STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

January 14, 2022

Paul Wyman
Retirement Living Management Of Ionia, L.L.C.
1845 Birmingham SE
Lowell, MI 49331

RE: License #: AM340384943
Investigation #: 2022A1029020
Green Acres Of Ionia II

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 (231) 922-5309.

Sincerely,

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
Browningj1@michigan.gov
(989) 444-9614

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM340384943
Investigation #:	2022A1029020
Complaint Receipt Date:	11/15/2021
Investigation Initiation Date:	11/15/2021
Report Due Date:	01/14/2022
Licensee Name:	Retirement Living Management Of Ionia, L.L.C.
Licensee Address:	1845 Birmingham SE Lowell, MI 49331
Licensee Telephone #:	(616) 897-8000
Administrator:	Paul Wyman
Licensee Designee:	Paul Wyman
Name of Facility:	Green Acres Of Ionia II
Facility Address:	2552 Commerce Lane Ionia, MI 48846
Facility Telephone #:	(616) 527-3300
Original Issuance Date:	07/28/2017
License Status:	REGULAR
Effective Date:	01/28/2020
Expiration Date:	01/27/2022
Capacity:	12
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was transported to the hospital on November 12, 2021, as a result of a positive COVID-19 test however once she was at the hospital Green Acres of Ionia II refused to accept Resident A back to the facility stating they could not provide care for COVID-19 residents.	Yes
Resident A was locked in her room from the outside and direct care staff members struggled to find the key to unlock the door causing a delay to receive medical assistance.	No

III. METHODOLOGY

11/15/2021	Special Investigation Intake 2022A1029020
11/15/2021	Special Investigation Initiated – Letter - Email from APS Vicki Pohl
11/15/2021	Contact - Document Sent - Emailed administration Amber Fry and Calli Peabody at Green Acres of Ionia II
11/22/2021	Contact - Document Sent - Email sent an email received from licensee designee Paul Wyman
11/22/2021	Contact – Telephone call with Calli Peabody
11/29/2021	Contact – Document received – Updated policies received from Amber Fry
12/17/2021	Contact - Telephone call made and interviewed Kara Fullriede
12/17/2021	Inspection Completed On-site - Completed virtually due to COVID with Amber Fry and Calli Peabody
12/28/2021	Contact - Telephone call made to Life Emergency Medical Services Spoke to Jeff W.
12/29/2021	Contact - Telephone call made to direct care staff member, Sarah Rodel.
12/29/2021	Contact - Telephone call made to called direct care staff member, Abby Fields.

12/29/2021	Inspection Completed On-site - Met with Calli Peabody, direct care staff members, Brianna Wiles and Danielle Curtiss, and Resident A
01/03/2022	Contact - Telephone call made to Relative A1
01/03/2022	Contact - Document Sent Emailed Vicki Pohl, Adult Protective Services and Calli Peabody
01/03/2022	Contact - Telephone call made to Julie Elkins, AFC licensing consultant
01/06/2022	Exit conference with licensee designee, Paul Wyman. There was no answer and a detailed voice mail was left.

ALLEGATION:
Resident A was transported to the hospital on November 12, 2021, as a result of a positive COVID-19 test however once she was at the hospital Green Acres of Ionia II refused to accept Resident A back to the facility stating they could not provide care for COVID-19 residents.

INVESTIGATION:

Before receiving this complaint on November 15, 2021, I received a call from Kelly Nelson, Regional director for Retirement Living Management Of Ionia, L.L.C on November 12, 2021. A discussion ensued regarding the AFC's facility policy for resident's who test positive for COVID-19 while living in the facility. Ms. Nelson stated residents are "sent out of the facility" until they are testing negative and facility administration drops the resident's individual care rate to the basic room rate during that time. Ms. Nelson stated facility administration was told by Michigan Occupational Safety and Health Administration (MIOSHA) that since the AFC facility does not have a respirator program in place, direct care staff members at any Green Acres facilities cannot provide care for residents once they test positive. Ms. Nelson stated approximately six months ago one of the corporation's facilities in Mt. Pleasant were cited by MIOSHA because the facility did not have the means to fit test for respirators and per MIOSHA respirators were required when caring for COVID-19 residents. Ms. Nelson stated since that citation by MIOSHA, residents testing positive for COVID-19 have been sent to the hospital for care or to a resident's family member. In the past, Ms. Nelson stated COVID-19 hubs in Frankenmuth, Traverse City, or Kalamazoo were also used. Ms. Nelson stated this option allowed resident to be provided with care for 10 days and return to the facility upon completing their care and a negative COVID test. Ms. Nelson stated that she was informed recently by AFC licensing consultants, Bridget Vermeesch and Elizabeth Elliott that she was not able to send COVID-19 positive residents out of the facility if they did not need medical care. Ms. Nelson stated

that she would forward the COVID-19 policies and the MIOSHA violation for review by email. Ms. Nelson sent over a list of COVID-19 hubs that have been utilized in the past for COVID-19 positive residents.

On November 12, 2021, I called and left voice mails for both Amber Fry and Kelly Nelson regarding Resident A's discharge from Sparrow Ionia Hospital. I then sent an email to Amber Fry and Calli Peabody at Green Acres of Ionia II to inform them that Resident A was ready to be discharged and return to Green Acres of Ionia II from Sparrow Ionia Hospital. They were informed in this email that the facility must continue to provide care even if the resident was positive for COVID-19 and medically able to quarantine at the facility. I also informed them a 30 day discharge could be given to any resident but the discharge could not be back dated. They were instructed to reach out to the hospital and make a plan to return any residents to the facility that did not meet admission criteria at Sparrow Ionia Hospital.

On November 15, 2021, a complaint was received via a rejected adult protective services referral from Centralized Intake alleging that Resident A was transported to the hospital due to a COVID-19 positive result from a rapid test. Green Acres of Ionia II was refusing to take Resident A back to the facility even after she was not displaying any symptoms. According to Complainant, Green Acres of Ionia II staff stated Resident A needed to stay at a family member's home for ten days if she could not remain at the hospital for care.

On November 22, 2021, I sent an email to licensee designee Paul Wyman clarifying again that residents who tested positive for COVID-19 were to remain in the facility and per licensing rules, they were not able to send residents to the hospital if they were not meeting criteria for hospital admission. Mr. Wyman responded the same day indicating that all residents who were sent out of Green Acres of Ionia II would be returned to Green Acres of Ionia II and they would resume providing care.

On November 22, 2021, I spoke with Green Acres of Ionia II Administrator, Calli Peabody who was informed that all adult foster care facilities who had residents testing positive for COVID-19 were remaining in the home and the facility was continuing to provide care using quarantine measures and personal protective equipment (PPE) supplies. Calli Peabody confirmed that Resident A was discharged to a family members home to complete her quarantine and recover from COVID-19 and she would return to Green Acres of Ionia II on November 22, 2021. Ms. Peabody stated the decision to send residents to the hospital or relative's home was made from the COVID-19 policy which was enacted after Green Acres Mount Pleasant received a violation from MIOSHA for not having proper fit testing equipment to provide care to residents with COVID-19.

On November 29, 2021, I reviewed the violation from MIOSHA and the updated COVID-19 guidelines that have been implemented at Green Acres of Ionia II. According to the report from the Michigan Occupational Safety and Health Administration (MIOSHA), there was an inspection completed on December 15, 2020-January 14, 2021 at Green

Acres Mt. Pleasant resulting in a citation and notification of penalty on February 17, 2021 which prompted the change to their COVID-19 policy.

1. "Rule 7 (6): The employer shall require face coverings in shared spaces, including during in person meetings and in the restrooms and hallways.
    a. The employer did not require face coverings in shared spaces including in person meetings.
2. Rule 8 (3): In establishments that that provide medical treatment or housing to known or suspected cases of COVID-19, the employer shall ensure the employees in frequent or prolonged close contact with such cases are provided with and wear, at a minimum, and N95 respirator, goggles or face shield, and a gown.
    a. The employer did not ensure the employees in frequent or prolonged close contact with known or suspected cases of COVID-19 were provided with and wear at a minimum, an N95 respirator.
3. Rule 4 (1): The employer shall develop and implement a written COVID-19 preparedness and response plan consistent with the current guidance for COVID-19 from the US Centers for Disease Control and Prevention (CDC) and recommendations in Guidance on Preparing Workplaces for COVID-19 developed by Occupational Health and Safety Administration (OSHA).
    a. The employer did not develop and implement a written COVID-19 preparedness and response plan. The firm's COVID-19 protocols did not include an employee exposure determination required by Rule 3 of MIOSHA emergency rules."

The document, *House Guidelines*, submitted from Green Acres of Ionia II was also reviewed. In this three page document edited February 2021 which resident and designated representatives sign is the following statement regarding COVID-19:

> *"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."*

The *House Guidelines* were updated on November 29, 2021 after this incident to reflect the following change in their policy.

Quarantine Procedure:

1. *Residents will quarantine in their apartment for at least 10 days due to the following:*
    a. *Are positive for Covid-19*
    b. *They are symptomatic of COVID-19 and awaiting testing.*
    c. *They had close contact (within 6ft or less and for 15 minutes or more) with someone who has tested positive for COVID-19 in the last 14 days and the resident is not fully vaccinated for COVID-19. (Fully vaccinated is considered 2 weeks after the 2nd COVID-19 vaccine dose). Residents*

who are fully vaccinated against COVID-19 are not required to quarantine due to a close contact with someone who tested positive for COVID-19.

On December 17, 2021, a virtual onsite investigation via facetime with Calli Peabody and Amber Fry due to COVID-19 positive cases in the facility. Ms. Fry explained a MIOSHA citation was received for the Green Acres facility in Mt. Pleasant on February 17, 2021, which prompted corporate administration at Green Acres to change their policy regarding COVID-19 and how positive cases were handled. Ms. Fry stated she sent the first COVID-19 procedures to resident families in June 2020 and those were in effect until December 2021 when this investigation occurred. Ms. Fry stated she has since updated the *House Guidelines* and resent it to the families. Ms. Fry stated the residents' families did not pushback regarding quarantining when there was a positive COVID case. The new *House Guidelines* were sent out the week of December 10, 2021. Amber Fry stated after they were told they had to bring the residents back by this licensing consultant on November 12, 2021, they were still in the process of purchasing a fit test kit and purchasing a respirator program in place at Green Acres of Ionia II so they continued to refuse to allow the resident back to Green Acres of Ionia II after they were told they needed to provide care. This was the reason that Resident A remained living with a relative for the ten days of her quarantine and did not return until November 22, 2021.

On December 17, 2021, I interviewed direct care staff member, Kara Fullriede. She stated when the pandemic first started there was one resident who tested positive but she was not showing symptoms and she remained at Green Acres of Ionia II. She stated the facility rules changed after that time and another wave of COVID-19 when the numbers started to increase. Ms. Fullriede states direct care staff members were told by administration that due to a MIOSHA citation because positive COVID-19 residents could not remain at the facility because there was no respirator program. Ms. Fullriede stated at that point any resident positive with COVID-19 was either sent to the hospital or with a family for care. Ms. Fullriede did not know the reason for the delay in picking up residents from the hospital who were not symptomatic. Ms. Fullriede stated visitors are currently screened with a temperature check, encouraged to wear a mask, sanitize their hands, and sign in with their information. They have masks available and full PPE to use if someone visits someone that are COVID-19 positive. Ms. Fullriede stated direct care staff use KN95 masks now and a different type of mask when caring for COVID-19 positive residents along with wearing full PPE.

On December 28, 2021, a call was made to Life Emergency Medical Services regarding the call to Green Acres of Ionia II. I spoke with Jeff W. who confirmed that EMS went to the home to assist Resident A on November 12, 2021. Green Acres of Ionia II direct care staff member told them they could not house COVID-19 patients and they wanted Resident A to be transferred to the hospital so they transported her to Sparrow Ionia due to her COVID-19 diagnosis after a rapid test came back positive. According to the call log report, Resident A was exhibiting symptoms of COVID-19 because she was experiencing congestion and diarrhea.

On December 29, 2021, I called direct care staff member, Sarah Rodel who stated she thought during November 2021 there were a number of residents who were COVID-19 positive. Ms. Rodel stated direct care staff members were instructed if any resident had a positive test, they could not remain at the facility but instead had to be home with family or sent to the hospital. Ms. Rodel described this was a Green Acres policy for all their facilities. Ms. Rodel stated the policy has changed in December 2021 and since then all positive COVID-19 residents have remained at the facility. Since they have been quarantining the residents in their rooms, they have only had two new cases of COVID-19.

On January 3, 2022, I interviewed Relative A1 who confirmed that she had Resident A in her home from on November 12, 2021, when she picked her up from the hospital and she returned to Green Acres of Ionia II the morning of November 22, 2021. She stated she provided care for Resident A during this time because Resident A was diagnosed with COVID-19 and the facility policy did not allow residents to remain at the facility once diagnosed with COVID-19. Relative A1 stated she received paperwork back in September 2021 regarding the policy that any resident diagnosed with COVID-19 would either stay with a family member or be admitted to the policy. Relative A1 stated she did not agree with this because she was under the assumption they would care for the residents if they were living in the facility even if they were diagnosed with COVID-19. Relative A1 felt that because Resident A did not have an increase in her care needs during the time Resident A was COVID-19 positive, she could have stayed at Green Acres of Ionia II. Relative A1 stated her understanding was that as long as Resident A did not receive a feeding device, breathing apparatus, or nursing level care, then she would stay at the facility so she was surprised when she had to pick her up from the hospital to provide care. Relative A1 stated an administrator from Green Acres of Ionia II called her the morning of November 12, 2021 and someone from the hospital called her to see if she wanted to the do the antibody treatment in the afternoon for Resident A. Then at 6:00 p.m. Relative A1 stated she was called by the hospital and told Resident A could not return to Green Acres of Ionia II so Relative A1 needed to get Resident A from the hospital. Relative A1 stated she had to take an unpaid leave for two weeks from work until Resident A was returned to Green Acres of Ionia II. Relative A1 received the new procedures for COVID-19 in December 2021 and it is her understanding they are now quarantining the residents at the facility.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	Resident A tested positive for COVID-19 and was sent to Sparrow Ionia Hospital for evaluation by the staff members at Green Acres of Ionia II and per the current policy of the AFC facility. Upon learning from the hospital that Resident A did not meet the criteria for hospital admission, administrator Calli Peabody refused to allow Resident A to return to the facility based on the corporate COVID-19 positive policy. Resident A then spent the next 10 days living with Relative A1 despite not experiencing any serious medical change in her condition. During the virtual inspection on December 17, 2021, Ms. Fry stated the reason residents were not returned to Green Acres of Ionia after being advised by this consultant on November 12, 2021, to do so, was due to the facility trying to start a respirator program and follow MIOSHA guidelines. Resident A did not return to the facility until November 22, 2021. Consequently, Resident A's supervision, protection, and personal care needs were not provided by the licensee during this time from at least November 12, 2021, through November 22, 2021.
CONCLUSION:	**VIOLATION ESTABLISHED**

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, administrator Ms. Peabody and regional director Ms. Nelson reported that the facility updated *House Guidelines* on February 2021 to reflect that COVID-19 positive residents cannot remain at the facility and that they need to leave 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." The *House Guidelines* conflict with a resident's right to access their belongings and their room at their discretion; therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A was locked in her room from the outside and direct care staff members struggled to find the key to unlock the door causing a delay to receive medical assistance.

INVESTIGATION:

On November 15, 2021, a complaint was received via a rejected adult protective services referral from Centralized Intake alleging that Resident A was locked in her bedroom from the outside when emergency medical services (EMS) came to assist her and the direct care staff member at Green Acres Ionia II could not find the keys to her room causing a delay in medical treatment.

On December 17, 2021, I interviewed Kara Fullriede who stated that on November 12, 2021, Resident A was not feeling well and just tested positive for COVID-19. Ms. Fullriede stated Resident A was resting in her resident bedroom with the door shut and locked as other residents were trying to go in to visit with Resident A. Ms. Fullriede stated she and other direct care staff were monitoring Resident A while waiting for EMS personnel to arrive so Resident A could be taken to the hospital for evaluation. Ms. Fullriede stated she had the keys to Resident A's bedroom door with her the entire time and became flustered when she needed to open Resident A's bedroom door for EMS personnel. Ms. Fullriede denied not being able to find the keys rather than it took her a few tries to get the correct key on the key chain. Ms. Fullriede did not feel that there was any delay for her to receive care.

On December 17, 2021, a virtual on-site investigation was completed due to COVID-19 in the facility via facetime with administrator, Calli Peabody and regional director, Amber

Fry. Ms. Peabody stated each resident apartment has a main door to enter as well as a bedroom door. Ms. Peabody stated only the main door to each resident apartment is able to be locked. There is a master key ring that goes with the medication cart and only the employee has it. All the employees would know where to find the master key ring if they did not have one. Ms. Peabody stated that she believed the door was unlocked when EMS came to the home. If there is an emergency, they can find the keys pretty quickly because they are usually carrying them. Each person has their own set of keys they switch off at shift change with the next direct care staff member working. Ms. Peabody stated there has never been an issue with a direct care staff member being unable to find keys when EMS arrived at the facility. Ms. Peabody stated she believes direct care staff responded quickly during this incident.

On December 28, 2021, a call was made to Life Emergency Medical Services regarding the call to Green Acres of Ionia II. I spoke with Jeff W. from EMS who affirmed EMS went to the home to assist Resident A on November 12, 2021. The narrative provided by the crew that responded to the call does not mention a delay in getting to the patient or concerns regarding the direct care staff members response. They arrived at the facility on scene 9:13 a.m. and they made patient contact at 9:13 a.m. They left the scene at 9:30 a.m. for a time of scene of 17 minutes.

On December 29, 2021, I called direct care staff member, Abby Fields. She said the lead trainer Kara Fullriede took over to assist with Resident A after she received the positive test for COVID-19. She said that she has one key for all the doors and the medication passer will typically have the key. The direct care staff members will have a room key they keep on them for their whole shift. There are quite a few keys, at least five on this key ring. They carry them in case of an emergency. She feels that she could find the right key in case of an emergency but it may take a couple tries.

On December 29, 2021, I completed an unannounced on-site investigation at Green Acres of Ionia II. Calli Peabody, administrator at Green Acres of Ionia II gave me a tour of the facility and introduced me to various direct care staff members that were working. Each of the direct care staff members that were working, had a key ring on them which unlocked the resident apartments. Each resident has an apartment style room with a living area, bedroom, small dining area, private bathroom, and kitchenette. On the same key ring is also a key which opens the medication cart.

During this on-site investigation, I spoke with direct care staff members, Brianna Wiles and Danielle Curtiss who were in the office. Both of them had keys on them and felt confident they could assist in case of emergency. Neither of them was present on November 12, 2021 when Resident A was brought to the hospital due to COVID-19.

I interviewed Resident A at Green Acres of Ionia II. She did not remember when she was transported by EMS to the hospital but she heard from direct care staff members that she had COVID-19. Resident A stated she likes living at Green Acres of Ionia II. She stated, “All these people do all these things for me, cook, clean, I do not even have to make my own bed.” Resident A stated that direct care staff members would be able

to get into her room in case of an emergency because she usually leaves the door open and if not, they have a key to get in. Resident A has a diagnosis of dementia and was unable to remember specific events from the month prior.

APPLICABLE RULE	
R 400.14310	**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:	On November 12, 2021, Resident A was transported to the hospital after she was diagnosed with COVID-19. When Emergency Medical Services arrived at Green Acres of Ionia II, there is no indication there was a delay in providing treatment to due to her door being locked when they arrived. According to Life EMS, there is nothing documented in the call log regarding direct care staff member, Ms. Fullriede, not being able to find a key to enter the room. Ms. Fullriede stated there are keys that look similar on the key ring and she believes she may need to try a couple before finding the right key but she was able to open the room quickly. During the on-site investigation on December 29, 2021, all direct care staff members and administrator working had a key ring on them and were able to enter the residents' rooms in case of an emergency.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

Jennifer Browning

_______________________________1/6/2022__________
Jennifer Browning Date
Licensing Consultant

Approved By:

Dawn Timm

11/14/2022
____
Dawn N. Timm Date
Area Manager