GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 23, 2024

Megan Burch
AH Kentwood Subtenant LLC
Ste 1600
1 Towne Sq
Southfield, MI 48076

RE: License #: AL410397696
Investigation #: 2024A0357034
AHSL Kentwood Fieldstone

Dear Ms. Burch:

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 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 (616) 356-0100.

Sincerely,

Arlene B. Smith

Arlene B. Smith MSW, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor,
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4213

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410397696
Investigation #:	2024A0357034
Complaint Receipt Date:	05/30/2024
Investigation Initiation Date:	05/31/2024
Report Due Date:	07/29/2024
Licensee Name:	AH Kentwood Subtenant LLC
Licensee Address:	Ste 1600 1 Towne Sq Southfield, MI 48076
Licensee Telephone #:	(248) 203-1800
Administrator:	Megan Burch
Licensee Designee:	Megan, Burch
Name of Facility:	AHSL Kentwood Fieldstone
Facility Address:	5980 Eastern Ave SE. Kentwood, MI 49508
Facility Telephone #:	(616) 455-1357
Original Issuance Date:	01/22/2019
License Status:	REGULAR
Effective Date:	07/22/2023
Expiration Date:	07/21/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED, AGED

II. ALLEGATION(S)

	Violation Established?
The facility was insufficiently staffed on two overnight occasions.	Yes

III. METHODOLOGY

05/30/2024	Special Investigation Intake 2024A0357034 There were no resident names provided, therefore APS would not open a complaint.
05/30/2024	Contact - Document Received Email from Licensing Consultant, Anthony Mullins.
05/31/2024	Special Investigation Initiated - Telephone
07/18/2024	Inspection Completed On-site Unannounced inspection. Met with the Licensee Designee, Megan Burch.
07/18/2024	Contact - Telephone call made. Telephone interview with Med Tech, Arlette Vega.
07/19/2024	Contact - Telephone call made. Conducted telephone interview with Megan Terry, Med Tech.
07/19/2024	Contact - Telephone call made. Conducted telephone interview with Kendall Kirkland, Met Tech.
07/19/2024	Contact - Telephone call made. With Megan Burch, Licensee Designee and I requested information.
07/19/2024	Contact - Document Received Megan Burch, Licensee Designee, send an email containing: HCA, Face Sheet, Service Plan, and assessment plan for Resident A, B, and C. I reviewed the documents.
07/23/2024	Conducted a telephone exit conference with the Licensee Designee/Administrator, Megan Burke.

ALLEGATION: The facility was insufficiently staffed on two overnight occasions.

INVESTIGATION: On 07/18/2024, I made an announced inspection of the home and met with the Licensee Designee/Administrator, Megan Burch. I explained we had received a complaint of inadequate staffing on 3rd shift because there are residents who require a two-person transfer and on two occasions only one staff was working. She said: “It is true.” She went on to say she was expecting me because a staff person told her that they were making a complaint to the state. She stated that they had gone through a “rough patch with difficulty with staffing”. She explained that they have three residents in their facility, and they all require a two-person assist, usually with a Hoyer Lift. She went on to explain that a staff member, Kendall Kirkland, has schooling, and she does not work in the facility on Monday, Tuesday and on Wednesday. She works Thursday through Monday on 3rd shift. She reported the first occasion occurred on Memorial Day May 27, 2024, starting at 11:00 pm to 7:00 am. She said staff, Kendall Kirkland had let them know she was not able to work that shift because of her schooling. Ms. Burch reported no other staff had volunteered to work for her. Therefore, staff Megan Terry worked alone. She said that Hospice was notified, and they came in early and another staff who lives just around the corner also came in early. The second occasion occurred on May 20, 2024, when staff Arlette Vega worked alone on 3rd shift. She did not provide an explanation as to why. I asked her what they would do if an emergency happened in Fieldstone and she said the staff from the facility across the parking lot, Cobblestone, wound come to help. I asked if this meant that facility would be without staff and she said yes but in an emergency that is what they would do. I explained that they always have to have staff in a licensed facility.

On 07/18/2024, I conducted a telephone interview with, Med Tech, Arlette Vega. She was unable to remember the date but confirmed it was in May 2024. She stated” “I worked the 3rd shift alone.” She said we were “short staffed” in May. She was unable to remember how many residents were in the facility at the time, but she did confirm that there were three residents (two on Hospice) that required a two-person assist. She identified Resident A, Resident B and Resident C. I asked her if she was able to meet all of the resident’s needs. She said they were all checked and changed and she was able to get them all dressed in their beds but was unable to get them all out of bed and up for the day. I asked her she could evacuate all the residents in the event of a fire. She stated: “No.” She reported that this facility is a memory care unit, and I would not be able to have a conversation with any of the residents due to their diagnosis of Dementia or Alzheimer’s.

On 07/19/2024, I conducted a telephone interview with Megan Terry, Med Tech. She reported that she no longer works for the home and her last day was July 6, 2024, but she had worked there for a year, on 3rd. shift. I asked her if she had worked alone on 3rd shift and she said: “Quite a few shifts by myself, five or six times.” She said one of the staff who works 2nd shift has to leave the facility at 10:30 pm because he has another job and that leaves only staff in the facility for at least 30 minutes. I asked her about Memorial Day, and she explained that Ms. Kirkland goes to school on Monday, Tuesday and Wednesday, and she only works Thursday through Sunday because she attends her schooling. She said Ms. Kirkland had seen her

name on the schedule on Memorial Day and she had class that day so therefore she could not work. She explained that she knew Ms. Kirkland had notified Kenisha Sanders, Assistant Wellness Director, explaining why she could not work on that Monday. She also said she had direct knowledge that Ms. Kirkland had texted Ms. Sanders that she could not work on that Monday, and she had texted her on Sunday the day before. Ms. Terry said that she had to work alone because they did not replace Ms. Kirkland. She said she remembered that night because she had a new resident that was combative and unsettled. She reported she had to help her settle down and during that time she heard another resident's light go off and another resident was yelling for help go to the bathroom. She said she had difficulty in being adequate and efficient. She was uncertain how much time had passed but she did help the resident to the bathroom, and she was able to get him onto the toilet. She said she was able to conduct her safety checks and change every two hours, for each resident but she was not able to get the residents who used the Hoyer Lift up for the day. I asked if Hospice had come in early and she said: "No. They came in after breakfast." I asked if the individual who lived around the corner from the facility had come in early and she said: "Nobody came in early." She said she had understood that the Wellness staff, Ms. Sanders was to come in and work when they were short-handed, but no one came in all night. I asked her if she could evacuate all the residents if there was a fire and she stated: "Absolutely not." She went on to report that only four residents that can walk alone. If she could walk with them to the fire destination and she had to leave them alone to go back into the building to help more residents, the first residents would walk away because they cannot understand. She reported Resident A and Resident B use a Hoyer Lift and that requires two staff to be with them for the transfer. She reported Resident C uses a Sara Lift/Sit to Stand and requires a two-person assist to complete his transfers. I asked if she knew how many residents were in the facility on Memorial Day and she was uncertain how many were there.

On 07/19/2024, I conducted a telephone interview with Kendall Kirkland, Med Tech. She said she has worked in the facility since mid-April 2024. She explained that when she was hired, they she had come to an agreement with Ms. Burch, Licensee Designee/Administrator that she was going to school, and she could not work Monday, Tuesday or Wednesday because of her schooling, and they agreed that they would accept this arrangement because she was available to work Thursday through Sunday on 3rd. shift. She said that she saw her name on the staff schedule to work on Memorial Day and on the Saturday before and she could not work because those days. She said she had let Ms. Sanders, Assistant Wellness Director, know that she had school and could not work that Monday. She explained that Ms. Sanders told her she must work the holiday rotation even though they had an agreement that she would work four days with three off and not work Monday through Wednesday. She said she had responded to Ms. Sanders, if someone could switch with her, she could work the July 4th holiday if someone could work Memorial Day. She said the Ms. Sanders could not find anyone. She then said she had sent Ms. Sanders and others on their "group chat," that she could not work on Monday, and she did this on Saturday night and there was no response. She also said she

sent a private text message, to Ms. Sanders on Sunday night and no one responded that her shift would be covered. I asked her if she had worked alone on 3rd shift before and she stated two or three times. She said she had personal knowledge that Ms. Vega and Ms. Terry had worked alone several times. She reported that she worked alone on Saturday July 6, 2024, from 11:00pm to 1:30 am. She reported that had let Ms. Sanders know she was working alone and there was no response. She reported around 1:30am Kenisha Sanders, Assistant Wellness Director, came in to work. I asked her about residents who require a two-person transfer. She identified Resident A and Resident B, who require a Hoyer Lift and Resident C who uses a Sit to Stand. I asked her if she could evaluate all the residents alone on 3rd shift and she said: “Absolutely not.” She reported that the facility is a Memory Unit and all of the residents, have a type of Alzheimer’s or Dementia diagnosis and they cannot exit from the facility alone. She also reported that I could not have a conversation with any of the residents due to their diagnosis.

On 07/19/2024, I telephoned Ms. Burke and requested information on the three residents that had been identified as requiring a two-person assist. I requested their Health Care Appraisal and Assessment Plan. Ms. Burke stated she would send the requested information to me, via email.

On Friday 07/19/2024 at 3:47 pm I received all of the requested documents which I reviewed. I had also asked her for the census for the facility on Memorial Day, 05/27/2024, and May 20, 2024. As of the date of his document I have not received a response to the census of these dates.

Resident A was admitted to the facility on 08/30/2022 and she is 96 years old. Her diagnosis was recorded as Alzheimer’s Disease, Dementia, Osteoarthritis, Adult Failure to Thrive, Abnormal weight loss, (weight 88 pounds) Anxiety, Incontinent of bowel and bladder, Severe Impairment memory loss and she is unable to walk, uses a wheelchair and requires a two-person mechanical lift. She requires total care with grooming and personal hygiene She has limited social skills, and she is forgetful and does not have thinking abilities with shorter term memory loss with sever impairment. She requires the use of a wheelchair and has had repeated falls. Her assessment plan indicated she requires total assistance including two-person utilization of mechanical lift to assist with safety in transfers. She is receiving Hospice Care.

Resident B was admitted on 07/26/2018 and she is 84 years old. She is serviced by Area Agency on Aging. Her Resident Health Care Appraisal indicated that she was disoriented, Dementia/Alzheimer’s, thinking impaired, forgetful, unable to communicate Severely Impaired. She requires total with grooming and personal hygiene. Her assessment plan indicated she requires a Hoyer lift for all transfers. She uses a wheelchair and is receiving Hospice Care.

Resident C was admitted to the facility on 10/13/1921 and is 77 years of age. His Health Care Assessment reported he has Anxiety, Dementia, Frontotemporal

Neurocognitive Disorder. In his assessment plan he has noted vision impairment, difficult remembering, dependent on staff for all mobility ambulation escort needed, and he is dependent on staff for all grooming, personal hygiene needs, and he requires help with dressing and undressing. He has severe memory impairment, is not ambulatory, non-verbal and bed bound. His assessment plan stated that he requires hand on assistance. His assessment plan reported the use of a Hoyer Lift and that he requires two-person assist with all transfers. All three staff identified in this report reported that he uses a Sit to Stand. He is wheelchair bound and is receiving Hospice Care.

On 07/23/2024, I provided Ms. Burch an exit conference. I explained my findings as noted above. Ms. Burch acknowledged the lack of adequate staffing and stated she understands my findings and will develop and submit a corrective action plan addressing the above established rule violations. She had no further information to provide and had no additional questions to ask concerning the Special Investigation.

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:	It was alleged that on two occasions the facility was inadequately staffed. The Licensee Designee, Ms. Burch acknowledged that on Memorial Day, 05/27/2024 there was only one staff on duty to care for the residents on 3rd shift. She confirmed that three residents require two-person assistance for their transfers. She also acknowledged that on 05/20/2024 only one staff worked on 3rd shift. Upon review of Resident A, Resident B, and Resident C's assessment plans it was confirmed that all three require a two-person assist with all transfers. Megan Terry, Med Tech confirmed that she worked alone on 3rd shift on Memorial Day, 05/27/2024 and that Resident A, Resident B and Resident C all require a two-person assist to transfer.

	Arlette Vega, Med Tech confirmed she worked alone on 05/20/2024. She confirmed that Resident A, Resident B, and Resident C require a two-person assist for transfers. During this investigation there was evidence found that at a minimum of two days (05/27/2024 and 05/20/2024), staff worked alone with three residents who require two-person assistance with transfers. The ratio of direct care staff to residents was not adequate to carry out the responsibilities defined in the act and in these rules. Therefore, a violation is established of the rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(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:	On 07/18/2024, Megan Burch, Licensee Designee, confirmed they have three residents, Resident A, Resident B and Resident C, who have documented in their assessment plans that they required two-person assistance with transfers. She confirmed that on 05/20/2024, and on 05/27/2024, they only had one staff caring for all the residents. Resident A and Resident B require the use of a Hoyer Lift and Resident C uses a sit-to-stand device. All three residents require two-person assistance with transfers, and this is identified in their assessment plans. All three Med Techs, Ms. Terry, Ms. Vega and Ms. Kirkland confirmed that they have worked with only one staff on 3rd shift. They confirmed that they were not able to meet all of the resident’s needs by getting them up for breakfast in the morning when they worked alone. They also confirmed that they could not evacuate all of the residents alone in the event of a fire due to the three residents who require a two-person transfer and all of the residents in the memory care unit that have a diagnosis of Alzheimer’s and or Dementia and they cannot follow directions.

	During this investigation there was evidence found that the Licensee failed to provide sufficient direct care staff on duty for supervision, personal care and protection of all the vulnerable adults in the facility. Therefore, there is a violation to the rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend the Licensee provide an acceptable plan of corrections.

Arlene B. Smith 07/23/2024

Arlene B. Smith Date
Licensing Consultant

Approved By:

Jerry Hendrick 07/23/2024

Jerry Hendrick Date
Area Manager