GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 29, 2024

Theodora Calvas
Kernway Assisted Living, Inc.
3118 Kernway Drive
Bloomfield Hills, MI 48304

RE: License #: AS630385198
Investigation #: 2024A0991015
Kernway Assisted Living of Bloomfield

Dear Theodora Calvas:

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 (248) 975-5053.

Sincerely,

Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630385198
Investigation #:	2024A0991015
Complaint Receipt Date:	03/12/2024
Investigation Initiation Date:	03/13/2024
Report Due Date:	05/11/2024
Licensee Name:	Kernway Assisted Living, Inc.
Licensee Address:	3118 Kernway Drive Bloomfield Hills, MI 48304
Licensee Telephone #:	(248) 202-0057
Administrator:	John Calvas
Licensee Designee:	Theodora Calvas
Name of Facility:	Kernway Assisted Living of Bloomfield
Facility Address:	3118 Kernway Drive Bloomfield Hills, MI 48304
Facility Telephone #:	(248) 202-0057
Original Issuance Date:	01/19/2018
License Status:	REGULAR
Effective Date:	07/19/2022
Expiration Date:	07/18/2024
Capacity:	6
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
The home does not have sufficient staff. Residents are being left unattended for 45 minutes to an hour because there is only one staff per shift and staff are assisting other residents. A resident let a visitor into the home and there was no staff in sight for 30 minutes after the visitor entered the home. There are six residents in the home and three of the residents use a wheelchair. Staff would not be able to safely evacuate the residents in an emergency, as three of the residents require a Hoyer lift.	No
The owners of the facility, Theodora and John Calvas, are being verbally aggressive towards Resident A, who has a traumatic brain injury, making threats to kick her out because they have not received payments, and they stopped transporting her to her appointments.	Yes
Medications are not being properly stored and are kept at the bedside.	Yes
Residents are not receiving a diabetic diet as prescribed.	No
There are no curtains in the bathrooms and the residents do not have privacy. The bathrooms are not wheelchair accessible, so three of the residents cannot shower.	No
Additional Findings	Yes

III. METHODOLOGY

03/12/2024	Special Investigation Intake 2024A0991015
03/12/2024	Contact - Document Received Additional allegations received- added to open investigation
03/13/2024	Special Investigation Initiated - Telephone Call to complainant
03/13/2024	APS Referral Referred to Adult Protective Services (APS) Centralized Intake

03/20/2024	Inspection Completed On-site Unannounced onsite inspection- interviewed staff and residents
03/22/2024	Contact - Document Sent Request for documentation sent to licensee designee
04/02/2024	Contact - Document Sent Email to/from Adult Protective Services (APS) worker, John Cavanaugh
04/02/2024	Contact - Document Sent Second request for documentation sent to licensee designee
04/07/2024	Contact - Document Received Staff schedule, assessment plans, fire drill records
04/22/2024	Contact - Telephone call made Interviewed home manager, Myra Charleston
04/22/2024	Contact - Telephone call made Interviewed staff, Shelby Daniel
04/22/2024	Contact - Telephone call made To Resident A's case manager- voicemail full
04/22/2024	Contact - Telephone call made Interviewed administrator, John Calvas
04/23/2024	Contact - Telephone call made Left message for APS worker
04/24/2024	Contact - Document Received Email from APS worker
05/08/2024	Inspection Completed On-site Unannounced onsite inspection for impromptu fire drill
05/14/2024	Exit Conference Via telephone with licensee designee, Teddy Calvas

ALLEGATION:

The home does not have sufficient staff. Residents are being left unattended for 45 minutes to an hour because there is only one staff per shift and staff are assisting other residents. A resident let a visitor into the home and there was no staff in sight for thirty minutes after the visitor entered the home. There are six residents in the home and three of the residents use a wheelchair. Staff would not be able to safely evacuate the residents in an emergency, as three of the residents require a Hoyer lift.

INVESTIGATION:

On 03/12/24, I received an anonymous complaint regarding the care of the residents at Kernway Assisted Living of Bloomfield. On 03/13/24, I received additional allegations regarding Kernway Assisted Living of Bloomfield, which were added to the investigation. I initiated my investigation on 03/13/24 by making a referral to Adult Protective Services (APS) Centralized Intake and by contacting the complainant.

On 03/13/24, I interviewed the complainant via telephone. The complainant stated that she worked in the home for three years, but she walked off the job yesterday. The complainant stated that there are six residents in the home. Three of the residents require Hoyer lifts to transfer. She stated that there is typically one direct care worker on shift for the afternoons and midnights. During the day there is usually one direct care worker and sometimes the activities girl or home manager as well. The complainant stated that during her three years working in the home, she never practiced a fire drill on her shift. She stated that it takes about five minutes to transfer one resident with a Hoyer lift, so she felt it would take a long time to get everybody out of the home if there was an emergency.

On 03/20/24, I conducted an unannounced onsite inspection at Kernway Assisted Living of Bloomfield. The staff in the home contacted the owner/licensee designee, Theodora (Teddy) Calvas. I interviewed Ms. Calvas via telephone. Ms. Calvas stated that there are currently six residents in the home. They always have one caregiver and sometimes two or three caregivers in the home. Ms. Calvas stated that Resident B, Resident E, and Resident F require a Hoyer lift for transfers. Resident B can stand and transfer, but it is easier with a Hoyer lift. Resident A is semi-independent and is going to therapy. She can walk, but she prefers to use her wheelchair. Resident A can transfer in and out of bed to her wheelchair on her own. She can get up and out of the home on her own if there is an emergency. Resident B is working on transfers. She can sit on the edge of the bed and transfer to a wheelchair, but she would need staff assistance. She can maneuver in her wheelchair independently. Resident C can walk independently with a walker, but he prefers to use a wheelchair. He requires minimal staff assistance. Resident D walks with no problem. She does not use a walker and does not require staff assistance, but staff typically provide standby assistance. Resident E and Resident

F are both on hospice and require the use of a Hoyer lift. Ms. Calvas stated that Resident E has a sliding door in her room and Resident F's room is near an egress door. Ms. Calvas stated that if there was a real emergency, they could put the residents in sheets and pull them out of the home. Ms. Calvas stated that they do practice fire drills in the home. Her husband, John Calvas, does the fire drills and they have been in the required parameters. They cover all three shifts and practice with one staff on the midnight shift.

Ms. Calvas stated that she had no knowledge of staff leaving or a visitor being in the house for 30 minutes without staff being present. She was not aware of a resident letting anyone into the home. She stated that staff are very attentive to guests. Ms. Calvas stated that if staff are changing briefs, then they would be in the resident's bedroom for a few minutes. She stated that they give showers when there are two people on shift, typically from 2:00pm-4:00pm or when the other residents are sleeping at night or in the morning. Ms. Calvas felt the home had adequate staff.

On 03/20/24, I interviewed direct care worker, Kim Langston. Ms. Langston stated that she does not typically work in the home, but she has been filling in shifts since the home is short staffed. She stated that one direct care worker is enough to care for the six residents in the home. She stated that they all get the proper care they need. She stated that they practiced a fire drill when she first came to the house, and she felt that all the residents could be safely evacuated. She stated that she would slide them out on blankets if she needed to in case of a real fire.

On 03/20/24, I interviewed the activities coordinator, Arnetta Stokes. Ms. Stokes stated that she is at the home on weekdays and every other Saturday for two hours from 2:00pm-4:00pm. She stated that she is not a direct care worker and does not administer medications or provide care. She does not practice fire drills. She stated that she felt one staff should be enough to care for the residents in the home, but some of the older staff find it harder to transfer the residents. She stated that at certain times it would be beneficial to have two staff on shift. She stated that they have issues keeping staff as people come in, go through training, and then leave. She was not aware of the residents being unattended to or left alone. She stated that the residents are typically up and about in the living room area. Staff always watch them. She was not aware of a visitor coming to the home and staff not being present for any extended amount of time.

On 03/20/24, I interviewed Resident A. Resident A stated that she has lived in the home for about a year. She stated that the home cannot keep steady staff and they always have staff coming and going. Resident A stated that they never practice fire drills. She could not recall a time when they set off the alarm and made the residents go outside.

On 03/20/24, I interviewed Resident B. Resident B stated that staff are trying their best, but they have limited staff in the home. She stated that staff are on their cell phones a lot and will be giggling and laughing while the residents are waiting for care. Most of the staff do their best. She stated that sometimes she must wait for help if staff are taking care of another resident. She felt it would be better if they had more staff on shift, as it is

hard for one person to do the kitchen and everything else. Resident B stated that they do not practice fire drills in the home. She never heard the smoke detectors go off and was never taken outside to evacuate, including at night. Resident B stated that she uses a wheelchair because she cannot use her leg. Staff use a Hoyer lift to transfer her. One staff can operate the Hoyer lift. They have not dropped or hurt her.

On 03/20/24, I interviewed Resident C. Resident C stated that he has lived in the home for six months. He stated that there are always staff present in the home. They are usually pretty quick to help if he needs assistance. He never noticed staff not being around. Resident C stated that he is able to get in and out of bed and into his wheelchair on his own. He likes to use his wheelchair because he does not trust walking after falling at his last placement. Resident C stated that he felt there was enough staff in the home. Resident C stated that they do not practice fire drills. He stated that they do not set off the alarm and take the residents outside.

During the onsite inspection, I observed Resident D, Resident E, and Resident F in the living room area of the home. They were unable to participate in an interview due to limited cognitive and verbal abilities.

On 04/22/24, I interviewed the home manager, Myra Charleston, via telephone. The home manager stated that she has worked in the home for nearly four years. She stated that they typically have one staff on shift, and the activities person is in the home from 2:00pm-4:00pm each day. Ms. Charleston stated that she was not aware of any visitors coming into the home and being left alone for 30 minutes. She stated that they check and change the residents, which could take up to 15 minutes at most. They typically do this when everyone is stable. The residents are usually sitting in their chairs or sleeping. She stated that no relatives or visitors ever expressed any concerns to her about the residents not being attended to for a period of time. Ms. Charleston stated that there are currently six residents in the home. Resident A is a standby assist. She can get in and out of bed and into her wheelchair on her own. Resident B is working on standing and transferring, but they still use a Hoyer lift to transfer her. Resident C is mostly independent. He can walk, but he prefers to use his wheelchair. Resident C can transfer to and from his bed on his own. Resident E and Resident F are on hospice and require a Hoyer lift for transfers. Ms. Charleston stated that she has been working in this field for 30 years, so she does not have any issues providing care to the six residents in the home on her own. She stated that some of the younger staff may need assistance. She stated that most of the residents sleep all day. Four of the residents must be checked and changed every two hours, so she staggers them. She stated that they do practice fire drills, and it is hard. She stated that they set off the alarm and get everybody out one by one. She takes Resident A and Resident C out, then Resident E. She walks with Resident D and takes Resident B out in her chair. She stated that if she needed to, she would use the Hoyer sling to pull Resident F out of the building. Ms. Charleston stated that she last practiced a fire drill in February, and they did not time how long the practice drill took. She stated that she did not think they practiced fire drills when the residents were sleeping. Ms. Charleston stated that Resident E has a sliding door in her room and

Resident F is across the hall, so depending on where the fire was located, they could use this exit as well.

On 04/22/24, I interviewed direct care worker, Shelby Daniel. Ms. Daniel stated that she has been working in the home for three and a half years. She typically works the midnight shift. She stated that there are currently six residents in the home. She stated that one staff is usually enough for the midnight shift, as the residents are typically in bed. During the day shift, all of the residents are up and are dependent on staff for their care. She stated that it is difficult for one staff as they are responsible for cooking, cleaning, and providing direct care. Ms. Daniel stated that she has never practiced a fire drill. She stated that it would be difficult to evacuate all of the residents. Three of the residents, Resident B, Resident E, and Resident F require a Hoyer lift. Resident A and Resident C can transfer themselves and Resident D can walk but would wait for staff to assist her. She stated that the residents in the front of the house could go out the front door and the residents on the right could go out the door in Resident E's bedroom. She stated that she thought it would take longer than ten minutes to get everyone out of the house. Ms. Daniel stated that she was not aware of any time when the residents were left unattended for more than thirty minutes.

On 04/22/24, I interviewed the owner/administrator, John Calvas, via telephone. Mr. Calvas stated that there are currently six residents in the home. He did not think the residents had ever been left alone. He stated that they try to have staff be polite to visitors, but he did not know if staff did not talk to somebody for 30 minutes and it is not staff's responsibility to greet visitors. Mr. Calvas stated that he thinks one staff is enough to care for the six residents in the home. He stated that it is "the best staffing ratio in the state and industry." He stated that it is not perfect, but it is the best in the industry. Mr. Calvas stated that they practice fire drills once a month and cover the daytime, afternoon, and midnight shifts each quarter. He pushes the alarm, and they take the residents to the exits. The caregivers do the work, but he facilitates a little bit. On a super cold day, they go to the door and do not go outside. Mr. Calvas stated that he tries to conduct fire drills with some dignity for the residents. He feels that it is "cruel and unusual punishment" to wake up the residents while they are sleeping to conduct a fire drill, so they conduct fire drills during the midnight shift, but not while the residents are sleeping. He stated that he would not do a fire drill at 2:30am because that is cruel. Mr. Calvas stated that the drills are conducted with one staff on shift and the times documented are accurate.

I received and reviewed the assessment plans for the residents at Kernway Assisted Living of Bloomfield. I noted the following relevant information:

- Resident A uses a wheelchair and cannot walk. Staff will assist with walking and mobility. She is going to physical therapy and is a standby assist for transfers.
- Resident B is a one-person transfer. A Hoyer lift is optional. She can stand and take a few steps. She uses a walker and wheelchair.

- Resident C walks independently. He uses a walker and wheelchair for comfort and safety. Staff will assist him with walking/mobility for safety.
- Resident D uses a walker as needed. Staff will supervise walking/mobility. Resident D is independent in ambulation but unable to walk 50 meters without help, or supervision is needed for confidence in hazardous situations.
- Resident E requires the assistance of one other person for transfers and to offer assistance with ambulation.
- Resident F- assessment plan not provided.

I received and reviewed copies of the fire drill reports from Kernway Assisted Living of Bloomfield from January-March 2024. The reports note a fire drill was conducted on 01/24/24 at 6:45am (midnight shift) and it took two minutes and twenty seconds to evacuate six residents. A drill was conducted on 02/17/24 at 11:30am (day shift) and it took two minutes and fifty seconds to evacuate six residents. A drill was conducted on 03/20/24 at 5:15pm (afternoon shift) and it took two minutes and forty-five seconds to evacuate six residents. On 04/22/24, I requested copies of the fire drill reports from 2023, but I did not receive the requested documentation.

I received and reviewed a copy of the staff schedule from February-April 2024. It shows one direct care worker scheduled to work each shift from 12:00am-8:00am, 8:00am-4:00pm, and 4:00pm-12:00am or 7:00am-3:00pm, 3:00pm-11:00pm, and 11:00pm-7:00am.

On 05/08/24, I conducted an unannounced onsite inspection at Kernway Assisted Living of Bloomfield. The administrator, John Calvas, and direct care worker, Kim Langston, were present. Mr. Calvas stated that there are currently five residents in the home. I requested an impromptu fire drill be conducted to time how long it would take for one direct care worker to evacuate the residents in the home. Mr. Calvas became upset at this request and did not understand which rule violation was being investigated. I explained to Mr. Calvas that I was investigating a complaint to determine if they had sufficient staff on duty to ensure the safety and protection of the residents, which includes being able to safely evacuate the residents in case of a fire. Mr. Calvas stated that they have the best staffing ratio in the industry and are in compliance with the one to twelve staffing ratio required by licensing. I advised Mr. Calvas that the licensing rules also require sufficient direct care staff to meet the needs of the residents and ensure their protection and safety, which may require additional staff if they have several residents who require wheelchairs or Hoyer lifts. Mr. Calvas became more upset when advised that he could not assist the direct care worker on shift with evacuating the residents. I advised Mr. Calvas that the fire drill needed to be conducted with one direct care worker, as this is the typical staffing pattern in the home. While at times there are additional individuals at the home, including the licensee designee, administrator, and activities director, the home usually has one staff on shift and a fire could occur during that time. Mr. Calvas stated that he felt this was a “witch hunt” and that I could document in my report that he was being “abrasive and uncooperative.”

Mr. Calvas entered the home and instructed staff, Kim Langston, to get all of the residents in their wheelchairs to prepare for a fire drill. I advised Ms. Langston that the residents should remain where they were to accurately time how long it would take to evacuate if a fire spontaneously occurred. Mr. Calvas set off the alarm and Kim Langston began to evacuate the residents. She used a Hoyer lift to transfer Resident B to her wheelchair, which took approximately two minutes and thirty seconds. Resident A evacuated the home on her own. Ms. Langston assisted Resident D with walking out of the home. The other two residents were already in their wheelchairs and Ms. Langston pushed their wheelchairs out of the home. It took approximately 5 minutes and 25 seconds to evacuate the five residents from the home. This evacuation time falls within the “slow” range for evacuation capability according to the Bureau of Fire Services, as it is less than eight minutes but more than three minutes. It should be noted that three of the residents were already in their wheelchairs when the fire drill was conducted. Mr. Calvas noted that the home has several exits that can be used for egress, including a sliding door in the resident’s bedroom, so the residents would be taken out from the door closest to where they were in the home. Kim Langston also stated that in case of a real fire, she would get the residents out safely and would pull them out on a blanket if necessary.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that the home does not have sufficient direct care staff on duty for the supervision, personal care, and protection of the residents. The home currently has five residents in care with at least one direct care worker per shift. It took approximately five minutes and twenty-five seconds for one staff to evacuate the home during an impromptu fire drill, but three of the residents were already in their wheelchairs. The length of time to evacuate at night would likely be longer, but the home is equipped with several egress doors located in or near resident bedrooms, which would help expedite the evacuation process. None of the staff who were interviewed had knowledge of residents being left unattended for 30 minutes to an hour due to staff helping other residents.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14318	**Emergency preparedness; evacuation plan; emergency transportation.**
	(5) A licensee shall practice emergency and evacuation procedures during daytime, evening, and sleeping hours at least once per quarter. A record of the practices shall be maintained and be available for department review.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that emergency and evacuation procedures are not practiced during daytime, evening, and sleeping hours at least once per quarter. The complainant, as well as the staff who works during the midnight shift, both stated that they had not practiced fire drills during the time they worked in the home. Resident A, Resident B, and Resident C all stated that they had not practiced fire drills. They did not recall hearing the smoke detectors go off or going outside to practice evacuating. The administrator, John Calvas, stated that he conducts fire drills during the midnight shift, but does not conduct them when the residents are sleeping because he believes that would be “cruel and unusual punishment.” I received and reviewed copies of the fire drill reports from Kernway Assisted Living of Bloomfield from January-March 2024. The fire drill reports all showed evacuation times of less than three minutes, which does not appear to accurately reflect the amount of time it would take to evacuate the residents, as it took over five minutes for one staff to evacuate five residents during an unannounced daytime fire drill at the home when three residents were already in their wheelchairs. Fire drill records from 2023 were requested but were not provided during the investigation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The owners of the facility, Theodora and John Calvas, are being verbally aggressive towards Resident A, who has a traumatic brain injury, making threats to kick her out because they have not received payments, and they stopped transporting her to her appointments.

INVESTIGATION:

On 03/13/24, I interviewed the complainant via telephone. The complainant stated that she worked in the home for three years, but she walked off the job yesterday because she did not like how the owners, Teddy and John Calvas, were treating the residents. She stated that they took in Resident A, who was an accident victim and has a head injury. Resident A has lived in the home for approximately one year. Resident A has a lawsuit pending, so the owners have not been paid yet from the insurance company. They gave a discharge notice to Resident A in January, and she was supposed to move out by February, but she is still living in the home. They stopped transporting Resident A to her appointments after they gave the discharge notice. The complainant stated that the owners yell at Resident A, calling her “a freeloader” and telling her that she is unappreciative. She stated that she stepped in whenever this happened. Sometimes Resident A argued back or went into her room and closed the door. She stated that she never heard the owners swear at Resident A, but they raised their voices. John Calvas has told Resident A, “You think you’re pissed? I’m pissed.” The complainant stated that she walked off the job after the most recent verbal altercation, because she did not want to be a part of it. She stated that John Calvas also forces the residents to go to bed when they are watching tv and do not want to go to sleep. He believes none of the residents should be up after 10:00pm.

On 03/20/24, I conducted an unannounced onsite inspection at Kernway Assisted Living of Bloomfield. The staff in the home contacted the owner/licensee designee, Teddy Calvas. I interviewed Ms. Calvas via telephone. Ms. Calvas stated that she was not aware of anyone being verbally aggressive towards Resident A. She stated that Resident A has a traumatic brain injury, and she may perceive people as arguing with her. Resident A meddles and tries to run the house, so they have to tell her to stay in her lane. Resident A gets offended easily and wants to be important. Ms. Calvas stated that they issued a discharge notice, but they have since retracted it. They are working with the attorneys to figure out payment. Ms. Calvas stated that she was not aware of her husband, John Calvas, yelling at Resident A or making comments about her not paying. She stated that Resident A often interprets things differently and the reality is not what she perceives to be true. Ms. Calvas stated that they do not force anyone to go to bed at a certain time, but the residents need their rest, so they like them to be in bed so they can get up early. She stated that the residents are never forced to turn off the tv and go to bed.

On 03/20/24, I interviewed Resident A. Resident A stated that she has lived in the home for about a year. She stated that she has a lawsuit from a car accident, and they are still working with the insurance company to figure out her payments. Resident A stated that the other day, John Calvas came into her room and called her “a freeloader”. He got in her face and told her that she could pay. She stated that Mr. Calvas attacked her dignity, character, and intelligence. Resident A stated that the owners have been rude

to her for the past six months. They told her that they were tired of playing games with her and could not keep going through this. They gave her a 30-day discharge notice in January 2024. Teddy Calvas told her that they were stopping all services and were no longer taking her to her appointments or physical therapy. Resident A stated that they told her she was on her own because she could not pay.

On 03/20/24, I interviewed Resident B. Resident B stated that she never heard Teddy Calvas or her husband, John, arguing with Resident A. She stated that they don't yell, but she has heard them being frustrated with Resident A. She stated, "Who wouldn't be?" She stated that they never yell at her, as their personalities click, and they are good to her. Resident B stated that sometimes the workers in the home are gruff and appear frustrated because there is not enough help.

On 03/20/24, I interviewed Resident C. Resident C stated that he has lived in the home for six months. He did not have any complaints or concerns about the home. He never heard anyone yell or get frustrated. He was never forced to go to bed at a certain time. He is able to watch tv whenever he likes.

On 04/22/24, I interviewed the home manager, Myra Charleston. Ms. Charleston stated that she has worked in the home for nearly four years. She stated that she never observed Teddy or John Calvas yelling at Resident A, but Resident A told her about it. Resident A told her that John Calvas "went off on her." He was upset because they are not getting paid and raised his voice at her. Teddy Calvas came in and told him to leave. Ms. Charleston stated that you cannot believe everything Resident A says, as Resident A can be a troublemaker. She stated that Resident A was issued a 30-day discharge notice and Ms. Calvas stopped transporting her to her appointments. Ms. Charleston stated that there are no house rules or specific bedtimes for the residents. The bedtime depends on each resident. Some of the residents go to bed right after dinner, while others stay up to watch tv. She stated there was a time when Resident B complained about having to go to bed at a certain time, but then she got a tv in her room and now it is fine.

On 04/22/24, I interviewed direct care worker, Shelby Daniel, via telephone. Ms. Daniel stated that she has worked in the home for three and a half years. She typically works the midnight shift. Ms. Daniel stated that she never saw a verbal altercation between Resident A and Teddy or John Calvas. She stated that she heard about an altercation from another staff person. They told her that John Calvas and Resident A "got into it," but she did not know any additional details. Ms. Daniel stated that Teddy Calvas has told her that she wants the residents in bed by 9:00 or 10:00pm, but if the residents want to watch tv, they are not forced to go to bed. She stated that most of the residents are usually in bed when she gets to the home for her shift.

On 04/22/24, I interviewed the administrator, John Calvas. Mr. Calvas stated that Resident A has been living in the home for over a year. He stated that he didn't think he had an argument with Resident A and was unaware of a verbal altercation with her. He

stated that they recently had a staff person, Penny Atkins, walk off the job. On the night she quit, Teddy Calvas and Resident A were speaking. Penny Atkins “butted her way in” to the conversation. He stated that Penny and Teddy were talking at the other end of the hall. He did not say anything to Penny or Resident A. Penny told them that she was quitting, and he told her that they were sorry to see her go. When asked why Penny walked off the job, Mr. Calvas stated that he did not know. He stated that Penny has told them that she was going to quit four or five times, but they always let her come back. He stated that she is older and is no longer able to do the job. Mr. Calvas stated that he would not say he confronted Resident A about not paying to live in the home. He stated that she has a case manager who is in charge. She has a lawyer, transportation services, a physical therapist, and an occupational therapist and none of them are being paid. He stated that they do not discuss this with Resident A. After a moment of hesitation, Mr. Calvas stated that he did not call Resident A unappreciative or a freeloader. When told that a staff stated they witnessed this verbal altercation, Mr. Calvas stated that was impossible and never happened. He stated that he would never have a conversation with Resident A in front of staff. He stated that they issued a 30-day notice for Resident A in late December or January, but his wife verbally rescinded the notice ten days later. When asked if they stopped providing transportation to Resident A’s appointments, Mr. Calvas stated that they were never under any obligation to provide transportation. He stated that she has a case manager and the insurance company who arrange transportation. One of the transportation companies quit because they were not being paid. He would not provide an answer as to whether or not they had previously been providing transportation.

I reviewed a copy of the 30-day discharge notice dated 01/01/2024 which was given to Resident A. It notes that Kernway Assisted Living will no longer be able to provide caregiving services (and a bed) effective 30 days from the date of the letter. The letter also advises that Kernway Assisted Living will no longer provide any ancillary services as a courtesy effective 01/01/2024. Kernway will not provide any off-campus services, no transportation services, including transportation and attendant care services to any medical or non-medical off-campus locations. It notes that limited services may be provided with pre-payment. The document was presented under nonpayment for services and notes that it may be retracted if payment is received in full within 30 days.

I reviewed a copy of Resident A’s resident care agreement dated 03/24/23. It notes that the basic fees do not include any transportation and that family and friends will provide transportation. It also states that auto and health insurance may provide transportation. It notes that the resident is responsible for all transportation fees and there is a charge of $45 an hour for companion care.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: (f) Subject a resident to any of the following: (iii) Derogatory remarks about the resident or members of his or her family.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident A was subjected to derogatory remarks. The complainant and Resident A both stated that the administrator, John Calvas, called Resident A “a freeloader” because they had not received payment for her to live in the home. Mr. Calvas denied these allegations and stated that he would never have this conversation in front of a staff person. However, the complainant and Resident A used the same language during separate interviews to describe the altercation. Resident A stated that Mr. Calvas attacked her dignity, character, and intelligence.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(3) A licensee shall assure the availability of transportation services as provided for in the resident care agreement.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that the facility did not ensure the availability of transportation. Resident A’s resident care agreement dated 03/24/23 notes that the basic fees do not include any transportation and that family and friends will provide transportation. It also states that auto and health insurance may provide transportation. Resident A has a case manager through her personal injury lawsuit, who is responsible for arranging transportation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Medications are not being properly stored and are kept at the bedside.

INVESTIGATION:

The complaint also alleged that medications are not being stored properly and are kept at the bedside. On 03/20/24, I interviewed the licensee designee, Teddy Calvas, via telephone. Ms. Calvas stated that medications are always locked up. No medications are kept in bedrooms, as this is forbidden. Ms. Calvas stated that creams are kept locked up with the medications too.

During my unannounced onsite inspection on 03/20/24, I walked through the home and resident bedrooms. I noted that Resident A had a prescription cream, Ammonium Lactate Cream 12%- apply to affected area twice daily, and prescription eye drops, Polyvinyl Alcohol 1.4% Lubricating Eye Drops- instill one drop into both eyes three times daily which were being stored in her bedroom. Resident A stated that she always keeps these in her room and uses the cream and eyedrops as needed.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident A's prescription medications, Ammonium Lactate Cream 12% and Polyvinyl Alcohol 1.4% Lubricating Eye Drops were not kept in a locked cabinet or drawer. I observed the prescription cream and eyedrops in Resident A's bedroom on 03/20/24. Resident A was self-administering these medications as needed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents are not receiving a diabetic diet as prescribed.

INVESTIGATION:

On 03/20/24, I interviewed the licensee designee, Teddy Calvas. Ms. Calvas stated that none of the residents in the home are prescribed a special diet. She stated that they check blood sugar for Resident B and Resident C, but they are not prescribed a special diet.

During the onsite inspection on 03/20/24, I interviewed Resident B and Resident C. They both stated that they are not prescribed a special diet.

I received and reviewed the assessment plans for all of the residents in the home. The special diets section on Resident C's assessment plan notes that he is lactose intolerant, but it does not indicate that he is prescribed a diabetic diet. None of the other assessment plans specify a special diet.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that residents are not receiving a special diet as prescribed. Resident B and Resident C stated that they are not prescribed a special diet. None of the residents' assessment plans indicated that a special diet was prescribed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

There are no curtains in the bathrooms and the residents do not have privacy. The bathrooms are not wheelchair accessible, so three of the residents cannot shower.

INVESTIGATION:

On 03/20/24, I interviewed the licensee designee, Teddy Calvas, via telephone. Ms. Calvas stated that Resident E and Resident F are on hospice. They receive bed baths from the hospice aide as part of their hospice plan. She stated that the other residents are showered. Resident B alternates between getting a bed bath and being showered. Ms. Calvas stated that some of the staff are not comfortable transferring Resident B to the shower, so she typically showers Resident B. Ms. Calvas stated that Resident B's plan does not specify which type of bath she should receive.

On 03/20/24, I interviewed the activities coordinator, Arnetta Stokes. Ms. Stokes stated that the residents always appear clean and have good hygiene. They are showered or given bed baths frequently. She did not have any concerns about the care of the residents.

During the onsite inspection, I interviewed Resident A, Resident B, and Resident C. Resident A stated that she can shower. Resident C stated that he can get in and out of the shower without any issues. Staff provide assistance if needed. Resident B stated that she mostly receives bed baths. She stated that she got into the shower once, but it is difficult due to her restrictions in movement. I observed Resident D, Resident E, and Resident F. They were unable to participate in an interview due to limited cognitive and verbal abilities. All of the residents appeared to be clean and had good hygiene. There were no odors in the home.

I reviewed the shower schedule for the home, which shows that each resident is being showered at least three times a week. It notes hospice showers Resident E and Resident F.

During the onsite inspection, I observed the bathrooms in the home. One of the bathrooms in the home had privacy film on the windows while the bathroom in the back of the home had semi-sheer curtains. The bathrooms were equipped with barrier free showers that could accommodate a shower chair.

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that the residents are not being bathed at least weekly or more often if necessary. All of the residents in the home were observed to be clean and

	had good hygiene during my unannounced onsite inspections. According to the licensee designee and the shower schedule, Resident E and Resident F are bathed by hospice aids. Resident A, Resident C, and Resident D receive showers in the home at least three times a week. Resident B alternates between bed baths and showers due to her limited mobility.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14407	**Bathrooms.**
	(2) Toilets, bathtubs, and showers shall provide for individual privacy.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that the bathrooms do not provide individual privacy. I observed privacy film on one of the bathroom windows and semi-sheer curtains on the bathroom located in the back of the house.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

During my investigation, the complainant, the licensee designee, and Resident A all stated that Resident A moved into Kernway Assisted Living of Bloomfield one year ago, following an accident in which she sustained a traumatic brain injury (TBI). I reviewed the facility information in the Bureau Information Tracking System (BITS) as well as the facility's original licensing study report and program statement. The home is approved for the aged population only. There is no documentation showing that they are approved to accept residents with a traumatic brain injury.

APPLICABLE RULE	
R 400.14103	**Licenses; required information; fee; effect of failure to cooperate with inspection or investigation; posting of license; reporting of changes in information.**
	(5) An applicant or licensee shall give written notice to the department of any changes in information that was previously submitted in or with an application for a license, including any changes in the household and in personnel-related information, within 5 business days after the change occurs.

ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the licensee did not contact the department to change the population served by the facility prior to admitting Resident A who has a traumatic brain injury. The facility is approved to accept the aged population only and is not approved for residents with a traumatic brain injury.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: (c) The resident appears to be compatible with other residents and members of the household.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident A is not compatible with the population served by the home. Resident A was admitted to the facility due to a traumatic brain injury. The facility is approved to accept the aged population only.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 03/20/24, I conducted an unannounced onsite inspection at Kernway Assisted Living of Bloomfield. I requested to review the resident files in the home. Staff did not have access to the resident files, as they were locked up and staff did not have a key to access the files. On 03/22/24 and 04/02/24, I sent requests to the licensee designee via email for copies of the residents' assessment plans, resident care agreements, and resident identification records. Upon receiving and reviewing the requested documents, I noted the following:

- Resident A's assessment plan was signed by the licensee designee on 03/24/23. Resident A noted that she received and signed the assessment plan on 03/13/24.
- A licensing assessment plan form was not provided for Resident E. The licensee provided care plans (Modified Barthel Index (Shah Version): Self Care

Assessment) dated 2022 and October 1, 2023 for Resident E. The care plans did not include signatures and did not address all of the information on the licensing assessment plan form.
- An assessment plan was not provided for Resident F.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Resident A did not sign a written assessment plan at the time of admission. Resident A's assessment plan was dated 03/24/23 and Resident A received and signed the document on 03/13/24. A licensing assessment plan was not provided for Resident E or Resident F.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 03/20/24, I conducted an unannounced onsite inspection at Kernway Assisted Living of Bloomfield. I requested to review the resident files in the home. Staff did not have access to the resident files, as they were locked up and staff did not have a key to access the files. On 03/22/24 and 04/02/24, I sent requests to the licensee designee via email for copies of the residents' assessment plans, resident care agreements, and resident identification records. Upon receiving and reviewing the requested documents, I noted the following:

- Resident A's Resident Care Agreement was signed by the licensee designee on 03/24/23. Resident A indicated that she received and signed the Resident Care Agreement on 03/13/24. Resident A noted on the Resident Care Agreement form that she contested and had not yet received a copy of the AFC Resident Rights, the home's discharge policy, and the home's refund agreement, as the boxes on the form were checked that they had been provided.
- The Resident Care Agreement for Resident D was dated 06/01/22.
- The Resident Care Agreement for Resident E was dated 11/21/21.
- The Resident Care Agreement for Resident F was dated 10/18/22.

On 05/14/24, I conducted an exit conference via telephone with the licensee designee, Teddy Calvas, and reviewed the licensing violations. Ms. Calvas stated that she has already addressed some of the violations and would submit a corrective action plan.

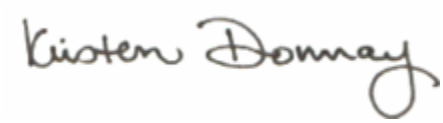
APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following: (g) An agreement by the resident to follow the house rules that are provided to him or her. (h) An agreement by the licensee to respect and safeguard the resident's rights and to provide a written copy of these rights to the resident. (i) An agreement between the licensee and the resident or the resident's designated representative to follow the home's discharge policy and procedures. (j) A statement of the home's refund policy. The home's refund policy shall meet the requirements of R 400.14315.
ANALYSIS:	Based on a review of the documentation, Resident A's Resident Care Agreement was signed by the licensee designee on 03/24/23. Resident A indicated that she received and signed the Resident Care Agreement on 03/13/24. Resident A noted on the Resident Care Agreement form that she contested and had not yet received a copy of the AFC Resident Rights, the home's discharge policy, and the home's refund agreement, as the boxes on the form were checked that they had been provided.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(9) A licensee shall review the written resident care agreement with the resident or the resident's designated representative and responsible agency, if applicable, at least annually or more often if necessary.

ANALYSIS:	Based on a review of the documentation, the Resident Care Agreements provided for Resident D, Resident E, and Resident F were not reviewed and updated annually. The Resident Care Agreement provided for Resident D was dated 06/01/22. The Resident Care Agreement for Resident E was dated 11/21/21. The Resident Care Agreement for Resident F was dated 10/18/22.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

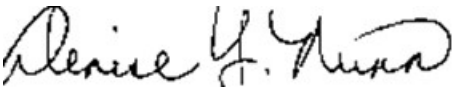
Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.



05/14/2024

Kristen Donnay — Date
Licensing Consultant

Approved By:



05/29/2024

Denise Y. Nunn — Date
Area Manager