GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 30, 2022

Rebecca Nagey
Rhema-Armada Village Operating, LLC
22600 W. Main Street
Armada, MI 48005

RE: License #: AL500382675
Investigation #: 2022A0617017
Pine View Assisted Living

Dear Ms. Nagey:

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 dates 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 licensee or licensee designee and a date.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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 (248) 975-5053.

Sincerely,

Eric Johnson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL500382675
Investigation #:	2022A0617017
Complaint Receipt Date:	05/03/2022
Investigation Initiation Date:	05/06/2022
Report Due Date:	07/02/2022
Licensee Name:	Rhema-Armada Village Operating, LLC
Licensee Address:	22600 W. Main Street Armada, MI 48005
Licensee Telephone #:	(586) 473-3227
Administrator:	Rebecca Nagey
Licensee Designee:	Rebecca Nagey
Name of Facility:	Pine View Assisted Living
Facility Address:	22580 Main Street Armada, MI 48005
Facility Telephone #:	(586) 473-3227
Original Issuance Date:	08/02/2016
License Status:	REGULAR
Effective Date:	01/01/2021
Expiration Date:	12/31/2022
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Facility is short staffed. Understaffing results in poor supervision of residents. There is no medication technician on some shifts.	Yes
Noncertified staff are required to pass medications.	No
Resident A is allowed to take his narcotic medication at his leisure in the afternoon, instead of being monitored by a medication technician. His unit is unattended at times.	Yes

III. METHODOLOGY

05/03/2022	Special Investigation Intake 2022A0617017
05/03/2022	APS Referral Adult Protective Services (APS) referral denied
05/06/2022	Special Investigation Initiated - Letter Email sent to Licensee Designee Ms. Naggey
05/09/2022	Contact - Document Received Email rec from Ms. Nagey- I received the following: Staff schedule for April 2022, Resident A file, Resident Registry, Staff list with contact information, and Resident A's Mar
05/16/2022	Inspection Completed On-site On 05/16/22, I conducted an unannounced onsite investigation of the facility. During the onsite investigation I interviewed licensee designee Rebecca Nagey, staff Jeannie Wesley, Megan Misch, Rebecca Shewfelt, HR VB Heidi Nickel-Blommer, facility scheduler Megan Frazier, Resident A, Resident B, Resident C, and Resident D.
06/23/2022	Contact - Document Sent Email sent to LD Ms. Nagey
06/23/2022	Contact - Document Received Email received from Ms. Nagey

06/23/2022	Contact - Telephone call made TC made to Ms. Nagey
06/23/2022	Contact - Telephone call made I interviewed Business office Manager Diane Tomas
06/24/2022	Exit Conference I held an exit conference with licensee designee Rebecca Nagey to inform her of the results of the investigation.

ALLEGATION:

Facility is short staffed. Understaffing results in poor supervision of residents. There is no medication technician on some shifts.

INVESTIGATION:

On 05/03/22, I received a complaint on the Pine View Assisted Living facility. The complaint indicated Resident A (age 73) resides at Advantage Living of Armada - Assisted living. Resident A is allowed to take his narcotic medication at his leisure in the afternoon, instead of being monitored by a medication technician. His unit is unattended at times. There is no medication technician on some shifts. There are 43 residents in the facility and 3 more coming. There are two staff on 3rd shift (10 pm-615 am) every weekend. There are two care managers and two medication technicians for three units on second shift. There are concerns of understaffing on every shift. Understaffing contributes to potential neglect of patients in the facility. Staff who are not certified to pass medication are required to pass medication.

On 05/16/22, I conducted an unannounced onsite investigation of the facility. During the onsite investigation, I interviewed licensee designee Rebecca Nagey, staff Jeannie Wesley, Megan Misch, Rebecca Shewfelt, HR VB Heidi Nickel-Blommer, facility scheduler Megan Frazier, Resident A, Resident B, Resident C, and Resident D.

This facility is one of three connected licensed AFC large facilities. The other two connected facilities are AL500382676 The Villages Community and AL500382677 Meadow Ridge Assisted Living.

During the onsite investigation, I interviewed facility's staff scheduler Megan Frazier. Ms. Frazier stated that there is one schedule for all three facilities. Staff are assigned to a building when they arrive to work. The facility, The Villages Community AL500382676 is operated as an independent care facility and staff do not provide those residents with 24-hour care and supervision. I received and reviewed the staff schedule for the week of 05/15/22-05/21/22. According to the schedule, direct care staff are scheduled from 6 am to 2:15pm, 2pm to 10:15pm, and 10pm to 6:15am. The medication passers are scheduled from 6 am to 2:30 pm and 2pm to 10:30pm.

I observed the following scheduling issues with regards to all three facilities:

- I observed that on 05/15/22, there was only one person scheduled from 10pm to 4am to cover all three facilities.
- On 05/16/22, there were only two people scheduled to work from 10pm to 6am to cover all three facilities.
- On 05/19/22, there were only two people scheduled to work from 10pm to 6am to cover all three facilities.
- On 05/21/22, there were only two people scheduled to work from 10pm to 6am to cover all three facilities.

On 06/23/22, I received and reviewed the staff schedule for June 2022. The facility continues to create one schedule for all three facilities. However, during the onsite investigation on 05/16/22, I informed facility scheduler Ms. Frazier that there must be at least one staff member always working in each building. According to the schedule on 06/06/22, the facility only had two people scheduled to work from 10pm to 6am to cover all three facilities. On 06/27/22, the facility has only two people scheduled to work from 11pm to 6am to cover all three facilities. According to the schedule, there are only two people scheduled to work from 10pm to 6am on 07/02/22.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours.
ANALYSIS:	According to Ms. Frazier, there is one schedule for all three facilities, the other two connected facilities are AL500382676 The Villages Community and AL500382677 Meadow Ridge Assisted Living. Staff are assigned to a building when they arrive to work. The Villages Community AL500382676 is operated as an independent care facility and staff do not provide those residents with 24-hour care and supervision. Each facility did not have at least one person working at all times. On 05/15/22, I observed that there was only one person scheduled from 10pm to 4am to cover all three facilities. On 05/16/22, there were only two people scheduled to work from 10pm to 6am to cover all three facilities. On 05/19/22, there were only two people scheduled to work from 10pm to 6am to cover all three facilities. On 05/21/22, there were only two people scheduled to work from 10pm to 6am to cover all three

	facilities. On 06/23/22, I reviewed the staff schedule for June 2022 which demonstrates that the facility continues to create one schedule for all three facilities. According to the schedule on 06/06/22, the facility only had two people scheduled to work from 10pm to 6am to cover all three facilities. On 06/27/22, the facility only has two people scheduled to work from 11pm to 6am to cover all three facilities. According to the schedule there are only two people scheduled to work from 10pm to 6am on 07/02/22. There is a violation of this rule due to the facility not having at least 1 direct care staff member to 20 residents during normal sleeping hours per facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	According to Ms. Frazier, there is one schedule for all three facilities. Staff are assigned to a building when they arrive to work. According to the staff schedules, each facility did not have at least one person working at all times. The facility continues to create one schedule for all three facilities and therefore does not have sufficient direct care staff on duty at all times.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Noncertified staff are required to pass medications

INVESTIGATION:

During the onsite investigation on 05/16/22, I reviewed the facility job description for the medication technician (med tech) position. According to the job description, med techs are required and expected to assist other care managers with daily duties required of your specific shift. They are also required to document food intake, bowel movements and answer call lights and alarms.

During the onsite investigation on 05/16/22, I interviewed Human Resource Business Partner (HR VB) Heidi Nickel-Blommer, facility scheduler Megan Frazier. They both stated that only medication technicians pass medications. Medication technicians are dual trained and are expected to assist with direct care responsibilities when needed.

On 06/23/22, I received and reviewed the medication training for the following med techs and direct care staff members: R. Shewfelt, J. Wesley, T. Lecluyse, D. Chapman, H. Junga, Cynthia Casillas, Mackenzie Starks and Karlie Friedmann. All staff members medication training were completed. The staff that trainings were reviewed and verified, matched the initials on the resident's medication logs.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	I received and reviewed the medication training for the following staff members: R. Shewfelt, J. Wesley, T. Lecluyse, D. Chapman, H. Junga, Cynthia Casillas, Mackenzie Starks and Karlie Friedmann. All staff members' medication training were completed. The staff trainings that were reviewed and verified, matched the initials on the resident's medication logs.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A is allowed to take his narcotic medication at his leisure in the afternoon, instead of being monitored by a medication technician. His unit is unattended at times.

INVESTIGATION:

During the onsite investigation, I interviewed direct care staff Megan Misch. Ms. Misch stated that Resident A resides at AL500382676 The Villages Community. According to Ms. Misch, The Villages Community is referred to as "the commons" and it is an independent care facility. Staff do not provide personal care for the residents who reside at The Villages Community. Staff do not complete routine checks on residents, but they will assist when a resident calls for help. Resident rooms are equipped with pull cords that will alert staff that the resident requires assistance.

During the onsite investigation, I interviewed med tech Jeannie Wesley. According to Ms. Wesley, typically the Villages Community is supervised by the on-shift med techs. According to Ms. Wesley, there are several residents who reside at The Villages Community who administer their own medications unsupervised. Resident A is not one of the residents who administer his own medications unsupervised.

During the onsite investigation, I interviewed med tech Rebecca Shewfelt. According to Ms. Shewfelt, The Villages Community is considered independent living. Ms. Shewfelt stated that there are five residents who give themselves their medications unsupervised. Medications that are administered by the residents unsupervised are not documented. It is the responsibility of the resident to maintain a medical record and routine for their medications.

During the onsite investigation on 05/16/22, I requested a copy of medical orders in writing regarding the supervision of residents administered medications. The facility could not provide an order from a medical professional stating that the residents are not required to be supervised during the giving, taking or applying of prescription medications. Residents who administer their own medications, keep their medication in their rooms. Ms. Bloomer stated that each resident room is equipped with a locked medication box for the resident's use. I observed the rooms to be equipped with locking medications boxes. However, residents do not utilize the available locking box to store their medications.

During the onsite investigation, I completed a medication review which included review of the resident medications and medication logs for Resident A and observed the following errors:

> Resident A's medication Phenytoin Sodium extended 100mg was discontinued on 05/08/22. Since the prescription medication is no longer required by Resident A, it should have been properly disposed of after consultation with a physician or a pharmacist.
>
> The facility was out of Resident A's medications, Acetaminophen extra strength and Baclofen Tab.

During the onsite investigation, I reviewed Resident D's file. According to Resident D's medical documents, she is diagnosed with Dementia without behavior disturbance. According to med tech Ms. Shewfelt, Resident D administers her own medications without supervision.

During the onsite investigation, I completed a medication review which included review of the resident medications and medication logs for Resident D and observed the following medications were missing staff initials on the Medication Administration Record (MAR):

- Aspirin tab delayed release 81mg was not signed from 05/01/22 to 05/16/22. The MAR list the medication was administered unsupervised/self-administration.

- Lasix tablet 20MG was not signed from 05/01/22 to 05/16/22. The MAR list the medication was administered unsupervised/ self- administration.
- Levothyroxline sodium tab 75mcg was not signed from 05/01/22 to 05/16/22. The MAR list the medication was administered unsupervised/self-administration. The MAR indicates the medication is to be given every Monday through Friday.
- Lisinopril Tab 10mg was not signed from 05/01/22 to 05/16/22. The MAR list the medication was administered unsupervised/ self-administration.
- Metamucil powder was not signed from 05/01/22 to 05/16/22. The MAR list the medication was administered unsupervised/self-administration.
- Methotrexate tab 2.5 mg was not signed from 05/01/22 to 05/16/22. The MAR list the medication was administered unsupervised/self-administration. The MAR indicates the medication is to be given on Fridays only.
- Metoprolol Tartrate tab 50mg was not signed from 05/01/22 to 05/16/22. The MAR list the medication was administered unsupervised/self-administration.
- Multivitamin women tab was not signed from 05/01/22 to 05/16/22. The MAR list the medication was administered unsupervised/self-administration.
- Potassium Chloride pack 20MEQ was not signed from 05/01/22 to 05/16/22. The MAR list the medication was administered unsupervised/self-administration.
- Probiotic cap was not signed from 05/01/22 to 05/16/22. The MAR list the medication was administered unsupervised/self-administration.
- Tylenol 8 hour arthritis pain tab was not signed from 05/01/22 to 05/16/22. The MAR list the medication was administered unsupervised/self-administration.
- Vitamin D3 50mcg was not signed from 05/01/22 to 05/16/22. The MAR list the medication was administered unsupervised/self-administration.
- Pentoxifylline ER tab extended 400mg was not signed from 05/01/22 to 05/16/22. The MAR list the medication was administered unsupervised/self-administration.

During the onsite investigation, I interviewed Resident B. Resident B resides at The Villages Community. According to Resident B, the facility provides the perfect living conditions. She can access and reach staff in needed. She stated that she administers her own medication with no supervision or assistance from staff. I observed her medications sitting on the counter in her kitchen and in her bathroom non locking medicine cabinet. There was also a collection of an assortment of pills in a plastic ziplock bag on the top of the cabinet. Medication was not locked despite the room being equipped with a locked box.

During the onsite investigation, I interviewed Resident C. Resident C resides at The Villages Community. She stated that she administers her own medication with no supervision or assistance from staff. I observed her medications sitting on the counter in her kitchen. The medication was not kept in the original containers as they were

combined into a weekly pill divider. Medication was not locked despite the room being equipped with a locked box. According to Resident C, she is treated well at the facility and staff provides good care for her. Resident C stated that she is able to get assistance from staff when needed.

During the onsite investigation, I interviewed Resident D. Resident D resides at The Villages Community. She stated that she administers her own medication with no supervision or assistance from staff. I observed her medications sitting on the counter in her kitchen. The medication was not kept in the original containers as they were combined into a weekly pill divider. I also observed an assortment of pills in a container on her coffee table next to her recliner chair. Medication was not locked despite the room being equipped with a locked box. Resident D stated that she is treated well and loves living at the facility. Resident D had a family member visiting and the family member stated that Resident D is cared for well.

During the onsite investigation, I interviewed Resident A. Resident A resides at The Villages Community. Resident A stated that he has no issues living at the facility. He stated that he is very independent but if he requires staff assistance he can easily get a hold of them. Resident A stated that staff administers his medications, and he does not administer any medications himself or is unsupervised.

On 06/23/22, I interviewed Business office Manager Diane Tomas. According to Ms. Thomas, The Villages is apartment style independent care facility. The facility provides residents with three meals a day and they only have to pay for room and board. If a resident requires assistance administering medications, there is an additional cost. The cost is dependent on how much medication the resident has. The more medication the resident has, the more they are required to pay.

On 06/23/22, I went to the facility website, www. theorchardsmi.com/armada-village. According to the website The Villages Community (also known as “the commons”) offers one-bedroom apartments for those residents who are independent. Pineview, offers assistance with dressing, toileting, bathing, etc. Meadow Ridge provides full services for those residents who struggle with dementia.

On 06/24/22, I held an exit conference with licensee designee Rebecca Nagey to inform her of the results of the investigation. Ms. Nagey confirmed that staff do not do routine checks on the residents at The Villages Community facility. Ms. Nagey stated that those residents are more self-sufficient, and staff is available if needed. According to Ms. Nagey, the residents who administer their own medications, were approved to do so by their guardians and care physicians. Ms. Nagey confirmed that the facility does not have those orders in writing, but she is actively working on it. Ms. Nagey could not confirm if the residents who self-administer medications are receiving the medications or following the prescribed dosage and during the correct times.

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:	According to Ms. Misch, The Villages Community is referred to as “the commons” and it is an independent care facility. Staff do not provide personal care for the residents who reside at The Villages Community. Staff do not complete routine checks on residents, but they will assist when a resident calls for help. Resident rooms are equipped with pull cords that will alert staff that the resident requires assistance. Ms. Nagey confirmed that staff do not conduct routine checks on the residents at The Villages Community facility. Ms. Nagey stated that those residents are more self-sufficient, and staff is available if needed.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15305	**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:	The Villages Community is referred to as “the commons” and is operated as an independent care facility. Staff do not provide personal care for the residents who reside at The Villages Community. Staff do not complete routine checks on residents, but they will assist when a resident calls for help. Resident rooms are equipped with pull cords that will alert staff that the resident requires assistance. Licensee Designee Ms. Nagey confirmed that staff do not conduct routine checks on the residents at The Villages Community facility. Ms. Nagey stated that those residents are more self-sufficient, and staff is available if needed. The facility is not providing care for resident’s personal needs, including protection and safety, at all times.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Residents B, C, D, E, and F all self-administer their medications with no supervision or assistance from staff. During the onsite investigation on 05/16/22, I observed Resident B's medications sitting on the counter in her kitchen and in her bathroom in a non-locking medicine cabinet. There was also a collection of an assortment of pills in a plastic zip lock bag on the top of the cabinet. Medication was not kept in a locked cabinet or drawer despite the room being equipped with a locked box. On 05/16/22, I observed Resident C's medications sitting on the counter in her kitchen. The medication was not kept in the original containers as they were combined into a weekly pill divider. Resident C's medication was not kept in a locked cabinet or drawer despite the room being equipped with a locked box. On 05/16/22, I observed Resident D's medications sitting on the counter in her kitchen. The medication was not kept in the original containers as they were combined into a weekly pill divider. I also observed an assortment of pills in a container on Resident D's coffee table next to her recliner chair. Resident D's medication was not kept in a locked cabinet or drawer despite the room being equipped with a locked box.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	During the onsite investigation, I reviewed Resident D's file. According to Resident D's medical documents, she is diagnosed with Dementia without behavior disturbance. According to med tech Ms. Shewfelt, Resident D administers her own medications without supervision. Ms. Nagey could not confirm if the residents who self-administer medications are receiving the medications or following the prescribed dosage during the correct times according to label instructions.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(3) Unless a resident's physician specifically states otherwise in writing, the giving, taking, or applying of prescription medications shall be supervised by the licensee, administrator, or direct care staff.
ANALYSIS:	Residents B, C, D, E, and F self-administer their medications with no supervision or assistance from staff. The facility could not provide an order in writing from a resident's physician indicating that the residents are not required to be supervised during the giving, taking or applying of prescription medications. Residents who administer their own medications, keep their medication in their bedrooms.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend a six-month provisional license.

06/28/22

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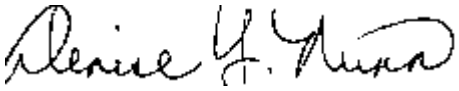
Eric Johnson Date
Licensing Consultant

Approved By:



06/30/2022

_____

Denise Y. Nunn Date
Area Manager