GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 27th, 2021

Marie Wieland
Lansing Care Group, LLC
5101 NE 82nd Ave,
Vancouver, WA 98662

RE: License #:	AH330386131
Investigation #:	2021A1021027
	Robinwood Landing Alzheim

Dear Ms. Wieland:

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.
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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. Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH330386131
Investigation #:	2021A1021027
Complaint Receipt Date:	03/29/2021
Investigation Initiation Date:	03/30/2021
Report Due Date:	05/28/2021
Licensee Name:	Lansing Care Group, LLC
Licensee Address:	Ste 200 5101 NE 82nd Ave, Vancouver, WA 98662
Licensee Telephone #:	517-203-3044
Administrator/ Authorized Representative:	Marie Wieland
Name of Facility:	Robinwood Landing Alzheim
Facility Address:	1634 Lake Lansing Road Lansing, MI 48912
Facility Telephone #:	(517) 203-3044
Original Issuance Date:	11/30/2018
License Status:	REGULAR
Effective Date:	05/31/2020
Expiration Date:	05/30/2021
Capacity:	66
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Employees are under the influence of drugs.	No
Staff Person 1 treated Resident B disrespectfully.	No
There is inadequate staff at the facility.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/29/2021	Special Investigation Intake 2021A1021027
03/30/2021	Special Investigation Initiated - Letter Referral sent to centralized intake
03/30/2021	Contact - Telephone call made interviewed complainant
04/05/2021	Inspection Completed On-site
04/06/2021	Contact-Telephone call made Interviewed caregiver Alaina Leece
04/06/2021	Contact-Telephone call made Interviewed caregiver Jaliene Gonzalez
04/07/2021	Contact-Telephone call made Interviewed SP1
04/13/2021	Contact-Telephone call made Interviewed medication technician Laura Switzer
04/27/2021	Exit Conference Exit conference with authorized representative Marie Wieland

ALLEGATION:

Employees are under the influence of drugs.

INVESTIGATION:

On 3/29/21, the licensing department received a complaint with allegations employees are under the influence of drugs while working.

On 3/30/21, the allegations in this report were sent to centralized intake at Adult Protective Services (APS).

On 3/30/21, I interviewed the complainant by telephone. The complainant alleged employees leave the facility on their breaks to smoke marijuana and then come back to the facility to finish their shift. The complainant alleged management is aware of this and has not acted.

On 4/5/21, I interviewed administrator Marie Wieland at the facility. Ms. Wieland reported she has heard rumors of employees using marijuana at the facility but has no evidence that rumors are true. Ms. Wieland reported she has not observed any employees under the influence. Ms. Wieland reported she addressed the rumors in a recent staff meeting to on the facility drug use policy. Ms. Wieland reported employees do not consent to a drug screen upon hire but if there is suspicion of drug use while working, management can request a drug test to be completed.

On 4/5/21, I interviewed medication technician Rochele Johnnyjohn at the facility. Ms. Johnnyjohn reported she never has seen any caregivers under the influence of drugs while at the facility. Ms. Johnnyjohn reported she has never heard any rumors of employee using drugs.

On 4/5/21, I interviewed caregiver Mckenzie Weaver at the facility. Ms. Weaver reported she is unaware of employees using drugs at the facility.

On 4/5/21, I interviewed caregiver Kristen Guttridge at the facility. Ms. Guttridge reported there are employees that use marijuana during non-working hours while off duty. Ms. Guttridge reported no current employees use drugs while working.

On 4/6/21, I interviewed caregiver Alaina Leece by telephone. Ms. Leece reported she has never worked with anyone that has been under the influence of drugs. Ms. Leece reported no concerns with employee drug use at the facility.

I reviewed the facility *Drug and Alcohol* policy. The policy read,

> *"The community reserves the right to require testing if the community determines, in its sole discretion, that reasonable suspicion exists. Reasonable suspicion is when the community observes that the employee's behavior, conduct or condition indicates that he or she is under the influence of drugs or alcohol on the job, or where circumstances indicate that a work group, department, or shift, or other group of employees may be under the influence or otherwise violating Company policy. Examples may include strange or erratic behavior, non-typical*

work performance; drug paraphernalia or activity on particular shifts or in particular work groups; or an investigation of possible violation of Company policy in which drug use or abuse is suspected."

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(a) Assume full legal responsibility for the overall conduct and operation of the home.**
ANALYSIS:	Interviews with management and staff members revealed there is lack of evidence to support the allegation that staff members abuse drugs while at the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff Person 1 treated Resident B disrespectfully.

INVESTIGATION:

The complainant alleged staff person 1 (SP1) called Resident B a "dummy."

Ms. Wieland reported it was brought to her attention that SP1 called Resident B a dummy in the dining hall because Resident B ate an orange peel. Ms. Wieland reported the shift supervisor addressed the issue with SP1 and re-educated SP1 on appropriate behaviors. Ms. Wieland reported she has no concerns with care SP1 provides to residents. Ms. Wieland reported SP1 completed training on Resident Rights and Responsibilities when SP1 was hired. Ms. Wieland reported it was an isolated issue and was addressed immediately.

Ms. Johnnyjohn reported it was brought to her attention by another caregiver that SP1 called Resident B a dummy after he ate an orange peel. Ms. Johnnyjohn reported she contacted Ms. Wieland to inform her of the situation. Ms. Johnnyjohn reported Ms. Wieland told her to re-educate SP1 on appropriate behaviors when providing care to residents. Ms. Johnnyjohn reported she re-educated SP1 on treating residents with respect. Ms. Johnnyjohn reported SP1 reported she did call Resident B a dummy but did not mean any wrongdoing.

On 4/5/21, I interviewed programming director Lisa Curtis at the facility. Ms. Curtis reported she heard SP1 call Resident B a dummy in the dining hall. Ms. Curtis reported she went to Ms. Johnnyjohn to inform her of the situation. Ms. Curtis

reported SP1 reported she was not thinking before she spoke to Resident B. Ms. Curtis reported Ms. Johnnyjohn addressed the situation immediately. Ms. Curtis reported she has no concerns about residents being treated disrespectfully at the facility.

On 4/7/21, I interviewed SP1 by telephone. SP1 reported she did call Resident B a dummy in the dining hall. SP1 reported she was having a rough day and she did not realize she said it until someone spoke to her about it. SP1 reported she did not mean to call Resident B a dummy. SP1 reported she received re-education from the shift supervisor following the incident. SP1 reported she received training on dementia and Resident Rights upon hire.

I reviewed SP1 employee record. SP1 employee record revealed she completed Resident Rights and dementia training on 9/1/20.

I reviewed written documenting of incident with SP1 and Resident B. The documentation read,

> *"An allegation was made of caregiver (SP1) speaking inappropriately to (Resident B) in the dinning room. Reported to admin by caregiver, Shelly J. Discussion resulted in corrective action of Shelly providing verbal education to (SP1). (SP1) denied allegations though voiced understanding of education provided. No further action."*

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(1) Personal care and services that are provided to a resident by the home shall be designed to encourage residents to function physically and intellectually with independence at the highest practical level.
ANALYSIS:	Interviews with staff members revealed SP1 called Resident B a dummy in the dining hall. The facility provided education to SP1 and addressed the issue immediately. SP1 completed education and training on resident rights and dementia training. The events that occurred were an isolated issue, addressed immediately, appropriately, and are not a systemic issue at the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

There is inadequate staff at the facility.

INVESTIGATION:

The complainant alleged there is lack of staff at the facility. The complainant alleged on 3/25 and 3/26 there was lack of staff to care for the residents. The complainant alleged on 3/25 on third shift there was two caregivers for 46 residents. The complainant alleged on 3/26 for first shift there was two caregivers and two medication technicians and on 3/26 for second shift there was one nurse and three caregivers. The complainant alleged resident needs are not met as they are not toileted and do not receive showers.

Ms. Wieland reported the facility is working through staffing issues. Ms. Wieland reported the facility has 46 residents and has slowed down admissions due to staffing issues. Ms. Wieland reported for first shift there is to be four or five caregivers with a nurse and a medication technician. Ms. Wieland reported for third shift there is to be two-three caregivers with a medication technician. Ms. Wieland reported if a caregiver does not show for their shift, the shift supervisor and management will work to find replacement by calling staff members. Ms. Wieland reported the facility does not have a mandation policy but plans to start soon. Ms. Wieland reported the facility has not had a mandation policy as caregivers have voiced concerns over such policy and have reported they will resign if said policy is enacted. Ms. Wieland reported management will work open shifts, if needed. Ms. Wieland reported the facility is currently hiring but sometimes no one applies or shows up for interviews. Ms. Wieland reported the facility has been in contact with staffing agencies since January. Ms. Wieland reported she has reach out to multiple agencies on multiples occasions, but the agencies do not have staff members as well. Ms. Wieland reported the facility started a contract with Interim staffing on 3/19 with their first shift on 3/26. Ms. Wieland reported the agency will continue to provide coverage until the facility has stabilized their staffing needs.

On 4/6/21, I interviewed caregiver Jaliene Gonzalez by telephone. Ms. Gonzalez reported there is lack of staff at the facility. Ms. Gonzalez reported on nightshift on 3/25, she worked with one medication technician. Ms. Gonzalez reported there are 46 residents in the facility. Ms. Gonzalez reported there are 10 residents that are a two person assist, seven residents with behavior issues, four residents that are incontinent, and four residents on oxygen. Ms. Gonzalez reported on that night, one resident was exit seeking which resulted in increased time spent with that resident. Ms. Gonzalez reported resident needs were not met, such as rounding and changing of clothes, due to lack of staff.

On 4/13/21, I interviewed medication technician Laura Switzer by telephone. Ms. Switzer reported there is lack of staff at the facility. Ms. Switzer reported on third shift on 3/25, she worked with one caregiver. Ms. Switzer reported that shift was her third shift at the facility, and she was not yet off orientation. Ms. Switzer reported there are 46 residents at the facility. Ms. Switzer reported five residents have behavior issues. Ms. Switzer reported these residents require increased time and attention of the caregivers and the other resident needs are not met because of the lack of staff.

I reviewed the staff schedule for third shift for 3/25. The schedule revealed there was three caregivers and a medication technician scheduled. However, two caregivers did not report for their shift which resulted in one caregiver and one medication technician.

I reviewed the staff schedule for first and second shift for 3/26. The schedule revealed on first shift there was four caregivers and a medication technician scheduled. Two caregivers did not report for their shift. Two different caregivers filled in the vacant shifts which resulted in one medication technician, one nurse and three caregivers. On second shift there was three caregivers and two medication technicians scheduled. One caregiver reported to duty late and a medication technician called in. The facility secured a different caregiver to work which resulted in three caregivers for the entire shift, one medication technician for the entire shift, and two caregivers that worked a partial shift.

I reviewed service plans for Resident A, B, C, and D. The service plans revealed one resident was a fall risk, two residents required frequent rounding, four residents were a two person assist, one resident had a catheter, two residents were incontinent, four residents had orientation difficulties, two residents had oxygen, and two residents had behavior issues.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	Interview with management revealed the facility is to have two or three caregivers with a medication technician. On third shift on 3/25 there was one medication technician and one caregiver responsible for 46 residents. Interviews with staff revealed there is insufficient staff and that residents' needs are not met due to the staff shortages. The cognitively impaired resident population is subjected to potential harm due to the lack of available staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Ms. Switzer reported she was in the orientation process on 3/25. Ms. Switzer reported it was her third shift working in the building and on 3/25 she did not have any staff member orientating her. Ms. Switzer reported she was the sole person responsible for medication administration.

Ms. Wieland reported Ms. Switzer was hired on 3/18. Ms. Wieland reported Ms. Switzer trained with a staff member on 3/21, 3/22, and 3/23. Ms. Wieland reported Ms. Switzer expressed competency and the result was her working alone on 3/25. Ms. Wieland reported the facility then had Ms. Switzer come back for an additional three days of training.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following: **(g) Medication administration, if applicable.**
ANALYSIS:	Ms. Switzer worked at the facility administering medications without fully completing the staff training program.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 4/27/21, I conducted an exit conference with authorized representative Marie Wieland by telephone.

IV. RECOMMENDATION

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

Kimberly Horst 4/19/21

Kimberly Horst Date
Licensing Staff

Approved By:

Russell Misiak 4/20/21

Russell B. Misiak Date
Area Manager