GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

Connie Clauson
Assured Care Assisted Living, LLC
Suite 203
3196 Kraft Ave SE
Grand Rapids, MI 49512

March 27, 2024

RE: License #: AL110283714
Investigation #: 2024A0579020
The Willows Assisted Living #1

Dear Connie 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 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 that I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Cassandra Duursma

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(269) 615-5050
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL110283714
Investigation #:	2024A0579020
Complaint Receipt Date:	03/18/2024
Investigation Initiation Date:	03/18/2024
Report Due Date:	05/17/2024
Licensee Name:	Assured Care Assisted Living, LLC
Licensee Address:	Suite 203, 3196 Kraft Ave SE, Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Nora Ramirez
Licensee Designee:	Connie Clauson
Name of Facility:	The Willows Assisted Living #1
Facility Address:	3507 Hollywood Road, St. Joseph, MI 49085
Facility Telephone #:	(269) 428-0715
Original Issuance Date:	11/14/2007
License Status:	REGULAR
Effective Date:	09/26/2022
Expiration Date:	09/25/2024
Capacity:	20
Program Type:	ALZHEIMERS, AGED

II. ALLEGATION(S)

	Violation Established?
Records were not provided as requested.	No
The home does not provide adequate activities.	No
There are untreated bedbugs.	No
Additional Finding	Yes

III. METHODOLOGY

03/18/2024	Special Investigation Intake 2024A0579020
01/31/2024	Special Investigation Initiated - Letter Complainant
02/15/2024	Contact - Telephone call Received Relative A1
02/15/2024	Contact - Document Sent Karen Hodge, Baruch Senior Ministries
02/16/2024	Contact - Telephone Call Received Nora Ramirez, Administrator
02/16/2024	Contact - Document Sent Relative A1
02/19/2024	Contact - Document Sent Relative A3
02/20/2024	Contact - Face to Face Resident A Nora Ramirez, Administrator
02/26/2024	Contact - Document Received Nora Ramirez, Administrator
03/01/2024	Contact - Document Received Nora Ramirez, Administrator

03/11/2024	Contact - Document Sent Cindy McLaughlin, Lincoln Senior Center
03/13/2024	Contact - Document Received Relative A3
03/14/2024	Contact - Face to Face Alyssa Sass, DCW
03/18/2024	Contact- Document Sent Nora Ramirez, Administrator
03/20/2024	Contact- Document Received Nora Ramirez, Administrator
03/21/2024	Contact- Document Sent Nora Ramirez, Administrator
03/22/2024	Contact- Telephone Call Made Alyssa Sass, DCW
03/22/2024	Contact- Telephone Call Made Ayanna Hunter, DCW
03/22/2024	Contact- Telephone Call Made Relative A3
03/24/2024	Contact- Documentation Received Relative A3
03/25/2024	Contact- Face to Face Nora Ramirez, Administrator
03/26/2024	Contact- Telephone Call Made Jennifer Thierbach, DCW
03/27/2024	Exit Conference Nora Ramirez, Administrator

ALLEGATION:

Records were not provided as requested.

INVESTIGATION:

On 1/31/24, I emailed the complainant confirming receipt of the allegations.

On 2/15/24, Relative A1 requested my assistance with obtaining Resident A's records so a new placement could be sought for Resident A. Relative A1 stated a new placement was arranged but she feels false information was shared with the new placement because Resident A was not admitted and therefore, relatives would like all Resident A's paperwork. Relative A1 stated they have been waiting for Resident A's paperwork since 1/31/24.

On 2/15/24, I contacted Karen Hodge from Baruch Senior Ministries to obtain the contact information for Ms. Ramirez. Ms. Hodge reported she was aware that Resident A's relatives were looking for a new placement for Resident A as of 1/31/24. She stated she believes relatives requested the documentation be available within 24 hours which was not sufficient time. She stated Ms. Ramirez would be able to provide additional details and they would cooperate with providing any additional documentation requested.

On 2/16/24, I exchanged emails with Ms. Ramirez who reported when Resident A's relatives gave a 30-day discharge notice to them on 1/31/24, they did not request all Resident A's documentation. Rather, they requested a "health document" be completed for his new placement. Ms. Ramirez reported that document and the other necessary documents for his new placement were sent to the potential new placement. She stated copies of Resident A's file were only recently requested, are available at the home, and have been waiting for Relative A3 to pick them up.

On 2/16/24, I exchanged emails with Relative A1 informing that Resident A's records were available for pick up at the home. Relative A1 reported a relative did go to the home previously to pick the records up but DCWs did not know where they were located, and Ms. Ramirez was not available, so the documents were not obtained at that time.

On 2/19/24, I exchanged emails with Relative A3 who reported she was not able to receive records of Resident A's physician contacts, only physician orders, and she received only the partially completed Medication Administration Record (MAR) for February 2024, after 2/12/24, the MAR noted "went electronic." She stated no additional MAR sheets were received. Relative A3 reported she requested records from March 2022 to the present. I agreed to address this at the home.

On 2/20/24, Ms. Ramirez stated the necessary paperwork was immediately prepared and given to Resident A's potential new placement when they were notified

the intentions were for Resident A to discharge within 30 days of 1/31/24. She stated paperwork was not the reason Resident A was not admitted to the new placement. She stated Resident A was evaluated twice at this home by staff at the potential new placement. She stated it was determined based on the in-person assessments that the potential new placement did not have an opening for the level of care Resident A needed based on their in-person assessments. She stated the documentation relatives requested has been available in the home since 2/8/24 but Relative A3 did not come to pick them up. She stated DCW Amanda Welch called to inform Relative A3 of where the records could be located if she was not available, but Relative A3 did not respond. Ms. Welch was present at this time in the conversation and reported this was true.

On 3/4/24, I received Resident A's paperwork. Included was Resident A's assessment plan, *Health Care Appraisal,* physician's orders on a physician contact form, "After Visit Summary", and MAR sheets from March 2022 to February 2024, except for November 2023.

On 3/13/24, I met with the Licensee Designee for Resident A's former potential placement. He reported The Willows staff was timely with providing the requested documentation needed to consider Resident A for placement and that did not contribute to why Resident A was not placed in a home he oversees. He stated after his staff evaluated Resident A twice, it was determined his care needs were more significant than relatives expressed and there was not availability for placement at a home he oversees with the level of care Resident A needs.

APPLICABLE RULE	
R 400.15302	**;provision of resident records at time of discharge.**
	(8) At the time of discharge, a licensee shall provide copies of resident records to the resident and his or her designated representative when requested, and as determined appropriate, by the resident or his or her designated representative. A fee that is charged for copies of resident records shall not be more than the cost to the licensee of making the copies available.
ANALYSIS:	Guardian A and Relative A1 requested assistance with obtaining records for Resident A while arranging a new placement for him. Ms. Ramirez reported she cooperated immediately with the documentation needed for Resident A's potential placement on 1/31/24 and relatives did not request Resident A's full records for themselves at that time. She stated records were made available to relatives on 2/8/24 but were not picked up at that time.

	The Licensee Designee for Resident A's potential placement on 1/31/24, reported this home was "timely" with providing the documentation they requested. Based on the interviews completed, there is insufficient evidence copies of records were not made available at the time of discharge, as requested, due to Resident A not discharging from the home. Rather, relatives were seeking potential new placements for Resident A. Furthermore, there is no timeframe noted in the rule for when these records must be provided, and the records were reported to be provided "timely" to the first potential placement and within a week for relatives.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The home does not provide adequate activities.

INVESTIGATION:

On 2/15/24, Relative A1 expressed concern that Resident A's overall health is declining because he does not receive adequate activities in the home. She stated due to allegations of bedbugs in the home, Resident A can no longer attend his day program.

On 2/20/24, Ms. Ramirez said there are daily activities for residents, but Resident A chooses not to participate and only leaves his room for meals. She stated Resident A prefers to stay in his room with his door locked and likely would not open his door or speak to me. She stated he previously attended day program, which is one activity he enjoyed, but he is no longer attending. I inquired why his day program services ended and Ms. Ramirez reported she believes his relatives ended his transportation to the program in anticipation of him moving.

Resident A initially did not open his door but after approximately two minutes, he agreed to allow me to enter his room and to speak to me. Resident A reported he does not like to do activities in this home, he prefers to go to Lincoln Senior Center for day program and he would prefer to go there every day. He stated he has not been able to attend day program and reported he does not know why. He requested my assistance with getting back to day program. I attempted to discuss other topics, but Resident A primarily kept inquiring about day program and requesting my assistance with returning to the program. I agreed to investigate this further.

On 3/4/24, I reviewed Resident A's assessment plan. There were no specifications regarding his participation in activities. In the area of Life Enrichment Activities/Socialization, Resident A had a score of 0.00 indicating he is either independent in life enrichment and socialization activities or he has consistent resistance to life enrichment and socialization activities.

On 3/12/24, I exchanged emails with Cindy McLaughlin from Lincoln Senior Center. She reported transportation for Resident A to the program was stopped when she was made aware of allegations of residents testing positive for COVID-19 and bedbugs in the home. She stated it is the transportation policy, to protect all attendees, that if a day program attendee lives in a home with cases of COVID-19 or bedbugs, they cannot be transported. She stated Ms. Ramirez confirmed there were cases of COVID-19 in the home but denied bedbugs. She stated she attempted to speak to Ms. Ramirez on 2/7/24 when these concerns were presented to her and again twice on 2/8/24. She stated it took approximately 10 days before Ms. Ramirez contacted her back to discuss the allegations. She stated she needed signed documents prepared to reinstate Resident A's transportation, it took "a few weeks" before Ms. Ramirez returned that paperwork, and the services were immediately reinstated once the paperwork was received. She stated Resident A has been back attending day program since 3/6/24. She stated Resident A's relatives did not end his services at the Senior Center in anticipation of him moving, they wanted him to attend as well.

On 3/13/24, I received an email from Relative A3 which was a forwarded exchange between her and Ms. Ramirez on 2/9/24 discussing bedbugs at The Willows. Relative A3 reported Lincoln Senior Center is concerned about alleged bedbugs in the home and have left messages requesting Ms. Ramirez confirm or deny the allegations. Ms. Ramirez replied the allegations were false and she would be calling Lincoln Senior Center.

On 3/14/24, I spoke with DCW Alyssa Sass on-site while reviewing records. She confirmed Resident A was not present at the home today because he was attending day program at Lincoln Senior Center.

On 3/22/24, I completed a telephone interview with Ms. Sass who reported Resident A has refused to engage in activities the entire time he has lived at this home, which is over two years. She stated he will attend meals and enjoys his day program, but

he otherwise “locks himself in his room” and does not want to be bothered. She stated she does not believe DCWs encourage him to attend activities anymore because he has refused for years, and it is known he does not want to do activities in the home.

On 3/22/24, Relative A3 reported Resident A does prefer going to Lincoln Senior Center and was upset that he could not attend for several weeks but she also has concerns that there are no activities being provided in the home.

On 3/24/24, I received a forwarded email from Relative A3. The email was an exchange between her and Ms. Ramirez on 2/23/24 where Ms. Ramirez stated she cannot sign Resident A’s form to return to Lincoln Senior Center because it requires COVID testing and Relative A3 has refused COVID testing for Resident A in the past. Relative A3 responded that she did not want Resident A being tested if he was not exhibiting symptoms but was fine with him being tested for this reason. Relative A3 also requested a calendar of the activities in the home as she is not certain there is one and Ms. Ramirez has never provided her one.

On 3/25/24, I completed an on-site investigation and spoke to Ms. Ramirez who confirmed that part of the delay with completing the paperwork to have Resident A return to Lincoln Senior Center was due to her understanding that Relative A3 did not want Resident A tested for COVID unless he was ill.

I inquired about a calendar of activities and Ms. Ramirez reported there are calendars available in the common area of the home for residents and their visitors to take. I requested a copy while observing a resident’s room. Ms. Ramirez returned with a calendar of activities in less than a minute.

On 3/26/24, I complete a telephone interview with DCW Jennifer Thierbach. She reported Resident A previously did not like to engage in activities for several years but DCWs would always remind everyone at breakfast and at lunch of the upcoming activities for the morning and afternoon. She stated DCWs would also knock on resident’s doors and invite them to attend but Resident A would primarily refuse to even acknowledge DCWs knocking at his door, and he keeps his door locked. She stated recently, Resident A has engaged in cardio drumming one time and has possibly done a few other activities. She stated he was kept home from Lincoln Senior Center due to concerns for COVID and there was a delay with him returning because Relative A3 reported she did not want him tested for COVID unless he was ill and a COVID test was required for him to return. After our phone conversation, Ms. Thierbach sent me a photo of Resident A participating with cardio drumming which she reported was taken that morning.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**

	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Resident A, Relative A3, Ms. Ramirez, Ms. Sass, and Ms. McLaughlin confirm Resident A attends Lincoln Senior Center, he enjoys attending, and there was several weeks that he could not attend the program due to reported communication and paperwork delays. Resident A, Ms. Ramirez, and Ms. Sass report he does not like to do activities in the home, he only prefers to go to Lincoln Senior Center. Ms. Thierbach reported Resident A previously did not engage with activities but has been more recently. Resident A's assessment plan did not specify activity requirements for Resident A, rather it noted he is either independent in life enrichment and socialization activities or he has consistent resistance to life enrichment and socialization activities. Based on the interviews completed, there is insufficient evidence Resident A did not receive personal care as specified in his assessment plan.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The home has had bedbugs.

INVESTIGATION:

On 2/20/24, Ms. Ramirez denied that there have been bedbugs in this home or in Resident A's room. She stated other homes on this campus have had a few incidents of bedbugs but transferring between homes was stopped at that time to prevent them from spreading to this home. She stated there is a contract in place with Rentokil for bedbug prevention/maintenance in this home and all the homes on this campus.

Resident A denied knowledge of bedbugs in this home or in his room.

On 3/12/24, Ms. McLaughlin stated she had heard that there were bedbugs at this home which is why transportation of Resident A to the program was stopped. She stated Ms. Ramirez denied there ever being bedbugs at this home at that time.

On 3/13/24, I received an email from Relative A3 which was a forwarded exchange between her and Ms. Ramirez on 2/9/24 discussing bedbugs at The Willows. Relative A3 reported Lincoln Senior Center is concerned about alleged bedbugs in the home and have left messages requesting Ms. Ramirez confirm or deny the allegations. Ms. Ramirez replied the allegations were false and she would be calling Lincoln Senior Center.

On 3/20/24, I exchanged emails with Ms. Ramirez who reported The Willows campus is now under contract with Rose Pest Solutions. She stated the campus maintenance person, Jon Thierbach, was also trained on how to manage bedbugs following the recommendations of Rose Pest Solutions, including bagging items, washing and drying in high heat, steaming, and using a pest control powder. She stated he has not had to use those measures at this home and no professional services have been done because there have not been bedbugs in this home.

On 3/21/24, I observed documentation confirming The Willows campus had a contract with Ehrlich Pest Control in November 2023 and currently has a contract with Rose Pest Solutions as of 3/11/24.

On 3/22/24, I received Intake 200151 which alleged there are bedbugs in the home.

On 3/22/24, Ms. Ramirez and I exchanged emails and she stated there are disgruntled staff falsely reporting bedbugs in the homes and now if a bug is seen in the home all DCWs report them as bedbugs. She stated if a bug is reported by DCWs, she and Mr. Thierbach immediately inspect the area. She stated they have not witnessed a bedbug in this home.

On 3/22/24, I completed a telephone interview with DCW Alyssa Sass who denied bedbugs ever being in this home.

On 3/22/24, I completed a telephone interview with DCW Ayanna Hunter who denied knowledge of bedbugs in this home.

On 3/22/24, I completed a telephone interview with Relative A3 who denied seeing bedbugs in this home.

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:	Ms. Ramirez, Ms. Sass, Ms. Hunter, and Guardian A3 denied bedbug activity in this home. Ms. Ramirez provided confirmation, via billing statement, that there is a contract for The Willows with Rose Pest Solutions as of 3/11/24 and treatment would be sought from them if needed. Ms. Sass reported this as well. Based on the interviews completed and documentation reviewed there is insufficient evidence to support allegations that an insect, rodent, or pest control program is not maintained as necessary to protect the health of residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 3/4/24, I received and reviewed Resident A's records. Resident A's Medication Administration Record (MAR) for November 2023 was not found.

On 3/14/24, while on-site I reviewed Resident A's records again. Resident A's Medication Administration Record for November 2023 was not found.

Ms. Sass attempted to locate the document but could not locate it while I was on-site. Ms. Sass stated the log was accidentally misplaced because she is certain it was completed.

On 3/18/24, I exchanged emails with Ms. Ramirez who reported she has attempted to locate the November 2023 MAR, but she is unable to locate it and believes it was accidentally misplaced. She stated the home transitioned to electronic records in February 2024 so this will not be an issue moving forward.

APPLICABLE RULE	
R 400.15316	**Resident Records**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information:

	(d) Health care information, including all of the following: **(ii) Medication logs.**
ANALYSIS:	Resident A's MAR for November 2023 was not available during this investigative period. Ms. Ramirez and Ms. Sass reported they believe the form was accidentally misplaced. Based on the interviews completed and documentation observed, there is sufficient evidence medication logs were not provided as required by the department.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of corrective action, I request the status of the license remain the same.

Cassandra Duursma 3/27/24

Cassandra Duursma Date
Licensing Consultant

Approved By:

Russell Misiak 3/27/24

Russell B. Misiak Date
Area Manager