GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 13, 2022

Linda West
Westgate Holdings LLC
5585 Brooklyn Rd
Jackson, MI 49201

RE: License #: AM380392463
Investigation #: 2022A0007016
Victorian Jewell Assisted Living

Dear Ms. West:

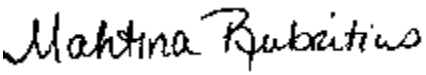
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (313) 456-0380.

Sincerely,



Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. #9-100
Detroit, MI 48202
(517) 262-8604

Enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AM380392463
Investigation #:	2022A0007016
Complaint Receipt Date:	03/23/2022
Investigation Initiation Date:	03/25/2022
Report Due Date:	05/22/2022
Licensee Name:	Westgate Holdings LLC
Licensee Address:	5585 Brooklyn Rd Jackson, MI 49201
Licensee Telephone #:	(517) 764-4163
Administrator:	Linda West
Licensee Designee:	Linda West
Name of Facility:	Victorian Jewell Assisted Living
Facility Address:	5585 Brooklyn Rd South Jackson, MI 49201
Facility Telephone #:	(517) 764-4163
Original Issuance Date:	08/11/2018
License Status:	REGULAR
Effective Date:	02/11/2021
Expiration Date:	02/10/2023
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL ALZHEIMERS AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
There was an incident where Resident A got a hold of a pair of scissors and cut her own hair.	Yes
Resident B left the home, without shoes, and there was snow on the ground.	Yes
Staff stated they did not have time to clean up a bowel movement.	No
There are questionable disciplinary actions towards the residents.	No

III. METHODOLOGY

03/23/2022	Special Investigation Intake - 2022A0007016
03/25/2022	Special Investigation Initiated – Telephone to Complainant #1.
03/28/2022	Contact - Telephone call received from Individual #1, additional information.
03/29/2022	Inspection Completed On-site - Unannounced - Face to face contact with Ms. West, Administrative Staff, Resident A, Resident D, Mrs. West, Licensee Designee.
05/18/2022	Contact - Telephone call made - Message left for Employee #1.
05/18/2022	Contact - Telephone call made - Message left for Employee #2.
05/18/2022	Contact - Telephone call made to facility, no answer.
05/18/2022	Contact - Telephone call made to Mrs. West, Licensee Designee. Additional information gathered.
05/18/2022	Contact - Document Received - Email received from Mrs. West, Licensee Designee. Contact information for Employee #3 and Employee #4.

05/18/2022	Contact - Telephone call received from Employee #2. Interview.
05/19/2022	Contact - Telephone call made to Employee #1 and Employee #3.
05/19/2022	Contact - Telephone call made to Mrs. West, no answer.
05/19/2022	Contact - Document Sent - Email sent to Mrs. West regarding the exit conference.
05/23/2022	Contact - Telephone call received – Exit Conference conducted with Mrs. West, Licensee Designee, and Ms. West, Administrative Staff.
05/24/2022	Contact - Telephone call made to Mrs. West, additional information gathered regarding guardians for Resident A and Resident D.
05/24/2022	Contact - Telephone call made to Guardian A. Message left.
05/24/2022	Contact - Telephone call made to Family Member A. Interview.

ALLEGATIONS:

There was an incident where Resident A got a hold of a pair of scissors and cut her own hair.

INVESTIGATION:

On March 25, 2022, I spoke with Individual #1. He stated that staff must pay attention and supervise Resident A, as she will get into things. Resident A will wander into the bathroom and put soap in her hair. Individual #1 stated that staff were not paying attention to Resident A, and she got into the laundry room. The facility has rollers and curlers for hair styling. Resident A got a hold of scissors and chopped her hair off. Once staff saw what happened, Employee #1 shaved her head, cutting her hair short (to make it appear intentional). Individual #1 stated staff were not truthful about what really happened and how Resident A's hair ended up so short.

During the interview, Individual #1 provided some background history. He reported that he argued with Employee #2, then he was called into a meeting with the owner.

On March 29, 2022, I conducted an unannounced on-site investigation and made face to face contact with Ms. West, Administrative Staff. She stated that her mother, Linda West, Licensee Designee, was on her way to the office.

During my interview with Ms. West, I inquired about Resident A. Ms. West informed me that Resident A has dementia and psychiatric diagnoses. Ms. West stated that she was not aware of Resident A getting a hold of scissors.

While at the facility, I made face to face contact with Resident A. I observed her sitting at the dining room table. She appeared to be neat and clean. Due to her diagnoses, I did not interview Resident A.

Mrs. West reported that Employee #1 gave Resident A the haircut. Mrs. West was not aware of Resident A cutting her own hair. Mrs. West did not know how Resident A would get access to the scissors. Resident A is not left alone in the bathroom (because she gets into things). According to Mrs. West, Resident A is diagnosed with bipolar and schizophrenia disorders.

On May 18, 2022, I interviewed Employee #2. She recalled that she was working with Employee #1 and called for assistance with Resident C. Employee #1 left Resident A in the laundry room, sitting in the chair, and went to assist Employee #2. While Resident A was in the laundry room, she got a hold of the scissors, cutting her hair. Employee #2 asked Employee #1 why she would leave the resident in the laundry room and Employee #1 said she didn't think of it (the fact that she could get a hold of the scissors).

On May 19, 2022, I interviewed Employee #1. She stated that she could not remember who she was working with, but they were getting ready, and Employee #1 sat Resident A down in the chair for a quick second. Resident A was in the laundry room. Employee #1 then went to help with another resident for a quick second. According to Employee #1, Resident A got ahold of the scissors and "she chopped her hair." When Employee #1 returned to the laundry room, Resident A was cutting her hair. Employee #1 informed me that Resident A did not have any other injuries.

On May 23, 2022, I conducted the exit conference with Mrs. West, Licensee Designee and Ms. West, Administrative Staff. We discussed the investigation, the findings, and my recommendations. Mrs. West appeared to be surprised that Resident A got a hold of the scissors, cutting her own hair. Both explained that this information should have been brought to their attention. They plan to address this matter in a staff meeting.

On May 24, 2022, I spoke with Mrs. West, as I needed some additional information. During the conversation, she stated that Employee #1 said she cut Resident A's hair. Employee #1 was pulled aside and told that she did not need to cut her hair because they have a hairdresser. Mrs. West informed me that Resident A has several siblings that look after her. She provided me with the contact information for Family Member A.

On May 24, 2022, I spoke with Family Member A, who is a sister to Resident A and helps their brother, Guardian A. Family Member A stated that she has cared for

Resident A, and she requires a lot of supervision. When she was caring for Resident A, it was “all hands-on deck.” Family Member A informed me that Resident A would get into the soap, body-wash etc. Family Member A stated that Resident A was not easy to supervise. Family Member A stated that Resident A’s hair “is always darling.” We discussed the incident. Family Member A replied that she could see Resident A getting a hold of scissors and cutting her hair. Family Member A stated that Resident A would use play scissors to try and cut her hair in the past. Family Member A stated that she understood that staff needed to supervise Resident A and reiterated the challenges of caring for her. Family Member A informed that she would be speaking to her brother (Guardian A), and she would also let him know about our conversation. Family Member A reported that overall, everything was going well at the facility, they do a good job, and that they had no complaints.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	According to Individual #1, staff must pay attention and supervise Resident A, as she will get into things. Resident A got a hold of scissors and chopped her hair off. According to Employee #2, Employee #1 left Resident A in the laundry room, sitting in the chair, and went to assist Employee #2. While Resident A was in the laundry room, she got a hold of the scissors, cutting her hair. According to Employee #1, Resident A got ahold of the scissors and “she chopped her hair.” When Employee #1 returned to the laundry room, Resident A was cutting her hair. Based on the information gathered during this investigation and provided above, it’s concluded that there is a preponderance of the evidence to support the allegations that Resident A was not treated with dignity and her personal needs, including protection and safety, were not attended to at all times in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATIONS:

Resident B left the home, without shoes, and there was snow on the ground.

INVESTIGATION:

On March 25, 2022, I interviewed Individual #1. Regarding Resident B, Individual #1 stated that about a month ago, Employee #3 and Employee #4 were working on 3rd shift. The trash day is on Tuesday. Employee #3 was taking the trash to the road and Employee #4 was in the facility sleeping. Apparently, the staff inside the facility did not hear the alarm. Resident B went out the backdoor (with bare feet) and was observed walking up the snowy driveway, by Employee #3. Employee #3 observed Resident B outside and brought her back into the facility. Individual #1 did not witness the incident but was told about it at shift change.

On March 29, 2022, I interviewed Ms. West, Administrative Staff. Regarding Resident B, Ms. West informed me that Resident B was experiencing mental decline and she was on hospice. Resident B would regularly try to pack her things. According to Ms. West, Resident B went out the backdoor of the facility. In addition, that the family was notified regarding the incident.

While at the home, I reviewed the file for Resident B and her diagnoses of Dementia was noted on *AFC Assessment Plan*.

Ms. West reported that they keep families informed of incidents that occur at the home. In addition, that on January 10, 2022, Employee #2 documented an observation on the system noting that Resident B kept trying to go outside. The incident was also reported during shift change. According to Ms. West, Resident B was receiving hospice services and she passed away on February 24, 2022.

According to Mrs. West, Licensee Designee, Resident B had a wander guard, and she was often very confused. Resident B would pack her belongings, saying it was time to go home. Regarding the incident, Resident B was outside for about 15-20 seconds. No incident report was written. Employee #2 noted the incident on the system.

During the interview with Employee #2, she stated that she heard about the situation but did not witness the incident.

On May 19, 2022, I interviewed Employee #1. She stated that she heard about the situation, as her mother, Employee #3 saw her outside and brought her back into the facility. Resident B was not outside for very long. Resident B was not wearing any shoes.

On May 19, 2022, I interviewed Employee #3. She stated she could not recall who she was working with that day, but she had gone to take the trash out. There are

alarms on the doors; however, she questioned why the other worker did not hear the alarms. Employee #3 stated that she was taking the trash out and did a “U turn” when she observed Resident B outside without a coat and shoes. According to Employee #3, it was very icy out. Resident B was not outside for long; however, Employee #3 stated she was very upset, as Resident B was frail and did not weigh very much. She immediately took her back into the facility, wrapping a blanket around her and sitting her on the couch.

During the exit conference, Mrs. West, Licensee Designee, agreed to submit a written corrective action plan to address the established violations.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	According to Individual #1, Resident B went out the backdoor (with bare feet) and was observed walking up the snowy driveway, by Employee #3. According to Mrs. West, Licensee Designee, Resident B had a wander guard, and she was often very confused. Resident B would pack her belongings, saying it was time to go home. Regarding the incident, Resident B was outside for about 15-20 seconds. Ms. West reported that they keep families informed of incidents that occur at the home. Employee #2 stated that she heard about the situation, as her mother, Employee #3 saw Resident B outside and brought her back into the facility. Employee #3 stated that she was taking the trash out and did a "U turn" when she observed Resident B outside without a coat and shoes. According to Employee #3, it was very icy out. Based on the information gathered during this investigation and provided above, it's concluded that there is a preponderance of the evidence to support the allegations that Resident B was not treated with dignity and her personal needs, including protection and safety, were not attended to at all times in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATIONS:

Staff stated they did not have time to clean up a bowel movement.

INVESTIGATION:

During the interview, Individual #1 recalled that one long-term staff member quit because of the communication challenges on the job. Individual #1 stated that Employee #1 usually works second shift, and she has "bad work ethics."

When he arrived at work, Employee #1 stated that she wanted to warn Individual #1 that Resident C had a BM and it was all over the place in the bathroom.

According to Individual #1, there were “shit swirls” on the floor. It appeared that they tried to clean up the BM; however, Employee #1 did not use the correct cleaning methods and did not sanitize the bathroom. Individual #1 ended up having to clean up the mess correctly.

Individual #1 did not agree with how things were being done and he told the staff that they were not doing their jobs; then he was called into the office by the owner, Mrs. West, Licensee Designee.

During my interview with Ms. West, Administrative Staff, she reported to have no concerns regarding Employee #1 cleaning messes in the facility. Ms. West has worked with Employee #1 for many years. Ms. West informed that staff work with another employee on shift, and no concerns have been brought to her attention.

During my interview with Ms. West, Administrative Staff, and Mrs. West, Licensee Designee, Mrs. West reported that she did not have any issues with Employee #1 not cleaning up correctly and following protocols.

During the interview with Employee #2, she stated that she has not witnessed Employee #1 not cleaning properly; however, that she (Employee #1) does not always do things in the smartest way. In addition, that she (Employee #1) sometimes does the “bare minimum.”

On May 19, 2022, I interviewed Employee #1. She stated that she was aware of the procedures for cleaning BMs. I inquired about the incident regarding Individual #1 being notified that there was a big mess for him to clean. Employee #1 stated she did not recall this situation.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.

ANALYSIS:	During my interview with Ms. West, Administrative Staff, she reported to have no concerns regarding Employee #1 cleaning messes in the facility. According to Individual #1, it appeared that they tried to clean up the BM; however, Employee #1 did not use the correct cleaning methods and did not sanitize the bathroom. Individual #1 ended up having to clean up the mess correctly. During the interview with Employee #2, she stated that she has not witnessed Employee #1 not cleaning properly; however, that she (Employee #1) does not always do things in the smartest way. Employee #1 stated that she was aware of the procedures for cleaning BMs. While it may not be fair that a different employee was required to clean the facility, the BM was cleaned; thus, maintaining the safety conditions in the home.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATIONS:

There are questionable disciplinary actions towards the residents.

INVESTIGATION:

Individual #1 stated that Resident D is 40- years of age but that she has the mind of an eight-year-old. Resident D is friends with Resident C. Resident C was away at an appointment. Resident D was standing by the window, waiting for Resident C to return. According to Individual #1, Employee #2 tells Resident D to get away from the window; then repeating the command stating, "'I said get away from the window!'" Resident D told Employee #2 to "'go to hell!'" Employee #2 then told Resident D to go to her room. Individual #1 stated that staff are not to discipline the residents. Resident D came out of her room and Employee #2 said to her "'nobody told you that you can come out of your room, go back to your room!'" This made Resident D cry. Individual #1 witnessed this incident firsthand. When asked why this was not addressed sooner, Individual #1 stated that he was trying to stay united. Now, other staff have complained that he's a "big meanie." Individual #1 asked for a $2.00 raise, which was not awarded.

During the interview with Ms. West, Administrative Staff and Mrs. West, Licensee Designee, Mrs. West reported that Resident D cries if a balloon pops, or if it's storming outside. Cognitively, Resident D is about seven-years old. Mrs. West reported that staff have to be more "stern" with Resident D. Resident D will stomp her feet etc. if there is something she does not like. Staff will ask her not to stomp her feet. Resident D likes Resident C, and Resident D has to be redirected, as she won't stay out of his room. Resident D will get mad if redirected.

While at the facility, I interviewed Resident D. She informed me that Resident C is her friend. She recalled that Resident C had a fall and had to go to the hospital. Resident D confirmed that she was waiting by the window for Resident C to return from the hospital. Resident D stated that she did not know a staff member by the name of [Employee #2]. Resident D did not confirm that Employee #2 or any staff member has yelled at her, said something to make her upset, or made her cry. Resident D reported that things are good in the home, the food is good, and she is taken care of. Resident D did not report any concerns.

Mrs. West stated that Employee #2 is a good worker; she was recently employee of the month. Employee #2 is studying nursing and will be moving to a new job soon. Mrs. West also informed me that she terminated an employee (Employee #5) a few months ago. She recently disputed unemployment claims. There had been incidents occurring, including one staff being chased down the hall by Employee #5, and staff were going to quit because of his behaviors. There was a concern that he "man handled" a previous resident, and he would argue with residents who have dementia.

I interviewed Employee #2. She stated that she no longer works for the home but when she worked there, she and Employee #5 had opposite ideas about how to deal with issues. Regarding the situation, she stated that Resident C had already returned from the hospital and was sitting at the dinner table. Employee #2 was sitting at the computer. Resident D kept trying to hold Resident C's hand and hug him. Employee #2 stated that Resident D has "a mind of a child" and she was instructed to redirect Resident D when she tried to hold Resident D's hand etc. When Resident D was redirected, she did cry. Employee #5 then told Resident D to talk to him about what was making her upset and offered her some cookies. Employee #2 denied telling Resident D that she had to go back to her room. Employee #2 stated that Resident D never went to her room to begin with because she sat down with Employee #5 and had cookies.

I interviewed Employee #1 and she reported that she has not observed any inappropriate discipling in the home.

On May 24, 2022, I interviewed Resident D's guardian, Guardian D. I inquired if she had informed him that she had any concerns about the way she was treated in the home; he stated she had not but included that she was limited, and he was not sure if she would be able to expound on that. I inquired about her crying easily and he informed me that he was not aware of that information. In conclusion, Guardian D

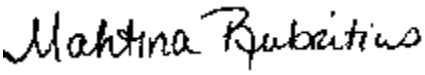
stated that he did not have any concerns, he had not witnessed anything concerning, and Resident D has not brought any concerns to his attention. He followed up by stating that if the allegations were found to be true, he would like to be notified. I informed him that after speaking to him, my investigation was concluded; however, any substantiated investigation would also be available on-line for review.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.

ANALYSIS:	According to Individual #1, Employee #2 tells Resident D to get away from the window; then repeating the command stating "'I said get away from the window!'" Resident D told Employee #2 to "'go to hell!'" Employee #2 then told Resident D to go to her room. Individual #1 stated that staff are not to discipline the residents. Resident D came out of her room and Employee #2 said to her "'nobody told you that you can come out of your room, go back to your room!'" This made Resident D cry. Mrs. West reported that Resident D cries if a balloon pops, or if it's storming outside. Cognitively, Resident D is about seven-years old. Resident D did not confirm that Employee #2 or any staff member has yelled at her, said something to make her upset, or made her cry. Employee #2 admits to redirecting Resident D and this made her cry. Employee #2 denied telling Resident D that she had to go back to her room. I interviewed Employee #1 and she reported that she has not observed any inappropriate discipling in the home. While it's clear that an incident did occur, Resident D has a history of crying, and becomes upset if redirected. Based on the information gathered during this investigation and provided above, it's concluded that there is not a 51% preponderance of the evidence to support the allegations that Resident D was mistreated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

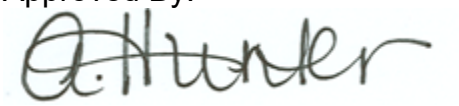
Contingent upon receipt of an acceptable written corrective action plan, I recommend no change to the status of the license.



5/24/2022

Mahtina Rubritius Date
Licensing Consultant

Approved By:



6/13/2022

Ardra Hunter Date
Area Manager