GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 22, 2023

Christina Cotton
Bowman Place
1215 N. Elm Street
Three Rivers, MI 49093

RE: License #: AH750378305
Investigation #: 2023A1021078
Bowman Place

Dear Christina Cotton,

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 #:	AH750378305
Investigation #:	2023A1021078
Complaint Receipt Date:	08/09/2023
Investigation Initiation Date:	08/14/2023
Report Due Date:	10/08/2023
Licensee Name:	Bowman AID OPCO LLC
Licensee Address:	Ste 3700 330 N. Wabash Chicago, IL 60611
Licensee Telephone #:	(312) 725-7010
Administrator:	Abigail Mulholland
Authorized Representative:	Christina Cotton
Name of Facility:	Bowman Place
Facility Address:	1215 N. Elm Street Three Rivers, MI 49093
Facility Telephone #:	(269) 279-0088
Original Issuance Date:	04/25/2017
License Status:	REGULAR
Effective Date:	10/25/2022
Expiration Date:	10/24/2023
Capacity:	61
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Facility accepts residents that are not appropriate.	No
Residents are left wet and not cared for.	Yes
Employees sleep while working.	Yes
Facility roof is leaking.	No
Additional Findings	Yes

III. METHODOLOGY

08/09/2023	Special Investigation Intake 2023A1021078
08/09/2023	APS Referral complaint came through from APS. APS denied investigating
08/14/2032	Special Investigation Initiated - Face to Face
08/15/2023	Contact-Letter sent Letter sent to Authorized Representative with name change instructions
08/16/2023	Contact-Telephone call made Interviewed SP8
08/17/2023	Contact-Telephone call made Interviewed SP7
08/17/2023	Contact-Telephone call made Interviewed SP9
08/22/2023	Exit Conference

The complainant alleged the facility is not fully staffed, medications are not administered, and residents fall. These complaints were investigated under special investigation report: AH750378305_SIR_2023A1021078. The complainant identified some concerns that were not related to home for the aged licensing rules and statutes. Therefore, only specific items pertaining to homes for the aged provisions

of care were considered for investigation. The following items were those that could be considered under the scope of licensing.

ALLEGATION:

Facility accepts residents they are not equipped to care for.

INVESTIGATION:

On 08/09/2023, the licensing department received a complaint from Adult Protective Services (APS) with allegations the facility accepts residents they are not equipped to care for. The complainant did not provide a resident name and due to the anonymous complaint, I was unable to obtain additional information.

APS denied the allegations in this report for investigation.

On 08/14/2023, I interviewed administrator Abigail Mulholland at the facility. Ms. Mulholland reported the facility can accept residents that are a two person assist or residents that use a mechanical lift. Ms. Mulholland reported the facility encourages residents to maintain their independence while aging in place. Ms. Mulholland reported every day the facility has a stand-up meeting to discuss any resident concerns. Ms. Mulholland reported if a caregiver has a concern about a resident, such as resident needs cannot be met, a management team member will review the resident service plan and observe the resident. Ms. Mulholland reported the facility can arrange for home care services and hospice care services. Ms. Mulholland reported the facility encourages resident independence and is hesitant to implement mechanical lifts on residents because the facility wants to maintain residents' independence as much as possible. Ms. Mulholland reported the needs of the residents are met and the facility is equipped to care for residents.

On 08/14/2023, I interviewed staff person 4 (SP4) at the facility. SP4 reported there are a few residents that are on home care or hospice services. SP4 reported there are no residents that are too high of acuity. SP4 reported residents' needs are met at the facility.

On 08/14/2023, I interviewed SP9 at the facility. SP9 reported residents receive good care at the facility and the needs are met. SP9 reported there are a few residents that require increased staff time and assistance, but the needs of the resident are met.

On 08/14/2023, I observed multiple residents at the facility. The residents were out of bed, dressed, and engaged with others at the facility. I did not observe any residents that appeared their needs were not met.

On 08/16/2023, I interviewed SP8 by telephone. SP8 reported the facility has increased census and there is a variety of resident needs at the facility. SP8

reported a few residents expect 1:1 care which the facility does not provide. SP8 reported residents' needs are met and resident needs are not outside the scope of practice.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(9) A home shall not admit a resident who requires continuous nursing care services of the kind normally provided in a nursing home as specified in MCL 333.21711(3) and MCL 333.21715(2).
ANALYSIS:	Interviews conducted and observations made revealed lack of evidence to support the allegation the facility is not equipped to care for residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents are left wet and not attended to.

INVESTIGATION:

Ms. Mulholland reported it is expected that residents are checked on every two hours. Ms. Mulholland reported currently there are no residents with a urinary tract infection. Ms. Mulholland reported there is one resident with minor skin breakdown due to cellulitis. Ms. Mulholland reported she has not received any complaints from family members, staff, or residents that care is inadequate. Ms. Mulholland reported residents receive good care at the facility.

On 08/14/2023, I interviewed SP3 at the facility. SP3 reported she typically works first shift and has reported for her shift and observed residents that appeared they have not been checked on for many hours. SP3 reported she has observed residents' briefs saturated and urine stains on their sheets. SP3 reported there is a caregiver checklist that caregivers are to check when tasks are completed, however, many caregivers do not complete the checklist.

On 08/16/2023, I interviewed SP8 by telephone. SP8 reported she typically works first shift and has observed residents that appeared they have not been checked on throughout the night. SP8 reported she has observed dried urine on bedsheets.

On 08/17/2023, I interviewed SP9 by telephone. SP9 reported she has observed residents left in bed and covered in urine and feces. SP9 reported at times the residents are not taken out of bed in a timely manner.

I observed the caregiver checklist for 08/11-08/07 and 08/04-08/03. There was a checklist for each shift. On the checklist, residents were coded as scheduled (caregivers were to provide support every two hours), reminder (remind resident to use restroom every two hours) or pendent (resident would use pendent for assistance). In addition, the shift supervisor was to initial that a variety of tasks were completed for their section of rooms they were responsible for. The checklist revealed on multiple shifts and multiple days caregivers were not documenting that they provided residents with the scheduled assistance.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	Interviews conducted revealed multiple caregiver concerns on residents not receiving the assistance they require. In addition, review of caregiver checklist revealed the facility could not demonstrate that the residents received their scheduled assistance.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Employees sleep while working.

INVESTIGATION:

The complainant alleged third shift employees sleep while working and leave residents unattended.

Ms. Mulholland reported there is a third shift worker, SP6, that is on a final warning because she has been caught sleeping while working. Ms. Mulholland reported she has one picture of the employee sleeping while working. Ms. Mulholland reported the facility discipline process is first warning, second warning, and then final warning. Ms. Mulholland reported this employee is on the final warning.

On 08/17/2023, I interviewed SP7 by telephone. SP7 reported she works on third shift and has witnessed SP6 sleeping on the job. SP7 reported it is difficult as there are only two caregivers assigned to work on third shift and if a caregiver is sleeping it can be difficult to meet the needs of the residents. SP7 reported she has

witnessed SP6 sleeping multiple times and has brought the concerns to the administrator.

On 08/17/2023, I interviewed SP9 by telephone. SP9 statements were consistent with those made by SP7.

I reviewed discipline action taken for SP6. SP6 was issued a written warning for sleeping on the job on 05/25/2023. In addition, SP6 was issued a final warning on 08/11/2023 for sleeping on the job.

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:	Interviews conducted and review of documentation reveled multiple occasions in which SP6 was not awake while working at the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Facility roof is leaking.

INVESTIGATION:

The complainant alleged the roof is caving in and is leaking in resident rooms.

Ms. Mulholland reported approximately two weeks ago in the hallway area near A hallway, there was a leak due to the condensation lines in the ceiling. Ms. Mulholland reported the facility contacted a local company to fix the condensation lines and the maintenance director fixed the drywall. Ms. Mulholland reported a bucket was placed to catch the water, but it was a small leak. Ms. Mulholland reported residents were not affected by this leak. Ms. Mulholland reported in room 117, the roof was leaking, and the resident was immediately moved to a different room. Ms. Mulholland reported this leak was due to the facility needing a new roof. Ms. Mulholland reported she has spoken with the corporate office, and they are in the process of getting bids for a new roof. Ms. Mulholland reported resident room 117 will not be rented until the roof is addressed.

SP1 reported there was a small leak in the hallway near A hall. SP1 reported it was addressed by maintenance very quickly. SP1 reported resident in room 117 was moved to a different room due to the ceiling leaking. SP1 reported both issues were addressed immediately and in a timely manner.

SP2 and SP3 statements were consistent with those made by Ms. Mulholland and SP1.

I observed the ceiling in the facility. I observed new drywall on the ceiling in the hallway near A hall. There was no current water leak. I also observed resident room 117. I observed the facility working on the drywall on the ceiling, but I did not see any current water leaking.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	Interviews conducted and observations made revealed the facility had condensation lines that leaked and a small leak in the roof. Both issues were addressed immediately, and the facility took appropriate action.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 07/19/2023, the Licensing Department received notice the management company for the facility would be changing. The licensee requested information on changing the facility name.

On 07/20/2023, licensing consultant Julie Viviano provided instructions on changing the facility name.

While onsite, Ms. Mulholland reported that the facility name had changed to Lakehouse Three Rivers.

On 08/15/2023, I sent an email to authorized representative Christina Cotton with instructions on changing the facility name and the request was to be completed within five business days of the change.

As of 08/22/2023, the Licensing Department had not received request for a name change.

APPLICABLE RULE	
R 325.1913	**Licenses and permits; general provisions.**
	(2) The applicant or the authorized representative shall give written notice to the department within 5 business days of any changes in information as submitted in the application pursuant to which a license, provisional license, or temporary nonrenewable permit has been issued.
ANALYSIS:	Interviews conducted revealed the facility changed the name to Lakehouse Three Rivers. The applicant or authorized representative did not provide written notice to the Department for this change.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Kimberly Horst 08/21/2023

Kimberly Horst Date
Licensing Staff

Approved By:

Andrea L. Moore 08/21/2023

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