GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 17, 2021

Rebecca Nagey
Rhema-Armada Village Operating, LLC
22600 W. Main Street
Armada, MI 48005

RE: License #: AL500382677
Investigation #: 2022A0617004
Meadow Ridge Assisted Living

Dear Ms. Nagey:

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.

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 (248) 975-5053.

Sincerely,

Eric Johnson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL500382677
Investigation #:	2022A0617004
Complaint Receipt Date:	10/21/2021
Investigation Initiation Date:	10/25/2021
Report Due Date:	12/20/2021
Licensee Name:	Rhema-Armada Village Operating, LLC
Licensee Address:	22600 W. Main Street Armada, MI 48005
Licensee Telephone #:	(586) 473-3227
Administrator:	Rebeca Nagey
Licensee Designee:	Rebeca Nagey
Name of Facility:	Meadow Ridge Assisted Living
Facility Address:	22590 W. Main Street Armada, MI 48005
Facility Telephone #:	(586) 473-3227
Original Issuance Date:	08/02/2016
License Status:	REGULAR
Effective Date:	01/01/2021
Expiration Date:	12/31/2022
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS; AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was smacked on the face with an open hand by staff Maryann Boyd allegedly to wake the resident up.	Yes

III. METHODOLOGY

10/21/2021	Special Investigation Intake 2022A0617004
10/21/2021	APS Referral Adult Protective Services referral received - not assigned
10/25/2021	Special Investigation Initiated - Letter Email sent to Licensee designee Rebecca Nagey
10/26/2021	Contact - Document Received Email from Ms. Nagey.
10/28/2021	Contact - Document Received I received and reviewed MaryAnn Boyd's employee file.
11/04/2021	Inspection Completed On-site I completed an unannounced onsite investigation of the Meadow Ridge facility. I interviewed director of nursing Denise Pauli, Licensee Designee Rebecca Nagey and Resident A.
11/04/2021	Contact - Telephone call made TC to Ms. Boyd
12/16/2021	Contact - Telephone call made I conducted a phone interview with Ms. MaryAnn Boyd.
12/16/2021	Exit Conference I held an exit conference with licensee designee Rebeca Nagey informing her of the findings of the investigation.

ALLEGATION:

Resident A was smacked on the face with an open hand by staff Maryann Boyd allegedly to wake the resident up.

INVESTIGATION:

On 10/21/21, I received a complaint for the Meadow Ridge Assisted Living facility. The complaint indicated that a resident assistant/staff member employed during the night shift at Meadow Ridge at Advantage Living Center-Armada named Mary Anne Boyd smacked Resident A with an open hand on her face about three-weeks ago to wake her up, according to Mary Anne when she was asked why she did that. Management was notified of this, and they claimed to have they addressed it with Mary Anne, but the outcome is unknown and seems to be nothing at that time. Mary Anne also smacked Resident A on her thigh because Resident A, who was seated on the toilet at that time, getting dressed with Mary Anne's assistance, spit on the floor. This left a red mark. There was a picture of the red mark and management has it and are "addressing" the incident with Mary Anne. There is allegedly an investigation going on, however Mary Anne is still working there, however she was moved to the assisted living section of Advantage Living Center Armada. There were staff witnesses to the two incidents and the concern beyond these two known incidents is what Mary Anne may have done to memory care residents when she was alone with them. After smacking Resident A on the thigh, Mary Anne knew someone witnessed this and she then pretended that she was playing "patty cake" (aka pat-a-cake) with Resident A in an attempt to play it off.

On 10/28/21, I received and reviewed MaryAnn Boyd's employee file. Ms. Boyd has completed the required trainings. I reviewed a disciplinary action form for Ms. Boyd dated 09/19/21. The form indicated that Ms. Boyd was disciplined for being rude and disrespectful to staff and residents. The disciplinary action form further indicated that, Ms. Boyd yelled in Resident A's face and lightly smacked her on her cheek. On 10/15/21, Ms. Boyd received another disciplinary action for slapping Resident A's upper left thigh after her shower for spitting on the floor. Ms. Boyd was removed from the Meadow Ridge facility and transferred to another facility that did not consist of memory care residents. Ms. Boyd was sent to sensitivity training and placed on a 30-day probation as a part of the disciplinary action.

On 10/28/21, I reviewed a written statement completed by staff Megan Klusendorf. The statement stated that Ms. Boyd slapped Resident A's upper left thigh after her shower for spitting. Ms. Boyd stated that she had a "reaction". This is not the first time I have witnessed her hit a resident. I have seen her hit Resident A on another occasion.

On 11/04/21, I completed an unannounced onsite investigation of the Meadow Ridge facility. I interviewed director of nursing Denise Pauli, Licensee Designee Rebecca Nagey and Resident A.

According to Ms. Pauli, it was reported to her that staff Maryann Boyd and Megan Kluesendorf, were getting Resident A into the bathroom to use the restroom when Resident A started spitting on the floor. MaryAnn hit Resident A on the leg. When MaryAnn was questioned, she stated that it was a "kneejerk reaction" and she only tapped Resident A on the leg. Ms. Pauli stated that she disciplined Ms. Boyd by having

her complete sensitivity training, and by transferring her to another facility that did not consist of residents who were in need of memory care. According to Ms. Pauli and Ms. Nagey, they were unaware of any other incidents of Resident A being hit or slapped.

During the onsite on 11/04/21, I interviewed Resident A. Resident A stated that staff take good care of her. However, Resident A is diagnosed with Dementia and was unable to answer my questions clearly and accurately. Resident A appeared to be happy as she hugged and kissed on many of the staff at the facility. I did not observe any marks or bruises on Resident A.

On 12/16/21, I conducted a phone interview with Ms. MaryAnn Boyd. Ms. Boyd stated that Resident A was spitting on the floor, and she smacked Resident A on the face as a reaction. According to Ms. Boyd, she didn't mean to do it, it just happened. She didn't feel that she smacked Resident A that hard because Resident A continued to spit. Ms. Boyd stated that this was the first and only time she smacked Resident A or any other resident. Ms. Boyd stated that she has been terminated and is no longer employed for the company.

On 12/16/2021, I held an exit conference with licensee designee Rebeca Nagey informing her of the findings of the investigation.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on the information gathered through my interviews, documentation reviews, and onsite investigation, the facility is in violation of this rule. Ms. Boyd has been disciplined multiple times for conduct and behavior that is detrimental to the residents. Other staff have witness Ms. Boyd hit Resident A on multiple occasions and Ms. Boyd admitted to hitting Resident A as an "reaction".
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(a) Use any form of punishment.** **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	Based on the information gathered through my interviews, documentation reviews, and onsite investigation, the facility is in violation of this rule. Ms. Boyd has been disciplined multiple times for conduct and behavior that is detrimental to the residents. Other staff have witness Ms. Boyd hit Resident A on multiple occasions and Ms. Boyd admitted to hitting Resident A as an "reaction".
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

12/16/21

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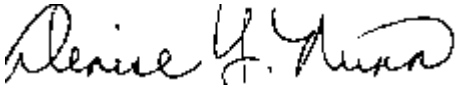
Eric Johnson Date
Licensing Consultant

Approved By:



12/17/2021

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Denise Y. Nunn Date
Area Manager