GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 24, 2022

Chuck Sekrenes
Bella Vita of Hartland, LLC
Suite A
2430 E Hill Rd
Grand Blanc, MI 48439

RE: License #: AH470393393
Investigation #: 2022A1027023
Bella Vita of Hartland

Dear Mr. Sekrenes:

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 by the licensee authorized representative and dated.

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) 241-1970.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 241-1970

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH470393393
Investigation #:	2022A1027023
Complaint Receipt Date:	01/06/2022
Investigation Initiation Date:	01/06/2022
Report Due Date:	03/05/2022
Licensee Name:	Bella Vita of Hartland, LLC
Licensee Address:	Suite A 2430 E Hill Rd Grand Blanc, MI 48439
Licensee Telephone #:	(810) 603-7228
Administrator:	Breona Woods
Authorized Representative:	Chuck Sekrenes
Name of Facility:	Bella Vita of Hartland
Facility Address:	2799 Bella Vita Dr. Hartland, MI 48353
Facility Telephone #:	(810) 746-7800
Original Issuance Date:	08/19/2020
License Status:	REGULAR
Effective Date:	02/19/2021
Expiration Date:	02/18/2022
Capacity:	79
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Residents were treated poorly, and four residents died in the past three months.	No
The facility was short staffed on nights.	Yes
Additional Findings	Yes

The complainant identified some concerns that were not related to licensing rules and statutes for a home for the aged. Therefore, only specific items pertaining to homes for the aged provisions of care were considered for investigation. The following items were those that could be considered under the scope of licensing.

III. METHODOLOGY

01/06/2022	Special Investigation Intake 2022A1027023
01/06/2022	Special Investigation Initiated - Letter Email sent to administrator Breona Woods requesting an employee list
01/19/2022	Inspection Completed On-site
01/20/2022	Contact - Telephone call made Telephone interview conducted with administrator Breona Woods
01/24/2022	Inspection Completed-BCAL Sub. Compliance
01/24/2022	Contact - Document Received Email received from Ms. Woods with requested information
02/02/2022	Exit Conference Conducted with authorized representative Chuck Sekrenes

ALLEGATION:

Residents were treated poorly, and four residents died in the past three months.

INVESTIGATION:

On 1/6/22, the department received a complaint which alleged staff treat residents "harsh." Additionally, the complaint alleged four residents died in the past three months.

On 1/19/22, I conducted an on-site inspection at the facility. I interviewed care staff Tabatha Zamudio. Ms. Zamudio stated she had not witnessed care staff treating residents disrespectfully or "harsh." Ms. Zamudio stated staff work well as a team and "we work for them (the residents)." Additionally, Ms. Zamudio stated one resident had passed away while receiving hospice services in the past three months. I interviewed activities care staff Danielle Canton whose statements were consistent with Ms. Zamudio. Ms. Canton stated, "staff are wonderful to residents and if she saw anything concerning, she would report it." I interviewed care staff Gail Turner whose statements were consistent with Ms. Zamudio and Ms. Canton. I interviewed Resident A who stated staff are caring and respond to his call pendant. While on-site, I reviewed training records for care staff Haley Rippetoe and cook Elizabeth Andrews.

On 1/19/22, I conducted an interview with the complainant. The complainant stated staff were treating residents "roughly by their demeanor." The complainant stated most of the staff no longer work for the facility. The complainant stated one resident fell out of bed and passed away.

On 1/20/22, I conducted a telephone interview with administrator Breona Woods. Ms. Woods stated she had not witnessed residents being mistreated by staff. Ms. Woods stated there was a previous employee who allegedly mistreated a resident, in which she conducted an internal investigation with no findings and the staff member no longer works for the facility. Additionally, Ms. Woods stated a staff member reported concerns regarding resident care to her and after further investigation, there were no findings. Ms. Woods stated the facility had at least one resident who passed away while receiving hospice services but would check the facility's records and follow up with the department.

On 1/24/22, I received an email from Ms. Woods which read there were four residents who died while receiving hospice services. The email read one resident died in October 2021, two residents in November 2021 and one resident in January 2022.

I reviewed the facility's resident roster which read there were seven residents in assisted living and nine residents in memory care.

APPLICABLE RULE	
R 325.1931	**Employees; 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.

For Reference: **R 325.1901**	**Definitions.**
	"Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	Staff interviews, along with Resident A’s interview, and review of facility documentation revealed residents are treated with dignity and provided protection.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility was short staffed on nights.

INVESTIGATION:

On 1/6/22, the department received a complaint which read the facility was understaffed and there were no staff working night shift.

On 1/19/22, I conducted an on-site inspection at the facility. I interviewed facility care staff Tabatha Zamudio. Ms. Zamudio stated the staff work together as a team to fill open shifts, including herself, care staff Haley Rippetoe and administrator Breona Woods. Ms. Zamudio stated staff work 12-hour shifts and sometimes work partial shifts. Ms. Zamudio stated there were 16 residents in the facility. Ms. Zamudio stated one resident requires a two person assist on the assisted living unit. While on-site, I reviewed the staff schedule for December 2021 and January 2022 with Ms. Zamudio. Ms. Zamudio stated two staff were assigned to dayshift, in addition to care staff Ms. Turner, who works 6:00 AM through 2:00 PM four days per week. Ms. Zamudio stated one care staff was assigned to night shift in which the care staff would need to call for emergency assistance if they needed help. Additionally, Ms. Zamudio stated the administrator Breona Woods was in the process of hiring additional staff and resident admissions were on hold, until additional staff were hired and trained. Ms. Zamudio stated four staff hired were receiving training, in which three would work night shift and one would work a 2:00 PM through 10:00 PM shift. I interviewed activities care staff Danielle Canton who stated the facility was

short staffed and that she assisted with caregiving. Ms. Canton stated there were two residents who required a two person assist. I interviewed care staff Gail Turner who stated there was one resident who required a two person assist on the assisted living unit and two other residents who may require a two person assist, depending on their strength that day. I interviewed Resident A who stated the facility was short staffed. Additionally, Resident A stated staff respond to his call pendant timely and provide him good care.

On 1/20/22, I conducted a telephone interview with administrator Breona Woods. Ms. Woods statements were consistent with Ms. Zamudio. Ms. Woods stated staff have worked to together to cover all shifts, including the night shift. Ms. Woods stated she hired six staff, in which two staff are in the process of being trained, two staff start training next week and two staff need to complete their new hire paperwork.

I reviewed the resident roster which read consistent with statements from Ms. Zamudio.

I reviewed the employee list which read consistent with statements from Ms. Zamudio and Ms. Woods. The list read there were seven care staff, one activity care staff, a housekeeper and two kitchen staff.

I reviewed the staff schedule for December 2021 and January 2022 which read consistent with statements from Ms. Zamudio and Ms. Woods.

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:	Staff interviews along with review of facility documentation revealed one staff member worked night shift. The facility lacked sufficient staff on duty on night shift to meet the needs of the residents requiring two person assist.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 1/19/22, at the on-site inspection, review of employee files for care staff which revealed kitchen staff Elizabeth Andrews' training records read she received a "Weekly/Monthly Kitchen Cleaning Checklist" on 6/29/21 and a list of instructions for maintaining the kitchen dated 6/30/93. Review of employee file for Haley Rippetoe revealed she had received training on reporting requirements, medications, personal care, and standard precautions.

On 1/20/22, I conducted a telephone interview with administrator Breona Woods. Ms. Woods stated the facility's training program which was called their "toolbox" does not include training on resident rights and responsibilities.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following: **(a) Reporting requirements and documentation.** **(b) First aid and/or medication, if any.** **(c) Personal care.** **(d) Resident rights and responsibilities.** **(e) Safety and fire prevention.** **(f) Containment of infectious disease and standard precautions.** **(g) Medication administration, if applicable.**
ANALYSIS:	Review of staff training records revealed the employee records lacked verification of training on resident rights and responsibilities, safety, and fire prevention. Interview with Ms. Woods revealed the training was not in the facility's "toolbox" which was utilized to train staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 2/2/2022, I shared the findings of this report with authorized representative Chuck Sekrenes. Mr. Sekrenes verbalized understanding of the citations.

IV. RECOMMENDATION

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

1/24/22

Jessica Rogers Date
Licensing Staff

Approved By:

01/31/2022

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section