090311311
Investigation #:	2023A0123005
	Plainview Assisted Living

Dear Mr. Stevens:

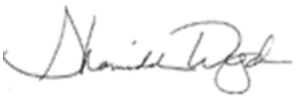
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AL090311311
Investigation #:	2023A0123005
Complaint Receipt Date:	10/13/2022
Investigation Initiation Date:	10/14/2022
Report Due Date:	12/12/2022
Licensee Name:	Plainview Assisted Living, LLC
Licensee Address:	202 Plainview Drive Auburn, MI 48611
Licensee Telephone #:	(989) 662-7202
Administrator:	Quenten Flint
Licensee Designee:	Daniel Stevens
Name of Facility:	Plainview Assisted Living
Facility Address:	202 Plainview Drive Auburn, MI 48611
Facility Telephone #:	(989) 662-7202
Original Issuance Date:	07/11/2011
License Status:	REGULAR
Effective Date:	01/10/2022
Expiration Date:	01/09/2024
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The facility is not the cleanest as far as resident rooms not being taken care of.	No
The facility is infested with bed bugs.	No
The residents are not properly taken care of and are neglected. Residents are dying constantly. One resident has MRSA, and the wound has been infected with ants.	No
There is only one staff that works nights.	Yes

III. METHODOLOGY

10/13/2022	Special Investigation Intake 2023A0123005
10/14/2022	Special Investigation Initiated - Letter APS referral completed.
10/14/2022	APS Referral
10/20/2022	Inspection Completed On-site I conducted an unannounced on-site inspection at the facility.
10/20/2022	Contact - Telephone call made I made a call to administrator Quenten Flint.
11/16/2022	Inspection Completed On-site I conducted a follow-up on-site at the facility. I interviewed staff and residents.
11/29/2022	Contact- Telephone call made I made a call to hospice nurse Amanda Dudek.
11/29/2022	Contact- Telephone call made I made a call to hospice nurse Allyson Leipert.
12/01/2022	Contact- Telephone call made I spoke with administrator Quenten Flint via phone.
12/01/2022	Exit Conference I spoke with licensee designee Dan Stevens via phone.

ALLEGATION: The facility is not the cleanest as far as resident rooms not being taken care of.

INVESTIGATION: On 10/20/2022, I conducted an unannounced on-site visit at the facility. I interviewed staff Carrie Austin. Staff Austin stated that she has worked at the facility for over two years. She stated that the facility has a housekeeper that comes in once per week, and the staff clean and vacuum as needed. She stated that housekeeping was in yesterday.

On 10/20/2022, I interviewed staff Alicia Parady at the facility. She stated that she has worked at the facility for a year. She stated that staff clean daily, and housekeeping cleans once per week. She stated that soiled briefs are taken out every shift. She denied that the facility is ever just dirty.

On 10/20/2022, during my unannounced on-site investigation I observed the facility, resident bedrooms, and 16 of the 18 residents. The residents appeared clean and appropriately dressed. The facility appeared clean as well. No issues were noted.

On 10/20/2022, I made a call to administrator Quenten Flint. He denied the allegations. He stated that he keeps on top the cleanliness of the facility.

On 11/16/2022, I conducted a follow-up on-site at the facility. All residents present in the home were observed to be clean and appropriately dressed. The facility, and resident bedrooms also appeared clean. There were no issues noted.

On 11/16/2022, I conducted a follow-up on-site at the facility. I interviewed staff Brianna Pine. She stated that she has worked at the facility for about two and a half years. She stated that she works all shifts. She stated that staff have daily cleaning tasks. Things are spot cleaned, and the floor is vacuumed as needed. She stated that everything is done regularly.

On 11/16/2022, I interviewed staff Hannah Boothe. She stated that she returned to employment at the facility in August 2022. She stated that for the most part, the resident rooms are always clean, but there is one resident who will eat in their room and leave crumbs on the floor. She stated that the facility has housekeeping.

On 11/16/2022, I interviewed Resident A at the facility. Resident A stated that his room and bathroom is kept clean. Resident A was observed to be clean and appropriately dressed. He stated that the facility is a very nice place to stay.

On 11/16/2022, I interviewed Resident B at the facility. Resident B stated that the staff keeps the facility clean. He stated that he vacuums his own room and has done so for the past year.

On 11/16/2022, I interviewed Resident C at the facility. Resident C stated that the facility stays clean on a regular basis, and that his room is always clean.

On 11/29/2022, I spoke with hospice nurse Amanda Dudek of The Care Team. She stated that she worked in the facility for about four years up until March 2022. She stated that the facility was phenomenal and was one of the best facilities that she has worked in. She stated that unless something dramatically has changed, she does not see the allegations being true. She stated that if something was going on, she would have seen it.

On 11/29/2022, I spoke with the current hospice nurse Allyson Leipert, from The Care Team. She stated that she has never seen the facility dirty, and that it has been clean and tidy.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	On 10/20/2022, I conducted an unannounced on-site visit at the facility, and a follow-up visit on 11/16/2022. The facility and resident bedrooms were observed to be clean, and no issues were noted. Resident A, Resident B, and Resident C reported that the facility and their rooms are kept clean. Staff Austin, Staff Parady, Staff Pine, and Staff Boothe, and hospice nurse Allyson Leipert were all interviewed and reported that staff clean the facility. There is no preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The facility is infested with bed bugs.

INVESTIGATION: On 10/20/2022, I conducted an unannounced on-site visit at the facility. I interviewed staff Carrie Austin. She stated that the facility did have bed bugs, but they were treated. She stated that it took about three weeks, and it was at the beginning of September 2022 when a family member of a resident brought the bed bugs in, which spread to about five to six rooms. I did not observe any bugs in the facility during this on-site.

On 10/20/2022, I interviewed staff Alicia Parady at the facility. She stated that she has worked at the facility for a year. She stated that the facility did have bed bugs, that were treated, and that they recently got the all-clear. She stated that there are

currently no signs of bedbugs. She stated that she thinks someone may have moved into the facility with the bed bugs.

On 10/20/2022, I made a call to administrator Quenten Flint. He denied the allegations and stated that the bed bugs had been treated. On 11/16/2022, I conducted a follow-up on-site at the facility. Staff Flint stated that Orkin came in twice for re-checks.

On 11/16/2022, I conducted a follow-up on-site. I interviewed staff Quenten Flint. He stated that the bed bugs were treated, and Orkin provided the services. During this on-site Staff Flint provided an Orkin invoice dated 10/03/2022. The invoice stated that mattresses, box springs, and bed frames of the rooms with active bed bug activity was treated, and that box springs and mattresses were placed in encasements. Furniture, base boards, and closets were treated, as well as adjacent rooms which were treated in a preventative manner. I did not observe any bugs in the facility during this on-site.

On 11/16/2022, I conducted a follow-up on-site at the facility. I interviewed staff Brianna Pine. She stated that the bed bugs happened months ago, and that Orkin came in to treat them.

On 11/16/2022, I interviewed staff Hannah Boothe at the facility. She stated that the bed bugs started in one room and were treated. She stated that Orkin came out more than once, and that all beds now have mattress protectors. She stated that Orkin used to come regularly to spray the perimeter of the facility, but the new owners stopped using Orkin, so staff had to stay on top of things being left on the floor. She stated that when the facility got the bed bugs, is when they got Orkin services back.

On 11/16/2022, I interviewed Resident A at the facility. Resident A denied having any bugs in his room.

On 11/16/2022, I interviewed Resident B at the facility. Resident B stated that he had not seen any bed bugs when the facility did have them. He stated that it was the rooms down the hall from him that had bed bugs.

On 11/16/2022, I interviewed Resident C at the facility. Resident C denied that there have been bed bugs, and that he was unaware of any.

On 11/29/2022, I spoke with the current hospice nurse Allyson Leipert, from The Care Team. She stated that the bed bug situation occurred right before she started seeing residents in the facility and that it was rectified. She stated that she has been seeing residents in the facility for about two months. She stated that she has not heard of or seen anything for her to think otherwise.

APPLICABLE RULE	
R 400.15401	**Environmental health.**
	(5) An insect, rodent, or pest control program shall be maintained as necessary and shall be carried out in a manner that continually protects the health of residents.
ANALYSIS:	Staff Carrie Austin, staff Alicia Parady, administrator Quenten Flint, Staff Brianna Pine, and Staff Hannah Boothe were interviewed and reported that the bed bugs were present in the facility, but they have been treated. An Orkin in-service dated for 10/03/2022 verifies that the facility had the bed bugs professionally treated. Hospice nurse Allyson Leipert stated that the bed bug situation occurred before she started providing services to residents in the facility, and that the situation was rectified. Resident A and Resident B denied seeing any bed bugs in their room. Resident C denied being aware of any bed bugs. There is no preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The residents are not properly taken care of and are neglected. Residents are dying constantly. One resident has MRSA, and the wound has been infected with ants.

INVESTIGATION: On 10/20/2022, I conducted an unannounced on-site visit at the facility. I interviewed staff Carrie Austin. Staff Austin denied the allegations. She stated that one resident had MRSA about three months ago and denied that there were any ants in his wound. She stated that a lot of the residents are on hospice, and they pass while on hospice care.

On 10/20/2022, I interviewed staff Alicia Parady at the facility. She stated that she has worked at the facility for a year. She denied the allegations. She stated that Resident A had MRSA. She denied that any ants were in his wound. She stated that Resident A is on hospice, and his family is not very involved. She stated that Resident A currently has wound care due to an ulcer. She stated that during COVID-19 last year, there were a few resident deaths.

On 10/20/2022, I observed 16 of the 18 residents who reside in the facility, as well as their rooms. They appeared to be clean and appropriately dressed. No issues were noted.

On 10/20/2022, I made a call to administrator Quenten Flint. He denied the allegations. He stated that Resident A is on hospice, and the family of Resident A refuses to assist.

On 11/16/2022, I conducted a follow-up on-site. I interviewed Staff Flint. Staff Flint stated that Resident A had MRSA. He stated that Resident A has dementia and a history of stroke, and due to his diabetes, he is susceptible to getting ulcers. He stated that the wound that had MRSA was tested and treated right away, and Resident A began wound care services through The Care Team.

On 11/16/2022, I obtained a copy of the facility's *Resident Register*. The documentation shows that four residents passed away in 2022. Resident D passed away on 01/09/2022, Resident E on 02/08/2022, Resident F on 09/18/2022, and Resident G on 08/02/2022. Incident reports were reviewed regarding the resident's deaths. Resident D was sent to the hospital on 01/07/22 after staff went to get her for lunch and found her pale, unresponsive, and having difficulty breathing. She passed two days later at the hospital. An incident report dated 02/08/2022 states that Resident E passed while on hospice care. An incident report dated 09/18/2022 notes that Resident F pass on hospice, and an incident report dated 08/02/2022 states Resident G passed while on hospice as well. A fifth incident report regarding Resident H was obtained during this on-site. It notes that she passed while on hospice on 07/18/2022. Her discharge dated was not noted on the *Resident Register.*

On 12/01/2022, I inquired with administrator Quenten Flint regarding Resident D's death. He stated that Resident D had severe COPD, heart disease, and chronic kidney disease, and tested positive for COVID-19 on 11/28/2021. An email received from Staff Flint on 11/29/2021 confirms that Resident A had tested positive for COVID-19 on 11/28/2021.

On 11/16/2022, I conducted a follow-up on-site at the facility. I interviewed staff Brianna Pine. She denied the allegations. She stated that in the last six months that deaths have gone down significantly. She stated that resident care needs are being met. She stated that she never saw ants on Resident A, and that she does his wound care some days, and that Resident also has a wound care nurse.

On 11/16/2022, I interviewed staff Hannah Boothe at the facility. She stated that the only death recently was one resident on hospice, and the death was expected. She stated that the resident passed away in August 2022. She stated that in regard to the ants, a third shift staff person said that she saw ants on the floor in Resident A's room. One of his bandages was on the floor, and some ants were on the bandage. She stated that she was never told that any ants were in Resident A's wound.

On 11/16/2022, I interviewed Resident A at the facility. Resident A appeared clean and appropriately dressed. Resident A denied ever having ants in his room, or any bugs crawling on him. He stated that he thinks his needs are being met by staff, and that they help him with personal care and laundry. I observed that Resident A's foot was wrapped with dressings. Resident A stated that he stepped on something metal, and that his foot is healing. He stated that his foot and dressing get checked daily.

On 11/16/2022, I interviewed Resident B at the facility. He stated that he is independent in personal care. Resident B appeared clean and appropriately dressed.

On 11/16/2022, I interviewed Resident C. Resident C stated that staff are meeting his personal care needs. Resident C appeared clean and appropriately dressed.

On 11/29/2022, I spoke with hospice nurse Amanda Dudek of The Care Team. She stated that she worked in the facility for about four years up until March 2022. She stated that the facility was phenomenal and was one of the best facilities that she has worked in. She stated that unless something dramatically has changed, she does not see the allegations being true. She stated that if something was going on, she would have seen it.

On 11/29/2022, I spoke with the current hospice nurse Allyson Leipert, from The Care Team. She stated that Resident A does not have untreated MRSA, and there were no ants in his wound. She stated that Resident A has chronic diabetic wounds and a history of MRSA. She stated that she currently sees three residents in the facility, and that she has never questioned the care received.

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:	Staff Austin denied the allegations. She stated that Resident A had MRSA about three months ago, and there were no ants in his room. She stated that residents who passed away were on hospice. Staff Parady denied the allegation. She stated that Resident A's MRSA did not have ants in his wound. She stated that there were a few resident deaths last year due to COVID-19. Administrator Quenten Flint denied the allegation, and that Resident A's MRSA was treated right away.

	A copy of the Resident Register reflects there have been four residents who passed away in 2022. Incident reports received indicate that five residents passed in 2022 and four were on hospice. Staff Brianna Pine denied the allegations and stated that resident care needs are being met. She denied ever seeing ants in Resident A's wound. Staff Hannah Boothe denied the allegations and stated that the most recent death was a resident on hospice. She stated that the ants were reportedly on Resident A's bandage that was left on the floor. Resident A's hospice nurse denied the allegations and stated that there were no ants in Resident A's wound, and she did not express any concern regarding the care of her other patients that reside in the facility. Resident A, Resident B, and Resident C did not report and personal care concerns. There is no preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: There is only one staff that works nights.

INVESTIGATION: On 10/20/2022, I conducted an unannounced on-site visit at the facility. I interviewed staff Carrie Austin. She stated that there is one staff on shift at night. There are two to three residents that require a two-person assist. She stated that all of the residents would require assistance with getting out in event of need to be evacuated.

On 10/20/2022, I interviewed staff Alicia Parady at the facility. Staff Parady stated that there are three staff on first and second shift, and two on third shift.

On 11/16/2022, I conducted a follow-up on-site. I interviewed Staff Flint. He stated that two nights per week there is one staff on shift due to staffing issues. He stated that about 80% of the residents have dementia.

On 11/16/2022, Staff Flint provided me with a copy of the November and October 2022 schedules. He stated that there was conflict with staff, so there were some days where there was only one staff working. On 12/01/2022, I made a follow-up call

with Staff Flint to verify the dates where there were only one staff working third shift. The dates for October 2022 where there was only one staff working are as follows: 10/10/22, 10/12/22, 10/15/22 thru 10/18/22, 10/22/22, 10/24/22 thru 10/27/22, and 10/31/2022. The dates for November 2022 where there was only one staff working are as follows: 11/07/22, 11/15/2022, and 11/28/22. For the October 2022 and November 2022 schedules there appears to be 2-3 staff that worked first and second shifts.

On 11/16/2022, I was provided with copies of the fire drills for the facility dating back to May 2022. The drills times ranged between three minutes and 38 seconds, and six minutes and three seconds. The six-minute drill was conducted on 09/21/2022 at 1:45 am, with three staff and 18 residents noted. Per the *Resident Register*, there are 18 residents who currently reside in the facility.

On 11/16/2022, I conducted a follow-up on-site at the facility. I interviewed staff Brianna Pine. She stated that there are about three to four staff on first and second shift, and usually one to two staff on second shift.

On 11/16/2022, I interviewed staff Hannah Boothe at the facility. She stated that there is supposed to be three staff on first and second shifts and two people on third shift.

On 11/16/2022, I interviewed Resident C. Resident C stated that most of the time they have enough staff working, and that they do get coverage when someone calls in sick.

On 11/29/2022, I spoke with the current hospice nurse Allyson Leipert, from The Care Team. She stated that everywhere is short staffed right now, but this facility is more adequately staffed.

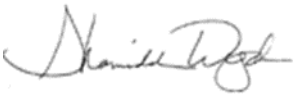
APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Staff Carrie Austin reported that there is one staff on shift at night and two to three residents that require a two-person assist. Administrator Quenten Flint reported that there have been one staff scheduled on shift at night due to staffing issues, and that 80% of the residents have dementia.

	The staff schedule was reviewed with Staff Flint who stated that there was 11 days in October 2022 and three days in November 2022 where there was one staff on third shift. Staff Brianna Pine reported that there are usually one to two staff on third shift. There is a preponderance of evidence to substantiate a rule violation in regard to insufficient staffing on third shift.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/01/2022, I spoke with licensee designee Dan Stevens via phone. I informed him 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).



12/01/2022

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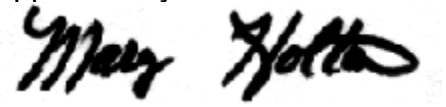
Shamidah Wyden Date
Licensing Consultant

Approved By:



12/01/2022

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Mary E. Holton Date
Area Manager