GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 4, 2022

Leah Allen
AUGUST HAUS ASSISTED LIVING LLC
1201 Village Parkway
Gaylord, MI 49735

RE: License #: AL690392652
Investigation #: 2022A0360033
AUGUST HAUS ASSISTED LIVING LLC

Dear Ms. Allen:

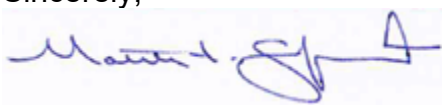
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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 (866) 865-0006

Sincerely,



Matthew Soderquist, Licensing Consultant
Bureau of Community and Health Systems
Ste 3
931 S Otsego Ave
Gaylord, MI 49735
(989) 370-8320

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL690392652
Investigation #:	2022A0360033
Complaint Receipt Date:	07/07/2022
Investigation Initiation Date:	07/07/2022
Report Due Date:	08/06/2022
Licensee Name:	AUGUST HAUS ASSISTED LIVING LLC
Licensee Address:	1201 Village Parkway Gaylord, MI 49735
Licensee Telephone #:	(989) 732-6374
Administrator:	Leah Allen
Licensee Designee:	Leah Allen
Name of Facility:	AUGUST HAUS ASSISTED LIVING LLC
Facility Address:	1201 Village Parkway Gaylord, MI 49735
Facility Telephone #:	(989) 448-7094
Original Issuance Date:	10/23/2018
License Status:	REGULAR
Effective Date:	04/23/2021
Expiration Date:	04/22/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Direct care staff lifted Resident A causing a bruise on her armpit.	No
Additional Findings	Yes

III. METHODOLOGY

07/07/2022	Special Investigation Intake 2022A0360033
07/07/2022	Special Investigation Initiated - Telephone home manager Cindy Morrison
07/07/2022	Inspection Completed On-site Resident A, Cindy Morrison home manager
07/07/2022	Contact - Telephone call made Relative 1-A
07/07/2022	APS Referral online complaint
07/07/2022	Contact - Telephone call made Officer Cole Nagy Gaylord City Police
07/08/2022	Contact - Telephone call received APS worker Penny Kelly
07/14/2022	Contact - Telephone call made DCS Selena Pelton
07/28/2022	Inspection Completed On-site Resident A, home manager Cindy Morrison
07/28/2022	Contact - Telephone call made DCS Sean Pelton
08/04/2022	Exit Conference With licensee designee Leah Allen

ALLEGATION: Direct care staff lifted Resident A causing a bruise on her armpit.

INVESTIGATION: On 7/07/2022 I was assigned a complaint from the LARA online complaint system.

On 7/07/2022 I was contacted by home manager Cindy Morrison. Ms. Morrison stated Resident A informed her of a bruise she received yesterday when two direct care staff lifted her into bed after sliding down onto the floor.

On 7/07/2022 I conducted an onsite inspection at the facility. The home manager Cindy Morrison stated Resident A informed her of a bruise on her arm pit that she stated she received from being lifted back into bed by her arms. She stated Resident A told her direct care staff Selena and Sean Pelton lifted her back into bed. Ms. Morrison showed me a photo of Resident A's arm pit which had a one inch by three-inch red in color bruise. Ms. Morrison stated if the direct care staff are unable to lift residents safely, they are supposed to contact EMS for a lift assist.

While at the facility on 7/07/2022 I interviewed Resident A. Resident A stated that on 7/06/2022 at about 11 p.m. she hit her call button for assistance and direct care staff Sean Pelton came to the room. She stated he was wearing his pants low, and she told him to pull them up and that she wanted direct care staff Selena Pelton to assist her to the bathroom. She stated that she had slid down the side of the bed to the floor and got caught on the bed rail. She stated both Selena and Sean Pelton grabbed her by the arms and pulled her back onto the bed. She stated they were kind of rough and could not tell if they were being rough intentionally or not. Resident A stated she is not supposed to be lifted by her arms and that she has a note on her wall by the bed which reminds all staff they are not supposed to lift her by the arms. I observed a handwritten note on the wall that stated, "Please do not pull on [Resident A's] arms to assist with her transfers. Do use the transfer belt on the back of her chair and put it back there for the next person to use. Thank you, PT." Resident A stated she has a bruise on her arm pit and that Ms. Morrison took a photo of it.

On 7/07/2022 I contacted Relative 1-A. Relative 1-A stated he was aware of the bruise and stated he may contact the police.

On 7/07/2022 I made an Adult Protective Services (APS) complaint.

On 7/07/2022 I was contacted by Officer Cole Nagy from the Gaylord City Police Department. Officer Nagy stated the bruise seems to have been caused in the regular course of assistance and stated he did not anticipate any charges would be filed.

On 7/08/2022 I was contacted by APS worker Penny Kelly. Ms. Kelly stated she has been to the facility and interviewed Resident A. She stated she would not be substantiating her APS investigation.

On 7/14/2022 I contacted direct care staff Selena Pelton. Ms. Pelton stated on 7/06/2022 at 1:30 a.m. Resident A hit her call button for assistance in using the

bathroom. She stated she went to Resident A's bedroom and while she was helping locate her slippers Resident A slid off the side of the bed and became trapped in the bedrail. She stated Resident A did not want the other direct care staff Sean Pelton to help lift her up so she tried to lift her by putting Resident A's arm over her head and standing up, but she was to heavy. She stated she then had Mr. Pelton contact EMS who responded to the facility for a lift assist and lifted Resident A by the arms.

On 7/28/2022 I conducted an unannounced onsite inspection at the facility. Resident A stated she did not remember EMS coming to the facility for a lift assist and that she remembers direct care staff Selena and Sean Pelton lifting her back into bed.

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 complaint alleged direct care staff lifted Resident A causing a bruise on her armpit. Resident A stated direct care staff Selena and Sean Pelton lifted her by her arms on 7/06/2022 leaving a bruise in her arm pit. Ms. Morrison showed me a photo of a one inch by three-inch bruise on Resident A's arm pit area. Ms. Pelton stated she was unable to lift Resident A and Resident A did not want Mr. Pelton to assist so they contacted EMS for a lift assist who came to the facility and lifted Resident A back into bed. Gaylord City Police Officer Cole Nagy stated they would not be pressing any charges as the bruising appeared to be accidental. APS worker Penny Kelly stated she would not be substantiating her APS investigation. There is not a preponderance of evidence to indicate that staff failed to treat Resident A with dignity and respect and that her personal needs, including protection and safety were not attended to at all times.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION: While at the facility on 7/07/2022 I observed a bedrail on Resident A's bed. Resident A stated that her son installed the bedrail. The bedrail was very loose and was more than four inches away from the mattress. Resident A stated when she slid off the bed on 7/06/2022 she became trapped between the bedrail and mattress.

On 7/07/2022 I interviewed the home manager Cindy Morrison. Ms. Morrison provided me with Resident A's written assessment plan and health care appraisal. Neither of them documented the use of the bedrail. Ms. Morrison acknowledged that she does not have any documentation that a licensed physician authorized the use of the bedrail. She stated she would contact the physician and request an order and make sure that the bedrail was properly installed.

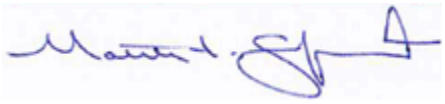
On 7/28/2022 I conducted an unannounced onsite inspection at the facility. Ms. Morrison stated she has put in a request to Resident A's physician for an order for the use of the bedrail however she has not received it yet.

APPLICABLE RULE	
R 400.15306	**Use of assistive devices.**
	(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization.
ANALYSIS:	Resident A had a bedrail installed on her bed and there was no authorization in writing by a licensed physician.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 08/04/2022 I conducted an exit conference with licensee designee Leah Allen. Ms. Allen concurred with the findings of the investigation and stated she would submit a corrective action plan for approval.

IV. RECOMMENDATION

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



08/04/2022

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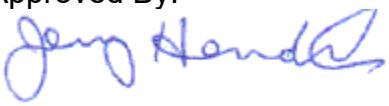
Matthew Soderquist Date
Licensing Consultant
Approved By:



08/04/2022

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Jerry Hendrick Date
Area Manager