GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 7, 2022

Daryl Miron
Lakeview Assisted Living, LLC
1100 N Lake Shore Dr
Gladstone, MI 49837

RE: License #: AL210259500
Investigation #: 2022A0221013
Lakeview Assisted Living

Dear Mr. Miron:

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 (906) 226-4171.

Sincerely,

Theresa Norton, Licensing Consultant
Bureau of Community and Health Systems
234 West Baraga
Marquette, MI 49855
(906) 280-2519

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL210259500
Investigation #:	2022A0221013
Complaint Receipt Date:	02/16/2022
Investigation Initiation Date:	02/17/2022
Report Due Date:	04/17/2022
Licensee Name:	Lakeview Assisted Living, LLC
Licensee Address:	1100 N Lake Shore Dr Gladstone, MI 49837
Licensee Telephone #:	(906) 428-7000
Administrator:	Daryl Miron
Licensee Designee:	Daryl Miron
Name of Facility:	Lakeview Assisted Living
Facility Address:	1100 N. Lakeshore Drive Gladstone, MI 49837
Facility Telephone #:	(906) 428-7000
Original Issuance Date:	03/19/2004
License **Status:**	REGULAR
Effective Date:	09/19/2020
Expiration Date:	09/18/2022
Capacity:	19
Program Type:	AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Fire drills are not being conducted properly.	Yes
Resident A was bedbound and developed contractures. Should have been moved to skilled nursing facility.	No
Main kitchen is very dirty.	No

III. METHODOLOGY

02/16/2022	Special Investigation Intake 2022A0221013
02/17/2022	Special Investigation Initiated - Telephone Phone call to Complainant.
02/17/2022	Inspection Completed On-site
02/17/2022	Contact - Face to Face Interview with Administrator Courtney Wiltzius, Nurse Amy Gagne, Staff Kathy Olsen, and Staff Helen.
02/17/2022	Contact - Document Received Schedule received.
03/03/2022	Contact - Face to Face Interviews with Staff Dawn Sandberg, Daisy Johnson, and Letisha Lavigne.
03/03/2022	Contact - Face to Face Interviews with Licensee Daryl Miron, Administrator Courtney Wiltzius, and Nurse Amy Gagne.
03/24/2022	Contact - Telephone call made Phone call to Jim Rasanen, OFS.
04/04/2022	Contact - Telephone call made Phone call to Guardian A.
04/07/2022	Contact - Telephone call made Phone call to Guardian A.
04/07/2022	Exit Conference Exit interview with Administrator Courtney Wiltzius.

ALLEGATION: Fire drills are not being conducted properly.

INVESTIGATION: The complainant reports that fire drills are not being conducted properly in the facility. The complainant stated that residents are not evacuating the building. The complainant stated, “I know that’s against the law.”

On 02/27/2022, Consultant Maria DeBacker and I conducted an unannounced on-site inspection at the facility. We met with Administrator Courtney Wiltzius and Nurse Amy Gagne. Ms. Wiltzius produced the documented fire drills for the facility. The documented drills were written as conducted at the proper times of one per shift, per quarter, along with the times of evacuation. When asked where the meeting point was for the residents, Ms. Wiltzius stated that residents go and stand in front of the nearest exit doors. When asked to clarify, Ms. Wiltzius stated, “They don’t go outside.”

On 02/27/2022 and 03/03/2022, six staff (Kathy Olsen, Helen Brandt, Dawn Sandberg, Daisy Johnson, and Letisha Lavigne) were interviewed. All staff reported that residents do not evacuate the building during practice fire drills.

On 03/03/2022, an exit conference was conducted with Licensee Daryl Miron and Administrator Courtney Wiltzius informing them of the findings of this report and the expectation of an acceptable corrective action plan.

On 03/24/2022, a phone call was conducted with Office of Fire Safety Officer Jim Rasanen informing him of the finding of this report.

APPLICABLE RULE	
R 400.15318	**Emergency preparedness; evacuation plan; emergency transportation.**
	(5) A licensee shall practice emergency and evacuation procedures during daytime, evening, and sleeping hours at least once per quarter. A record of the practices shall be maintained and be available for department review.
ANALYSIS:	The facility has been conducting proper fire drills as per the record of practice drills. As evidenced by staff interviews and admittance of Administrator Courtney Wiltzius, residents have not been exiting the building, but going to the nearest exit door. The residents have not been evacuating the building during practice fire drills.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A was bedbound and developed contractures. Should have been moved to skilled nursing facility.

INVESTIGATION: The complainant stated that Resident A should not have been at Lakeview, as he needed skilled nursing care. The complainant stated "(Resident A) was bedbound, developed contractures, and should not have been able to stay at Lakeview."

Interviews with six staff and Nurse Amy Gagne were conducted on 02/27/2022 and 03/03/2022.

Nurse Gagne stated that Resident A had developed contractures and stated that staff, along with Upper Peninsula Home Health nurses were attending to his needs by providing proper therapy. Nurse Gagne stated that she, U.P Home Health, and Guardian A were working with the VA and Resident A was scheduled to go to the skilled nursing facility in Iron Mountain, but he had declined rapidly and EMT's were called, and Resident A passed away at the hospital on 10/16/2021.

The staff interviewed stated they were instructed by Nurse Gagne on how to do therapy on the contracted legs of Resident A. No staff reported that Resident A was "too much to care for". All staff stated Resident A' health had been declining over a period of weeks.

Guardian A was interviewed on 04/07/2022. Guardian A stated that Resident A had resided at Lakeview Assisted Living since 05/04/2020. Guardian A stated he 'was more that pleased' with the level of care provided by staff at Lakeview Assisted Living. Guardian A stated he was aware that Resident A's health was declining. He stated that Resident A was scheduled to go into the skilled nursing facility at the VA in Iron Mountain, but his health declined in the meantime, and he passed away at the hospital on 10/16/2021.

APPLICABLE RULE	
R 400.15310	
	(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:	The facility was in the process of moving Resident A to a skilled nursing facility. The facility, along with Guardian A, and U.P. Home Health were making plans to admit Resident A to the (VA) Veteran's Hospital (skilled nursing) in Iron Mountain, MI. due to Resident A's declining health. Unfortunately, Resident A declined rapidly and 911 was contacted and he passed away in the hospital on 10/16/2021.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Main kitchen is very dirty.

INVESTIGATION: The complainant reported that "The main kitchen area is so dirty, that the health department would close it down if they saw it."

On 04/07/2022, an unannounced inspection was conducted at Lakeview Assisted Living I by this consultant. The main kitchen area was thoroughly inspected along with Administrator Courtney Wiltzius. The kitchen refrigerator, freezer, pantry, prep areas, dishwashing area, and floors were found to be clean in all areas with no issues.

Staff members working in the kitchen stated there is a regular cleaning schedule that is followed to ensure cleanliness.

APPLICABLE RULE	
R 400.15402	**Food service.**
	(4) All food service equipment and utensils shall be constructed of material and that is nontoxic, easily cleaned and maintained in good repair. All food services equipment and eating and drinking utensils shall be thoroughly cleaned after each use.
ANALYSIS:	The main kitchen area was inspected thoroughly on 04/07/2022. This consultant, along with Administrator Courtney Wiltzius inspected the main kitchen found it to be very clean with no issues.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

An exit conference was conducted with Administrator Courtney Wiltzius on 04/07/2022. Ms. Wiltzius was informed of the findings of this report and the expectation of an acceptable corrective action plan.

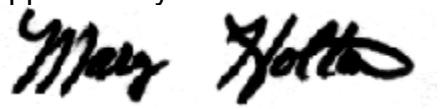
IV. RECOMMENDATION

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

04/07/2022

Theresa Norton Date
Licensing Consultant

Approved By:



04/07/2022

Mary E Holton Date
Area Manager