STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

January 11, 2022

Paul Wyman
Retirement Living Management of Greenville
1845 Birmingham SE
Lowell, MI 49331

RE: License #: AL590279843
Investigation #: 2022A0466010
Green Acres of Greenville

Dear Mr. Wyman:

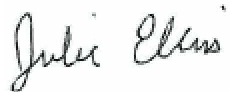
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (517) 284-9727.

Sincerely,



Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL590279843
Investigation #:	2022A0466010
Complaint Receipt Date:	11/12/2021
Investigation Initiation Date:	11/12/2021
Report Due Date:	01/11/2022
Licensee Name:	Retirement Living Management of Greenville
Licensee Address:	1845 Birmingham SE Lowell, MI 49331
Licensee Telephone #:	(616) 897-8000
Administrator:	Julie Poole
Licensee Designee:	Paul Wyman
Name of Facility:	Green Acres of Greenville
Facility Address:	1601 Winter Creek Court Greenville, MI 48838
Facility Telephone #:	(616) 754-8850
Original Issuance Date:	05/17/2007
License Status:	REGULAR
Effective Date:	04/09/2020
Expiration Date:	04/08/2022
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION

	Violation Established?
Resident A and Resident B were told they were not able to stay and quarantine at the facility after they tested positive for COVID-19.	Yes
The facility did not seek timely medical attention for Resident A and Resident B when their heath began declining due to COVID-19.	No

III. METHODOLOGY

11/12/2021	Special Investigation Intake - 2022A0466010.
11/12/2021	Special Investigation Initiated – Telephone call to licensing consultant, Jennifer Browning, interviewed and reported that the facility has residents with COVID-19.
11/12/2021	Contact - Document Received-from Jennifer Browning.
11/12/2021	Contact - Document Received- Facility documents received.
12/06/2021	Contact - Telephone call made to Relative A2 interviewed.
12/06/2021	Contact - Document Sent- Email to facility to see if there are any active COVID cases currently.
12/06/2021	Contact - Document Received Administrator Julie Poole reported that the facility has 3 positive cases currently the most recent resident tested positive on 12/03/2021.
12/06/2021	Contact - Document Received from Complainant.
12/06/2021	Inspection Completed On-site -No in person inspection could be conducted based on the facility having COVID-19 positive residents.
12/28/2021	Contact - Document Received email from Complainant.
01/06/2022	Contact - Document Sent to administrator Julie Poole.

01/07/2022	Contact-Telephone call made to Relative A2 interviewed for a second time.
01/07/2022	Contact-Telephone call made to Kelly Nelson, regional director, interviewed.
01/07/2022	Contact-Telephone call made to administrator Julie Poole, interviewed.
01/09/2022	Contact – Documents received from administrator Julie Poole.
01/10/20222	Exit Conference with licensee designee Paul Wyman.

ALLEGATION: Resident A and Resident B were told they were not able to stay and quarantine at the facility after they tested positive for COVID-19.

INVESTIGATION:
Complainant reported on 11/12/2021, that on 11/11/2021, she got a call from the facility reporting that Resident A had tested positive for COVID-19. Complainant reported she was told the facility policy is that residents have to leave the facility for 14 days after testing positive for COVID-19. Complainant reported the facility asked if she was willing to take Resident A. Complainant reported she agreed at that time to come and get Resident A on 11/12/2021. Complainant reported she did not like it, but wanted Resident A gone from the facility. Complainant reported that at 8 AM Relative A1 called to inform her that Resident A was very confused on the phone and sounded bad. Complainant reported she and Relative A1 decided she was not equipped to care for Resident A. Complainant reported she called the facility to tell them that she was not picking up Resident A. Complainant reported that later that morning the facility called to report Resident B also tested positive for COVID-19 and wanted Complainant to pick up both Resident A and Resident B. Complainant reported the facility violated licensing regulations by “kicking them out of their residence when they got sick.” Complainant reported being concerned that if the hospital discharges Resident A and Resident B, they would not be able to return to the facility because both would still have a positive COVID-19 status.

On 11/12/2021, I interviewed licensing consultant Jennifer Browning who reported that on 11/12/2021, she received a voicemail message from administrator Julie Poole, stating the facility had two more residents test positive for COVID-19. Mrs. Browning stated administrator Poole reported the facility policy changed a few months back stating residents who are COVID-19 positive cannot stay at the facility. Mrs. Browning reported administrator Poole stated residents are being sent to a COVID hub, the hospital or home with relatives after the resident tests positive for COVID-19.

On 11/12/2021, Mrs. Browning reported Kelly Nelson, regional director stated the facility policy is that residents are required to be out of the facility while they have COVID-19 and are not allowed back until they test negative. Mrs. Browning reported Ms. Nelson stated residents are not charged their individual care level fees while out of the facility due to being COVID-19 positive. Mrs. Browning reported Ms. Nelson stated they were told by Michigan Department of Labor and Economic Opportunity Michigan Occupational Safety and Health Administration (MIOSHA) that because the facility did not have a respirator program in place, the facility cannot care for residents who are COVID-19 positive. Mrs. Browning reported another licensed AFC owned by the licensee was cited by MIOSHA because the AFC facility did not have the means to fit test for respirators. Mrs. Browning reported Ms. Nelson stated according to the MIOSHA violations, the facility needed to use respirators when caring for COVID-19 positive residents. Mrs. Browning reported Ms. Nelson stated this violation occurred approximately six months ago. According to Mrs. Browning, Ms. Nelson stated residents are sent to the hospital or they go to a family members home after testing positive for COVID-19. Mrs. Browning reported residents testing positive for COVID-19 have gone to the COVID hub in Frankenmuth, Traverse City, or Kalamazoo. Mrs. Browning reported Ms. Nelson stated they go there for 10 days and then when they test negative, they return to the facility. Mrs. Browning reported that Ms. Nelson stated facility direct care staff members have been going through the social worker at United Memorial Hospital who helped get residents to a COVID hub. Mrs. Browning reported Ms. Nelson stated she has spoken with licensing consultant Elizabeth Elliott (in Grand Rapids) and Bridget Vermeesch (Mt. Pleasant) and both told Ms. Nelson she could not send residents out of the AFC facility only because the resident tested positive for COVID-19. Mrs. Browning reported that Ms. Nelson stated she would send the MIOSHA paperwork with the violation, the letter they sent to the resident's families, and their COVID-19 procedures.

On 11/12/2021, I reviewed *House Guidelines* which documented in number 13 of the document: "In the event that a resident needs treatment, care, or recovery including isolative care due to an infectious illness, the resident and/or designated representative will be notified and may be asked to remove resident from the facility if and Retirement Living Management is unable to provide the necessary care under local, state, or federal health requirements." *House Guidelines* were updated 02/2021 which was noted on each page above the page number.

On 11/12/2021, I reviewed *RLM COVID-19 Protocol Update 9/13/2021* in the Positive COVID-19 Case Associated with the Facility Procedure: "A resident who tests positive for COVID-19 will be sent out to their hospital of choice or with family and unable to return for a minimum of 10 days."

On 11/12/2021, I reviewed a MIOSHA report dated 02/17/2021 and authored by Sundari Murthy which documented that another AFC facility owned/operated by the same licensee was cited and fined $7,000 for not having a respiratory program, not requiring face coverings in shared spaces including in-person meetings, not having N-95 respirators, and not having a COVID-19 preparedness and response plan.

On 12/06/2021, I interviewed Relative A2 who reported that on 09/21/2021, she received correspondence from the facility that included Policy and Procedure updates. Relative A2 reported changes to the policy/procedure were highlighted so the changes could be readily seen. Relative A2 reported she signed the policies and sent back the signature page to the facility. Relative A2 reported that policy updates were made to the *House Guidelines* and *RLM COVID-19 Protocol Update 9/13/2021*. Relative A2 reported she never received a written discharge notice from the facility when she was asked to pick up Resident A and Resident B due to them both testing positive for COVID-19. Relative A2 reported she never took either Resident A or Resident B home with her because Resident A's condition changed and emergency medical service (EMS) was contacted. Relative A2 reported that both Resident A and Resident B left the facility by EMS on 11/11/2021. Relative A2 reported that both Resident A and Resident B passed away at the hospital.

On 01/07/2021, I interviewed Ms. Nelson who reported Resident A and Resident B who are husband and wife were hospitalized for COVID-19 on 11/11/2021 at United Memorial Hospital in Greenville. Ms. Nelson stated on 11/10/202, the ambulance was called but would not take Resident A to the hospital because Relative A2 declined to send Resident A to the hospital. Ms. Nelson stated that when an ambulance is declined, someone needs to sign for it. Ms. Nelson stated that Resident A is her own guardian but that she was informed that Relative A2 declined the ambulance, not Resident A. Ms. Nelson reported that she did not have any documentation of the ambulance being declined. Ms. Nelson reported Resident A tested positive for COVID-19 on 11/10/2021 and had a fever. Ms. Nelson stated the plan for Resident A was to go to Relative A2's home on 11/11/2021. Ms. Nelson stated on 11/11/2021, Resident B tested positive for COVID-19. Ms. Nelson stated Resident B had been isolating from Resident A since Resident A tested positive for COVID-19 on 11/10/2021. Ms. Nelson stated on 11/11/2021, Resident A started to decline and Resident A's family decided they wanted her to go to the hospital. Ms. Nelson stated the ambulance came and took both Resident A and Resident B to the hospital on 11/11/2021. Ms. Nelson stated both Resident A and Resident B died at the hospital.

On 01/07/2021, I interviewed administrator Poole who reported that Resident A and Resident B who are husband and wife were hospitalized for COVID-19 on 11/11/2021 at United Memorial Hospital in Greenville. Administrator Poole stated on 11/10/202, she called an ambulance and the ambulance would not take Resident A to the hospital because hospital was full and they had no beds. Administrator Poole reported that she told the emergency medical technician that she was concerned about Resident A because of her fever and because she was diabetic. Administrator Poole reported that the ambulance agreed to take Resident A to the hospital. Administrator Poole reported that she had to go assist another resident and when she came back, she saw the ambulance pulling away. Administrator Poole reported that is when she learned Relative A2 refused to send Resident A to the hospital. Administrator Poole stated that when an ambulance is declined, someone

needs to sign for it. Administrator Poole reported that she did not have any documentation of the ambulance being declined. Administrator Poole reported that she worked overnight to monitor Resident A as she was concerned and wanted to make sure her vitals were monitored. Administrator Poole reported Resident A tested positive for COVID-19 on 11/10/2021 and had a fever. Administrator Poole stated Resident A was to go to Relative A2's home on 11/11/2021. Administrator Poole stated on 11/11/2021, Resident B tested positive for COVID-19. Ms. Nelson stated Resident B had been isolating from Resident A since Resident A tested positive for COVID-19 on 11/10/2021. Administrator Poole stated on 11/11/2021, Resident A started to decline and the family decided they wanted her to go to the hospital. Administrator Poole stated the ambulance came and took both Resident A and Resident B to the hospital on 11/11/2021. Administrator Poole stated both Resident A and Resident B died at the hospital.

On 01/09/2022, administrator Poole provided a signature page signed by Relative A2 on 09/23/2021, acknowledging the changes to *House Guidelines* and *RLM COVID-19 Protocol Update 9/13/2021*.

APPLICABLE RULE	
R 400.15304	**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 the following resident rights: **(j) The right of reasonable access to and use of his or her personal clothing and belongings.** **(p) The right of access to his or her room at his or her discretion.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**

ANALYSIS:	Complainant, Relative A2, administrator Poole and regional director Nelson all reported that the facility updated *House Guidelines* on 02/2021 to reflect that COVID-19 positive residents cannot remain at the facility requiring that such residents need to leave the facility for no less than 10 days. I reviewed the *House Guidelines* which documented in number 13 of the document: "In the event that a resident needs treatment, care, or recovery including isolative care due to an infectious illness, the resident and/or designated representative will be notified and may be asked to remove resident from the facility if and Retirement Living Management is unable to provide the necessary care under local, state, or federal health requirements." Although the *House Guidelines* were signed by Relative A2 on 09/23/2021, the *House Guidelines* conflict with a resident's right to access their belongings and their room at their discretion regardless of diagnosis status; therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(a) The licensee shall notify the resident, the resident's designated representative, the responsible agency, and the adult foster care licensing consultant not less than 24 hours before discharge. The notice shall be in writing and shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the licensee.** **(iii) The location to which the resident will be discharged, if known.**

ANALYSIS:	Relative A2 and regional director Nelson reported that Resident A and Resident B were not issued a written 30-day discharge. On 11/10/2021, when Resident A tested positive for COVID-19, administrator Pool contacted Relative A2 to inform her that Resident A was COVID-19 positive and to inquire if she was willing to care for Resident A in her home as Resident A could not stay at the facility to isolate due to the facility's policies. On 11/11/2021 Relative A2 was informed that Resident B was COVID-19 positive and therefore the facility wanted Relative A2 to take Resident B home with her also. While Relative A2 was at the facility on 11/11/2021, Resident A's medical condition changed which required EMS to be contacted. EMS took both Resident A and Resident B to the hospital. Resident A and Resident B passed away while at the hospital. Although the intent of the facility was to discharge Resident A and Resident B without a written discharge notice, that did not occur due to them both being hospitalized on 11/11/2021 therefore there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The facility did not seek timely medical attention for Resident A and Resident B when their heath began declining due to COVID-19.

INVESTIGATION:
Complainant reported on 11/12/2021, that on 11/11/2021she called the facility to talk with Resident A. Complainant reported it took the facility direct care staff members close to an hour to go to Resident A and Resident B's room to assist Resident A with the phone. Complainant reported that when she did talk with Resident A, she recognized right away Resident A was not well. Complainant reported she could hear each breath go in and out, Resident A's voice was unusually deep, she was confused and Resident A could not pass a mini mental status exam. Complainant reported she immediately phoned Relative A1 and told him Resident A needed immediate hospital evaluation. Complainant reported direct care staff said Resident A was "fine." Complainant reported Relative A1 insisted EMS be called, which occurred, and EMS took both Resident A and Resident B to the emergency room (ER). Complainant reported neither Resident A nor Resident B was able to get out of their chair which is unusual as both Resident A and Resident B normally ambulate and go to the dining room for meals and participate in activities at the facility. Complainant reported that Resident A was confused and her O2 level was low. Complainant described Resident B as being "pretty much nonresponsive and unable to wake up." Complainant reported Relative A1 felt the need to notify the police about what was happening because he felt direct care staff would impede their ability to obtain help from EMS. Complainant reported administrator Julie Poole was monitoring Resident A and Resident B and she did not think either resident needed to be transported to the hospital. Complainant reported as of 11/12/2021 Resident A

was currently hospitalized on a ventilator, getting a central line installed and would be transferred to another hospital shortly. Complainant reported Resident B continued to be non-responsive and would also be admitted once a bed opens up. Complainant reported Resident A and Resident B needed medical assistance sooner than when it was received. Complainant reported that she and Relative A1 should not have had to insist direct care staff members call EMS for help. Complainant reported direct care staff members should be taking proper care and know when to call EMS for assistance. Complainant reported that she believes it is likely that Resident A and Resident B will not live thru this episode. Complainant reported that the facility was neglectful in caring for Resident A and Resident B as they didn't recognize an emergent situation.

On 11/12/2021, Mrs. Browning reported that Kelly Nelson, regional director reported that Resident A and Resident B are still in the hospital. Mrs. Browning reported that Ms. Nelson stated they went in yesterday and were admitted to United Memorial Hospital / Greenville. Mrs. Browning reported that Ms. Nelson stated that the ambulance would not take Resident A to the hospital on 11/11/2021 due to the hospital being full. Mrs. Browning reported that Ms. Nelson stated Resident A tested positive for COVID-19 and had a high fever. Mrs. Browning reported that Ms. Nelson stated the hospital changed their mind and were going to take Resident A but Relative A2 was at the facility and signed off refusing the ambulance. Mrs. Browning reported that Ms. Nelson stated Resident B had been isolating from Resident A once she was diagnosed with COVID-19. Mrs. Browning reported that Ms. Nelson stated on 11/11/2021, Resident A started to decline and the family decided they wanted her to go to the hospital. Mrs. Browning reported that Ms. Nelson stated the ambulance came and said that they would take both Resident A and Resident B to the hospital which they did.

On 11/11/2021, Mrs. Browning reported that Ms. Nelson stated administrator Poole was at the facility during the midnight shift on 11/10/2021 to monitor Resident A's vitals the night before she went into the hospital on 11/11/2021. Mrs. Browning reported that Ms. Nelson stated Resident A is independent and Resident B requires more assistance. Mrs. Browning reported that Ms. Nelson stated Resident A will try to assist Resident B as he is her husband and Relative A1 does not want Resident A to assist but also does not Resident A and Resident B in separate bedrooms. Mrs. Browning reported that Ms. Nelson stated Resident A and Resident B do not have a power of attorney (POA) yet because neither resident has been deemed incompetent.

On 01/07/2021, I interviewed Relative A2 who reported that she nor Relative A1 never declined any medical intervention once Resident A and Resident B were diagnosed with COVID-19. Relative A2 reported that she and Relative A1 did decline for Resident B to be sent to the hospital on 11/09/2021 when he fell and his head hit a table in his room. Relative A2 reported that there were no abrasions and that Resident B appeared uninjured. Relative A2 did not believe that the facility was monitoring Resident A and Resident B's blood oxygen level.

On 01/07/2021, I reviewed the death certificates for Resident A which documented that Resident A died on 11/13/2021 at 9:29pm at United Memorial Hospital / Greenville. Cause of death is listed as COVID-19 pneumonia.

On 01/07/2021, I reviewed the death certificates for Resident A which documented that Resident A died on 11/21/2021 at 9:38pm at United Memorial Hospital / Greenville. Cause of death is listed as COVID-19.

On 01/09/2021, administrator Poole provided *Observations for Resident A*:

- 11/10/2021, 4:15pm, DCW alerted nurse that resident has a fever of 103.9 and doesn't feel good. Rapid COVID test performed with positive result. Relative A2 notified.
- 11/10/2021, 4:45pm, Relative A1 notified of Resident A's positive COVID test, Relative A2 is extremely upset and begins to blame the facility for not having 100 % of the staff vaccinated.
- 11/10/2021, 5:00pm, I called the ambulance to have Resident A sent to the hospital. The ambulance came and stated that the hospital was full and if they took Resident A that she would be back in 30 minutes. I spoke with the ambulance driver and informed them that Resident A needs to go to the hospital. In the meantime, I had to run to another resident room. When I started to head back, the ambulance was pulling away and I was informed that Relative A2 approved the resident from not having to be transferred to the hospital. I called Relative A1 to notify him immediately that Resident A was not being transferred to the hospital and would be here.
- 11/10/2021, 7:30pm, both administrator Poole and the nurse went to assess Resident A before leaving and her vitals were stable.
- 11/11/2021, 3am, temperature 102.3 and O2 was 92.
- 11/11/2021. 5:00am, temperature was 97.1 and O2 was 95.
- 11/11/2021, 11:30am, Resident says he feels okay, her throat hurts her when she coughs, she feels exhausted. Temperature 100.0 and 02 was 93.
- 11/11/2021, 11:45am nurse assessed Resident A, temperature 100.1 O2 92, dry non-productive cough noted. Resident denies pain at this time. Resident encouraged to drink fluids and stay hydrated.

On 01/09/2021, administrator Poole provided the following *Vital History* for Resident B

- 11/11/2021, temperature 97.8.
- 11/11/2021, pulse ox 95.

In the *Observations for Resident B*, tested positive for COVID-19 on 11/11/2021 at 12pm and Relative A2 notified at 12pm.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Although Complainant reported that the facility did not seek timely medical attention for Resident A and Resident B when their heath began declining due to COVID-19, there is not enough evidence to support that allegation. Resident A was diagnosed with COVID-19 on 11/10/2021 and temperature and blood oxygen levels were being monitored. Resident A’s blood oxygen remained in the 90’s while at the facility and Resident A’s temperature fluctuated. Resident B was diagnosed as COVID-19 positive on 11/11/2021 and temperature and blood oxygen levels were being monitored. Resident B’s blood oxygen remained in the 90’s and Resident A never had a fever while at the facility. Both residents were taken and admitted to the hospital within one day of being diagnosed with COVID-19.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 1/10/2021, I contacted licensee designee Paul Wyman to conduct an exit conference and he understood the reason for the violation.

IV. RECOMMENDATION

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

01/10/20222

Julie Elkins Date
Licensing Consultant

Approved By:

01/11/2022

Dawn N. Timm Date
Area Manager