GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 12, 2021

Keith Fisher
Trilogy Health Care of Clinton, LLC
#2
303 N. Hurstbourne Pkwy
Louisville, KY 40222-5185

RE: License #: AH330336309
Investigation #: 2021A1028026
The Willows at East Lansing

Dear Mr. Fisher:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action. Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,
Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 204-4300

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

## I. IDENTIFYING INFORMATION

| **License #:** | AH330336309 |
|---|---|
| | |
| **Investigation #:** | 2021A1028026 |
| | |
| **Complaint Receipt Date:** | 06/01/2021 |
| | |
| **Investigation Initiation Date:** | 06/01/2021 |
| | |
| **Report Due Date:** | 07/01/2021 |
| | |
| **Licensee Name:** | Trilogy Health Care of Clinton, LLC |
| | |
| **Licensee Address:** | #2<br>303 N. Hurstbourne Pkwy<br>Louisville, KY  40222-5185 |
| | |
| **Licensee Telephone #:** | (517) 203-4042 |
| | |
| **Authorized Representative and Administrator:** | Keith Fisher |
| | |
| **Name of Facility:** | The Willows at East Lansing |
| | |
| **Facility Address:** | 3500 Coolidge Road<br>East Lansing, MI  48823 |
| | |
| **Facility Telephone #:** | (517) 203-4042 |
| | |
| **Original Issuance Date:** | 02/13/2014 |
| | |
| License **Status:** | REGULAR |
| | |
| **Effective Date:** | 09/23/2020 |
| | |
| **Expiration Date:** | 09/22/2021 |
| | |
| **Capacity:** | 36 |
| | |
| **Program Type:** | AGED |

## II. ALLEGATION(S)

| | **Violation Established?** |
|---|---|
| The facility is understaffed to meet the needs of residents. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 06/01/2021 | Special Investigation Intake<br>2021A1028026 |
| 06/01/2021 | Special Investigation Initiated - Letter<br>APS referral emailed to Centralized Intake - 2021A1028026 |
| 06/01/2021 | APS Referral<br>APS referral emailed to Centralized Intake - 2021A1028026 |
| 06/15/2021 | Inspection Completed On-site<br>2021A1028026 |
| 06/15/2021 | Contact – Face to Face<br>Interviewed Authorized Representative/Administrator Keith Fisher and employee A, B, and C at the facility |
| 06/15/2021 | Contact – Face to Face<br>Interviewed Resident A at the facility |
| 06/24/2021 | Contact – Telephone call made<br>Interviewed Resident A's authorized by telephone |
| 07/12/2021 | Exit Conference |

**ALLEGATION:**

**The facility is understaffed to meet the needs of residents.**

**INVESTIGATION:**

On 6/1/21, the Bureau received the allegations from the online compliant system. The complainant wished to remain anonymous, so I am unable to verify any information or concerns.

On 6/1/21, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 6/15/21, I interviewed administrator and authorized representative Keith Fisher at the facility. Mr. Fisher reported the facility is not understaffed and has not been for a while and that they are always hiring. Mr. Fisher reported the facility has not really had to utilize agency staff due to the current number of facility employees. Mr. Fisher reported there are 16 residents in the memory care unit with one medication technician and one care staff scheduled for each of the shifts in the unit. Mr. Fisher reported the facility also uses a float care staff person if needed. Mr. Fisher reported that if a call-in were to happen or extra assistance was required in the unit, a staff care person from another building or management would assist. Mr. Fisher reported while call-ins do happen, there is a policy in place to cover shift shortages. Mr. Fisher provided a copy of the working staff schedule, attendance policy, and Resident A's medication record with record notes for my review.

On 6/15/21, I interviewed Employee 1 at the facility. Employee 1 reported the facility is not understaffed in the memory care unit and "it's fine with two care staff". Employee 1 reported "when there is a call-in, other staff are pulled from the other side to help cover". Employee 1 reported there are two residents that require two person assists, but "it has never been an issue with assisting either of the residents with only two staff on this side of the building". Employee 1 reported the residents that require two-person assist have not incurred any falls. Employee 1 reported there is a float care staff person who works a staggered schedule to assist when needed.

On 6/15/21, I interviewed Employee 2 at the facility. Employee 2's statements are consistent with employee A's statements.

On 6/15/21, I interviewed Employee 3 at the facility. Employee 3 reported "two care staff is not enough staff for the memory care unit, especially due to two of the residents being two people assist". Employee 3 expressed concern while the two person assist residents have not incurred any falls, "the potential for an accident could still happen and the resident or myself or my co-worker could get hurt by only having two people in this unit at a time". Employee 3 reported call-ins do occur on all shifts and staff is pulled from other buildings, but it is difficult to cover the call-ins. Employee 3 reported there is a float care staff person but that care staff person is often utilized in the other building. Employee 3 reported "there really should be three full time care staff in this unit".

On 6/15/21, I interviewed Resident A at the facility. Resident A reported “I wish to return to my own home, but otherwise staff are nice and helpful”. Resident A reported no falls and no concerns with care.

On 6/15/21, I reviewed Resident B and Resident C’s record notes and service plan, which revealed both require two person assist. Resident B and Resident C have not incurred any falls.

On 6/15/21, I completed a walk through of the memory care unit, noting there was one care staff person, one med technician, and an activities director present. The facility was clean and the residents were cleaned and well groomed.

On 6/23/21, I reviewed the working staff schedule from March 2021 to June 2021 which revealed a pattern of call-ins across all shifts. The review also revealed a pattern of only two care staff persons total working second and third shifts despite the presence of a float care staff person.

On 6/23/21, I reviewed the facility attendance policy which revealed clear staffing attendance procedures with corrective measures for attendance violations for all care staff. The policy also requires every staff member to review, sign, and date for compliance.

On 6/24/21, I interviewed Resident A’s authorized representative by telephone. Resident A’s authorized representative reported there were no concerns with Resident A’s care but reported “there is usually only one to two care givers in the building when I visit”.

On 6/25/21, I made a third attempt to contact Employee 4 but have been unsuccessful in making contact.

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1931 (5)** | **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: | Interviews with the authorized representative and care staff reveal the facility has one medication technician and one care staff person with a staggered float staff person scheduled for the memory care unit daily. Interviews also revealed call-ins across all shifts with call-ins being filled by other facility staff.<br><br>However, review of the working staff schedules revealed a pattern of only two care staff total working throughout the three shifts, even with a staggered float person scheduled.<br><br>Of the service plans reviewed, Resident B's and Resident C's service plan reveal both residents are two person assist with all transfers. Resident B and Resident C have not incurred any falls. However, due to the consistent pattern of only having two care staff available between the hours of 2pm to 6am, the residents reviewed are at potential risk of harm or injury because there is not enough staff available to safely meet the resident's needs. |
|---|---|
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the license remained unchanged.

6/25/21

Julie Viviano — Date
Licensing Staff

Approved By:

7/9/21

Russell B. Misiak — Date
Area Manager