GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 7, 2022

Steven Steffey/Pam Reese
Eley Acres Holdings LLC
1012 N. Leroy Street
Linden, MI 48430

RE: License #: AH030379710
Investigation #: 2022A1028085
Vicinia Gardens of Otsego

Dear Mr. Steffey and Ms. Reese:

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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
Cell (616) 204-4300

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

I. IDENTIFYING INFORMATION

License #:	AH030379710
Investigation #:	2022A1028085
Complaint Receipt Date:	09/16/2022
Investigation Initiation Date:	09/19/2022
Report Due Date:	11/16/2022
Licensee Name:	Eley Acres Holdings LLC
Licensee Address:	1012 N. Leroy Street Linden, MI 48430
Licensee Telephone #:	(810) 577-6928
Administrator:	Kelly Steffey
Authorized Representative:	Steven Steffey
Name of Facility:	Vicinia Gardens of Otsego
Facility Address:	700 Eley Street Otsego, MI 49078
Facility Telephone #:	(269) 350-0718
Original Issuance Date:	09/02/2016
License **Status:**	REGULAR
Effective Date:	03/02/2022
Expiration Date:	03/01/2023
Capacity:	56
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was left outside the facility in the dark by staff for several hours.	Yes
Additional Findings	No

III. METHODOLOGY

09/16/2022	Special Investigation Intake 2022A1028085
09/19/2022	Special Investigation Initiated - Letter
09/19/2022	APS Referral APS referral sent to Centralized Intake.
10/05/2022	Contact - Face to Face Interviewed ED/Pam Reese at the facility.
10/05/2022	Contact - Face to Face Interviewed Employee A at the facility.
10/05/2022	Contact - Face to Face Interviewed Employee B at the facility.
10/05/2022	Contact - Face to Face Interviewed Resident A at the facility.
10/05/2022	Contact - Document Received Received Resident A's service plan from ED/Pam Reese.
12/01/2022	An addendum to special investigation report was completed after the violation was issued and due to the facility providing further information on 11/30/2022.

ALLEGATION:

Resident A was left outside the facility in the dark by staff for several hours.

INVESTIGATION:

On 9/16/2022, the Bureau received the allegations anonymously from the online complaint system.

On 9/19/2022, Adult Protective Services (APS) made referral to Homes for the Aged (HFA) through Centralized Intake.

On 10/5/2022, I interviewed the facility executive director, Pam Reese, at the facility. Ms. Reese reported the facility is in the process of changing ownership and the former executive director that this alleged incident occurred under is no longer employed at the facility. Ms. Reese reported no knowledge of the incident due to being newly employed at the facility and expressed concern about this incident and for the resident. Ms. Reese provided me a copy of Resident A's service plan. Ms. Reese reported she was unable to find any other documentation pertaining to this incident.

On 10/5/2022, I interviewed Employee A at the facility who reported Resident A is often assisted outside to a designated smoking area to enjoy a cigarette. Employee A reported that while Resident A is of good cognition, staff are to stay with Resident A during the smoke break for safety. Employee A reported staff must assist Resident A with wheelchair mobility due to generalized weakness and for safety due to being legally blind. Employee A reported knowledge that on 9/10/2022 Resident A was left outside of the building during a smoke break for several hours on second shift, even though Resident A utilized [their] call light pendant to call for assistance. Employee A reported it was hours before staff found Resident A outside and Resident A's call light went unanswered for a long time. Employee A reported the incident was reported to the former executive director but is unsure if education or counseling was provided to the staff involved in the incident. Employee A reported Resident A "was upset and shaken due to being left outside".

On 10/5/2022, I interviewed Employee B at the facility. Employee B reported knowledge Resident A was left outside during a smoke break for several hours on 9/10/2022. Employee B reported staff must assist Resident A with wheelchair mobility due to Resident A being unable to propel the wheelchair. Employee A reported Resident A used the call light pendant to call for assistance, but staff did not show up until a couple of hours later. Employee B reported the incident was reported to the former executive director, but to [their] knowledge no counseling or re-education was provided to any staff about this incident.

On 10/5/2022, I interviewed Resident A at the facility. Resident A confirmed [they] were left outside of the facility for almost two hours after enjoying a cigarette break. Resident A reported using the call light pendant multiple times to call for staff assistance and no staff came to help [them] back inside until about two hours later.

Resident A also confirmed [they] require assistance from staff with wheelchair mobility due to generalized weakness and for safety due to being legally blind and because of other health conditions.

On 10/25/2022, I reviewed Resident A's service plan which revealed Resident A requires staff assistance with mobility due to being *unable to walk* and Resident is *blind.*

On 12/01/2022, an addendum to this special investigation report was completed after violation was issued and due to the facility providing the department further information on 11/30/2022.

On 11/30/2022, the facility presented the prior requested call light log and video footage of Resident A's incident occurring on 9/10/2022.

Review of the call light log revealed Resident A's call light was activated four times at the following times while Resident A was outside on the facility patio:

- 19:56:52 (7:56pm) with staff response time 12:20 minutes
- 20:21:32 (8:21pm) with staff response time 25:41 minutes
- 20:58:12 (8:58pm) with staff response time 11:34 minutes
- 21:25:40 (9:21pm) with staff response time 23:30 minutes

Review of the video footage revealed the following:

- There were 29 entrances/exits total through the back door of the facility. Twenty-seven (27) of the entrances/exits were staff members. Two of the exits were a woman and toddler child.
- The video camera is located inside the dining room in the upper right corner and is aimed at the back door of the facility.
- At 19:52:31 (7:52pm), Resident A is wheeled through the back door of the facility by one staff member and parked outside on the patio. Visibility of Resident A outside the facility is significantly limited/obstructed due to the placement of video camera being located in the dining room. Resident A cannot be clearly seen once outside on the patio.
- At 22:12:30 (10:13pm) two staff exit the building and bring Resident A back inside the facility.

There are 29 entrances/exits through the back patio door viewed on the video footage. It cannot be determined if staff interacted with Resident A during those 29 entrances/exits due to the placement of the video camera inside the dining room and due to the placement of Resident A outside the facility and out of view of the video camera. It can only be determined that Resident A pressed the call light four times during the total time while outside the facility from 7:52pm to 10:13pm and while the pendant was reset those four times by staff, Resident A was not brought back into the facility until 10:13pm.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	It was alleged and confirmed Resident A was left outside unattended by staff on 9/10/2022 during a smoke break. Resident is legally blind and through interviews and onsite inspection, it was revealed staff are supposed to remain with Resident A outside while smoking for Resident A's safety. Resident A utilized the call light pendant to call for assistance and while the staff reset the pendant four times, staff did not bring Resident A back into the facility until 10:13pm. There is no evidence the prior executive director took corrective action with staff involved with this incident. There is also no evidence the prior executive director provided any staff counseling or re-education concerning this incident. While this incident occurred under prior executive director, the facility's owner, operator, and governing body are responsible to ensure the protection, safety, supervision, and safety for all residents. Therefore, the facility is in violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the receipt of an approved corrective action plan, I recommend the status of this license remains unchanged.

Julie Viviano

Julie Viviano

10/25/2022

11/30/2022 - Addendum

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Julie Viviano Date
Licensing Staff

Approved By:

11/02/2022

12/06/2022 - Addendum

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Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section