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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 2, 2021

Nadine Carlson
Ascension Health III AFC
952 N M-37 Hwy
Hastings, MI 49058

RE: License #: AS410386016
Investigation #: 2022A0583004
Ascension Health III AFC

Dear Ms. Carlson:

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 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) 356-0183.

Sincerely,

Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410386016
Investigation #:	2022A0583004
Complaint Receipt Date:	11/01/2021
Investigation Initiation Date:	11/01/2021
Report Due Date:	12/01/2021
Licensee Name:	Ascension Health III AFC
Licensee Address:	952 N M37 Hwy Hastings, MI 49058
Licensee Telephone #:	(248) 342-2698
Administrator:	Nadine Carlson, Designee
Licensee Designee:	Nadine Carlson, Designee
Name of Facility:	Ascension Health III AFC
Facility Address:	1947 Millbank St SE Grand Rapids, MI 49508
Facility Telephone #:	(616) 805-4203
Original Issuance Date:	02/09/2017
License Status:	REGULAR
Effective Date:	08/09/2021
Expiration Date:	08/08/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, DEVELOPMENTALLY DISABLED, MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
A video camera is utilized in the facility's communal living room without permission of residents or their legal decision makers.	Yes
Resident A is using the facility's communal living room for sleeping.	Yes

III. METHODOLOGY

11/01/2021	Special Investigation Intake 2022A0583004
11/01/2021	Special Investigation Initiated - Telephone Licensee Designee Nadine Carlson
11/01/2021	Inspection Completed On-site Staff Karlee Olthouse, Staff Heidey Merriman, Resident A, Resident B, Resident C
11/01/2021	Exit Conference Licensee Designee Nadine Carlson

ALLEGATION: A video camera is utilized in the facility's communal living room without permission of residents or their legal decision makers.

INVESTIGATION: On 11/01/2021 I received complaint allegations via telephone from Licensee Designee Nadine Carlson. Ms. Carlson stated Resident A currently receives hospice care. Ms. Carlson stated Resident A has been "screaming a lot" at night which has kept other residents awake because all resident bedrooms are located in the same wing of the facility. Ms. Carlson stated she and hospice staff formulated and executed a plan to set up Resident A's bed in the facility's communal living room and placed a non-recording video monitor above Resident A's bed for further monitoring. Ms. Carlson stated Resident A has been sleeping in the communal living room for approximately three weeks. Ms. Carlson acknowledged she has not obtained approval from residents' legal decision makers to utilize the video camera at the facility.

On 11/01/2021 I completed an onsite investigation at the facility and privately interviewed Staff Karlee Olthouse, Staff Heidey Merriman, Resident A, Resident B, and Resident C.

Staff Karlee Olthouse stated she was aware that Licensee Designee Nadine Carlson placed a non-recording video camera in the communal living room to monitor Resident A who sleeps in the facility's communal living room at night. Ms. Olthouse

stated the non-recording video camera has been placed in the facility's communal living room for approximately three weeks.

Staff Heidey Merriman stated she does not work at the facility often however she has observed a video camera in the facility's communal living room.

I observed Resident A sitting on the facility's living room couch with adequate hygiene. Resident A was unable to complete an interview as a result of her declining health and cognitive status.

Resident B and Resident C both stated there is video camera located in the facility's communal living room.

I observed a non-recording video camera mounted in the facility's communal living room.

On 11/01/2021 I completed an Exit Conference with Licensee Designee Nadine Carlson via telephone. Ms. Carlson agreed that she was not in compliance with licensing rule R 400.14304 (1) (o) (2) and would rectify the situation immediately by removing the video camera. Ms. Carlson stated she would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights as specified in subrule (1) of this rule.**
ANALYSIS:	Staff Karlee Olthouse, Heidi Merriman, and Licensee Designee Nadine Carlson each stated the facility contains a non-recording video camera installed in the living room common area. I observed a non-recording video camera installed in the facility's communal living room. Ms. Carlson acknowledged she has not obtained approval from residents' legal decision makers to utilize the video cameras at the facility.

	There is a preponderance of evidence to substantiate violation of the applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A is utilizing the facility's communal living room for sleeping.

INVESTIGATION: On 11/01/2021 I received complaint allegations via telephone from Licensee Designee Nadine Carlson. Ms. Carlson stated Resident A currently receives hospice care. Ms. Carlson stated Resident A has been "screaming a lot" at night which has kept other residents awake because resident bedrooms are all located in the same wing of the facility. Ms. Carlson stated she and hospice staff formulated and executed a plan to set up Resident A's bed in the facility's communal living room. Ms. Carlson stated Resident A has been sleeping in the communal living room for approximately three weeks.

On 11/01/2021 I completed an onsite investigation at the facility and privately interviewed Staff Karlee Olthouse, Staff Heidey Merriman, Resident A, Resident B, and Resident C.

Staff Karlee Olthouse stated she was aware that Licensee Designee Nadine Carlson moved Resident A's bed to the facility's communal living room approximately three weeks ago because Resident A woke other residents during the night. Ms. Olthouse stated she objected to moving Resident A's bed to the facility's communal living room however Ms. Carlson stated, "the state would never find out therefore it was a freebee". Ms. Olthouse stated Resident A has been sleeping in the communal living room for approximately three weeks.

Staff Heidey Merriman stated she does not work at the facility often however she has observed Resident A's bed located in the facility's communal living room.

I observed Resident A sitting on the facility's living room couch with adequate hygiene. Resident A was unable to complete an interview as a result of her declining health and cognitive status.

Resident B and Resident C both stated Resident A sleeps in the facility's communal living room.

I observed Resident A's bed was located in the corner of the facility's communal living room.

On 11/01/2021 I completed an Exit Conference with Licensee Designee Nadine Carlson via telephone. Ms. Carlson agreed that she was not in compliance with licensing rule 400.14408 (2) and would rectify the situation immediately allowing

Resident A to sleep in her bedroom rather than the communal living room Ms. Carlson stated she would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14408	**Bedrooms generally.**
	(2) A living room, dining room, hallway, or other room that is not ordinarily used for sleeping or a room that contains a required means of egress shall not be used for sleeping purposes by anyone.
ANALYSIS:	Staff Karlee Olthouse, Heidi Merriman, and Licensee Designee Nadine Carlson each stated Resident A has been sleeping in the faculty's communal living room. I observed Resident A's bed was located in the corner of the facility's communal living room. Ms. Carlson acknowledged Resident A has been sleeping in the facility's communal living room for approximately three weeks. There is a preponderance of evidence to substantiate violation of the applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend the license remain unchanged.

11/02/2021

Toya Zylstra Date
Licensing Consultant

Approved By:

11/02/2021

Jerry Hendrick Date
Area Manager