GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 3, 2021

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

| | |
|---|---|
| RE: License #: | AH330386131 |
| Investigation #: | 2021A1021042 |
| | 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.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the authorized representative 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 (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 #:** | 2021A1021042 |
| | |
| **Complaint Receipt Date:** | 08/10/2021 |
| | |
| **Investigation Initiation Date:** | 08/10/2021 |
| | |
| **Report Due Date:** | 10/09/2021 |
| | |
| **Licensee Name:** | Lansing Care Group, LLC |
| | |
| **Licensee Address:** | Ste 200<br>5101 NE 82nd Ave,<br>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<br>Lansing, MI 48912 |
| | |
| **Facility Telephone #:** | (517) 203-3044 |
| | |
| **Original Issuance Date:** | 11/30/2018 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 05/31/2021 |
| | |
| **Expiration Date:** | 05/30/2022 |
| | |
| **Capacity:** | 66 |
| | |
| **Program Type:** | AGED<br>ALZHEIMERS |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Facility has insufficient staff on second shift. | No |
| Resident N's medications have been found on the floor. | Yes |
| Resident N does not receive showers. | No |
| Additional Findings | No |

## III. METHODOLOGY

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|---|---|
| 08/10/2021 | Special Investigation Intake<br>2021A1021042 |
| 08/10/2021 | Special Investigation Initiated - Telephone<br>interviewed APS worker |
| 08/18/2021 | Inspection Completed On-site |
| 08/20/2021 | Contact - Document Received<br>Received additional information on Resident A |
| 08/23/2021 | Contact-Telephone call made<br>Interviewed administrator Marie Wieland |
| | Exit Conference |

**ALLEGATION:**

**Facility has insufficient staff on second shift.**

**INVESTIGATION:**

On 8/10/21, the licensing department received a complaint from Adult Protective Services with allegations the facility has insufficient staff on second shift. APS reported the staff are overworked.

On 8/10/21, I interviewed APS worker Gene Mellen by telephone. Mr. Mellen reported a family member alleged the facility does not have sufficient staff on second shift and due to lack of staff residents are not receiving adequate care.

On 8/18/21, I interviewed assistant Cheryl Pion at the facility. Ms. Pion reported there are 49 residents at the facility. Ms. Pion reported on second shift there are 4-5 caregivers scheduled and one-two medication technician. Ms. Pion reported the facility is using agency staffing to assist with staff shortages. Ms. Pion reported the facility is actively hiring. Ms. Pion reported if there is staff shortage, management will work the floor.

On 8/18/21, I interviewed caregiver Alaina Leece at the facility. Ms. Leece reported there are to be five caregivers and two medication technicians on second shift. Ms. Leece reported on this day there are only three caregivers. Ms. Leece reported she is responsible for 16 residents. Ms. Leece reported for her residents there are two residents on oxygen, one resident with behaviors, one resident that is a two person assist, and all residents required assistance with bedtime routine. Ms. Leece reported she can meet the needs of the residents.

On 8/18/21, I interviewed medication technician Kristen Guttridge at the facility. Ms. Guttridge reported staffing has improved over the past months. Ms. Guttridge reported on second shift there are to be four caregivers and two medication technicians. Ms. Guttridge reported if there is a staff shortage, typically a caregiver will stay over to fill the shortage. Ms. Guttridge reported the facility is using agency staffing which is helping with the staff shortage. Ms. Guttridge reported all necessary care is provided to the residents and residents receive adequate care.

On 8/18/21, I interviewed medication technician Katie Dunlap at the facility. Ms. Dunlap reported staffing has improved. Ms. Dunlap reported the facility is usually short staffed once a week. Ms. Dunlap reported when a caregiver calls off for their shift, another caregiver will stay over until a replacement is found. Ms. Dunlap reported medications are administered on time and are not late.

On 8/18/21, I interviewed caregiver Brandon Scott at the facility. Mr. Scott reported he is responsible for 15 residents. Mr. Scott reported one resident is a two person assist, and three residents have behaviors. Mr. Scott reported when there is a shortage of staff, it can be difficult to complete all tasks, but the residents receive adequate care. Mr. Scott reported he can meet the needs of the residents.

On 8/24/21, I interviewed administrator Marie Wieland by telephone. Ms. Wieland reported the facility is actively hiring. Ms. Wieland reported staffing has improved

and the facility is able to meet the needs of the residents. Ms. Wieland denied allegations the facility has insufficient staff.

I reviewed staff schedule for 8/4-8/18. The schedule revealed the staffing ratios were consistent with the statements made by facility caregivers.

| **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:** | Interviews with staff members and management revealed there is adequate staff on second shift to meet the needs of the residents. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**Resident N's medications have been found on the floor.**

**INVESTIGATION:**

The complainant alleged family members have found Resident N's medications on the floor.

Ms. Pion reported Relative N1 has brought to administration attention that medications were found on Resident N's floor. Ms. Pion reported medication technicians were placing the medications in a cup for Resident N to take. Ms. Pion reported mediation technicians are to now place the medications physically in Resident N's mouth to ensure they are administered. Ms. Pion reported she is unsure when Relative N1 found the medications on the floor.

Ms. Guttridge reported she was informed by Relative N1 that a medication was found on the floor. Ms. Guttridge reported this occurred last week and she informed Ms. Weiland. Ms. Guttridge reported medication technicians are now to place all medications in Resident N's mouth to ensure the medications are administered.

Ms. Wieland reported it was brought to her attention from Relative N1 that a medication pill was found the floor. Ms. Wieland reported the medication was

believed to be Tylenol. Ms. Wieland reported she informed staff to document the missed medication. Ms. Wieland reported Resident N likes to throw the cup of medications in his mouth and medications sometimes fall out of the cup. Ms. Wieland reported medication technicians are now to place the cup of medications directly into Resident N's mouth. Ms. Wieland reported since this update there have been no issues with missed medications. Ms. Wieland reported she is aware of three instances that this occurred all of which occurred in late July 2021.

I reviewed chart notes for July and August for Resident N. There was no mention of any medications found in Resident N's room.

I reviewed the medication administration record (MAR) for July and August for Resident N. There was no documentation of missed medications.

I reviewed the service plan for Resident N. The service plan read,

*"Update 8/9/12: Please assure that all of my medications are offered to me via spoon directly to my mouth. Or by placing the medication cup directly to my mouth. Please observe me following medication being given to assure I have swallowed it."*

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1932** | **Resident medications.** |
| | **(5) A home shall take reasonable precautions to ensure or assure that prescription medication is not used by a person other than the resident for whom the medication is prescribed.** |
| **ANALYSIS:** | Interviews with staff members and management revealed Resident N's medications would fall on the floor due to how the resident preferred to take the medications. This occurred multiple times in July, but the service plan was not updated until 8/9. Therefore, the facility did not reasonably comply to ensure Resident N received the medications that were prescribed to him. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION**:

**Resident N does not receive showers.**

**INVESTIGATION:**

The complainant alleged Resident N does not receive showers at the facility.

On 8/18/21, I interviewed director of resident care Alanna Thomas-Carroll at the facility. Ms. Thomas-Carroll reported Resident N is serviced plan for showers twice weekly. Ms. Thomas-Carroll reported Resident N can be sexually inappropriate with caregivers and the facility tries to have male caregivers shower Resident N. Ms. Thomas-Carroll reported the facility recently had a care conference with Resident N's family to provide re-education that they do not have to shower the resident. Ms. Thomas-Carroll reported sometimes Resident N will refuse a shower and this is documented by the caregivers.

Ms. Guttridge reported Resident N receives showers on Sunday and Wednesday. Ms. Guttridge reported sometimes Resident N refuses a shower and the family can talk him into taking a shower. Ms. Guttridge denied allegations the facility does not shower Resident N.

Ms. Dunlap and Mr. Scott had similar statements to those made by Ms. Guttridge.

I reviewed shower sheets for Resident. The shower sheets revealed Resident N received a shower on 8/1, 8/4, 8/6, 8/8, 8/11 and 8/16.

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1933** | **Personal care of residents.** |
| | **(2) A home shall afford a resident the opportunity and instructions when necessary for daily bathing, oral and personal hygiene, daily shaving, and hand washing before meals. A home shall ensure that a resident bathes at least weekly and more often if necessary.** |
| **ANALYSIS:** | Interviews with caregivers revealed Resident N is to receive a shower on Sunday and Wednesdays. Review of shower sheets revealed Resident N has received a shower at least once a week. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

On 9/3/21, I conducted an exit conference with authorized representative Marie Wieland by telephone. Ms. Wieland reported the facility provided education and direction to the medication technicians on how to administer medications to Resident N to prevent medications from falling on the floor. Ms. Wieland reported the delay in

updating the service plan was due to family dynamics, but the changes were put in place prior to 8/9.

## IV. RECOMMENDATION

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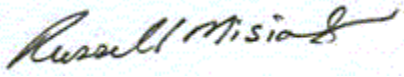
| Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license. |

9/1/21

Kimberly Horst Date
Licensing Staff

Approved By:



9/1/21

Russell B. Misiak Date
Area Manager