GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 21, 2024

Catherine Reese
New Friends Dementia Community, LLC
3700 W Michigan Ave
Kalamazoo, MI 49006

RE: License #: AL390299687
Investigation #: 2024A1024031
Vibrant Life Senior Living Kalamazoo Lodge 3

Dear Catherine Reese:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On 5/14/2024, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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 (616) 356-0183.

Sincerely,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL390299687
Investigation #:	2024A1024031
Complaint Receipt Date:	04/29/2024
Investigation Initiation Date:	05/01/2024
Report Due Date:	06/28/2024
Licensee Name:	New Friends Dementia Community, LLC
Licensee Address:	3700 W Michigan Ave Kalamazoo, MI 49006
Licensee Telephone #:	(269) 372-6100
Administrator:	Laurel Space
Licensee Designee:	Catherine Reese
Name of Facility:	Vibrant Life Senior Living Kalamazoo Lodge 3
Facility Address:	3708 W. Michigan Ave. Kalamazoo, MI 49006
Facility Telephone #:	(269) 372-6100
Original Issuance Date:	04/23/2012
License Status:	REGULAR
Effective Date:	04/20/2023
Expiration Date:	04/19/2025
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 4/28/2024, staff member Sparkle Young left her shift early at 3am leaving no other staff member with residents until the next morning shift at 6:45am.	Yes

III. METHODOLOGY

04/29/2024	Special Investigation Intake 2024A1024031
05/01/2024	Special Investigation Initiated - Face to Face with direct care staff member Sparkle Young
05/01/2024	Contact - Telephone call made with administrator Laurel Space
05/01/2024	Contact - Document Received-facility's *Staff Schedule*
05/02/2024	APS Referral not warranted
05/02/2024	Contact - Telephone call made with staff member Yewande Orimoloye
05/02/2024	Contact - Telephone call made direct care staff member Alexis Craft and Teanna Gill
05/02/2024	Exit Conference with licensee designee Catherine Reese
05/02/2024	Inspection Completed-BCAL Sub. Compliance
05/02/2024	Corrective Action Plan Requested and Due on 5/20/2024
05/14/2024	Corrective Action Plan Received
05/14/2024	Corrective Action Plan Approved

ALLEGATION: On 4/28/2024, staff member Sparkle Young left her shift early at 3am leaving no other staff member with residents until the next morning shift at 6:45am.

INVESTIGATION:

On 4/29/2024, I received this complaint from the Bureau of Community and Health Systems (BCHS) online complaint system. This complaint alleged that on 4/28/2024, staff member Sparkle Young left her shift early at 3am leaving no other staff member with residents until the next morning shift at 6:45am.

On 5/1/2024, I conducted an onsite investigation at the facility with direct care staff member Sparkle Young who stated that she is new to her position and responsible for creating the staff schedule and providing staff coverage in the event a staff person is not able to work. Sparkle Young stated last week she had to work multiple extra shifts for three days due to staff not showing up for work therefore she left her overnight shift early on 4/28/2024 at 3am because she was tired. Sparkle Young stated she was under the impression that leaving the residents without staff supervision was appropriate since the residents were sleeping. Sparkle Young stated she notified a staff member at another facility next door to check on the residents prior to her leaving and believed the next staff member that was scheduled to work arrived at 6:45am. Sparkle Young stated this is the first time she left her shift early and to her knowledge no resident was harmed or needed anything during this timeframe.

On 5/1/2024, I conducted an interview with administrator Laurel Space who stated that staff member Sparkle Young notified her today that she left her shift early at 3am on 4/28/2024 without another staff member present with residents until 6:45am. Laurel Space stated she had a discussion with Sparkle Young and reiterated the importance of never letting that happen again. Laurel Space stated disciplinary action will be taken against this staff member immediately.

On 5/1/2024, I reviewed the facility's staff schedule dated for 4/28/2024 which stated that a staff member called off on 4/28/2024 and Sparkle Young was scheduled to work overnight shift from 11pm until 7am.

On 5/2/2024, I conducted an interview with direct care staff member Yewande Orimoloye who stated on 4/28/2024 while working in another nearby facility owned by New Friends Dementia Community, LLC Sparkle Young came into the facility at 3am and stated that she was tired because she had already worked the morning shift for the day therefore she was leaving her overnight shift early. Yewande Orimoloye stated Sparkle Young was not originally scheduled to work the overnight shift and there was no other direct care staff member to care and supervise the residents. Yewande Orimoloye stated Sparkle Young then asked Yewande Orimoloye if she could check on the residents during the night as another staff member was not scheduled to arrive to work until 7am. Yewande Orimoloye stated she was able to check on the residents once during the night and observed the residents to be sleeping.

On 5/2/2024, I conducted interviews with Alexis Craft and Teanna Gill regarding this allegation. Alexis Craft stated she received a text message on the night of 4/28/2024 while she was on vacation and followed up the following day at which time she learned that Sparkle Young left her shift early at 3am with no other staff member present to care and supervise residents. Alexis Craft stated a direct care staff member arrived at 6:45am on 4/28/204. Alexis Craft stated due to Sparkle Young's negligence of leaving the residents unattended with no staff supervision, management decided to terminate Sparkle Young from employment today.

Teanna Gill stated while she was working in an adjacent facility owned by the licensee she was approached by Sparkle Young around 3am. Teanna Gill stated Sparkle Young reported she was leaving her shift early because she was tired and had been working since the morning shift on 4/27/2024. Teanna Gill stated the next scheduled direct care staff member would not be arriving until 6:45am. Teanna Gill stated this was very concerning for her because the residents did not have staff supervision. Consequently, Teanna Gill stated she contacted manager Alexis Craft who was on vacation at the time and did not respond to her phone call until the following day. Teanna Gill stated although residents were sleeping during this time and not in need of anything, she was very concerned for the residents not having any direct care staff present.

APPLICABLE RULE	
R 400.15206	**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 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours.

ANALYSIS:	Based on my investigation which included interviews with direct care staff members Sparkle Young, Yewande Orimoloye, Alexis Craft, and Teanna Gill, administrator Laurel Space along with my review of staff schedule there is evidence to support that on 4/28/2024 staff member Sparkle Young left her shift early at 3am leaving no other staff member with residents until the next morning shift at 6:45am. Yewande Orimoloye and Teanna Gill both stated while working in nearby facilities owned by the licensee, they were notified by Sparkle Young that she was leaving her shift early at 3am with no other staff member to be present with the residents until 6:45am. Both Alexis Craft and Laurel Space also stated that they were notified Sparkle Young left residents unattended from 3am until 6:45am which resulted in disciplinary action taken against Sparkle Young. Sparkle Young stated she left residents unattended from 3am until 6:45am because she was tired. Although residents were sleeping and not harmed, the ratio of direct care staff to residents was not adequate.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 5/2/2024, I conducted an exit conference with licensee designee Catherine Reese. I informed Catherine Reese of my findings and allowed her an opportunity to ask questions or make comments. On 5/14/2024, I received and approved an acceptable corrective action plan.

IV. RECOMMENDATION

An acceptable corrective action plan was approved therefore I recommend the current license status remain unchanged.

Ondrea Johnson

6/20/2024

Ondrea Johnson
Licensing Consultant

Date

Approved By:

Dawn Timm

06/21/2024

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Dawn N. Timm
Area Manager

Date