



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 14, 2021

Laura Kelling
American House Wyoming
5812 Village Dr SW
Wyoming, MI 48519

RE: License #: AH410402896
Investigation #: 2022A1028002
American House Wyoming

Dear Ms. Kelling:

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
Cell (616) 204-4300

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

I. IDENTIFYING INFORMATION

License #:	AH410402896
Investigation #:	2022A1028002
Complaint Receipt Date:	10/06/2021
Investigation Initiation Date:	10/08/2021
Report Due Date:	12/08/2021
Licensee Name:	AH Wyoming Subtenant LLC
Licensee Address:	STE 1600 One Towne Square Southfield, MI 48076
Licensee Telephone #:	(248) 827-1700
Authorized Representative/Administrator:	Laura Kelling
Name of Facility:	American House Wyoming
Facility Address:	5812 Village Dr SW Wyoming, MI 48519
Facility Telephone #:	(616) 622-2420
Original Issuance Date:	11/05/2020
License Status:	REGULAR
Effective Date:	05/05/2021
Expiration Date:	05/04/2022
Capacity:	166
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was found multiple times with feces in room and on self.	Yes
Facility is understaffed to meet the needs of residents.	No

III. METHODOLOGY

10/06/2021	Special Investigation Intake 2022A1028002
10/08/2021	Special Investigation Initiated - Letter 2022A1028002
10/08/2021	APS Referral APS referral emailed to Centralized Intake
11/03/2021	Contact - Face to Face Interviewed Admin Laura Kelling at facility
11/03/2021	Contact - Face to Face Interviewed care staff Susan Howe at facility
11/03/2021	Contact - Face to Face Interviewed care staff Ashley Hesselink at facility
11/03/2021	Contact - Face to Face Interviewed care staff Kayshlanie Lamboy at facility
11/03/2021	Contact - Face to Face Interviewed care staff Amy Dowdall at facility
11/03/2021	Contact – Document Received Received Resident A’s updated care plan from Ms. Kelling
11/18/2021	Contact – Telephone call received Interviewed the complainant by telephone
12/14/2021	Exit Interview

ALLEGATION:

Resident A was found multiple times with feces in room and on self.

INVESTIGATION:

On 10/8/21, the Bureau received the allegations from the online complaint system.

On 10/8/21, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 11/3/21, I interviewed authorized representative/administrator, Laura Kelling, at the facility. Ms. Kelling reported Resident A has resided at the facility since April 2020. Ms. Kelling reported Resident A resides in the memory unit of the facility. Ms. Kelling reported the facility has housekeeping staff and dedicated laundry staff to assist with facility cleaning and laundry. Ms. Kelling reported care staff will also help with the cleaning of resident rooms and laundry as needed. Ms. Kelling reported there are laundry services for every floor as well. Ms. Kelling reported Resident A's room is cleaned at minimum one time per week, but facility staff will clean the room throughout the week as needed. Ms. Kelling reported Resident A's room is usually clean, but Resident A does have toileting accidents intermittently and care staff will assist Resident A with clean up first and then will clean the bathroom and/or room afterwards. Ms. Kelling reported the lead housekeeping staff person was recently out for a period of time, so other housekeeping staff covered the vacancy with care staff assisting each shift as well with housekeeping duties until the lead housekeeper returned. Ms. Kelling provided me a copy of Resident A's service plan with record notes for my review.

On 11/3/21, I interviewed wellness director, Sarah Howe, at the facility. Ms. Howe reported Resident A resides in the memory care unit. Ms. Howe reported Resident A's room is cleaned once a week, but care staff will tidy up daily as needed. Ms. Howe reported Resident has bathroom accidents intermittently, but Resident A and the bathroom are always cleaned afterwards. Ms. Howe reported laundry is completed by the dedicated in-house laundry service and care staff will also assist with laundry if needed. Ms. Howe reported Resident A's trash is picked up daily. Ms. Howe also reported it was discovered Resident A has an allergy to yellow/orange vegetables and upon this discovery the service plan was updated so Resident A is not served any during mealtimes. Kitchen staff were also educated on Resident A's allergy and service plan update to prevent Resident A from being served yellow/orange vegetables.

On 11/3/21, I interviewed care staff person (CSP), Ashley Hesselink, at the facility. Ms. Hesselink reported Resident A's service plan was updated so Resident A is not served yellow/orange vegetables during mealtimes. The service plan was also reviewed with kitchen staff and there are instructions posted in the kitchen as precaution as well. Ms. Hesselink reported Resident A's room is cleaned once a week by housekeeping staff, but care staff tidy up daily or will clean the room if Resident A has a toileting accident. Ms. Hesselink reported Resident A does get up without assistance and while Resident is able to use the call light, Resident is not consistent with its use, so Resident A is on two checks throughout the day for care and safety. Ms. Hesselink reported no knowledge of Resident A having feces-stained clothing.

On 11/3/21, I CSP, Kayshlanie Lamboy, at the facility. Ms. Lamboy reported she works with Resident A often and Resident A gets up without assistance and does not use the call light. Ms. Lamboy reported Resident A can have intermittent accidents that require clean up. Ms. Lamboy reported housekeeping cleans Resident A's room once a week and care staff will also help spot clean rooms throughout the week as needed. Ms. Lamboy reported Resident A's room was cleaned today and the carpets were recently steam cleaned as well. Ms. Lamboy reported trash is removed after every shift. Ms. Lamboy reported laundry is completed by the in-house laundry staff, but care staff will also assist, especially on third shift when there is less resident activity. Ms. Lamboy reported no knowledge of Resident A having feces-stained clothing.

On 11/3/21, I interviewed CSP, Amy Dowdall, at the facility. Ms. Dowdall's statements are consistent with Ms. Howe's, Ms. Hesselink's, and Ms. Lamboy's statements. Ms. Dowdall also reported no knowledge of Resident A having feces-stained clothing. Ms. Dowdall reported Resident A participates in activities often during the week. Ms. Dowdall reported some activities are provided on the weekend as well.

On 11/3/21, I completed an inspection of the facility. The inspection revealed the facility was clean and residents were well groomed, and some were participating in activities.

On 11/3/21, I completed an inspection of Resident A's room and observation of Resident A. Resident A's bathroom and room were clean and Resident A was well groomed and content in [their] recliner.

Om 11/3/21, I received an email from Ms. Kelling with Resident A's updated care plan. The care of room cleaning was added to Resident A's service plan.

On 11/18/21, I interviewed the complainant by telephone. The complainant reported Resident A resides in the memory care unit of the facility. The complainant reported during several recent in-person visits since COVID-19 restrictions were lifted, Resident A was found with feces-stained clothing and feces in the bathroom, on the

carpet, and on linens that Resident A slept on. The complainant reported Resident A does have a history of diarrhea, but feces was found “all over the place” in Resident A’s room multiple times during visits. The complainant reported due to an increase of COVID-19 cases, the facility is on lock down and no visits are permitted currently. The complainant reported Resident A’s laundry is not appropriately washed before Resident A wears it because Resident A was found multiple times with feces-stained clothing on. The complainant reported Resident A’s room consistently had trash that was not being removed in a timely manner and during in-person visits, family was removing trash from Resident A’s room. The complainant reported Resident A requires assist with most care, especially toileting and donning clothing to include briefs and expressed concerns that staff are not assisting Resident A with toileting as often as the care plan states due to the condition Resident A’s room has been found in multiple times. The complainant reported these concerns were brought to management’s attention as well. The complainant provided me pictures of Resident A’s soiled room and bathroom and Resident A’s lunch time meal for my review.

On 11/18/21, I reviewed Resident A’s updated service plan. The review revealed Resident A requires assist with bathing and toileting with donning of briefs. Resident A requires supervision to stand by assist with dressing to include clothing is clean, during mealtimes, and cleaning of room. Resident A is on spot checks for safety during the day and at night. Resident A requires reminders to participate in activities. Monitoring of tasks is also completed due to Resident A’s visual deficit. Resident A has a history of flushing paper towels in toilet, causing flooding and clogging of toilet. Care staff are to assist Resident A every two hours during the day and evening with toileting and flushing of toilet to deter this behavior.

On 11/18/21, I reviewed the pictures the complainant provided me for my review. The pictures depicted various spots in Resident A’s room, bathroom, and on the carpet that were soiled with feces. The pictures also depicted sweet potatoes being served during mealtime.

APPLICABLE RULE	
R 325.1931	Employee; general provisions.
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident’s service plan.

ANALYSIS:	<p>Interviews with the administrator, care staff, and the complainant along with review of documentation reveal Resident A has a history of toileting accidents that require care staff assistance for dressing, appropriate hygiene, and safety. Resident A's service plan was recently updated with the added care of room cleaning assistance.</p> <p>Comparison of the original service plan with the update service revealed the following:</p> <ul style="list-style-type: none"> • Original service plan dated 4/13/2021 read: <i>Resident is independent with toileting. Staff to be aware that the resident is independent with toileting.</i> • Updated service plan dated 11/3/2021 read: <i>May need assistance with clothes and briefs. Resident continued to flush paper towels in toilet and caused flooding, plumber had to come out twice to unclog toilet. Paper towels are no longer stocked in res. room. Hand towel or towel next to sink to dry hands. Water valve is also turned off on toilet, staff to flush periodically throughout the day.</i> <p>There is also evidence Resident A's room, bathroom, and linens were soiled with feces on multiple occasions prior to the service plan update.</p> <p>Resident A was not provided appropriate supervision or assistance by the facility to prevent soiling of room, bathroom, and linens multiple times. Resident A's service plan was also not updated in a timely manner to reflect the increased assistance Resident A required to prevent soiling of room, linens, and clogging of toilet. Therefore, the facility is in violation of this rule.</p>
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

Facility is understaffed to meet the needs of residents.

INVESTIGATION:

On 11/3/21, Ms. Kelling reported the facility has been short staffed in the past due to the pandemic and due to “unfortunately, many people showing up for interviews and then being hired and never showing for work. Or never showing up for scheduled interviews or not passing the background check”. Ms. Kelling reported it has been

difficult to get and keep good care staff, but the facility is continuing to hire and staffing numbers have greatly improved recently. Ms. Kelling reported there are one to two care staff with a med tech, floor manager, and float person for first and third shifts. There are two to three care staff with a med tech, floor manager and float person for second shift. Ms. Kelling also reported there is no mandation because staffing has increased and the facility continues to offer bonuses, overtime, and will utilize agency staff as needed. Ms. Kelling provided me a copy of the working staff schedules from August 2021 to October 2021 for my review.

On 11/3/21, Ms. Howe reported the facility is close to reaching max capacity for staffing. Ms. Howe reported there are one to two care staff with a med tech, floor manager, and float person for first and third shifts. There are two to three care staff with a med tech, floor manager and float person for second shift. Ms. Howe reported agency staff is used as needed and bonuses and overtime are offered as well to prevent shift shortages.

On 11/3/21, Ms. Hesselink reported while there are call-ins intermittently, there is currently enough staffing to cover shifts to prevent shift shortages. Ms. Hesselink reported there are one to two care staff with a med tech, floor manager, and float person for first and third shifts. There are two to three care staff with a med tech, floor manager and float person for second shift. Ms. Hesselink also reported the facility is continuing to hire, offers overtime, and bonuses for shifts as well.

On 11/3/21, I CSP, Kayshlanie Lamboy, at the facility. Ms. Lamboy reported while call-ins occur, care staff will either stay to cover the call-ins, a float person will cover as well, or agency staff is utilized to prevent shift shortages. Ms. Lamboy reported staffing is continuing to increase and believes the facility is “staffed well” currently. Ms. Lamboy reported the facility is continuing to hire, offers bonuses, and overtime as well.

On 11/3/21, I interviewed CSP, Amy Dowdall, at the facility. Ms. Dowdall’s statements are consistent with Ms. Kelling’s, Ms. Howe’s, Ms. Hesselink’s, and Ms. Lamboy’s statements.

On 11/3/21, I completed an inspection of the facility and observed an appropriate number of care staff in the facility.

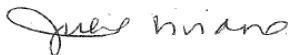
On 11/18/21, I interviewed the complainant by telephone. The complainant reported the facility is “chronically understaffed” and there is only one care staff on the floor on weekend shifts. The complainant reported no activities are being offered on the weekend either and Resident A sits in [their] room with hardly any interaction due to being understaffed. The complainant expressed concern about Resident A becoming depressed due to lack of interaction on the weekend because of understaffing and especially now that in-person visits are not being allowed.

On 11/18/21, I reviewed the working staff schedules for September 2021 to November 2021. The review revealed a total of 27 call-ins from September 2021 to November 2021. Agency staff, float staff, and/or facility staff covered the vacancies to prevent shift shortages. There is also evidence of new-hiring training on the working staff schedules as well.

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 the administrator, care staff, and the complainant reveal while occasional call-ins occur at the facility, use of a float care staff person, overtime and bonuses for facility care staff, and agency staff ensure shift vacancies are filled. Review of the working staff schedules also reveal a normalization of care staff to appropriately meet the needs of residents at the facility.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

Contingent upon the receipt of an approved corrective action plan, I recommend the license remain unchanged.

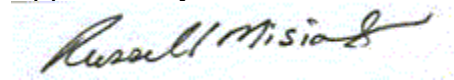


11/18/2021

Julie Viviano
Licensing Staff

Date

Approved By:



12/10/21

Russell B. Misiak
Area Manager

Date