GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 25, 2023

Jennifer Herald
Oliver Woods Retirement Village LLC
Suite 200
3196 Kraft Ave SE
Grand Rapids, MI 49512

RE: License #: AL780258989
Investigation #: 2023A0584042
Oliver Woods 1

Dear Ms. Herald:

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 that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9727.

Sincerely,

Candace Coburn, 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 #:	AL780258989
Investigation #:	2023A0584042
Complaint Receipt Date:	07/14/2023
Investigation Initiation Date:	07/14/2023
Report Due Date:	09/12/2023
Licensee Name:	Oliver Woods Retirement Village LLC
Licensee Address:	Suite 200 3196 Kraft Ave SE Grand Rapids, MI 49512
Licensee Telephone #:	(810) 334-8809
Administrator:	Andrew Green
Licensee Designee:	Jennifer Herard
Name of Facility:	Oliver Woods 1
Facility Address:	1310 W. Oliver Street Owosso, MI 48867
Facility Telephone #:	(989) 729-6060
Original Issuance Date:	04/16/2004
License Status:	REGULAR
Effective Date:	08/29/2021
Expiration Date:	08/28/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Resident A fell multiple times due to lack of updated assessed needs.	Yes
Resident A's medications were not as prescribed.	No
Resident A's personal belongings and bed were infested with bed bugs.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/14/2023	Special Investigation Intake 2023A0584042.
07/14/2023	Special Investigation Initiated – Telephone message to Joelle McGuire, Memorial Healthcare Home Health and Hospice.
08/01/2023	Contact – Telephone interview with Relative A 1.
08/02/2023	Contact - Face to Face investigation and physical inspection of facility,13 residents observed, interviews of direct care staff Shelby Root, housekeeping staff Tina Brewer and Courtney Wagner, Settings Director Nick Vonsteenburg, Wellness Director Arielle Radick, Licensee Designee Jennifer Herald.
08/03/2023	Contact - Face to Face interview with Relative A 2.
09/05/2023	Exit conference – Face to face with Jennifer Herald, Administrator Andrew Green and Nick Vonsteenburg at the facility.
09/07/2023	Contact – Telephone interview with Joelle McGuire.
09/07/2023	Contact – Email to Cheryl Hunt, Adult Protective Services Supervisor Shiawassee County Department of Health and Human Services.
09/11/2023	Contact – Telephone interview with Corso Care Clinical Care Director, Toni Graham.
09/14/2023	Contact – Exit conference update with Jennifer Herald.

ALLEGATIONS:

- **Resident A fell multiple times due to lack of updated assessment needs.**
- **Resident A's medications were not administered as prescribed.**
- **Resident A's personal belongings and bedding were infested with bedbugs.**

INVESTIGATION:

On 7/14/2023, the Bureau of Community and Health Systems (BCHS) received the above allegations via a telephone call from an anonymous complainant.

On 08/01/2023, I conducted a telephone interview with Relative A 1. Relative A 1 stated she recently was informed that Resident A had fallen five or six times between 6/16/2023 to 6/19/2023. According to Relative A 1, they were not notified of the falls by the facility. On 6/19/2023, Resident A was sent to Memorial Hospital emergency room (ER) at the request of Relative A 2. Relative A 1 stated that Resident A passed away on 7/1/2023 at the hospital. Subsequently, family members found live and dead bed bugs among Resident A's bed mattress and personal belongings.

On 8/2/2023, I conducted an onsite investigation of the facility. I inspected the facility and observed to be neat and clean.

I conducted interviews with Residents A, B, C, D, E, F, G, direct care staff Shelby Root, housekeeping staff members Tina Brewer and Courtney Wagner, facility director Nick Vonsteenburg, wellness director Arielle Radick, and licensee designee Jennifer Herald.

Residents A, B, C, D, E, F all reported that they receive attentive, quality care by staff, were aware facility staff members had found bed bugs in the facility. However, Residents A, B, C, D, E, and F all reported not witnessing any pest problem in their rooms, including the presence of bed bugs.

Ms. Root stated Resident A was under hospice care from the end of May 2023 until his admission into Memorial hospital. Ms. Root confirmed Resident A had a few falls in the facility between 6/16/2023 and 6/19/2023, which were documented on internal incident reports and reported to his hospice agency, Corso Care. Ms. Root stated she administered medications to Resident A as prescribed, recorded passed medications in his medication administration record (MAR), as well as provided ongoing review of Resident A's MAR for all facility shifts. Ms. Root stated she had not heard of or been made aware of any issues with Resident A's medication not being administered as prescribed. Ms. Root also stated she did not see evidence of bed bugs in Resident A's room, room #119, during times she was assisting him, but and did confirm the presence of a bedbug infestation in another resident's room, room #112.

Ms. Brewer and Ms. Wager both stated their job function is to clean the surfaces, floors, and bathroom areas of resident rooms and they do not strip the bed linens to do laundry. Ms. Brewer and Ms. Wagner both stated they did not observe any bed bugs in Resident A's room until 7/7/2023, when they observed both live and dead bed bugs on his personal items and mattress.

Ms. Radick provided me with Resident A's resident record, and a copy of his MAR for the months of May and June 2023. I did not observe any missing documentation on Resident A's May or June MAR records, indicating Resident A did not receive his medications as prescribed.

I reviewed Resident A's BCAL – 3265, *ASSESSMENT PLAN FOR AFC RESIDENTS* (assessment plan), drafted on 4/27/2023. According to documentation on Resident A's assessment plan on 4/27/2023, Resident A was alert to surroundings. There was no documentation on Resident A's assessment plan regarding walking or mobility assistance.

Ms. Radick provided me with *AFC Division Incident/Accident Reports* (IR) regarding Resident A falls. I reviewed documentation on IRs dated below with a synopsis of information as follows:

5/4/2023 – Relative A 2 assisting when Resident A fell in the shower. Vitals taken, left elbow tear noted and bandaged, and follow up notes 5/7/23 6x6 bruise on back with color improving noted on 5/8/2023. Hospice notified.

5/24/2023 – Resident A found on floor inside by the room door, two staff helped him up, did a vital assessment. Relative A 1, Relative A 2, Hospice notified, bump on the back of the head noted. Hospice followed up with a visit on 5/25/2023.

6/13/2023 – Resident A found sitting on floor in front of room. Hospice did assessment, Relative A 2 notified, no injuries found.

6/16/2023 – Resident A found on the floor after the staff heard yell for help. Resident A assisted to toilet, back into bed, Relative A 2 and hospice notified. On call hospice nurse assessed 3 small tears and indicated signs of terminal restlessness for Resident A.

6/17/2023 – During room check, Resident A found on the floor in his room. On call hospice nurse notified who did assessment, bandaging of four skin tears, and consulted with Relative A 2 of medication modifications.

6/18/2023 – During room check, staff found Resident A on the floor of his room. Resident A told them he was trying to go to the bathroom by himself. Hospice did assessment, did wound care on reopened skin tears, staff to continue to

monitor through the night, Relative A 2 notified. Follow up note that hospice was to come out on morning of 6/19/2023 to do evaluation regarding consistent falls. Relative A 2 took Resident A to be evaluated at ER before assessment was conducted and was admitted to hospital.

Mr. Vonsteenburg provided me with the facility contract with Griffin Pest Control, a professional pest treatment company, and a detailed timeline of communication between the facility and Griffin Pest Control regarding discovered bed bugs in the facility and treatment applications as follows:

4/27/2023 – Housekeeping discovers live bed bugs in unit #112 and notifies myself…Nick Vonsteenburg. Unit #112 prepped for Griffin Pest Control's arrival. Griffin Pest Control arrives. They proceeded to give the following units a "Proactive Liquid Barrier Chemical Treatment for Bed Bugs": #111, 112, 113, and 119…all units adjoining /near the infested unit but had no evidence of infestation themselves.

5/1/2023 – Housekeeping enters the unit #112 again to do a thorough clean and inspection for pests. Nothing was found. Unit was considered "all clear".

5/8/2023 – Complete inspection completed on #112 by Oliver Woods Housekeeping department and room is given "All Clear" status.

I reviewed more notes on 6/1/2023, 6/13/2023, 6/22/2023, and 6/25/2023 indicating live bed bugs were discovered in room #112 during inspections and the following treatments were applied:

6/1/2023 – [Unit 112 only] Griffin…out to do…a "Proactive Liquid Barrier Chemical Treatment for Bed Bugs".

6/20/2023 – Griffin…applied follow up "Apprehend" treatment and Anti-Fungal Spore Treatment [Unit 112 only]

A note from 6/27/2023 documented a follow up chemical treatment was done as a preventative for unit #103 due to that unit having bed bugs discovered earlier in the year.

7/3/2023 – Routine inspection of Unit #112 given "All Clear".

7/7/2023 – Routine Inspection of unit #112 "all Clear".

7/7/2023 – Unit #119 is directly across the hall from #112. [Resident A] passed away and family was in room moving items out. When doing so, they reported finding live bed bugs in unit #119…Room put on lockdown and heat treatment scheduled for 7/14/2023.

7/12/2023 – Routine inspection of unit #112 found 3 live bed bugs. Griffin scheduled to come heat treat this unit on 7/14/2023 at the same time they heat treat unit #119.

According to the notes from 4/27/2023, no other units around #112 were inspected or treated besides one preventative treatment done in #103 on 6/27/2023.

On 8/3/2023, I conducted an in-person interview with Relative A 2. Relative A 2 confirmed she was the durable power of attorney (DPOA) for Resident A. Relative A 2 stated she did not have any concerns about Resident A's medications not being administered to Resident A as prescribed. Relative A 2 was concerned regarding Resident A's increased falls in the facility, which resulted in bruising and skin tears. Relative A 2 stated she was very concerned that Resident A's room was directly across from a room that bedbugs were discovered multiple times in the last several months. Relative A 2 confirmed that when Resident A passed away, family members and housekeeping staff found bedbugs on Resident A's mattress and in personal belongings when removing them from the room. Relative A 2 stated the facility could have been more thorough and checked other rooms for possible infestations of bed bugs. Relative A 2 stated she often brought up concerns of the bed bug problem. However, the facility continued to discover the pests even after conducting treatments.

On 9/7/2023, I conducted a telephone interview with Memorial Healthcare Home Health and Hospice nurse Joelle McGuire. Ms. McGuire stated that she spoke with Resident A's family members after Resident A was admitted to the Memorial's hospice program on 6/19/2023. Ms. McGuire confirmed that during one conversation with Relative A 2, Relative A 2 reported their only concern was the bed bug infestation at the facility. According to Ms. McGuire, had Resident A's family members reported allegations that Resident A was abused or neglected while at the facility, Memorial Hospital staff members would have forwarded the allegations to Adult Protective Services.

I contacted Shiawassee County Department of Health and Human Services Adult Services Supervisor Cheryl Hunt via email and received a response that between 5/20/2023 and 6/20/2023, Shiawassee County Adult Protective Services did not receive any referrals from the State of Michigan Central Intake Unit regarding the neglect or abuse of Resident A by facility staff members.

On 9/11/2023, I conducted a telephone interview with Corso Care Clinical Care Director Toni Graham. Ms. Graham reviewed Corso Care hospice nurse notes and stated there was no mention of Resident A's medications not administered as prescribed, nor were there notes indicating the observance of bed bugs in the facility. Ms. Graham stated there were notes regarding Resident A's increase in falls, due to active end of life stage restlessness. Ms. Graham stated that according to documentation in the nurse's notes, an evaluation meeting was scheduled with facility staff members and Relative A 2 to take place the morning of 6/19/2023. Ms.

Graham stated that Relative A 2 contacted them and reported she was having Resident A transported to the ER. As a result of this, Resident A had to be discharged from Corso Care hospice in order to obtain medical treatment.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
DEFINITION:	"Assessment plan" means a written statement which is prepared in cooperation with a responsible agency or person, and which identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical and behavioral needs and well-being and the methods of providing the care and services, taking into account the preferences and competency of the individual.
ANALYSIS:	Based upon my investigation, which consisted of interviews with facility staff members, Relative A 1, Relative A 2, and Corso Care Clinical Director Toni Graham, as well as a review of facility documentation pertinent to the allegations, it has been confirmed that Resident A had fallen in the facility at least 6 times between 5/4/2023 and 6/18/2023. Documentation on Resident A's assessment plan determined he was last assessed by facility staff members on 4/23/2023. At that time, there was no documentation on Resident A's assessment plan indicating he required assistance with mobility and/or was at risk for falls. It has been established that Resident A's assessment plan was never updated to include his risks for falls and/or to include the interventions to be provided by direct care staff members to address this risk.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based upon my investigation, which consisted of interviews with facility staff members, Relative A 2, and Corso Care Clinical Director add name, as well as a review of facility documentation pertinent to the allegations, it has been determined there is no evidence to substantiate the allegation that medications were not administered to Resident A as prescribed while he was residing in the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.15401	**Environmental health.**
	(5) An insect, rodent, or pest control program shall be maintained as necessary and shall be carried out in a manner that continually protects the health of residents.
ANALYSIS:	Based upon my investigation, which consisted of interviews with facility staff members, Relative A 1, Relative A 2, and Corso Care Clinical Director Toni Graham, as well as a review of facility documentation pertinent to the allegations, it has been determined the facility contracted with a professional pest treatment company to address the bed bug pest infestation of two rooms where the pests were discovered between 4/23/2023 and 6/27/2023. However, the facility failed to proactively inspect all the rooms and other areas of the facility for signs of a bed bug infestation. Consequently, bed bugs were found in Resident A's room on 7/7/2023. It has been established the facility's pest control program was not carried out in a manner that protected the health of residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/14/2023, I conducted an exit interview via telephone with licensee designee Jennifer Herald and shared the findings of this investigation.

IV. RECOMMENDATION

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

9/25/2023

Candace Coburn — Date
Licensing Consultant

Approved By:

9/25/2023

Michele Streeter — Date
Area Manager