RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

April 25, 2017

Teresa Fowler
Lifehouse Prestige Commons Operations LLC
P.O. Box 120143
Grand Rapids, MI 49528-0143

RE: License #: AL500302889
Investigation #: **2017A0986006**
Prestige Commons I

Dear Mrs. Fowler:

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,

Roeiah Epps, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(586) 256-1776

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL500302889
Investigation #:	2017A0986006
Complaint Receipt Date:	01/24/2017
Investigation Initiation Date:	01/25/2017
Report Due Date:	03/25/2017
Licensee Name:	Lifehouse Prestige Commons Operations LLC
Licensee Address:	P.O. Box 120143 Grand Rapids, MI 49528-0143
Licensee Telephone #:	(616) 464-6122
Administrator:	Teresa Fowler
Licensee Designee:	Teresa Fowler
Name of Facility:	Prestige Commons I
Facility Address:	33503 23 Mile Road Chesterfield Twp., MI 48047
Facility Telephone #:	(586) 725-9300
Original Issuance Date:	05/26/2011
License Status:	REGULAR
Effective Date:	11/26/2015
Expiration Date:	11/25/2017
Capacity:	18
Program Type:	AGED ALZHEIMERS PHYSICALLY HANDICAPPED

II. ALLEGATION(S)

	Violation Established?
There is not enough staff at the facility. Two residents are on lifts, and only one staff person on all three shifts to assist them.	Yes
Resident A has dementia and passed away because of a bad case of flu. Resident A was vomiting and had diarrhea all through the night and was not allowed to be taken to the hospital until the next day.	No
The facility was not cleaned or sanitized after the flu.	No
Additional Findings	Yes

III. METHODOLOGY

01/24/2017	Special Investigation Intake 2017A0986006
01/25/2017	Special Investigation Initiated - Letter Adult Protective Services (APS) Supervisor Judy Valin
01/26/2017	Inspection Completed On-site Interviewed former administrator Suzi Savich, previous facility nurse Tara Gross and staff member Donna Cooper
04/06/2017	Inspection Completed On-site Interviewed current administrator Lorrie Worden, Wendy Ehnis director of clinical services; staff members Marlene Gentry and Morgan Gadowski; observed Resident B
04/10/2017	Contact - Telephone call made Facility cosmetologist Carol Ellison and voicemail left for former building maintenance director Robert Anderson
04/13/2017	Contact - Telephone call received Andrea Wedge regional marketing director
04/13/2017	Contact - Telephone call made Former building maintenance director Robert Anderson
04/14/2017	Contact - Telephone call made Former direct-care staff Felicia Jackson
04/14/2017	Exit Conference Licensee designee Teresa Fowler

04/24/2017	Contact - Telephone call made Resident B's adult daughter

ALLEGATION:

There is not enough staff at the facility. Two residents are on lifts, and only one staff person on all three shifts to assist them.

INVESTIGATION:

On 1/26/17, I conducted an unannounced onsite inspection at the facility and interviewed the former facility administrator, Suzi Savich; previous facility nurse, Tara Gross; and staff member, Donna Cooper.

On 1/26/17, Ms. Savage stated staffing is always an issue in adult foster care but felt as if staffing at the facility was sufficient.

On 1/26/17, Ms. Gross stated some staff have called off in the past month which has reduced staffing levels on some shifts, but she stated two to three staff are normally on each shift to care for all of the residents during the afternoon, two staff are scheduled for midnights and three to four staff are typically on the day shift including management. However, management is not on the schedule to provide direct-care to the residents. Ms. Gross also gave me a copy of the current staff schedule. Ms. Gross stated no residents utilize a Hoyer lift.

On 1/26/17, Ms. Cooper stated she believes the facility does a good job in caring for the residents. Ms. Cooper stated she has been employed at the facility for approximately two and half years and she has never had any issues or concerns with any of the residents care at the facility. Currently, Ms. Cooper stated she does not believe there is an issue with the facility being short staffed.

On 3/28/17, Lorie Worden administrator reported that five residents utilize walkers; three residents use a wheelchairs; one resident requires a Hoyer lift; two residents use Geri chairs; and only one resident ambulates independently.

On 4/6/17, I interviewed current administrator Lorrie Worden, Wendy Ehnis director of clinical services; staff members Marlene Gentry and Morgan Gadowski.

On 4/6/17, Ms. Worden stated she had recently taken over as the administrator and has corrected several issues at the facility such as training manuals and adjustments to the staff schedule. Ms. Worden stated that some staff have quit which does impact staffing ratios in providing direct care to residents. However, Ms. Worden stated she has recently hired new direct care staff and they are being trained and prepared to be on schedule full-time.

On 4/6/17, Ms. Ehnis also corroborated Ms. Worden explanation of the staff shortage due to employees ending their employment abruptly, but assured new staff had been hired and are currently being trained.

On 4/6/17, Ms. Gadowski stated she has been recently hired at the facility (February 2017) and since her time of being employed at the facility the facility has always been short staff. Ms. Gadowski stated sometimes there are two staff on the morning and afternoon shifts, but if a person calls in, only one staff person has been on schedule to care for all of the residents. Ms. Gadowski stated this impacts staff morale and staff's capability to effectively care for all of the residents. For example, Ms. Gadowski stated some residents may not be timely changed and some residents have been found in urine soaked filled diapers and linen when she arrives onto the morning shift. Ms. Gadowski stated all residents require assistance with personal care (toileting and bathing). Ms. Gadowski stated she has complained to management but she is not for sure if anyone has stated this to licensee designee Teresa Fowler.

On 4/6/17, Ms. Gentry also corroborated Ms. Gadowski's account of the facility being short staff. Ms. Gentry stated the facility has been short staff for some time. Ms. Gentry stated although this does not impact her capability to provide direct-care to residents because she is a dedicated worker, other direct-care staff are not as efficient. Ms. Gentry stated the turnover rate within the past few months has been so frequent, that only a few seasoned employees are currently on each scheduled shift. Ms. Gentry stated she has also found residents in urine soaked filled diapers and linen when she arrives onto the morning shift. Ms. Gentry stated all residents require assistance with personal care (toileting and bathing). Ms. Gentry stated she has complained to management but she is not for sure if anyone has stated this to licensee designee Teresa Fowler. Ms. Gentry stated she has no problem with reporting issues to management about direct-care staff not providing adequate care to the residents because she will even report herself if needed.

On 4/10/17, I interviewed the facility cosmetologist Carol Ellison. Ms. Ellison stated she visits the facility twice a week and typically sees approximately two staff members on each shift. However, more recently Ms. Ellison stated there has been a great increase in staffing. Ms. Ellison believes it is because I have been conducting a licensing investigation at the facility the past couple of months.

On 4/13/17, I interviewed former building maintenance director, Robert Anderson. Mr. Anderson stated he was employed at the facility for approximately six months and recently quit due to issues at the facility. Mr. Anderson stated there are typically two staff persons on each shift to care for all of the residents. Mr. Anderson stated this is not sufficient because staff cannot properly evacuate all the residents timely. Mr. Anderson stated all of the residents have mobility issues, which requires assistance from staff when they ambulate. Mr. Anderson stated he even conducted a fire drill at the facility and it was horrible. Mr. Anderson stated staff members clearly did not know how to conduct a fire drill and he offered to assist and train staff, but Ms. Worden refused his assistance.

On 4/14/17, I interviewed former direct-care staff member, Felicia Jackson. Ms. Jackson stated she worked at the facility during the month of January and recently quit working at the facility a few weeks prior due to the significant staff shortage. Ms. Jackson stated she was responsible for creating the staff schedule and always assured at least three staff were on each shift to care for all of the residents. However, when Ms. Worden became the new administrator recently, she requested that one staff member be removed from each shift. Ms. Jackson stated she told Ms. Worden this would cause the facility to be severely understaffed. Ms. Worden also informed Ms. Jackson, she could not schedule an on-call person in case someone called off work. As a result, more direct-care staff would call off work because of the demands of caring for all of the residents with less staff. Moreover, residents were now not being provided timely personal care (diaper and linen changes). Ms. Jackson stated all residents require assistance with personal care (toileting and bathing). On one occasion, Ms. Worden informed Ms. Jackson she would have to stay an additional shift because someone called in. Ms. Jackson stated she reminded Ms. Worden this is what she was trying to avoid when she (Ms. Jackson) told her not to change the schedule. Consequently, Ms. Jackson quit working at the facility.

APPLICABLE RULE	
R 400.15206	**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:	According to Ms. Worden, all residents have mobility issues and require staff assistance to ambulate with the exception of one resident. According to Ms. Gadowski, Ms. Gentry and Ms. Jackson, all residents require assistance with personal care. However, due to the significant staff shortage, residents are not provided timely personal care as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A has dementia and passed away because of a bad case of flu. Resident A was vomiting and had diarrhea all through the night and was not allowed to be taken to the hospital until the next day.

INVESTIGATION:

On 1/26/17, Ms. Gross stated Resident A always received timely medical attention during her time at the facility. Ms. Gross stated as soon as staff were aware her case of the flu got worse staff took her to the hospital. Ms. Gross stated the facility has an on-call physician, Dr. Eckel that sees all the residents and assures the medical treatment they require is adequate. Ms. Gross then showed me several physician notes and contacts to Dr. Eckel regarding Resident A's care. Ms. Gross also gave me a copy of the only hospitalization Resident A had since she was admitted to the facility from 10/11/16 which was sent to Dr. Eckel for review. Nothing in the facility's notes or physician contacts evidence that Dr. Eckel ever reported a problem with Resident A's medical care at the facility.

On 1/26/17, Ms. Cooper stated she has never had any issues or concerns that any resident had not received timely medical treatment at the facility. Ms. Cooper stated she does not believe that staff did not assure that Resident A received timely medical treatment.

On 4/6/17, Ms. Gentry stated she had heard from other staff members that Resident A was vomiting the night before she died but did not hear that staff did not take her for medical treatment as required. Ms. Gentry stated a lot of residents had the flu during this time. Ms. Gentry stated she recalls all residents receiving medical treatment that required it during the time Resident A passed away. Ms. Gentry stated she does not know any specifics about what occurred on the midnight shift when Resident A was vomiting because she did not work on that shift that day (12/27/16).

On 4/14/17, Ms. Jackson stated a lot of residents had the flu around the time Resident A passed away. Ms. Jackson stated she worked midnights when Resident A was vomiting and does not recall that Resident A was not taken to the hospital for medical attention as required. Ms. Jackson stated she was not providing direct-care to Resident A specifically, but recalls Resident A coughing that night and vomiting while another staff member was caring for her who no longer works at the facility. Overall, Ms. Jackson stated she has never had any issues or concerns that residents were not receiving timely medical attention.

On several occasions (1/26/17, 3/14/17, and 4/24/17) I left messages for Resident A's adult daughter and next of kin regarding her mother's care at the facility. However, she could not be reached for comment or was unavailable.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.

ANALYSIS:	According to all staff members interviewed at the facility, Resident A and all residents have been taken for timely medical treatment whenever required.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility was not cleaned or sanitized after the flu.

INVESTIGATION:

On 1/26/17, Ms. Gross stated all staff members are required to clean on each shift. Ms. Gross stated no special cleaning was done because of the flu, staff were just required to clean as normal to assure a clean environment as always.

On 1/26/17, Ms. Cooper stated the facility is always properly cleaned by staff and she has never had any issues or concerns regarding the facility not being sanitized properly.

On 1/26/17, I observed the facility to be in a clean and orderly appearance.

On 4/24/17, I interviewed Resident B's adult daughter (AD). AD stated she has never had any issues or concerns with the facility not being cleaned properly. AD stated there have been minor things in the past like a stain in her father's carpet and a dead bug on the floor, but staff timely corrected the issue when she brought it to their attention.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	According to all staff members interviewed and AD the facility has always been properly cleaned and maintained adequately to assure the residents' health and safety.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 4/5/17, the facility received a second complaint which alleged on 3/29/17, staff member Marlene Gentry pushed Resident B down the hall in his wheelchair and let go of his wheelchair handles causing him to crash into the wall. To this, staff member

Morgan Gadowski laughed at Resident B hitting the wall. Ms. Gentry was overheard earlier in the day complaining about caring for the residents because she talks very loud. Specifically, Ms. Gentry stated that the residents were "acting up" and that she didn't "have time for this."

On 4/6/17, I observed Resident B and attempted to interview Resident B. Due to Resident B's clinical diagnosis of dementia, it was hard for him to follow the line of questioning. I checked his legs and physical person for any significant injuries or scars, and observed no marks or bruises.

On 4/6/17, Ms. Worden and Ms. Ehnis stated an internal investigation had been completed by Andrea Wedge due to Ms. Worden being out of the office because her father had died. At the conclusion of the investigation, it was determined that Ms. Gentry and Ms. Gadowski would be suspended for one day.

On 4/6/17, Ms. Gentry stated the allegations are not totally true. Ms. Gentry stated Resident B gets into the food in the refrigerator and she re-directed him out of the dining and kitchenette area into the hallway as he was seated in his wheelchair. Ms. Gentry stated Resident B is capable of maneuvering his wheelchair with this feet and often does this. Ms. Gentry stated she did not push Resident B down the hall hard or cause him to crash into a wall. Ms. Gentry stated she may have made some of the statements alleged but does not believe they were made in a disrespectful manner. Ms. Gentry explained her statements were made in a joking tone, because the residents usually have prayer before meals and on 3/29/17 they forgot to pray so everyone was "acting up." Ms. Gentry stated she was suspended for one day without pay as a result of the allegations.

On 4/6/17, Ms. Gadowski corroborated Ms. Gentry's statements regarding the allegations. Ms. Gadowski stated the running joke about residents' behavior being out of sorts on 3/29/17 was that because they had not prayed before their meal that day. Ms. Gadowski stated Ms. Gentry re-directed Resident B into the hallway but did not push him hard down the hallway causing him to hit a wall. Ms. Gadowski stated she did not laugh at Resident B hitting the wall nor did she recall laughing. Ms. Gadowski also stated Resident B maneuvers his wheelchair by using his feet. Ms. Gadowski stated she was suspended for one day without pay as a result of the allegations.

On 4/13/17, Mr. Anderson stated he and the facility's cosmetologist Carol Ellison were standing in the hallway as they observed Ms. Gentry push Resident B down the hallway in his wheelchair and he went sailing about 15 feet down the hall without staff holding onto the handles of his wheelchair. As a result, Resident B crashed into the wall and ricocheted into the door frame. Ms. Gentry then came and pushed him away from the door and said, "Go on now, I have to work until 11 o'clock tonight, I don't have time for this." Immediately Ms. Gadowski laughed at Ms. Gentry's statements which was completely indignant to Resident B. Mr. Anderson stated he and Ms. Ellison were in shock and no staff member checked Resident B to assure he did not have any injuries. Consequently, Mr. Anderson checked Resident B for injuries and consoled him by

rubbing his shoulder. Mr. Anderson stated Resident B was visibly upset at what just occurred by his facial expression, but did not have any physical injuries. Mr. Anderson does not believe that management enforced the day suspensions of Ms. Gentry or Ms. Gadowski as stated. This is due to Ms. Wedge and not being consistent with who actually conducted the investigation and not interviewing Ms. Ellison before completing its investigation.

On 4/10/17, Ms. Ellison corroborated Mr. Anderson's explanation of what occurred on 3/29/17. Ms. Ellison stated Ms. Gentry stated in the past that one resident has caused her grief and often bad mouths other staff and residents. Ms. Ellison stated the facility needs to do better with caring for the residents and treating them with respect.

On 4/12/17, I interviewed the regional marketing director Andrea Wedge. Ms. Wedge stated she had not completed the investigation regarding the incident to Resident B. Ms. Wedge stated she just completed follow-up questions but made no specific findings.

On 4/14/17, I conducted the exit conference with licensee designee, Teresa Fowler. Ms. Fowler stated due to the management changes a lot of things at the facility have not been operating as usually. Ms. Fowler stated she makes no excuses for the breakdown in management not being clear as to what occurred in the investigation. Ms. Fowler stated moving forward, she would assure that management had better communication. Ms. Fowler also stated she is pleased that more staff has been hired to assure all residents' needs are being met. Ms. Fowler also stated she would complete the corrective action plan once the special investigation report was received.

On 4/24/17, AD stated Mr. Anderson informed her of the incident that took place with her father on 3/29/17. AD stated she was upset but glad her father sustained no injuries. Prior to this incident, AD had not had any issues or concerns regarding her father's care. AD stated Ms. Gentry has no filter and tends to be sweet, but really surprised she would do something like this to her father. AD visits the facility twice a week at different times and always found staff to be respectful of the residents. AD stated she was given a copy of the investigation from Ms. Ehnis and reports no other issues or concerns at this time regarding Resident B's care.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	On 3/29/17, Ms. Gentry pushed Resident B into the hallway to prevent him from getting to other residents' food in the kitchenette refrigerator. As a result of Ms. Gentry letting go of Resident B's wheelchair handles when she pushed him into the hallway, Resident B hit the wall and ricocheted off a door frame. Consequently, Resident B was not treated with dignity, and his safety and protection was not ensured.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the licensee submitting an acceptable corrective action plan, I recommend that the special investigation be closed with no change to the license.

4/25/17

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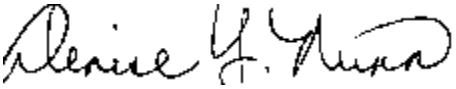
Roeiah Epps Date
Licensing Consultant

Approved By:



04/25/2017

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Denise Y. Nunn Date
Area Manager