GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 23, 2023

Wendy Haynes-Ennis
Trilogy Health Care of Clinton, LLC
303 N. Hurstbourne Pkwy
Louisville, KY 40222-5185

RE: License #: AH330336314
Investigation #: 2023A1021090
The Legacy at The Willows

Dear Wendy Haynes-Ennis:

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 #:	AH330336314
Investigation #:	2023A1021090
Complaint Receipt Date:	09/22/2023
Investigation Initiation Date:	09/25/2023
Report Due Date:	11/22/2023
Licensee Name:	Trilogy Health Care of Clinton, LLC
Licensee Address:	#2 303 N. Hurstbourne Pkwy Louisville, KY 40222-5185
Licensee Telephone #:	(517) 203-4042
Administrator/ Authorized Representative:	Wendy Haynes-Ennis
Name of Facility:	The Legacy at the Willows
Facility Address:	Legacy Bldg 3510 Coolidge Rd East Lansing, MI 48823
Facility Telephone #:	(517) 203-4042
Original Issuance Date:	02/13/2014
License Status:	REGULAR
Effective Date:	10/06/2022
Expiration Date:	10/05/2023
Capacity:	35
Program Type:	AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Facility had insufficient staff on 09/16 and 09/17.	Yes
Resident A's oxygen not properly placed.	Yes
Additional Findings	No

III. METHODOLOGY

09/22/2023	Special Investigation Intake 2023A1021090
09/25/2023	Special Investigation Initiated - On Site
09/25/2023	Contact - Telephone call made interviewed SP4
09/25/2023	Contact - Telephone call made interviewed SP5
10/23/2023	Exit Conference

ALLEGATION:

Facility has insufficient staff on 09/16 and 09/17.

INVESTIGATION:

On 09/22/2023, the licensing department received a complaint with allegations the facility had insufficient staff on 09/16 and 09/17.

On 09/25/2023, I interviewed administrator Wendy Haynes-Ennis at the facility. Ms. Haynes-Ennis reported that there are 22 residents in the facility. Ms. Haynes-Ennis reported the staffing guidelines call for two caregivers and one medication technician on first and second shift and one caregiver and one medication technician on third shift. Ms. Haynes-Ennis reported the facility does not have a mandation policy for staff shortages. Ms. Haynes-Ennis reported if there is a staff shortage, the manager and scheduler are expected to fill in until a replacement can be found. Ms. Haynes-Ennis reported activities and housekeeping are also in the unit for additional supervision. Ms. Haynes-Ennis reported there is adequate staff at the facility.

On 09/25/2023, I interviewed staff person 1 (SP1) at the facility. SP1 reported there are 22 residents in the facility. SP1 reported there are two or three residents that require a two person assist, one resident with continuous oxygen, one resident with a catheter, two residents that required additional staff assistance to manage behaviors, and the majority of residents are incontinent.

On 09/25/2023, I interviewed SP2 at the facility. SP2 reported staffing guidelines are to have two caregivers and one medication technician. SP2 reported there are times there is only one caregiver on the floor. SP2 reported there are various other staff members, such as activities, housekeeping, management, that can assist but they do not provide direct resident care. SP2 reported management does not work the floor. SP2 reported it is difficult to ensure residents receive the care they need.

On 09/25/2023, I interviewed SP3 at the facility. SP3 reported the facility has staff call off which results in a staff shortage. SP3 reported the facility tries to find replacement staff but it takes time and can be difficult to find replacement staff members. SP3 reported there are times there is only one caregiver and one medication technician working on the floor.

During my visit at the facility, I observed there to be one caregiver and one medication technician. There were two caregivers assigned to work the floor, but one caregiver had to leave for an unplanned medical appointment. The facility was working on finding a replacement, but for an extended time there was only one caregiver and one medication technician working the floor. I did not observe any management working the floor to assist with the staff shortage.

On 09/25/2023, I interviewed SP4 by telephone. SP4 reported on 09/16, there were two caregivers scheduled for second shift, but one caregiver did not report to the unit until 4:00pm. SP4 reported on 09/17, a caregiver did not report to the unit at the assigned time of 2:00pm. SP4 reported at 3:30pm additional help was requested as there was only one caregiver. SP4 reported finally around 5:00 or 6:00pm a caregiver came to the unit.

On 09/25/2023, I interviewed SP5 by telephone. SP5 reported there are staff shortages in the facility. SP5 reported when there is a staff shortage, the facility tries to find a replacement, but it can take time to find a replacement.

I reviewed the staff schedule for 09/16 and 09/17. On 09/17 on second shift there was a staff shortage and replacement workers were floated to the unit.

I reviewed service plans for the facility. The service plans revealed there was one resident that require two person assist for transfers, two residents that are completely dependent for mobility, seven residents that require staff assistance to transfer, six residents that require staff assistance to manage incontinence, two

residents that require two staff person to manage incontinence, one resident with behaviors, and two residents that are exit seeking.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
For Reference: 1901	**Definitions.**
	(p) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	The facility lacks an organized program of protection for the residents as evidenced by interviews conducted and observations made revealed the facility experiences employees not reporting for their shift. When this occurs, it takes time to find a replacement worker resulting in the facility working below their staffing ratios.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A's oxygen not properly placed.

INVESTIGATION:

On 09/22/2023, the licensing department received a complaint with allegations caregivers did not ensure Resident A was wearing her oxygen.

On 09/25/2023, I conducted an onsite investigation at the facility. Resident A was not at the facility and therefore, I could not interview nor visit Resident A.

SP1 reported Resident A has continuous oxygen. SP1 reported Resident A likes to take the nasal cannula off and caregivers are to check on Resident A to ensure the nasal cannula is placed correctly.

SP5 reported Resident A tends to remove the nasal cannula from her nose and the expectation is that caregivers are checking on Resident A to ensure the nasal cannula is properly placed. SP5 reported he believes the expectation is hourly checks but not certain. SP5 reported Resident A tends to sit in the common area of the facility and caregivers can quickly check on Resident A. SP5 reported he has observed Resident A's nasal cannula not properly placed.

I reviewed Resident A's service plan. The service plan read,

> *"Requires nursing assist with resp treatments-Nurses are assisting or administering respiratory treatments such as bi-pap, c-pap, oxygen, or nebulizer treatment."*

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	Review of Resident A's service plan revealed lack of detail on Resident A's use of oxygen. There was no clear direction on what type of respiratory equipment Resident A used, frequency of assistance with equipment, and caregivers' responsibility for assisting Resident A with equipment.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

10/03/2023

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Kimberly Horst Date
Licensing Staff

Approved By:

10/18/2023

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