GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 14, 2022

Anne Kesler
Country Woods Assisted Living, LLC
8504 Doe Pass
Lansing, MI 48917

RE: License #: AM230388695
Investigation #: 2023A0790002
Country Woods Assisted Living

Dear Ms. Kesler:

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. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Rodney Gill, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM230388695
Investigation #:	2023A0790002
Complaint Receipt Date:	10/14/2022
Investigation Initiation Date:	10/14/2022
Report Due Date:	12/13/2022
Licensee Name:	Country Woods Assisted Living, LLC
Licensee Address:	8504 Doe Pass Lansing, MI 48917
Licensee Telephone #:	(517) 224-8300
Administrator:	Anne Kesler
Licensee Designee:	Anne Kesler
Name of Facility:	Country Woods Assisted Living
Facility Address:	7021 Hartel Road Potterville, MI 48876
Facility Telephone #:	(517) 224-8300
Original Issuance Date:	08/27/2019
License **Status:**	REGULAR
Effective Date:	02/27/2022
Expiration Date:	02/26/2024
Capacity:	12

Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A passed away and family was not notified of her death.	No
Direct care staff members did not assist Resident A while she was using her wheelchair.	Yes
Resident A is missing some of her personal belongings after her room was packed up following her death.	Yes

III. METHODOLOGY

10/14/2022	Special Investigation Intake 2023A0790002
10/14/2022	Special Investigation Initiated – Telephone call made to Complainant to initiate this special investigation.
10/14/2022	Contact – Telephone call made to Relative A1.
10/14/2022	Contact - Document Sent to complainant. Emailed the Complainant Letter.
10/14/2022	APS Referral not necessary as the alleged victim is deceased.
10/19/2022	Inspection Completed On-site Spoke with direct care staff member (DCSM) Heather Buffington. Ms. Buffington was the only DCSM working and did not have time for an interview.
11/21/2022	Contact - Telephone call made to direct care staff member (DCSM) Ronda Ballman who functions as the house manager to schedule a second onsite inspection.
11/21/2022	Contact - Telephone call made to DCSM Heather Buffington.

11/22/2022	Inspection Completed On-site - Interviewed DCSM Ronda Ballman who functions as house manager. Ms. Ballman said Ms. Kesler had a meeting and was unable to come to the facility for the onsite investigation.
11/22/2022	Contact - Telephone call made to DCSM Sydney Fausett.
11/30/2022	Contact - Telephone call received from Complainant to provide additional information.
12/07/2022	Contact - Telephone call made to Complainant to ask several follow up questions for clarification purposes.
12/07/2022	Contact - Telephone call made to previous DCSM Connie Roblee.
12/07/2022	Inspection Completed-BCAL Sub. Compliance
12/07/2022	Corrective Action Plan Requested and Due on 12/23/2022
12/08/2022	Exit Conference with licensee designee Anne Kesler.
12/09/2022	Contact – Telephone call made to licensee designee Anne Kesler requesting documentation for Resident A be emailed to me as soon as administratively possible.
12/12/2022	Contact - Document Received from licensee designee Anne Kesler. Ms. Kesler emailed supporting documentation.

ALLEGATION:

Resident A passed away and family was not notified of her death.

INVESTIGATION:

**Please note the complaint intake received contained information that was not related to AFC Administrative Rules and therefore was not investigated by this consultant and is not included in this report.*

I interviewed Complainant on 10/14/2022 via phone and confirmed the allegations contained in this complaint were accurate.

I interviewed Relative A1 on 10/14/2022 via phone and Relative A1 said Resident A passed away on 09/21/2022 at approximately 5:00 a.m. She stated licensee designee Anne Kesler called and informed her and her family Resident A had passed away on

09/21/2022 sometime between 5:00 a.m. and 6:00 a.m. Relative A1 could not recall the exact time. Relative A1 stated this was the date of Resident A's death so Relative A1 confirmed being notified in a timely fashion.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(a) The death of a resident.**
ANALYSIS:	Based on information received during the interview with Relative A1 there is no evidence indicating licensee designee Anne Kesler failed to make reasonable attempts to contact Resident A's family to inform them Resident A had passed away.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Direct care staff members did not assist Resident A while she was using her wheelchair.

INVESTIGATION:

On 10/14/2022, I interviewed Relative A1 who stated while visiting the facility on several occasions she was told by DCSMs Heather Buffington and Connie Roblee that DCSM Ronda Ballman who functions as the house manager, told them not to assist Resident A with getting her wheelchair over the sliding glass door track/threshold which separates the living room and sun porch. Relative A1 stated trying to get over this track caused Resident A pain in her back. Relative A1 said Ms. Buffington and Ms. Roblee told her Ms. Ballman told them Relative A1 had an order from physical therapy (PT) stating Resident A needed to get her wheelchair over the track on her own. Relative A1 stated she never saw an order from PT stating this and said Ms. Buffington and Ms. Roblee told her they also never saw an order from PT indicating Resident A needed to do this on her own.

Relative A1 stated Resident A was released from PT toward the end of 06/2022 beginning of 07/2022. She said Ms. Ballman was telling the DCSMs not to assist Resident A over the track around the beginning of 08/2022. Relative A1 stated she

contacted the physical therapy service who worked with Resident A and they could not provide a PT order indicating Resident A was to get her wheelchair over the track on her own.

Relative A1 stated Resident A was 95 years old and suffered with severe back pain because of herniated/compressed discs. Relative A1 said Resident A would ask, beg, yell, and cry out for assistance getting her wheelchair over the track. She said Resident A would complain of extreme pain in her back from lifting her wheelchair over the track on her own.

I interviewed DCSM Heather Buffington on 11/21/2022 via phone. Ms. Buffington stated DCSM Ms. Ballman, who functions as the house manager, told her and other DCSMs working at the facility they were not to help Resident A get her wheelchair over the track even though Resident A would say it was causing her pain and hurting her back trying to get over the track on her own. She said Ms. Ballman told her Resident A was to do it herself to strengthen her core per PT. Ms. Buffington said she never saw an order from PT indicating Resident A was to get her wheelchair over the track on her own. She said it was hard for all the residents to get over the track but especially for Resident A given her age and physical limitations.

I interviewed DCSM Ronda Ballman during an onsite investigation on 11/22/2022. Ms. Ballman stated she received a verbal order from PT stating Resident A was to get her wheelchair over the track on her own to strengthen her core. Ms. Ballman explained Resident A was a "hypochondriac." Ms. Ballman stated Resident A thought she needed help but did not. Ms. Ballman said there is no written order from PT at the facility indicating Resident A was to get her wheelchair over the track between the living room and sun porch on her own. Ms. Ballman stated if there was a written order it would have been or would be in the possession of Resident A or her family. She said Resident A's family kept all Resident A's orders from PT in Resident A's room.

Ms. Ballman was asked to provide Resident A's most recent *Assessment Plan for AFC Residents, Health Care Appraisal,* orders from PT, and a Personal Property and Belongings Inventory List. Ms. Ballman said she does not have those documents available to her at the facility. She stated the requested documents are in the possession of licensee designee Anne Kesler.

I interviewed DCSM Sydney Fausett on 11/22/2022 via phone. Ms. Fausett stated DCSM Ms. Ballman, who functions as the house manager, told her and other DCSMs working at the facility they were not to help Resident A get her wheelchair over the track separating the living room and sun porch even though Resident A would say it was causing her pain and hurting her back trying to get over the track on her own. Ms. Fausett said Resident A would sometimes have a hard time getting her wheelchair over the track, but other times was able to maneuver it. She stated Resident A said she was experiencing pain in her back and/or her knees when attempting to get her wheelchair over the track. Ms. Fausett said Ms. Ballman told them Resident A was to do it herself

to strengthen her core per PT. Ms. Fausett said she never saw an order from PT indicating Resident A was to get her wheelchair over the track on her own.

I interviewed DCSM Connie Roblee on 12/07/2022 via phone. Ms. Roblee stated DCSM Ms. Ballman told her and other DCSMs working at the facility they were not to help Resident A get her wheelchair over the track even though Resident A said it was causing her pain and hurting her back trying to get over the track on her own. She said Ms. Ballman told them Resident A was to do it herself to strengthen her core per PT. Ms. Roblee said she never saw an order from PT indicating Resident A was to get her wheelchair over the track on her own. She said it was extremely difficult for Resident A to get over the track due to her age and physical limitations. Ms. Roblee said she specifically heard Resident A complain it was causing her pain in her back and buttocks when attempting to get her wheelchair over the track on her own.

Ms. Kesler was contacted by phone on 12/09/2022 and requested to provide the following documentation as soon as administratively possible: Resident A's *Assessment Plan for AFC Residents, Health Care Appraisal,* Inventory List from admission and any subsequent updates, photos of Resident A's belongings, and all doctor and PT orders available for Resident A. Ms. Kesler provided the requested documentation on 12/12/2022.

I reviewed Resident A's *Health Care Appraisal* and found that Resident A is diagnosed with unspecified spondylopathy, osteoarthritis, anxiety disorder, hyperlipidemia, sleep disorder, gastro-esophageal reflux disease without esophagitis, and weakness.

I reviewed Resident A's *Assessment Plan for AFC Residents* documented Resident A required help with eating/feeding, toileting, bathing, grooming (hair care, teeth, nails, etc.), dressing, personal hygiene, walking/mobility (needs help with transferring etc.), use of prosthesis (dentures, artificial limbs, etc. – leg brace is needed for walking/knee surgery replacement failed), and use of assistive devices (wheelchair bound). Resident A's *Assessment Plan for AFC Residents* also indicated Resident A had physical limitations (walking, transferring).

I reviewed three-months of Charting Notes for Resident A but found no relevant information pertaining to the allegations in this special investigation.

Ms. Kesler was asked to provide Physician's and physical therapy orders pertaining to this allegation. Ms. Kesler said she could not locate any and does not think any orders exist pertaining to this allegation.

I reviewed text messages between Ms. Kesler and Relative A1 discussing Resident A requesting help over the track between the living room and sun porch from 08/04/2022.

The first text message is from Relative A1 indicating Resident A would like to speak to Ms. Kesler about getting some help getting off the "sun porch" and down to her room. The message goes on to state, "Apparently Ronda won't help her and told others not to

either. [Resident A] says it hurts her back. This is the third time she's asked me to contact you, I'm giving in this time. I'm sure Ronda is trying to get her to push herself for her physical health."

I reviewed the following text message sent by Ms. Kesler: "I'll go in and talk with her in the a.m. What's weird about that porch is that she can take herself out there without any issues but sits and waits for someone to bring her back in? I just don't argue with her and bring her back in. But I'll talk with her tomorrow."

Relative A1 respond with, "I think the lip is higher from porch to living room, if I remember correctly."

The final text was Ms. Kesler's response to Relative A1 and read as follows: "The scoop is that AH requested PT again thru Careline/Matt and they came. They gave [Resident A] things to work on and as in the past she wasn't really motivated to do them. One thing they were doing was having her slowly go over the bump at the porch. [Resident A] was doing it. But, PT said it wasn't benefiting her to continue with them and they didn't feel she was a candidate to continue, as has been the case during her previous visits." "The girls said [Resident A] will manage the porch if they are unavailable. I suggested they help her whenever possible."

APPLICABLE RULE	
R 400.14303	**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:	There is evidence indicating DCSM Ms. Ballman told DCSMs working at the facility for a time they were not to help Resident A get her wheelchair over the sliding glass door track separating the living room and sun porch even when Resident A would say it was causing her pain and hurting her back, buttocks, and/or knees trying to get over the track on her own. There was evidence provided through text messages between licensee designee Anne Kesler and Relative A1 indicating PT was working with Resident A on and/or before 08/04/2022 and one thing they were doing was having Resident A "slowly go over the bump at the porch" as an exercise. The text goes on to state Resident A was doing it but it "wasn't benefiting her to continue with them". Ms. Ballman stated she received a verbal order from PT indicating Resident A was to get her wheelchair over the track on her own to strengthen her core. Although DCSM Ms. Ballman stated there was a verbal order for Resident A to move her wheelchair over the track independently, this order was never written down by Ms. Ballman nor any physical therapist. After Resident A expressed experiencing pain while trying to move her wheelchair over the track between the two rooms and asked DCSMs for assistance, assistance should have been provided per her written assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A is missing some of her personal belongings after her room was packed up following her death.

INVESTIGATION:

On 10/14/2022, I interviewed Relative A1 who stated she and another family member attempted to pick up Resident A's belongings from the facility on 09/26/2022. Relative A1 said family was never contacted by the licensee designee Anne Kesler nor any of the DCSMs asking what family would like to have done with Resident A's personal property and belongings. This is not an administrative AFC rule requirement and was not investigated.

Relative A1 said she received a text message from DCSM Heather Buffington stating Resident A's belongings were bagged up and moved to the basement prior to her and the other family member visiting the facility to pick up Resident A's personal property and belonging on 09/26/2022. Relative A1 said Ms. Buffington indicated Ms. Ballman stated Resident A's family gave permission to bag up Resident A's belongings and move them to the basement.

Relative A1 said DCSM Ms. Ballman met them at the door on 09/26/2022 and informed them four rings and two bracelets belonging to Resident A were missing. She said Ms. Ballman disclosed the lost jewelry had been taken off Resident A, cleaned up, placed in a baggie, and set on Resident A's bedside table after she had passed away. Relative A1 stated Ms. Ballman said she had a call into licensee designee Anne Kesler informing her of the missing jewelry.

Relative A1 said she was never given an inventory list documenting Relative A1's personal property and belongings. Relative A1 stated to her knowledge Resident A's personal property and belongings were not inventoried and no inventory list was ever created by the licensee.

Relative A1 stated law enforcement was contacted and investigated the four missing rings and two bracelets. She said the law enforcement found no evidence the jewelry had been stolen so closed their investigation. Relative A1 stated Ms. Ballman has come up with several different stories involving what may have happened to the missing jewelry but none of the stories have been corroborated. Relative A1 stated the four missing rings and two bracelets have not been found.

DCSM Heather Buffington stated she never saw an inventory list and was never asked to inventory Resident A's personal property and belongings upon Resident A's admission or death and discharge from the facility. She said a couple days after Resident A passed away her personal property and belongings were bagged up and she was asked to move the bags to the basement. Ms. Buffington stated she was not asked to bag up Resident A's personal property and belongings. She said she was asked to move the bags to the basement and helped Relative A1 carry the bags from the basement to her vehicle on 09/26/2022. Ms. Buffington said she heard that four rings and two bracelets Resident A wore were missing. She said she was told the missing rings and bracelets were taken off Resident A after she passed, placed in a baggie, and set on Resident A's bedside table. Ms. Buffington stated she was told the missing rings and bracelets were last seen sitting on the bedside table in the baggie and then were gone.

Ms. Buffington stated she was told DCSMs Ms. Ballman and Ms. Fausett took the four rings and two bracelets off Resident A and placed them in the baggie after she passed away. She said she was told Ms. Ballman and Mr. Fausett also packed up Resident A's personal property and belongings and moved them to the basement.

DCSM Sydney Fausett stated she never saw an inventory list and was never asked to inventory Resident A's personal property and belongings. She stated she helped Ms. Ballman bag up Resident A's personal property and belongings. Ms. Fausett said second shift DCSM Ms. Buffington moved the bags to the basement and helped Relative A1 carry the bags from the basement to her vehicle on 09/26/2022.

Ms. Fausett said she last saw Resident A's four rings and two bracelets on the right side of Resident A's room in a baggie on the bedside table. She does not know what happened to the missing jewelry.

DCSM Ms. Ballman stated Resident A's personal property and belongings were never bagged up or moved to the basement. She said Resident A's personal property and belongings were left untouched in her room and Resident A's family came the next day after she passed away which was on 09/22/2022, packed up Resident A's personal property and belongings, and removed them from the facility. Ms. Ballman said she did not know the family members who packed up and removed Resident A's personal property and belongings.

Ms. Ballman said police were contacted and conducted a preliminary investigation but found no evidence indicating the four rings and two bracelets had been stolen. She said police conducted interviews and then closed the investigation because of a lack of evidence a crime had been committed. Ms. Ballman stated she is unaware of an inventory of Resident A's personal property and belongings being completed nor a document being created.

Licensee designee Anne Kesler sent pictures she took of Resident A's belongings after she passed away. Ms. Kesler provided an *Inventory of Valuables* list filled out by Resident A's family at time of admission. The list included "assorted necklaces and earrings (20 – 30)." The list also included "TV, commode, air filter, photos (10), clown statues (7), glass vases (5), coloring books (4), books (6), nebulizer, outfits (20), and laptop.

Ms. Kesler said she always has family fill out an *Inventory of Valuables* List upon admission. Ms. Kesler said she normally asks family members not to bring anything of significant value to the facility to avoid the possibility of loss. She said she does provide a locked door to place valuable belongings in case a resident brings a belonging with them of significant value, and either the resident or resident's designated representative requests the item be locked up. She said she will sometimes lock up a valuable belonging if she sees a resident is being careless with a valuable belonging.

I conducted an exit conference with licensee designee Anne Kesler on 12/12/2022 via phone informing her there was a violation established during this special investigation and of the need to create and implement a Corrective Action Plan (CAP).

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(15) Personal property and belongings that are left at the home after the death of a resident shall be inventoried and stored by the licensee. A licensee shall notify the resident's designated representative, by registered mail, of

	the existence of the property and belongings and request disposition. Personal property and belongings that remain unclaimed, or for which arrangements have not been made, may be disposed of by the licensee after 30 days from the date that written notification is sent to the designated representative.
ANALYSIS:	Based on the information gathered during this special investigation through review of documentation provided and interviews with Relative A1, DCSM Heather Buffington, Ronda Ballman, Sydney Fausett, and licensee designee Anne Kesler, Resident A's personal property and belongings were not inventoried after her death while being packed by direct care staff members for storage.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, it is recommended that the status of the license remains unchanged

12/12/2022

Rodney Gill Date
Licensing Consultant

Approved By:

12/14/2022

Dawn N. Timm Date
Area Manager