GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 19, 2021

Marva Townsend
Trinity 30/60/100 dba Living Well-Adult Living Fac
1001 Lafayette SE
Grand Rapids, MI 49507

RE: License #: AL410380788
Investigation #: 2022A0467004
Living Well-Adult Living Facility

Dear Mrs. Townsend:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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,

Anthony Mullins

Anthony Mullins, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410380788
Investigation #:	2022A0467004
Complaint Receipt Date:	11/08/2021
Investigation Initiation Date:	11/09/2021
Report Due Date:	01/07/2022
Licensee Name:	Trinity 30/60/100 dba Living Well-Adult Living Fac
Licensee Address:	1001 Lafayette SE, Grand Rapids, MI 49507
Licensee Telephone #:	(616) 633-8284
Administrator:	Marva Townsend
Licensee Designee:	Marva Townsend
Name of Facility:	Living Well-Adult Living Facility
Facility Address:	1001 Lafayette SE, Grand Rapids, MI 49507
Facility Telephone #:	(616) 633-8284
Original Issuance Date:	11/21/2016
License Status:	1ST PROVISIONAL
Effective Date:	08/03/2021
Expiration Date:	02/02/2022
Capacity:	16
Program Type:	DEVELOPMENTALLY DISABLED, ALZHEIMERS' MENTALLY ILL, AGED, AGED, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
There is concern that the facility is infested with bugs as Resident A was observed with several bugs on him during his doctor's appointment on 11/4/21.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/08/2021	Special Investigation Intake 2022A0467004
11/09/2021	Special Investigation Initiated - Telephone
11/10/2021	Inspection Completed On-site
11/18/2021	The referral was sent to ED Wilson, Recipient Rights Director at Network 180
11/18/2021	An exit conference was completed with licensee designee, Marva Townsend

ALLEGATION: There is concern that the facility is infested with bugs as Resident A was observed with several bugs on him during his doctor's appointment on 11/4/21.

INVESTIGATION: On 11/8/21, I received a denied Adult Protective Services complaint stating that Resident A passed away over the weekend and the cause of death is unknown. On Thursday, 11/4/21, Resident A was taken to his scheduled primary care physician (PCP) appointment. While there, Resident A's oxygen and pulse were low and he was given oxygen to treat his symptoms prior to being transported to the emergency department (ED). During his PCP visit, staff noticed that Resident A had bugs of all different stages crawling all over his shoes, sock and feet. This information was relayed to licensee designee, Marva Townsend and she stated the facility does not have bugs. There are concerns that staff were neglectful to Resident A.

On 11/9/21, I commenced the investigation by speaking to the complainant. The complainant clarified that Resident A passed away at the AFC home this past weekend, on Sunday, 11/7/21. She stated that Resident A came into his doctor's office on 11/4/21 and his oxygen level was at 71%. Resident A was given 6 liters of oxygen. Due to Resident A's ongoing symptoms, the complainant called EMS and had Resident A transported to the ED. Prior to Resident A being transported to the

ED, the complainant stated that she went to check Resident A's pedal pulses due to the symptoms he was displaying. While doing so, the complainant lifted Resident A's leg and observed 20-30 bugs, which she believed to be fleas and lice, crawling on him. The licensee designee, Mrs. Townsend was made aware of this concern and denied having bugs at the AFC home. The complainant's observation of the bugs led to her requesting a care management consult for Resident A while in the ED. However, the consult was ultimately declined. After speaking to staff in the ED, the complainant stated that the care management consult was declined by Stacy Hawley (Resident A's guardian) due to Mrs. Townsend stating it wasn't needed.

The complainant also stated that Resident A had previously been seen in the ED on 6/18/21 due to a COPD exacerbation. As a result of this, Resident A received a home health nurse. Per the complainant, the home health nurse was concerned about the condition of the home and reportedly told the complainant that the home was filthy, the carpet was rolled up and staff were in the basement hanging out as opposed to being on the main floor with the residents. These concerns were relayed to Resident A's guardian. Although Resident A's cause of death is unknown, the complainant believes that it was likely related to his known medical diagnosis.

On 11/10/21, I spoke to staff member Catina Thomas at the facility during an unannounced onsite investigation. Ms. Thomas stated that Resident A went to his scheduled doctor's appointment on Thursday, 11/4/21 and he was sent to the ED due to his low oxygen level. Ms. Thomas confirmed that when Resident A was at his appointment, hospital staff called and stated that he had bugs on him. Ms. Thomas stated that the home is still being treated for bedbugs from the previous infestation, but she has not seen any bedbugs, nor have any residents made complaints of bedbugs. Ms. Thomas was unable to provide a date as to when the facility was last treated for bedbugs but believes it occurred sometime after Resident A was in the ED.

Prior to leaving the facility, I observed Resident A's room. His mattress had what appeared to be a powder substance on it. I asked Ms. Thomas and she stated the powder was used as bedbug treatment. The powder was also observed on the floor near the head of the bed. It should be noted that Resident A's mattress had several rips and tears in it. However, there was no visible sign of bedbugs. I then spoke briefly to Resident B in his room. Resident B denied any issues with bedbugs. I then went to room 206 and observed both beds. The bed near the window was observed to have multiple bedbugs on it. It should be noted that the wooden bedframe had two piles of what appeared to be bedbug residue in the corners, as well as residue throughout the whole bedframe. The pillowcase on this bed also appeared to have dried blood on it. Ms. Thomas was in the room and observed this as well. I also observed bedbug residue on the other bed in the room and took photographs. There was also some broken glass on the floor in the room and Ms. Thomas agreed to remove it.

After observing room 206, I spoke with Resident C, who is directly across the hall from room 206. Introductions were made and he allowed entry into his room. I asked Resident C if he's had any issues with bugs in his room. Resident C stated yes and that he removed a bedbug from his mattress today. Resident C lifted his blankets and showed me multiple bedbugs (dead and alive). After speaking to residents and observing their rooms, I told Ms. Thomas to inform Ms. Townsend that I would return to the facility on Friday morning to speak with her.

During a scheduled onsite investigation on 11/12/21, I asked Mrs. Townsend about the reported bedbugs. Mrs. Townsend stated that staff at Resident A's doctor's appointment did show her a bug that was from Resident A. Mrs. Townsend stated that she can't imagine where the bugs came from because every room in the facility gets treated every 3 weeks. Mrs. Townsend stated that she has not seen a bedbug in months. Mrs. Townsend stated that months ago, she witnessed a resident emptying a vial of bedbugs into the sink. She immediately told him to put them in the dumpster outside, to which he did. She stated that it's possible that other residents are bringing bugs in as well. Mrs. Townsend denied that she declined a care management consult while at Resident A's doctor appointment to address the bedbug issue.

Mrs. Townsend stated that the last time the facility received a professional bedbug treatment was sometime last month. Mrs. Townsend stated that her son also treats the home with a heat treatment. After the room is heated, it is vacuumed, including the mattresses. The linens are changed and washed as well. Mrs. Townsend stated that her son also treats the home with a form of powder and cleans it up in a week. The last time her son treated the home with powder was this past Saturday, 11/6/21, which was the same day that Resident A passed away. It should be noted that the facility was previously cited for bedbugs on 9/03/20 in SIR #2020A0357021 and more recently on 6/21/21 during the renewal inspection. Per the corrective action plan that was completed on 7/1/21 by Mrs. Townsend, the powder treatment remains in the room for three days, then the residue is vacuumed. The powder residue that was placed on Resident A's bed on 11/6/21, was still present during my initial onsite investigation on 11/10/21, which exceeds three days. Therefore, Mrs. Townsend is not in compliance with her corrective action plan.

I also asked Mrs. Townsend about the condition of Resident A's bed as there were tears and holes in the mattress. Mrs. Townsend stated that there was a mattress cover on the bed previously, so she is unsure why it was no longer there. Mrs. Townsend agreed that this was concerning. I then showed her the pictures of beds throughout the facility that had bedbugs and a significant amount of bedbug residue on them. Mrs. Townsend stated that she believes that maintenance tried to vacuum the bed frames. However, they were unable to do so. Therefore, she planned to have the bed frames removed. Mrs. Townsend stated that maintenance removed some of the wooden bed frames but were unable to complete the job in its entirety due to the beds being heavy. Per Mrs. Townsend, this was supposed to be completed months ago. Mrs. Townsend stated that she reached out to others in an

attempt to remove the beds and her attempts were unsuccessful. I asked Mrs. Townsend to send me receipts for her most recent bedbug treatments prior to the end of the day, which she did. However, the receipts were difficult to read via text.

On Monday, 11/15/21, I sent Mrs. Townsend a message asking to pick up a physical copy of the receipts to allow me to review them prior to the conclusion of my report. I obtained the receipts from Mrs. Townsend at 3:00 pm. On Tuesday, 11/16/21, I reviewed the two receipts submitted by Mrs. Townsend from Smitter Pest Control Company. The first receipt indicated that the home was treated on 10/6/21. During that treatment, specific rooms were treated and the whole first floor. The receipt does not specify which pests were targeted. The second receipt indicated that the home was serviced on 11/3/21. During this treatment, all common areas were treated and all even rooms. The targeted pest during this treatment were “ants, earwigs, mice, silverfish and spiders.” There is a checkbox for bedbugs to be targeted, which was not selected. There were no additional receipts provided. Therefore, there is no proof that the facility is being professionally treated for bedbugs.

On 11/18/21, an exit conference was completed with licensee designee, Mrs. Townsend. I informed her of the investigative findings and she stated she understands that it is being recommended that the facility’s license be revoked. The findings of this investigation will be addressed in the 12/2/21 compliance conference.

APPLICABLE RULE	
R 400.15401	**Environmental health.**
	(5) An insect, rodent, or pest control program shall be maintained as necessary and shall be carried out in a manner that continually protects the health of residents.
ANALYSIS:	On 11/10/21, an onsite investigation was completed at the facility. During the inspection, resident bedrooms were inspected, and the mattresses and wooden bedframes were observed with bedbugs and bedbug residue on them. The facility was previously cited for bedbugs, which resulted in the facility being placed a provisional license. The facility has not rectified the bedbug infestation that was previously cited. Therefore, this is a repeated rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED** **Repeat violation from 09/03/2020 and 06/21/2021.**

ADDITIONAL FINDINGS: Resident A’s Health care appraisal was not completed.

INVESTIGATION: On 11/10/21, I completed an unannounced onsite investigation at the facility. Due to the nature of the allegations, I asked Ms. Thomas for Resident A's Health care appraisal. The health care appraisal did not have any information on it other than Mrs. Townsend's name and the name of the facility. Ms. Thomas stated she was unsure if Resident A had completed forms elsewhere.
On 11/12/21, I explained to Mrs. Townsend that during my initial onsite investigation on 11/10/21, I requested to see Resident A's healthcare appraisal and the form was not completed. The healthcare appraisal form only had Mrs. Townsend's name on it. Mrs. Townsend stated that she had blank forms in the files in preparation to have the forms signed for the upcoming new year, although Resident A's health care appraisal isn't required to be updated until June 2022. She added that she was working on the file in her office and left the completed forms there. Mrs. Townsend provided me with a completed healthcare appraisal for Resident A. However, the form was not signed by Resident A's guardian. I again reiterated the importance of having all required licensing documents readily available in the event they are needed. Mrs. Townsend stated that going forward, she will leave documents in the medication room accessible to all staff.

On 11/18/21, an exit conference was completed with licensee designee, Mrs. Townsend. I informed her of the investigative findings and she stated she understands that it is being recommended that the facility's license be revoked. The findings of this investigation will be addressed in the 12/2/21 compliance conference.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	On 11/10/21, an unannounced onsite investigation was completed. I requested Resident A's health care appraisal. Ms. Thomas provided me with a blank form, with no identifying information other than the licensee designee's name and the name of the facility.

	Mrs. Townsend subsequently provided the requested form two days later on 11/12/21. However, the health care appraisal was not signed by Resident A's guardian. Therefore, a rule violation is established.
CONCLUSION:	**VIOLATION ESTABLISHED** **Repeat violation from 06/21/2021**

ADDITIONAL FINDINGS: Resident A's assessment plan was not completed.

INVESTIGATION: On 11/10/21**,** an unannounced onsite investigation was completed at the facility. Due to the nature of the allegations, I asked Ms. Thomas to review Resident A's assessment plan. The assessment plan was incomplete and missing the signature page. Ms. Thomas stated she was unsure if Resident A had completed forms elsewhere.

On 11/12/21, I explained to Mrs. Townsend that during my initial onsite investigation on 11/10/21, I requested to see Resident A's assessment plan and observed the form was not completed. The assessment plan did not have a signature page. Mrs. Townsend stated that she had blank forms in the files in preparation to have the forms signed for the new year, although Resident A's assessment plan isn't required to be updated until June 2022. She added that she was working on the file in her office and left the completed forms there. Mrs. Townsend provided me with a completed assessment plan. However, the form was signed by Resident A instead of his guardian. Mrs. Townsend stated that this was due to Resident A's guardian not being present at the time of admission. Despite this, she is still responsible to make sure this form is signed by his guardian. Mrs. Townsend stated that going forward, she will leave documents in the medication room accessible to all staff.

On 11/18/21, an exit conference was completed with licensee designee, Mrs. Townsend. I informed her of the investigative findings and she stated she understands that it is being recommended that the facility's license be revoked. The findings of this investigation will be addressed in the 12/2/21 compliance conference.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.

ANALYSIS:	On 11/10/21, an unannounced onsite investigation was completed. I requested Resident A's assessment plan and it was not completed. Mrs. Townsend subsequently provided me with a different assessment plan on 11/12/21, and it was not signed by Resident A's guardian. Therefore, a rule violation is established.
CONCLUSION:	**VIOLATION ESTABLISHED** **Repeat violation from 06/21/2021**

ADDITIONAL FINDINGS: Resident A was hospitalized on 11/4/21 due to a low oxygen level and an incident report was not completed.
INVESTIGATION: On 11/8/21, I received a denied Adult Protective Services complaint stating that Resident A passed away over the weekend and the cause of death is unknown. On Thursday, 11/4/21, Resident A was taken to a scheduled PCP appointment. While there, Resident A's oxygen and pulse were low, and he was given oxygen to treat his symptoms. He was then transported to the ED for further evaluation.

On 11/10/21, I made an unannounced onsite investigation. I spoke to staff member Catina Thomas. Ms. Thomas stated that Resident A went to his scheduled doctor's appointment on Thursday, 11/4/21 and he was sent to the ED due to his low oxygen level. On 11/12/21, Mrs. Townsend confirmed that Resident A was sent to the ED from his scheduled PCP appointment on 11/4/21 due to his low oxygen level. Mrs. Townsend acknowledged that she did not complete an incident report when Resident A was hospitalized for this incident and did not provide further explanation.

On 11/18/21, an exit conference was completed with licensee designee, Mrs. Townsend. I informed her of the investigative findings and she stated she understands that it is being recommended that the facility's license be revoked. The findings of this investigation will be addressed in the 12/2/21 compliance conference.

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(b) Any accident or illness that requires hospitalization.**

ANALYSIS:	Mrs. Townsend and Ms. Thomas confirmed that Resident A was hospitalized on 11/4/21 due to low oxygen. Mrs. Townsend acknowledged that she did not complete an incident report for this incident. Therefore, a violation is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Resident A passed away at the facility on 11/6/21 and an incident Report was not completed within 48 hours.

INVESTIGATION: On 11/10/21, an unannounced onsite investigation was completed at the facility. Upon arrival, I spoke to staff member Catina Thomas. Ms. Thomas stated that the licensee designee, Mrs. Marva Townsend was not present. Ms. Thomas called Mrs. Townsend and placed the phone on speaker to allow her to communicate with me briefly. Mrs. Townsend stated that she was away due to attending a funeral. Mrs. Townsend and Ms. Thomas both confirmed that Resident A passed away in the facility on Saturday, 11/6/21. I inquired about the incident report that should have been completed and sent to me within 48 hours of Resident A's passing, which would have been due to me by 11/8/21. Mrs. Townsend stated that she completed the incident report on 11/6/21 and tried to fax it to me. Mrs. Townsend stated that the fax must not have gone through. I asked Mrs. Townsend for a physical copy of the incident report. However, she stated it was completed but it is locked in her office and staff do not have access to it. I explained to Mrs. Townsend that any licensing forms need to be readily available at the facility and if she is going to lock forms in her office, staff should have a key whenever she's away from the facility.

On 11/12/21, I conducted an announced inspection to the AFC home. Upon arrival, I spoke to Ms. Thomas and she provided an office space to meet with Mrs. Townsend. Mrs. Townsend arrived at the facility and we discussed the allegations. Mrs. Townsend stated that Resident A had a doctor's appointment on Friday, 11/5/21 or Thursday, 11/4/21. Mrs. Townsend took Resident A to his scheduled doctor's appointment. While there, Resident A's oxygen level dropped, which led to staff at the doctor's office giving him oxygen and sending him to the ED via EMS. Upon discharge from the ED, EMS staff stated that Resident A needs to wear his oxygen continuously, but Resident A has always refused to do so, especially during daytime hours. Mrs. Townsend was adamant that she and staff at the home have always encouraged Resident A to wear his oxygen. Despite this, he would often remove his oxygen.

Mrs. Townsend stated that Resident A passed away this past Saturday, 11/6/21. Mrs. Townsend stated that while serving residents breakfast, she noticed that Resident A was not present, and this prompted her to go check on him. Mrs. Townsend stated that she discovered Resident A lying in his bed. Mrs. Townsend called Resident A by his name and he did not response. Mrs. Townsend then

attempted to shake him. There was still no response from Resident A so Mrs. Townsend went to the other side of the bed, which is when she said she could tell that Resident A was deceased as his hands were blue. Mrs. Townsend stated that Resident A's oxygen tank was on. However, it was on his chin instead of his nose. Mrs. Townsend stated that she immediately called EMS and they pronounced him dead when they arrived. Police were also involved.

Resident A was 69-year-old (DOB: 10/18/52) on the date of his death. He had been diagnosed with chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), hypertension and schizophrenia. In the days prior to his death, Mrs. Townsend stated that Resident A was "doing okay." She stated that Resident A would become winded when he returned inside the home after smoking cigarettes and had to sit down to catch his breath. Mrs. Townsend noted that Resident A's smoking increased over the summer to the point that he was smoking at least one pack of cigarettes per day. In addition to the medical diagnosis listed above, Mrs. Townsend stated that Resident A was "a little obese." Prior to Resident A's passing, Mrs. Townsend stated that "nothing really changed" and she did not notice him deteriorating.

Regarding Resident A passing, Mrs. Townsend stated that she did complete an incident report and faxed it to me and Kent County Recipient Rights on 11/6/21. However, she never received a confirmation page or an error page. Mrs. Townsend added that she just got a new fax machine approximately one week ago and she never knew the fax did not go through. It should be noted that during my initial onsite investigation on Wednesday, 11/10/21, Ms. Thomas and I were speaking to Mrs. Townsend via phone and Mrs. Townsend stated that the incident report was in her office, which staff did not have access to. I again explained to Mrs. Townsend that any licensing documentation, especially incident reports regarding a resident's death should be readily available. Mrs. Townsend provided me with a copy of the incident report from the passing of Resident A on 11/6/21. However, I have no way of confirming that the incident report was completed on 11/6/21 as Mrs. Townsend states it was since it was not available during my initial visit. Mrs. Townsend stated that she usually keeps incident reports and other required documentation in the medicine room, which staff have a key to.

On 11/18/21, an exit conference was completed with licensee designee, Mrs. Townsend. I informed her of the investigative findings and she stated she understands that it is being recommended that the facility's license be revoked. The findings of this investigation will be addressed in the 12/2/21 compliance conference.

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by

	telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: (a) The death of a resident.
ANALYSIS:	Mrs. Townsend confirmed that Resident A passed away in the facility on 11/6/21. Mrs. Townsend reportedly sent me a copy of the incident report via fax but it was never received. I did not receive a physical copy of the incident report until a scheduled onsite investigation on 11/12/21, which was 6 days after Resident A passed away. Therefore, a violation is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

The 2021 renewal inspection dated 6/21/21 resulted in a finding of both physical plant as well as quality-of-care violations. The corrective action plan addressing those prior violations was approved on 7/21/21 and the facility was placed on a provisional license effective 08/03/2021. While on a provisional license, the facility was cited on 08/24/2021 (SIR #2021A0467010) for a subsequent quality-of-care violation, which resulted in a recommendation of license revocation. The compliance conference for the recommended license revocation is scheduled for 12/02/2021. As a result of this current investigation, the facility is again being cited for the above referenced quality-of-care and physical plant violations. Therefore, license revocation remains the recommendation, and this will be addressed during the compliance conference scheduled for 12/02/2021.

Anthony Mullins 11/18/2021

Anthony Mullins Date
Licensing Consultant

Approved By:

Jerry Hendrick 11/19/2021

Jerry Hendrick Date
Area Manager