GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 29, 2023

Kathy Corbin
Trilogy Healthcare of Livingston, LLC
303 N. Hurstbourne Pkwy
Louisville, KY 40222-5185

RE: License #: AH470395495
Investigation #: 2023A1021040
The Legacy at Howell

Dear Ms. Corbin:

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 authorized representative 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 (517) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH470395495
Investigation #:	2023A1021040
Complaint Receipt Date:	02/28/2023
Investigation Initiation Date:	03/01/2023
Report Due Date:	04/30/2023
Licensee Name:	Trilogy Healthcare of Livingston, LLC
Licensee Address:	Suite 200 303 N. Hurstbourne Pkwy Louisville, KY 40222-5185
Licensee Telephone #:	(502) 412-5847
Administrator/ Authorized Representative:	Andrea Gold
Name of Facility:	The Legacy at Howell
Facility Address:	1550 Byron Road Howell, MI 48855
Facility Telephone #:	(517) 552-9323
Original Issuance Date:	10/29/2020
License Status:	REGULAR
Effective Date:	04/29/2022
Expiration Date:	04/28/2023
Capacity:	35
Program Type:	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Facility has insufficient staff on third shift.	Yes
Additional Findings	No

III. METHODOLOGY

02/28/2023	Special Investigation Intake 2023A1021040
03/01/2023	Special Investigation Initiated - Letter
03/02/2023	Inspection Completed On-site
03/08/2023	Contact - Telephone call made Interviewed SP1
03/08/2023	Contact - Telephone call made Interviewed SP2
03/29/2023	Exit Conference

ALLEGATION:

Facility has insufficient staff on third shift.

INVESTIGATION:

On 02/28/2023, the licensing department received a complaint with allegations the facility had insufficient staff on third shift on 2/18/2023.

On 03/01/2023, the allegations in this report were sent to centralized intake at Adult Protective Services (APS).

On 03/02/2023, I interviewed assistant director Sierra Sterley at the facility. Ms. Sterley reported there are 26 residents in the facility. Ms. Sterley reported on third shift the facility staffs two employees, but the facility can run with one employee. Ms. Sterley reported if there is only one employee working, a caregiver from the assisted living or health center is expected to round on the unit hourly. Ms. Sterley reported if the caregiver in the legacy unit needs assistance, they can call the nurse station at one of the facilities located on the campus. Ms. Sterley reported the facility does not

have a mandation policy for staff shortages. Ms. Sterley reported there is an on-call worker that is responsible for finding a replacement worker if there is a staff shortage. Ms. Sterley reported the facility is currently hiring for all shifts. Ms. Sterley reported in the facility, there is one resident that is a two person assist, one resident on oxygen, one resident with a catheter, one resident that can be aggressive, one resident that is incontinent, and all 26 residents are to be rounded on every two hours.

I observed the facility on the health campus. The facility is separated from the other facilities by a walkway and parking lot. To access the facility, a caregiver will have to walk outside, and it takes approximately three minutes to get from one facility to another.

On 03/08/2023, I interviewed staff person 1 (SP1) by telephone. SP1 reported she typically works third shift. SP1 reported often there is one caregiver in the facility. SP1 reported at times there is a medication technician scheduled for the building, but they are pulled to administer medications on other units. SP1 reported if there is one caregiver working, they can call the other units' phones for assistance. SP1 reported they will come but it does take time for them to walk to the unit. SP1 reported a few employees will proactively come to check on the facility but there are only a few that do this. SP1 reported there are three residents that tend to wander and are an elopement risk.

On 03/08/2023, I interviewed SP2 by telephone. SP2 reported she typically works second shift but has worked third shift. SP2 reported at times there is only one employee that works in the facility. SP2 reported if there is a caregiver and a medication technician, the medication technician is responsible for administering medications in other units. SP2 reported if the caregiver calls for assistance, sometimes the phone is not answered. SP2 reported it is uncommon for a worker from a different facility to round on the facility. SP2 reported it is unsafe for there to only be one employee in the unit.

I reviewed the staff schedule for 02/18/2023. The schedule revealed that there was one person scheduled that walked off the job. The manager then worked the shift.

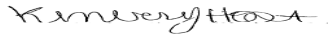
APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(a) Assume full legal responsibility for the overall conduct and operation of the home.** **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**

For Reference: R 325.1901	**Definitions.**
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	Interviews conducted revealed the facility tries to have two workers in the unit. However, review of the working staff schedules revealed on 02/18/2023 there was only one person working in the facility. When there is a staff shortage, there is an expected a worker from another facility will round and assist as needed. However, there are no set parameters for this worker as to how much and when they are to assist the unit. By doing so, this cognitively impaired resident population is subjected to potential harm due to the lack of available staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 03/29/2023, I conducted an exit conference with authorized representative Andrea Gold by telephone.

IV. RECOMMENDATION

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



03/08/2023

Kimberly Horst Date
Licensing Staff

Approved By:

03/27/2023

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