GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 8, 2023

John Drews
Country Living Of Hillsdale LLC
101 Village Green Blvd.
Hillsdale, MI 49242

RE: License #: AL300249260
Investigation #: 2023A1032024
Country Living Of Hillsdale LLC

Dear Mr. Drews:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Dwight Forde, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W. Unit 13, 7th Floor
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL300249260
Investigation #:	2023A1032024
Complaint Receipt Date:	01/03/2023
Investigation Initiation Date:	01/03/2023
Report Due Date:	03/04/2023
Licensee Name:	Country Living Of Hillsdale LLC
Licensee Address:	101 Village Green Blvd. Hillsdale, MI 49242
Licensee Telephone #:	(517) 398-5333
Administrator:	Alyson Goodman
Licensee Designee:	John Drews
Name of Facility:	Country Living Of Hillsdale LLC
Facility Address:	1127 N. Lake Pleasant Rd. Hillsdale, MI 49242
Facility Telephone #:	(517) 437-0239
Original Issuance Date:	09/19/2002
License Status:	REGULAR
Effective Date:	07/05/2021
Expiration Date:	07/04/2023
Capacity:	20
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was improperly discharged.	Yes
Resident A was observed to be in filthy clothing.	No
The home did not properly manage a pest problem.	No
Additional Findings	No

III. METHODOLOGY

01/03/2023	Special Investigation Intake 2023A1032024
01/03/2023	Special Investigation Initiated - Telephone Interview with Elizabeth Clark, Adult Protective Services Specialist
01/05/2023	Inspection Completed On-site
01/19/2023	Contact - Telephone call made Call to complainant; voicemail left
03/02/2023	Contact - Face to Face Interview with licensee designee John Drews
03/02/2023	Contact - Document Received Received Resident A's care agreement and assessment plan
03/07/2023	Exit Conference With licensee designee John Drews

ALLEGATION:

Resident A was improperly discharged.

INVESTIGATION:

On 1/3/23, I spoke with adult protective services (APS) specialist Elizabeth Clark, via telephone. Ms. Clark stated that she sat with Resident A at the hospital. She

reported that the home had sent Resident A for an evaluation but was unsure of the scope of that request. She stated that as far as she knew, Resident A had a urinary tract infection. She stated that she was provided information that the home would not take resident A back due to extreme behaviors, but she stated that while she was at the hospital with Resident A, that none of those behaviors were present.

On 1/5/23, I interviewed administrator Alyson Goodman at the home, along with APS Specialist Elizabeth Clark. Ms. Goodman stated that Resident A had been admitted to the home without some of her psychiatric medications. Ms. Goodman stated that several attempts were made to contact Resident A's placing agency, to obtain the medications. She stated that because this all occurred during the Christmas Holiday season, making contact was difficult. Ms. Goodman stated that a decision was made to have Resident A evaluated psychiatrically at Hillsdale Hospital, with the ultimate goal of getting Resident A stabilized on her medications. According to Ms. Goodman, Resident A was being disruptive in the home and causing chaos for the other residents by screaming loudly and making demands of staff time. Ms. Goodman stated that overall, Resident A was verbally aggressive and swatted at other residents. Ms. Goodman described receiving 26 calls from employees in an eight hour shift due to Resident A's behaviors. Ms. Goodman indicated that in a prior conversation with Resident A's responsible person, that a trip to the hospital might be needed, but acknowledged that on the day in question, the responsible person was not notified until after the transfer had taken place. Ms. Goodman stated that the home was advised that Resident A had been medically screened and it was determined that Resident A had a urinary tract infection (UTI) and was ready to return to the home. Ms. Goodman stated that the hospital did not perform a psychiatric evaluation as was requested. She reported that the hospital was asked to keep Resident A while she was receiving antibiotics for the UTI, so as to gauge whether the behaviors would remit. Ms. Goodman stated that the hospital asked that arrangements be made to collect Resident A, since treatment had been administered. Ms. Goodman stated that a decision was made to have Resident A remain at the hospital for further observation until it was determined that Resident A's behaviors were under control.

On 2/2/23, I interviewed Hillsdale Hospital Nursing Case Manager Breana Smith, via telephone. Ms. Smith stated that she received information from the night shift that the home refused to make arrangements to collect Resident A from the hospital. Ms. Smith stated that she spoke with personnel from the home, who wanted Resident A held for five days at a geriatric psychiatric unit. Ms. Smith stated that Lifeways had determined that Resident A was ineligible for such a unit.

On 3/2/23, I interviewed licensee John Drews in the home. Mr. Drews stated that he was not present when Resident A was in the hospital and was on vacation. He stated that since then, in consultation with the hospital, that they are willing to work with the home in instances where geriatric psych care may be required. He acknowledged that if a resident is returned to the home after being in the hospital for

stabilization, and their behaviors continue, that being sent back to the hospital might be a course of action.

APPLICABLE RULE	
R 400.15302	**Resident admission and discharge policy;**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge. If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home.**
ANALYSIS:	There was a dispute between the home and the hospital regarding Resident A's suitability to return to the home. The home did not wish to receive Resident A back into care without first being assessed in a geriatric psychiatric unit. The hospital did not consult with APS, nor did the home allow Resident A to return to assess whether the behaviors were in remission. The hospital representative conveyed that Lifeways, the Community Mental Health Authority, did not authorize Resident A to receive geriatric psychiatric care
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A was observed to be in filthy clothing.

INVESTIGATION:

On 1/5/23, Ms. Goodman denied that Resident A was sent to the hospital in dirty clothing, or that she was not properly dressed for the weather. Ms. Goodman denied that at any time during her stay, was Resident A left in filthy clothing.

I observed residents in the common area who appeared to be clean and appropriately dressed for the weather.

On 3/2/23, during an on-site inspection, I observed residents in the home. They appeared to be clean and well dressed. Two residents were sitting in the common area while a third was ambulating in a wheelchair.

APPLICABLE RULE	
R 400.15314	**Resident hygiene.**
	(6) A licensee shall afford a resident the opportunity to receive assistance in bathing, dressing, or personal hygiene from a member of the same sex, unless otherwise stated in the home's admission policy or written resident care agreement.
ANALYSIS:	Given the passage of time and based on observations of residents and an interview with Ms. Goodman, there is insufficient evidence to suggest that Resident A was left in filthy clothing
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The home did not properly manage an insect pest problem.

INVESTIGATION:

On 1/5/23, Ms. Goodman stated that bedbugs were observed in Resident A’s room after admission. Ms. Goodman surmised that the insects could have come with Resident A’s belongings upon transfer. Ms. Goodman advised that Resident A’s room was treated, and that Resident A was moved to an adjacent room in the interim. Ms. Goodman stated that Resident A was not confined to her room.

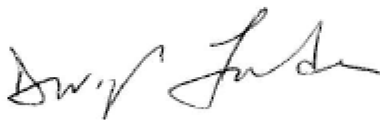
On 3/2/23, Mr. Drews accompanied me as I inspected the home. The home was clean and there did not appear to be evidence of a pest infestation. Mr. Drews discussed that he has his own steam treatment equipment which is used if there is evidence of bedbugs or other pests that require heat treatment. He advised that if there is evidence of a pest, that the insect is first bagged and identified, and if it is in fact a bedbug, that the room is heat treated to kill them.

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. Goodman acknowledged that there were insect pests observed once Resident A moved into the home. The home appears to have taken steps to address the isolated problem, and Mr. Drews demonstrated an awareness of effective procedures to deal with insect pests. There was no evidence of insect pests during the onsite inspection.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 3/6/23, I conducted an exit conference with licensee designee John Drews. I shared my findings. Mr. Drews expressed some disagreement with one of the findings and stated that he will address the issue upon receipt of the report.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change to the status of this license.



3/8/23

Dwight Forde
Licensing Consultant

Date

Approved By:

3/10/23

Russell B. Misiak
Area Manager

Date