GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 19, 2023

Nancy Posey and Theresa Posey
8470 Parshallville
Fenton, MI 48430

RE: License #: AM470078614
Investigation #: 2024A0466008
Hartland Assisted Living

Dear Nancy Posey and Theresa Posey:

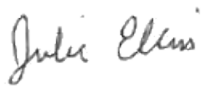
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Julie Elkins, 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 #:	AM470078614
Investigation #:	2024A0466008
Complaint Receipt Date:	10/27/2023
Investigation Initiation Date:	10/31/2023
Report Due Date:	12/26/2023
Licensee Name:	Nancy Posey and Theresa Posey
Licensee Address:	8470 Parshallville Fenton, MI 48430
Licensee Telephone #:	(810) 632-7760
Administrator:	Nancy Posey
Licensee Designee:	N/A
Name of Facility:	Hartland Assisted Living
Facility Address:	5978 Cullen Road Fenton, MI 48430
Facility Telephone #:	(810) 632-5509
Original Issuance Date:	11/22/1997
License Status:	REGULAR
Effective Date:	12/18/2022
Expiration Date:	12/17/2024
Capacity:	12
Program Type:	ALZHEIMERS AGED

II. ALLEGATIONS:

	Violation Established?
Residents are not getting proper care because the facility is understaffed.	No
Residents are being restrained at night by gait belts.	No
Additional Findings	Yes

III. METHODOLOGY

10/27/2023	Special Investigation Intake 2024A0466008.
10/27/2023	APS Referral denied.
10/31/2023	Special Investigation Initiated - On Site.
10/31/2023	Contact - Document Sent licensee Nancy Posey.
11/09/2023	Inspection Completed On-site- second time.
12/19/2023	Exit conference with licensee Nancy Posey.

ALLEGATION: Residents are not getting proper care because the facility is understaffed.

INVESTIGATION:
On 10/27/2023, Centralized Intake Adult Protective Services (APS) denied this intake and transferred to the Department of Licensing and Regulatory Affairs (LARA). Anonymous Complainant reported there 12 residents who live at Hartland Assisted Living and all have mental and physical health issues. Complainant reported it is unknown if the residents have a legal guardian or a power of attorney (POA). Complainant reported residents in the home are not getting the proper care needed as the home is understaffed. Complainant reported that there is only one direct care worker in the home between the hours of 7 p.m.-7 a.m. Because Complainant was anonymous, no additional information or details regarding the allegation could be gathered.

On 10/31/2023, I conducted an unannounced investigation and I interviewed direct care worker (DCW) Chelsea Fox, DCW Susan Talmadge and DCW Benita Blackmon who reported that there are 12 residents living at the facility and two DCWs on duty during daytime hours and one DCW from 7pm-7am. DCW Fox reported Resident I requires two-person direct care staff member assistance for

transfer, DCW Talmadge reported Resident B and Resident G require two-person direct care staff member assistance for transfer and DCW Talmadge and DCW Blackmon both reported Resident B and Resident I require two-person direct care staff member assistance for transfer. DCW Fox, DCW Talmadge and DCW Blackmon all reported a Hoyer lift for transfer assistance can be used if working independently. DCW Fox, DCW Talmadge and DCW Blackmon reported that there are enough DCWs on each shift to meet the needs of the residents. DCW Fox, DCW Talmadge and DCW Blackmon reported that no resident or family member has ever complained to them about residents not getting proper care during any time of day.

I interviewed Resident B, Resident C, Resident D and Resident J who all reported that they received proper care from DCWs on duty. Resident B, Resident C, Resident D and Resident J reported there is sufficient staff on duty to meet the needs of the residents and that they are taken good care of even at night when one DCW is on shift.

I interviewed Relative D1 who reported facility direct care staff members provide great care to residents and DCWs go above and beyond to meet the needs of the residents. Relative D1 reported that the facility is sufficiently staffed and all residents are getting proper care.

I reviewed resident records for Resident A, Resident B, Resident C, Resident D, Resident E and Resident F. The residents written *Assessment Plan for Adult Foster Care (AFC) Residents* and the *Health Care Appraisals* did not contain any documentation that any resident requires the assistance of two direct care workers for transferring or any other type of personal care.

On 11/09/2023, I conducted a second unannounced investigation and I reviewed resident records for Resident G, Resident H, Resident I, Resident J, Resident K and Resident L. The written *Assessment Plan for AFC Residents* and the *Health Care Appraisals* did not contain any documentation that any of these residents required the assistance of two direct care workers for transferring or any other type of personal care.

I interviewed DCW Danielle Wierenga and DCW Jacqueline Diaz who confirmed 12 residents live at the facility and two DCWs are on duty during daytime hours and one DCW from 7pm-7am. DCW Wierenga and DCW Diaz both reported Resident B and Resident I require two-person direct care staff member assistance for transfer or the use of the Hoyer lift if working independently. DCW Wierenga reported that working independently during the midnight shift is “a lot” but could not provide any examples of how the residents needs are negatively impacted. DCW Diaz reported she has worked independently at night and that it is manageable for one DCW because not all of the residents are up at the same time and if residents get up, they typically get up one at time. DCW Wierenga and DCW Diaz both reported that no resident or family member has ever complained to them about residents not getting proper care.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years. **(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.**
ANALYSIS:	Complainant, DCW Fox, DCW Talmadge, DCW Blackmon, DCW Wierengam DCW Diaz and Relative D1 reported that there are two DCWs on shift during the day and one DCW at night. I reviewed all 12 residents' written *Assessment Plans for AFC Residents* and *Health Care Appraisals* and determined that none of the records reviewed contained any documentation that any resident requires the assistance of two direct care workers for any reason. All DCWs interviewed reported a Hoyer lift is available for use when working independently to assist with transferring residents. Resident B, Resident C, Resident D and Resident J all reported that they recevied proper care from the DCWs on duty. Resident B, Resident C, Resident D and Resident J reported that there is sufficient staff on duty to meet the needs of the residents and that they are taken good care of at night when one DCW is on shift.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Residents are being restrained by gait belts at night.

INVESTIGATION:
On 10/27/2023, Centralized Intake APS denied this intake and transferred to LARA. Anonymous Complainant reported that residents are restrained at night with gait belts due to limited staffing. Complainant reported it is unknown if the residents have injuries. Because Complainant was anonymous, no additional information or details regarding the allegation could be gathered.

On 10/31/2023, I conducted an unannounced investigation and I interviewed DCW Fox who reported Resident A and Resident G both use gait belts. DCW Fox reported residents do not sleep in a gait belt and she was not aware of any resident injury due to using a gait belt.

I interviewed DCW Talmadge who reported that none of the residents use a gait belt and that she is not aware of any resident injury due to using a gait belt.

I interviewed DCW Blackmon who reported Resident A uses a gait belt but reported she does not sleep in it. DCW Blackmon reported she was not aware of any resident injury due to using a gait belt.

I interviewed DCW Wierenga who reported that gait belts are only used for physical therapy with the therapist and that no residents sleep with a gait belt. DCW Wierenga reported that she was not aware of any resident injury due to using a gait belt.

I reviewed resident records for Resident A, Resident B, Resident C, Resident D, Resident E and Resident F. The written *Assessment Plan for AFC Residents* and the *Health Care Appraisal*s did not contain any documentation that any resident was prescribed a gait belt including Resident A.

On 11/09/2023, I conducted a second unannounced investigation and I reviewed resident records for Resident G, Resident H, Resident I, Resident J, Resident K and Resident L. The written *Assessment Plan for AFC Residents* and the *Health Care Appraisals* for each resident did not contain any documentation that any resident is prescribed a gait belt including Resident G.

I interviewed DCW Wierenga who reported that gait belts are only used for physical therapy with the therapist and no residents sleep with a gait belt. DCW Wierenga reported that she was not aware of any resident injury due to using a gait belt.

I interviewed DCW Diaz who reported that she works midnights and reported residents do not sleep in gait belts and gait belts are never in bed with residents. DCW Diaz reported gait belts are used for physical therapy with the therapist only. DCW Diaz reported that she was not aware of any resident injury due to using a gait belt.

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(1) An assistive device shall only be used to promote the enhanced mobility, physical comfort, and well-being of a resident.

ANALYSIS:	Complainant reported that residents are being restrained with gait belts at night. I reviewed the written *Assessment Plan for Adult Foster Care (AFC) Residents* and the *Health Care Appraisals* for all 12 residents and none of the residents' records contained documentation that any resident is prescribed a gait belt including Resident A and Resident G. All DCWs interviewed reported that residents do not sleep in gait belts and no injuries have resulted due to using a gait belt.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 10/31/2023, I conducted an unannounced investigation and I did not observe a *Staff Schedule* in the facility. DCW Fox, DCW Talmadge and DCW Blackmon all reported the facility does not have a *Staff Schedule*. DCW Fox, DCW Talmadge and DCW Blackmon all reported DCWs that work at this facility, work the same schedule so there is no need for a written *Staff Schedule.* Consequently, there was no *Staff Schedule* available for review.

On 11/09/2023, I came to the facility unannounced for a second time and I did not observe a *Staff Schedule* in the facility.

APPLICABLE RULE	
R 400.14208	**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:	On 10/31/2023 and 11/09/2023, there was no staff schedule available for review as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 10/31/2023, at the time of my unannounced investigation, six current resident records (Resident G, Resident H, Resident I, Resident J, Resident K, Resident L)

were not available for department review. DCW Fox, DCW Talmadge and DCW Blackmon all reported licensee Nancy Posey had the records at another location. DCW Blackmon reported licensee Nancy Posey was not available to meet with me or provide the resident records at the time of the unannounced investigation. DCW Blackmon reported that she had no way to obtain the resident records (Resident G, Resident H, Resident I, Resident J, Resident K, Resident L) for department review.

APPLICABLE RULE	
R 400.14316	**Resident records.**
	(2) Resident records shall be kept on file in the home for 2 years after the date of a resident's discharge from a home.
ANALYSIS:	On 10/31/2023, six current resident records (Resident G, Resident H, Resident I, Resident J, Resident K, Resident L) were not available in the AFC facility for department review. DCW Fox, DCW Talmadge and DCW Blackmon all reported licensee Nancy Posey had the records at another location and therefore a violation as has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 10/31/2023, I reviewed the facilities fire drill records which documented that there was only one fire drill conducted for the third quarter 2023. This fire drill was completed on 7/6/2023. That was the last fire drill documented. The *Fire Drill* documentation was blank for third quarter 2023 evening and sleeping hours. There were no other fire drills documented in the fourth quarter portion of the *Fire Drill* Document.

DCW Fox, DCW Talmadge and DCW Blackmon had no knowledge if there were any additional fire drills done for the third quarter 2023.

On 11/09/2023, I came to the facility unannounced for a second time and I reviewed the facility's fire drill records again which were unchanged from my unannounced onsite investigation on 10/31/2023.

APPLICABLE RULE	
R 400.14318	**Emergency preparedness; evacuation plan; emergency transportation.**
	(5) A licensee shall practice emergency and evacuation procedures during daytime, evening, and sleeping hours at least once per quarter. A record of the practices shall be maintained and be available for department review.

ANALYSIS:	On 10/31/2023 and 11/09/2023, I reviewed the facility's *Fire Drills* documentation which recorded that their last fire drill was on 7/6/2023. There were no other fire drills documented in the third quarter for the evening or sleeping hours times as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend continuation of the current license status.

Julie Elkins

12/19/2023

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Julie Elkins Date
Licensing Consultant

Approved By:

Dawn Timm

12/19/2023

_____

Dawn N. Timm Date
Area Manager