GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 19, 2023

Mark Walker
Premier Operating Clarkston MC, LLC
7570 Dixie Hwy
Clarkston, MI 48346

RE: License #: AL630382793
Investigation #: 2023A0991033
The Pines Of Clarkston Memory Care

Dear Mr. Walker:

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:

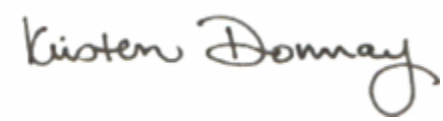
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

The issuance of a 1st provisional license was previously recommended in Special Investigation Report #: 2023A0991015. The 1st provisional license was issued effective 06/02/23. This recommendation remains in effect.

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 (248) 975-5053.

Sincerely,



Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630382793
Investigation #:	2023A0991033
Complaint Receipt Date:	08/23/2023
Investigation Initiation Date:	08/24/2023
Report Due Date:	10/22/2023
Licensee Name:	Premier Operating Clarkston MC, LLC
Licensee Address:	299 Park Ave - 6 Fl New York, NY 10171
Licensee Telephone #:	(419) 429-9984
Administrator:	Rebecca Nagey
Licensee Designee:	Mark Walker
Name of Facility:	The Pines Of Clarkston Memory Care
Facility Address:	7570 Dixie Hwy Clarkston, MI 48346
Facility Telephone #:	(248) 625-3400
Original Issuance Date:	03/22/2017
License Status:	1ST PROVISIONAL
Effective Date:	06/02/2023
Expiration Date:	12/01/2023
Capacity:	20
Program Type:	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
A caregiver was forced to work for more than 36 hours straight from 08/16/23-08/17/23.	No
Additional Findings	Yes

III. METHODOLOGY

08/23/2023	Special Investigation Intake 2023A0991033
08/24/2023	Special Investigation Initiated - Telephone Call to executive director, Rebecca Nagey
08/30/2023	Inspection Completed On-site Unannounced onsite inspection
08/30/2023	Contact - Document Received Staff schedule, resident register, employee list
10/11/2023	Contact - Telephone call made Left message for Rebecca Nagey, executive dir.
10/12/2023	Contact - Telephone call made Left message for direct care worker, Latonya Painter
10/12/2023	Contact - Telephone call made To Rebecca Nagey
10/16/2023	Contact - Telephone call made To direct care worker, Latonya Painter
10/16/2023	Contact - Telephone call made To Rebecca Nagey
10/19/2023	Exit Conference Via telephone with administrator, Rebecca Nagey

ALLEGATION:

A caregiver was forced to work for more than 36 hours straight from 08/16/23-08/17/23.

INVESTIGATION:

On 08/23/23, I received a complaint alleging that a caregiver was forced to work for more than 36 hours by herself from 08/16/23-08/17/23. I initiated my investigation on 08/24/23 by contacting the executive director, Rebecca Nagey. I requested a copy of the staff schedule, resident register, and staff contact information. A referral was not made to Adult Protective Services (APS), as there were no allegations of abuse or neglect.

On 08/24/23, I interviewed the executive director, Rebecca Nagey, via telephone. Ms. Nagey stated that they had two staff members who recently quit and walked out. She was not aware of anyone working for 36 hours straight. She stated that the supervisor, Melissa Almaraz, worked a 12-hour shift, was off for 6 hours, and then returned to work for 11 hours. She stated that there are four residents in the memory care building, so they only need one staff person on shift. Staff in the memory care building work 12-hour shifts from 6:00am-6:00pm and 6:00pm-6:00am. Staff are mandated to stay on shift if someone does not show up for the next shift until coverage is found.

On 08/30/23, I conducted an unannounced onsite inspection at The Pines of Clarkston Memory Care. I interviewed the home manager, Melissa Almaraz. Ms. Almaraz stated that they work 12-hour shifts, which typically run from 6:00am-6:00pm and 6:00pm-6:00am. Sometimes they have someone who comes in from 6:00pm-11:00pm as well. Ms. Almaraz stated that she worked on Wednesday 08/16/23 from 6:00am-6:00pm. She was off from 6:00pm-10:00pm, but then came back in and worked from 10:00pm on Wednesday 08/16/23 until 6:00pm on Thursday 08/17/23. She stated that she worked for 12 hours, was off for 4 hours, and then returned to work for 18 hours. She stated that this is not typical, but they had a staff person who quit that day, so she had to cover the shift. Ms. Almaraz stated that direct care worker, Latonya Painter, also worked on 08/16/23. Ms. Painter worked from 6:00am-6:00pm, and she also covered from 6:00pm-10:00pm until Ms. Almaraz returned. Ms. Painter worked for a total of 16 hours. Ms. Almaraz stated that they had three staff quit that week, so they were very short staffed. She stated that as the home manager, she is typically the person who works back-to-back shifts or covers when somebody does not show up for their shift. Ms. Almaraz stated that she slept during the four hours that she was off, and this was a sufficient amount of time. She stated that she did not sleep while on shift at the facility and did not have any issues supervising or caring for the residents. She stated that she has worked at the facility for six years and is used to working long shifts. They currently have four residents residing in the memory care building. Ms. Almaraz did not have any concerns about the care the residents are receiving.

On 08/30/23, I interviewed direct care worker, Emberyonn Pope-White. Mr. Pope-White stated that he has worked at The Pines of Clarkson Memory Care for about five weeks and is fully trained. He stated that he was not aware of anyone working for 36 hours straight. He stated that they typically work 12-hour shifts from 6:00am-6:00pm. The longest that he has had to work was 16 hours. If someone calls in, whoever can come in

to cover the shift will come in. He stated that there have been times when the home manager, Melissa Almaraz, got stuck on shift. He was not aware of anyone sleeping while on shift. He stated that he felt the needs of the residents were being met and they were well taken care of by the staff.

On 08/30/23, I interviewed Resident C. Resident C stated that he has lived at the facility since September 2021. He stated that staff are very responsive during the day, but sometimes it takes a while for staff to respond at night when he pushes his call button. This happens about once a week. Resident C stated that he has never seen staff sleeping, but he is not mobile, so he is not sure what happens when he is in his room. He stated that he needs assistance with transfers from his wheelchair. There is always at least one staff in the building. Someone comes in to cover when staff leave or take a break.

On 08/30/23, I interviewed Resident D. Resident D stated that he does not have any concerns or complaints about the facility. He was not aware of staff working for 36 hours straight. Resident D stated that if he needs help at night, staff will come, but he does not typically require assistance. Resident D stated that he never saw staff sleeping. He stated that staff usually come in around 7:00 or 8:00 in the morning and then different staff come in around 5:30. There was never a time when there was no staff in the building. He stated that they do not even go across the street to the other building without someone else being there.

On 10/16/23, I interviewed direct care worker, Latonya Painter. Ms. Painter stated that she has worked at The Pines of Clarkston since July 2023. She stated that she has never worked for 36 hours in a row, and she was not aware of any else working for 36 hours straight. She stated that she typically works from 6:00am-2:00pm. There have been times when she had to stay until 8:00pm or 10:00pm due to staff calling in for their shifts. If someone calls in, you cannot leave until coverage is found. She occasionally works a double shift. Ms. Painter stated that she usually works in the assisted living building, but there have been times when she covers shifts at the memory care building. If there are enough staff at the assisted living building, they will pull staff to go to the memory care building. Ms. Painter stated that the manager, Melissa Almaraz, typically covers extra shifts in the memory care building. She stated that Ms. Almaraz has worked several shifts in a row, but she usually leaves for a few hours to sleep and then comes back. Another staff covers while Ms. Almaraz is off for a few hours. Ms. Painter stated that she did not have any concerns about the care or supervision of the residents. She was not aware of anyone sleeping on shift or anyone being too tired to provide appropriate care.

I reviewed a copy of the staff schedule for the time period of 08/07/23-08/19/23. On Wednesday, 08/16/23 the schedule notes that Melissa Almaraz and Latonya (Tonya) Painter worked in the memory care building for 1st shift from 6:00am-6:00pm. The schedule notes Drea quit on 08/16/23. Drea's name is crossed out for 2nd shift on 08/16/23. Melissa and Tonya's names are handwritten in for 2nd shift on 08/16/23 from 6:00pm-6:00am, with 6am written under Melissa's name and 10pm written under

Tonya's name. Melissa is also scheduled to work 1st shift on 08/17/23 from 6:00am-6:00pm. The schedule does not note that Melissa left for several hours on 08/16/23.

The executive director, Rebecca Nagey, stated that the schedule does not accurately reflect who was working during those times, and that they need to do a better job of updating the schedule to reflect who was working and providing coverage. Ms. Nagey stated that she was unable to access the timesheets or time clock records from that period of time due to a change in management companies and time reporting software.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on the information gathered through my investigation there is insufficient information to conclude that the safety and protection of the residents was not attended to due to staff working for 36 hours in a row on 08/16/23-08/17/23. The home manager, Melissa Almaraz, worked on Wednesday 08/16/23 from 6:00am-6:00pm. She was off from 6:00pm-10:00pm, but then came back in and worked from 10:00pm on Wednesday 08/16/23 until 6:00pm on Thursday 08/17/23. None of the staff or residents had knowledge of staff sleeping on shift and there were concerns about resident needs not being met due to staff working long hours.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

During my investigation, I reviewed a copy of the staff schedule for the time period of 08/07/23-08/19/23. The schedule did not accurately reflect the hours or shifts worked when staff called in and other staff provided coverage. The schedule did not include the full names or job titles of the staff who were working. The executive director, Rebecca Nagey, stated that the schedule does not accurately reflect who was working during those times, and that they need to do a better job of updating the schedule to reflect who was working and providing coverage.

On 10/19/23, I conducted an exit conference with the administrator, Rebecca Nagey, as the licensee designee, Mark Walker, was not available. Ms. Nagey stated that they

would submit a corrective action plan and would make the necessary changes to the staff schedule.

APPLICABLE RULE	
R 400.15208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: (a) Names of all staff on duty and those volunteers who are under the direction of the licensee. (b) Job titles. (c) Hours or shifts worked. (d) Date of schedule. (e) Any scheduling changes.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the staff schedule was not updated to accurately reflect scheduling changes and the hours or shifts worked when staff called in or provided coverage. The staff schedule did not include the full names of the staff or job titles.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receiving an acceptable corrective action plan, I recommend that the 1st provisional license remains in effect.

10/19/23

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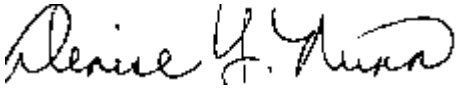
Kristen Donnay Date
Licensing Consultant

Approved By:



10/19/2023

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Denise Y. Nunn Date
Area Manager