



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

ORLENE HAWKS  
DIRECTOR

March 31, 2023

Paul Barber  
Directors Hall  
600 Golden Drive  
Kalamazoo, MI 49001

RE: License #: AH390236775  
Investigation #: 2023A1021045  
Directors Hall

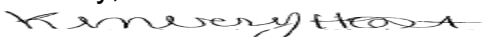
Dear Mr. Barber:

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 authorized representative 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 (517) 284-9730.

Sincerely,

  
Kimberly Horst, Licensing Staff  
Bureau of Community and Health Systems  
611 W. Ottawa Street  
Lansing, MI 48909

enclosure

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

**I. IDENTIFYING INFORMATION**

|                                       |   |
|---------------------------------------|---|
| <b>License #:</b>                     | AH390236775                             |
| <b>Investigation #:</b>               | 2023A1021045                            |
| <b>Complaint Receipt Date:</b>        | 03/16/2023                              |
| <b>Investigation Initiation Date:</b> | 03/17/2023                              |
| <b>Report Due Date:</b>               | 05/15/2023                              |
| <b>Licensee Name:</b>                 | Heritage Community of Kalamazoo         |
| <b>Licensee Address:</b>              | 2400 Portage St.<br>Kalamazoo, MI 49001 |
| <b>Licensee Telephone #:</b>          | (269) 343-5345                          |
| <b>Administrator:</b>                 | Amy Beach                               |
| <b>Authorized Representative:</b>     | Paul Barber                             |
| <b>Name of Facility:</b>              | Directors Hall                          |
| <b>Facility Address:</b>              | 600 Golden Drive<br>Kalamazoo, MI 49001 |
| <b>Facility Telephone #:</b>          | (269) 349-8694                          |
| <b>Original Issuance Date:</b>        | 03/01/1974                              |
| <b>License Status:</b>                | REGULAR                                 |
| <b>Effective Date:</b>                | 08/14/2022                              |
| <b>Expiration Date:</b>               | 08/13/2023                              |
| <b>Capacity:</b>                      | 89                                      |
| <b>Program Type:</b>                  | ALZHEIMERS<br>AGED                      |

## II. ALLEGATION(S)

|  | <b>Violation<br/>Established?</b> |
|--|-----------------------------------|
| Staff Person 1 inappropriate with residents. | Yes                               |
| Additional Findings                          | Yes                               |

## III. METHODOLOGY

|            |  |
|------------|--|
| 03/16/2023 | Special Investigation Intake<br>2023A1021045                     |
| 03/17/2023 | Special Investigation Initiated - Letter<br>referral sent to APS |
| 03/21/2023 | Inspection Completed On-site                                     |
| 03/31/2023 | Exit Conference  |

### **ALLEGATION:**

**Staff Person 1 inappropriate with residents.**

### **INVESTIGATION:**

On 03/16/2023, the licensing department received an anonymous complaint with allegations staff person 1 (SP1) treats residents disrespectfully. The complainant alleged SP1 was also found to be sleeping at the facility while on duty.

On 03/17/2023, the allegations in this report were sent to centralized intake at Adult Protective Services (APS).

On 03/21/2023, I interviewed administrator Amy Beach at the facility. Ms. Beach reported SP1 has been employed at the facility since November 2022 and is still employed at the facility. Ms. Beach reported there has been a few discipline issues with SP1. Ms. Beach reported SP1 has had some attendance issues as SP1 is dealing with family medical issues. Ms. Beach reported she witnessed an altercation with SP1 and another caregiver as both employees were upset with their daily assignment. Ms. Beach reported she counseled both employees on appropriate behavior at work. Ms. Beach reported there was an occurrence with an agitated resident becoming aggressive with staff members. Ms. Beach reported she was present when the resident was agitated and SP1 was also involved in the situation. Ms. Beach reported she was concerned that SP1 might have done something to the

resident, but she intervened before SP1 could have done something. Ms. Beach reported in January 2023, SP1 participated in the medication technician training course but did not complete it. Ms. Beach reported during the class, she left the course and came back with breakfast. Ms. Beach reported she was also very disruptive during the course.

On 03/21/2023, I interviewed SP2 at the facility. SP2 reported she was provided a photo of SP1 sleeping in a recliner in the common area of the facility at 7:02pm. SP2 reported SP1 was provided counseling on appropriate behavior at work. SP2 reported SP1 also tried to convince another medication technician to leave work early to give her a ride home. SP2 reported she spoke with the medication technician and SP1 on appropriate workforce behavior. SP2 reported there was an incident with inappropriate interactions with a resident. SP2 reported SP1 was moved to a different side of the memory care unit so that she would not be involved in the care of the resident.

I reviewed SP1 employee record. The employee record revealed SP1 received two disciplines on attendance and one discipline on sleeping on the job. One incident report dated 12/09/2022 read,

*“Staff member (1) was completing med pass around 2035 and was passing meds to a specific resident. The resident became agitated and proceeded to chase after (SP1) down the hall. Once they reached the dining area the resident stopped and began slamming the dining chairs into the dining table. After this, that is when (SP1) looked at the resident and stated “I’m going to call your husband to tell him how much of a whore you’re being” and then walked away. SP1 was not only the agitator, but she also did not attempt to redirect the resident while said resident was banging the chairs into the table. After this event took place, she asked me to give the resident her medicine.”*

I reviewed another incident report that was dated 12/16/22. Ms. Beach and SP2 reported they were not aware of this occurrence. The incident report read,

*“I tried giving (Resident A) her meds was going to take it. But she decided not to and started spitting her meds out. I was trying to give her some water but she decided she wanted nothing to do with me. I grabbed meds of her mouth and floor and ran towards med cart because she was chasing me and call me fat ass and little shit and then it was over. I didn’t try no more after that.”*

| <b>APPLICABLE RULE</b> |   |
|------------------------|---|
| <b>R 325.1931</b>      | <b>Employees; general provisions.</b>   |
|                        | <b>(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident’s service plan.</b> |

|                    |  |
|--------------------|--|
| <b>ANALYSIS:</b>   | Investigation completed revealed SP1 was hired in November 2022 and is still employed at the facility. Interviews conducted and documents revealed SP1 has not completed residents respectfully as evidenced by having two occurrences with treating residents disrespectfully by calling resident names and taking medications out of resident's mouth. |
| <b>CONCLUSION:</b> | <b>VIOLATION ESTABLISHED</b>   |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

Ms. Beach reported once an employee is hired, the employee completes orientation with human resources. Ms. Beach reported this training focuses on administrative topics such as benefits, time off, attendance, etc. Ms. Beach reported the employee then completes a tour of the facility, meets the management team, and is placed with a preceptor. Ms. Beach reported the preceptor is responsible for on-the-job training. Ms. Beach reported the employee is enrolled in *Welcome Aboard* and *Best Friends Workshop*. Ms. Beach reported these classes focuses on dementia training, abuse/neglect, resident rights, and reporting requirements. Ms. Beach reported SP1 did call off for shifts soon after she started employment. Ms. Beach reported SP1 was hired in November 2022 and completed these classes on 01/04/2023.

| <b>APPLICABLE RULE</b> |  |
|------------------------|--|
| <b>R 325.1931</b>      | <b>Employees; general provisions.</b>  |
|                        | <p><b>(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following:</b></p> <ul style="list-style-type: none"> <li><b>(a) Reporting requirements and documentation.</b></li> <li><b>(b) First aid and/or medication, if any.</b></li> <li><b>(c) Personal care.</b></li> <li><b>(d) Resident rights and responsibilities.</b></li> <li><b>(e) Safety and fire prevention.</b></li> <li><b>(f) Containment of infectious disease and standard precautions.</b></li> <li><b>(g) Medication administration, if applicable.</b></li> </ul> |
| <b>ANALYSIS:</b>       | Review of SP1's employee record revealed SP1 was hired in November 2022 and stated to pass medications soon after her date of hire. SP1 did not complete facility medication   |

|                    |   |
|--------------------|---|
|                    | administration training until January 2023. In addition, SP1 did not complete required training until January 2023. |
| <b>CONCLUSION:</b> | <b>VIOLATION ESTABLISHED</b>  |

**INVESTIGATION:**

Ms. Beach reported if an employee is hired with prior medication administration experience, the employee will shadow another medication technician and will be placed on a medication cart. Ms. Beach reported the employee will then complete the next medication technician training class. Ms. Beach reported SP1 had prior medication administration experience and did pass medications at the facility. Ms. Beach reported SP1 participated in the medication technician training course, but management did not feel SP1 was able to pass medications and was then taken off a medication cart.

I reviewed SP1's resume. The resume revealed SP1 worked in home care for seven years.

|                        |  |
|------------------------|--|
| <b>APPLICABLE RULE</b> |  |
| <b>R 325.1932</b>      | <b>Resident medications.</b>   |
|                        | <b>(3) If a home or the home's administrator or direct care staff member supervises the taking of medication by a resident, then the home shall comply with all of the following provisions:</b><br><b>(a) Be trained in the proper handling and administration of medication.</b> |
| <b>ANALYSIS:</b>       | SP1 administrated medications to residents without successfully completing medication technician training.   |
| <b>CONCLUSION:</b>     | <b>VIOLATION ESTABLISHED</b>   |

**IV. RECOMMENDATION**

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



3/22/2023

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Kimberly Horst  
Licensing Staff

Date

Approved By:



03/27/2023

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

Date