GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 1, 2023

Dean Bonesteel
Pineview Cottage, LLC
8121 Broken Ridge East
Harbor Springs, MI 49740

RE: License #: AH240389978
Investigation #: 2023A1021066
Pineview Cottage

Dear Mr. Bonesteel:

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

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

License #:	AH240389978
Investigation #:	2023A1021066
Complaint Receipt Date:	06/01/2023
Investigation Initiation Date:	06/06/2023
Report Due Date:	08/01/2023
Licensee Name:	Pineview Cottage, LLC
Licensee Address:	8121 Broken Ridge East Harbor Springs, MI 49740
Licensee Telephone #:	(810) 516-8928
Administrator/ Authorized Representative:	Dean Bonesteel
Name of Facility:	Pineview Cottage
Facility Address:	3498 Harbor-Petoskey Rd Harbor Springs, MI 49740
Facility Telephone #:	(231) 412-6069
Original Issuance Date:	08/03/2018
License Status:	REGULAR
Effective Date:	02/03/2023
Expiration Date:	02/02/2024
Capacity:	40
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A issued incorrect discharge.	No
Resident A treated disrespectfully.	No
Facility has insufficient staff.	No
Resident A did not receive medication.	No
Additional Findings	Yes

III. METHODOLOGY

06/01/2023	Special Investigation Intake 2023A1021066
06/05/2023	APS Referral complaint came from APS
06/06/2023	Special Investigation Initiated - Telephone interviewed administrator
06/08/2023	Contact - Document Received received Resident A documents
07/05/2023	Inspection completed on site

ALLEGATION:

Resident A issued incorrect discharge.

INVESTIGATION:

On 06/01/2023, the licensing department received a complaint from Adult Protective Services (APS) with allegations Resident A was issued an incorrect discharge notice.

On 06/05/2023, I interviewed administrator Hilde Bonesteel by telephone. Ms. Bonesteel reported Resident A has Parkinson's with Lewy body dementia. Ms. Bonesteel reported Resident A's needs have increased to the level that the facility

cannot meet his needs and it is not safe for Resident A. Ms. Bonesteel reported employees have been injured because Resident A refuses care. Ms. Bonesteel reported Resident A requires a Hoyer Lift, but the family is refusing to allow the use of a Hoyer Lift. Ms. Bonesteel reported the facility has requested for the use of agency workers and the family refused to provide this as well. Ms. Bonesteel reported family came to help assist but they refuse to provide any care to Resident A. Ms. Bonesteel reported Resident A needs a wheelchair, but the family feels he is more independent and does not require ambulation device. Ms. Bonesteel reported Resident A tries to ambulate and then falls. Ms. Bonesteel reported the facility could meet Resident A's needs if the family would be agreeable to a Hoyer Lift and the use of a wheelchair. Ms. Bonesteel reported the facility issued a 30-day discharge letter because of the increased care needs.

On 07/05/2023, I interviewed staff person 1 (SP1) at the facility. SP1 reported Resident A's care needs increased to the level that the facility could not meet, and it was not safe for Resident A to reside at the facility. SP1 reported the family refused to have Resident A use a Hoyer Lift and the staff members could not safety transfer Resident A. SP1 reported Resident A participated in physical therapy and then would try to ambulate in his room without his wheelchair which resulted in falls.

I reviewed chart notes for Resident A. The notes read,

> *"06/07/2023: summary for last quarter with resident. Staff continue to invest multiple service hour in care of this resident. Resident has been increasingly confused at times refusal to get up from bed pushing back against the 3rd shift care providers when they attempt to assist him even when resident saturated with urine and in need of assistance. An attempt was made to establish his get up time later in AM. But then resident would become agitated upon awakening and would attempt to get himself out of bed without assistance as he could not remember to use call pendent. Within the last 90 days there have been 2 falls following the bed alarm going off and caregivers running to the room responding immediately. Additional incident where resident was observed danger to himself when attempting to ambulate independently. Additionally resident was lifted by two to three staff when observed on the floor in front of reclining chair and toilet on multiple occasions. Resident recently found on floor in theater and assisted by three staff to get back into wheelchair. Multiple incidents provided by three staff to get back into wheelchair. Multiple incidences provide proof of cognitive decline such as need for constant supervision where he would be observed at med cart and moved to Memory Care unit to maintain his safety. Resident also lost ability to follow basic commands when transferring, proving difficult for staff.*
> *04/28/2023: Resident continues to be monitored closely due to extreme fall risk. Family continues to encourage PT for strengthening and balance. Resident continues to take supplements by family. Family is working toward trying to get resident in rehabilitation community. Chair alarms, bed alarm and pendent remain in place. Resident toileted every two hours. Participates in community activity as desired. Continue with medication as ordered by physician.*

04/17/23: discussion with residents' family. They will need until June to arrange to have resident moved to a SNF to active PT to continue to work on his independent ambulation. It was explained to the family that due to his cognitive issues/memory we would not be able to encourage ambulation as his mind does not coincide with inability to steady himself and walk safely.
04/12/2023: Resident continues to get up without assistance. States that he does not remember to push his pendent. Resident daughter in law called regarding a black gait belt with substantial handles. Additionally, a green blender bottle which we do his chocolate shakes in. additionally inquired about a TV wheelchair tray. Which was recommended by PT to try to slow the resident down and give hm a chance to think before he attempted to get up to walk. Additional discussion was had about the residents' cognitive abilities and the realistic goals that are being held by family and communities desire to keep resident as safe as possible inside an AL environment. Which did not include active PT for ambulation purposes. Suggested if that is family decision/goal then he needed to go to a skilled rehab and work on restoring his ambulation. Explained that in working with (Resident A) he cognitively does not have the ability to safety ambulate independently due to disease process. Verified that a meeting was scheduled for 5:00PM with (Relative A1) where they could discuss what their next steps are based on goal set."

I reviewed Resident A's discharge letter. The letter read,

"Due to (Resident A)'s increased needs, we are not able to provide care at the level he needs and that our standards require. When you spoke with Hilde, you had agreed to provide agency assistance for the morning hours. Since that time, we have had family support rather than agency support. While I understand the financial circumstances that have precipitated this decision, the family members who have come are not able to provide the assistance and/or care that is needed.

We understand that you are trying to find alternative placement for (Resident A) and do not yet have a set date. Unfortunately, because of the situation with his care needs and the difficulty placed on our staff, we are not able to accommodate an open-ended transition. Based on the date of your conversation with Hilde and our 30-day discharge policy- please see the attached- we will be discharging (Resident A) from Pineview on June 22nd."

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(8) A home shall not retain a resident if the resident has harmed himself or herself or others, or has demonstrated behaviors that pose a risk of serious harm to himself or herself or others, unless the home has the capacity to manage the resident's behavior.

ANALYSIS:	Interviews conducted and documents revealed Resident A's care needs had increased to a level that the facility could not maintain Resident A's safety. Therefore, Resident A was issued a discharge notice from the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A treated disrespectfully.

INVESTIGATION:

APS alleged that Resident A was treated disrespectfully. APS alleged the staff talks about hospice in front of Resident A and he doesn't want hospice. APS alleged the staff are rude sometimes, as one time they stated he has Depends on and they can't get him out the dining room.

SP1 reported the conversation regarding Hospice Care happened when Resident A's family requested for Resident A to stay in bed and not go to the dining room for meals. SP1 reported she spoke with Resident A's family and reported Resident A likes to go to the dining room, can go to the dining room, and is not at hospice care level. SP1 reported staff members always treated Resident A respectfully.

On 07/05/2023, I interviewed Resident B at the facility. Resident B reported care staff treat her well. Resident B reported staff members are caring and respectfully. Resident B reported no concerns with staff members.

On 07/05/2023, I interviewed Resident C at the facility. Resident C reported care staff are caring and treat all residents well. Resident C reported no concerns with staff at the facility.

While on site I observed multiple staff and resident interactions. I observed staff members having meaningful conversations, assisting with care needs, and engaging respectfully with the residents.

Resident A was no longer at the facility and therefore I was unable to interview Resident A.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(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.
ANALYSIS:	Interviews conducted and observations made revealed lack of evidence to support the allegation residents are treated disrespectfully.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Facility has insufficient staff.

INVESTIGATION:

APS alleged that the facility has insufficient staff.

SP1 reported she has no concerns with staffing in the assisted living unit at the facility. SP1 reported Resident A's family was upset with staffing levels because they wanted Resident A to have 1:1 care. SP1 reported there are 18 residents in the unit and typically there is one caregiver and one medication technician. SP1 reported there are no residents that are a two person assist, no residents that are a high fall risk, and no residents that have behaviors. SP1 reported if there is a staff call in, a worker will be requested to stay over past their shift for additional pay. SP1 reported typically the facility does not work below their staffing levels. SP1 reported the floor staff work together to ensure medications are administered on time and residents receive good care.

On 07/05/2023, I interviewed SP2 at the facility. SP2 reported she is responsible for eight residents. SP2 reported she will also assist with additional resident care while the other staff member is administering medications. SP2 reported there are no residents that are a two person assist, no residents with behaviors, and no residents that have frequent falls. SP2 reported staffing is adequate at the facility and residents receive good care.

On 07/05/2023, I interviewed Resident B at the facility. Resident B reported she has resided at the facility for over one year. Resident B reported there is significant staff at the facility. Resident B reported the care staff are very attentive and responsive to her needs.

On 07/05/2023, I interviewed Resident C at the facility. Resident C reported himself and his Resident D have resided at the facility for several months. Resident C reported staff are very attentive to their needs and he has no concerns with staffing levels.

I reviewed the staffing assignment sheets for 06/26/2023-07/05/2023. The staffing sheets revealed the staffing levels were met as described by SP1.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	Document reviewed and interviews conducted level of evidence to support the allegation there is lack of staff at the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A did not receive medication.

INVESTIGATION:

APS alleged that the facility ran out of Resident A's medications and were cutting the medication in half.

SP1 reported she administered medications to Resident A and there was never any medication errors and medications were not cut in ½. SP1 reported Resident A was on many vitamins and supplements. SP1 reported Resident A received medications as prescribed by his physician.

I reviewed Resident A's MAR. Medications were administered as prescribed by the physician.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.

ANALYSIS:	Interviews conducted and documents revealed lack of evidence to support the allegation Resident A did not receive medications.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
Resident A's discharge letter read,

"In the event that (Resident A)'s condition deteriorates even further, we will be processing an emergency discharge to the hospital, from which he will not be able to return to Pineview Cottage."

APPLICABLE RULE	
R 325. 1922	**Admission and retention of residents.**
	(13) A home shall provide a resident and his or her authorized representative, if any, and the agency responsible for the resident's placement, if any, with a 30-day written notice before discharge from the home. The written notice shall consist of all of the following: **(c) A statement notifying the resident of the right to file a complaint with the department. The provisions of this subrule do not preclude a home from providing other legal notice as required by law.**
ANALYSIS:	Review of Resident A's discharge letter revealed the letter omitted all information on the right of the resident to file a complaint with the Department. In addition, the facility cannot discharge a resident to the hospital as the hospital is not a discharge location.
CONCLUSION:	**VIOLATION ESTABLISHED.**

IV. RECOMMENDATION

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

07/10/2023

Kimberly Horst Date
Licensing Staff

Approved By:

07/31/2023

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