GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 25, 2024

Connie Clauson
Hale Area Assisted Living Corporation
3196 Kraft Ave, SE Suite 203
Grand Rapids, MI 49512

RE: License #: AH350338564
Investigation #: 2024A1010017
Hale Creek Manor

Dear Mrs. Clauson:

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) 241-1970.

Sincerely,
Lauren Wohlfert

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa NW Unit 13 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH350338564
Investigation #:	2024A1010017
Complaint Receipt Date:	11/22/2023
Investigation Initiation Date:	11/27/2023
Report Due Date:	01/22/2023
Licensee Name:	Hale Area Assisted Living Corporation
Licensee Address:	8096 Campbell Avenue Hale, MI 48739
Licensee Telephone #:	(989) 728-2525
Administrator:	Catherine Scofield
Authorized Representative:	Connie Clauson
Name of Facility:	Hale Creek Manor
Facility Address:	3191 M-65 Hale, MI 48739
Facility Telephone #:	(989) 728-1300
Original Issuance Date:	09/05/2014
License Status:	REGULAR
Effective Date:	03/05/2023
Expiration Date:	03/04/2024
Capacity:	43
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility has had bed bugs for beginning two years ago.	Yes

III. METHODOLOGY

11/22/2023	Special Investigation Intake 2024A1010017
11/27/2023	Special Investigation Initiated - Telephone Message left for the APS complainant, a call back was requested
12/13/2023	Contact - Telephone call received Interviewed APS complainant by telephone
12/13/2023	Inspection Completed On-site Completed inspection via Teams
01/29/2024	Contact – Document received Received the exterminator invoices for my review
03/25/2024	Exit Conference

ALLEGATION:

The facility has had bed bugs for beginning two years ago.

INVESTIGATION:

On 11/22/23, the Bureau received the allegations from Adult Protective Services (APS). The complaint was not assigned for APS investigation. The complaint read, "[Resident A] has resided at Hale Creek Manor for 8 years and the facility had bedbugs for the past two years. Upper management has not informed volunteers, hospice staff, and families of the bedbugs. [Resident A], in particular, has been in and out of her room constantly and it is upsetting her due to her understanding of the situation as a result of her dementia."

On 12/13/23, I interviewed the APS complainant by telephone. The APS complainant reported the first incident of bed bugs occurred in the facility approximately two years ago. The APS complainant said the facility has had bed bugs on and off since then. The APS complainant reported Resident A has had bed

bugs in her room as a result. The APS complainant stated Resident A's room was "sprayed" and received various heat treatments.

The APS complainant stated the last time Resident A had bed bugs in her room was approximately a few weeks ago, the exact date is unknown. The APS complainant said the facility contacted Resident A's family a few weeks ago and informed them Resident A's clothing needed to be laundered after bed bugs were found in her room. The APS complainant explained Resident A's family had to launder Resident A's clothing because some washing machines in the facility were not working at the time.

The APS complainant reported staff placed Resident A's clothing in trash bags that were not tied or closed off. The APS complainant stated the open bags of clothing were placed on the couch in Resident A's room for family to retrieve and launder. The APS complainant said this put Resident A's family at risk of bringing bed bugs into their home.

The APS complainant stated the facility also did not notify the visitors or outside service providers that there were bed bugs in the building. The APS complainant said it appeared as though the facility had no bed bug policy or procedure in place to address the issue. The APS complainant reported upper management encouraged staff not to inform resident family members or visitors that there were bed bugs in the facility.

On 12/13/23, I interviewed administrator Catherine Scofield via Teams. Ms. Scofield reported that approximately a year and a half ago a resident was admitted who unknowingly brought in bed bugs into the facility. Ms. Scofield stated the facility has been using an exterminator since the bed bugs were first observed. Ms. Scofield said the treatments provided by the exterminator consist of high heat treatments and chemical spraying. Ms. Scofield explained the exterminator was in the facility approximately 8 times within the last year and a half.

Ms. Scofield said when a resident's room is treated for bed bugs, the resident remains in a common area of the facility for approximately four or sometimes more hours. Ms. Scofield reported the residents are able to return to their rooms in the evening. Ms. Scofield said no resident had to spend the night outside of their room after the treatment was completed. Ms. Scofield stated Resident A did not suffer any distress from having to be outside of her room while it was treated.

Ms. Scofield reported it is the facility's procedure for staff to inform her immediately when a bed bug it observed. Ms. Scofield stated resident clothing is then laundered on high heat and she notifies the exterminator. Ms. Scofield said the facility does not have a written bed bug policy and procedure to her knowledge. Ms. Scofield stated the exterminator also provides preventative treatments when bed bugs are not detected in the facility.

On 1/29/24, I received copies of the Ehrlich exterminator invoices for my review. Invoices dated 5/23/23, 5/19/23, 9/11/23, 9/23/23 read heat treatments were completed in resident rooms where bed bugs were located. Invoices dated 1/25/23, 2/1/23, 3/1/23, 4/1/23, 5/1/23, 6/1/23, 7/1/23, and 8/1/23 read "BED BUG PROTECT+PREMIUM MULTI FAMILY" services were completed in the facility. Invoices dated 2/24/23, 3/13/23, 4/13/23, 5/12/23, 6/14/23, 7/13/23, and 8/9/23 read "PEST CONTROL MAINTENANCE" services were completed in the facility.

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: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	The interviews with Ms. Scofield, along with review of the Ehrlich exterminator invoices, revealed heat treatments and other bed bug extermination services were completed when bed bugs were found within the facility. However, Ms. Scofield denied knowledge regarding the facility having a written bed bug policy and procedure for staff to follow. This is not consistent with an organized program of protection.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Connie Clauson on 3/25/24.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

Lauren Wohlfert 01/31/2024

Lauren Wohlfert Date
Licensing Staff

Approved By:

03/15/2024

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