GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 4, 2024

Marina Galu
American House Wyoming
5812 Village Dr SW
Wyoming, MI 48519

RE: License #: AH410402896
Investigation #: 2023A1028079
American House Wyoming

Dear Marina Galu:

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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AH410402896
Investigation #:	2023A1028079
Complaint Receipt Date:	08/30/2023
Investigation Initiation Date:	08/30/2023
Report Due Date:	10/29/2023
Licensee Name:	AH Wyoming Subtenant LLC
Licensee Address:	STE 1600, One Towne Square Southfield, MI 48076
Licensee Telephone #:	(248) 827-1700
Administrator:	Tamara Monks
Authorized Representative:	Marina Galu
Name of Facility:	American House Wyoming
Facility Address:	5812 Village Dr SW, Wyoming, MI 48519
Facility Telephone #:	(616) 421-2675
Original Issuance Date:	11/05/2020
License **Status:**	REGULAR
Effective Date:	05/05/2023
Expiration Date:	05/04/2024
Capacity:	166
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff did not provide Resident A showers in accordance with the service plan.	Yes
Staff does not respond to call lights in a timely manner.	Yes
Additional Findings	No

III. METHODOLOGY

08/30/2023	Special Investigation Intake 2023A1028079
08/30/2023	Special Investigation Initiated - Letter 2023A1028079
08/30/2023	APS Referral APS referral made to Centralized Intake.
09/05/2023	Contact - Face to Face Interviewed Admin/Tamara Monks at the facility.
09/05/2023	Contact - Face to Face Interviewed Employee A at the facility.
09/05/2023	Contact - Face to Face Interviewed Employee B at the facility.
09/05/2023	Contact - Face to Face Interviewed Resident A at the facility.
09/05/2023	Contact - Document Received Received Resident A's record and working staff schedules from Admin/Tamara Monks.
09/06/2023	Contact – Telephone Call Received Received requested follow-up phone call from Resident A

ALLEGATION:

Staff did not provide Resident A showers in accordance with the service plan.

INVESTIGATION:

On 8/30/2023, the Bureau received the allegations from the online complaint system.

On 8/30/2023, a referral was made to Adult Protective Services (APS) through Centralized Intake.

On 9/5//2023, I interviewed the facility administrator, Tamara Monks, at the facility who reported knowledge of Resident A's concerns of not receiving a shower the week prior. Ms. Monks reported management met with Resident A to address the concerns and to review documentation of Resident A's refusal of showers. Ms. Monks reported Resident A refused showers on 8/25/23 because Resident A did not want a male caregiver to assist [them]. Resident A prefers female caregivers. Resident A was offered a shower on 8/28/23 but refused due to exhaustion from being out all day with family. Resident A received showers on 8/29/23 and 9/1/2023. Ms. Monks reported Resident A's shower schedule was reviewed with staff to ensure appropriate care. Ms. Monks provided me Resident A's record for my review.

On 9/5/2023, I interviewed Employee A at the facility who reported knowledge of Resident A voicing concerns about not receiving showers as scheduled or in a timely manner. Management met with Resident A to address the concerns and to confirm the shower schedule. Employee A reported management reviewed the refusals of showers with Resident A as well and that management was unaware Resident A had missed any showers until it was brought to their attention by Resident A. Employee A confirmed Resident A refused a shower on 8/25/23 due not wanting a male caregiver to assist and again on 8/28/23 due to being tired from being out with family the whole day. However, Resident A was provided showers on 8/29/23 and 9/1/2023.

On 9/5/2023, interviewed Employee B at the facility whose statements were consistent with Ms. Monks statements and Employee A's statements.

On 9/5/2023, I interviewed Resident A at the facility who reported not receiving a shower in over a week. Resident A confirmed they did refuse a shower on 8/25/23 due to not wanting a male caregiver to assist. Resident A reported it is in [their] service plan that [they] prefer only female caregivers. Resident A reported a shower was offered late on 8/28/23 but [they] declined due to being out of the facility all day and being exhausted upon return to the facility that evening. Resident A reported [they] do not receive showers as scheduled and/or when [they] push the call light, that [they] wait a long time for staff to respond or staff forget to respond at all.

Resident A reported “staff make excuses as to why they can’t give me a shower and I did refuse on [8/25] because I did not want a male to help me, and they know that. They did not offer me a make-up shower for the next day.” Resident A also confirmed [they] refused a shower on 8/28/23 due to being out all day and was tired. Resident A confirmed management met with [them] to address concerns, but [they] are not confident the issues have been resolved. Resident A reported they are scheduled to receive a shower tonight.

On 9/6/2023, I received a phone call from Resident A stating [they] did not receive a shower as scheduled. Resident A reported [they] pushed their call-light around 8:30pm and staff arrived before 9:00pm and stated staff were in the middle of something and could not provide a shower then but would be back shortly to provide Resident A a shower. Resident A pressed the call-light again at 9:30pm because staff still had not returned and requested the scheduled shower. Resident A reported staff arrived prior to 10:00pm and told Resident A showers are not given after 9:00pm. Resident A subsequently told staff it was a scheduled shower, but staff said they could not provide the shower because there were only one of them. Staff left and later returned after 10:15pm and offered Resident A a shower but Resident A was in the process of going to bed at that time. Resident A reported the staff member confirmed the shower schedule and would ensure Resident A receives a shower the next day. Resident A reported [they] called the wellness director hotline but no one answered. Resident A reported [they] have not spoken with management about not receiving the shower yesterday on 9/6/23 as scheduled.

On 9/6/2023, I made a phone call to Ms. Monks and management to obtain further information about Resident A not receiving the scheduled shower on 9/5/2023. I left a message for Ms. Monks requesting a return phone call. As of 9/11/2023, I have not received a return phone call. I also emailed Ms. Monks and management requesting a response and as of 9/11/2023, I have not received a response to my email.

On 9/11/2023, I reviewed Resident A’s service plan which revealed the following:

- Resident is own person and oriented x 4.
- Independent with eating, wheelchair and walker mobility, transfers, grooming, dressing, medication administration, and toileting.
- Requires moderate assistance with bathing.
- Does not demonstrate behaviors.

I reviewed the care log and noted no refusals of care for August 2023. All showers were marked as being provided to Resident A as scheduled.

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:	It was alleged the facility does not provide showers in accordance with the service plans or in a timely manner. Interviews, on-site investigation, and review of documentation reveal the facility did not provide Resident A showers in accordance with the service plan. Resident A is to receive showers every Tuesday and Friday. Resident A refused a shower on 8/25/2023 due to not wanting a male caregiver to assist. It is documented in Resident A's service plan that Resident A prefers female caregivers. Resident A was offered a make-up shower on 8/28/2023, three days after the initial refusal on 8/25/2023 but refused due to being exhausted from an all-day family outing. Resident A was provided a shower on 8/29/2023, four days after the initial refusal on 8/25/2023. During the on-site investigation on 9/5/2023, Resident A was to have a scheduled shower in accordance with the service plan. On 9/6/2023, Resident A informed me via telephone that a shower was not provided by staff as scheduled. The facility is in violation of not providing Resident A showers on scheduled days, not providing showers in a timely manner, and not offering a make-up shower in a timely manner. Violation found.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff does not respond to call lights in a timely manner.

INVESTIGATION:

On 9/5/2023, Ms. Monks reported there was a recent issue with the call-light system causing the system to not notify staff when a call-light was pressed unless staff visually monitored the system. The call-light system would 'ping' to staff phones to notify staff of alerted call-lights, but unbeknownst to her and staff, the system stopped auditorily notifying staff of call-lights. Ms. Monks reported the IT team was notified immediately and the system is still being worked on, but staff are aware of the issue and instructed to visually monitor the call-light phone application to ensure needs are met. Ms. Monks reported call-light response times should be under ten minutes or less but admitted they are not always. Ms. Monk also reported staff are

not consistent with re-setting the call-light in a timely manner either because most complete care first and then re-set the call-light. Ms. Monks provided me Resident A's call-light log and the working staff schedules for my review.

On 9/5/2023, Employee A's statements and Employee B's statements are consistent with Ms. Monks statement.

On 9/5/2023, Resident A reported the call-lights are not answered in a timely manner and that answering of call-lights in timely manner is not consistent. Resident A reported "one week, call-lights are answered shortly after being pressed and the next they are not. It's all over the place and it also depends on the staff assigned to work that day if they get answered appropriately." Resident A reported [they] have pushed their call-light in the past and waited more than 30 minutes to 45 minutes for staff to arrive. Resident A reported sometimes staff forget to reset the call-light, so [they] will reset the call-light or tell staff [they] will reset the call-light.

On 9/11/2023, I revealed Resident A's call-light log which revealed the following:

- There were 25 times total Resident A's call-light exceeded more than 15 minutes during August 2023.
- On 8/14/2023, the call-light time was 32 minutes.
- On 8/20/23, the call-light time was 40 minutes.
- On 8/23/23, the call-light time was 25 minutes at 1:02pm and 50 minutes at 5:44pm.
- On 8/25/23, the call-light time was 105 minutes.
- On 8/28/23, the call-light time was 32 minutes.
- On 8/30/23, the call-light time was 23 minutes.

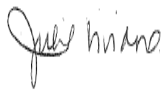
I reviewed the working staff schedules which revealed some staffing shortages from July 2023 to September 2023, but enough staff scheduled to prevent a shift shortage.

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:	It was alleged staff do not answer call-lights in a timely manner. Interviews, on-site investigation, and review of documentation reveal Resident A's call-light log had 25 total call-light times that exceeded more than 15 minutes. Five of the call-light times exceeded more than 30 minutes, with the longest call-light time being 102 minutes. The facility expectation is that call-light are to be answered in 10 minutes or less. However, there was an overall system issue and an inconsistency as to when staff are to reset the call-light, as some staff complete care first and then reset the call-light and other staff reset the call-light prior to completing care. Due to this inconsistency, it cannot be determined if the call-light response times as documented in the call-light log are accurate or not, therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, I recommend the status of this license remain the same.



9/11/2023

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Julie Viviano Date
Licensing Staff

Approved By:

01/04/2024

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