GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

Kory Feetham
AUGUST HAUS ASSISTED LIVING LLC
1201 Village Parkway
Gaylord, MI 49735

September 6, 2024

RE: License #: AL690392652
Investigation #: 2024A0360018
August Haus Assisted Living

Dear Mr. Feetham:

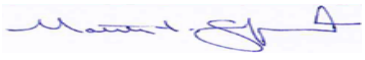
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (866) 865-0006.

Sincerely,



Matthew Soderquist, Licensing Consultant
Bureau of Community and Health Systems
931 S Otsego Ave Ste 3
Gaylord, MI 49735
(989) 370-8320
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL690392652
Investigation #:	2024A0360018
Complaint Receipt Date:	07/09/2024
Investigation Initiation Date:	07/10/2024
Report Due Date:	09/07/2024
Licensee Name:	AUGUST HAUS ASSISTED LIVING LLC
Licensee Address:	1201 Village Parkway Gaylord, MI 49735
Licensee Telephone #:	(989) 448-7094
Administrator/Licensee Designee:	Kory Feetham
Name of Facility:	August Haus Assisted Living
Facility Address:	1201 Village Parkway Gaylord, MI 49735
Facility Telephone #:	(989) 448-7094
Original Issuance Date:	10/23/2018
License Status:	REGULAR
Effective Date:	03/14/2023
Expiration Date:	03/13/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's two-hour checks were not completed.	Yes

III. METHODOLOGY

07/09/2024	Special Investigation Intake 2024A0360018
07/09/2024	APS Referral APS denied
07/10/2024	Special Investigation Initiated - On Site Resident A, Guardian A, Dani Marcinkowski Supervisor, Karyn Witte Harmony Hospice
07/10/2024	Inspection Completed On-site
07/11/2024	Inspection Completed On-site Administrator Heather Reno
07/11/2024	Contact - Document Received Heather Reno
07/11/2024	Contact - Document Received Guardian A
07/12/2024	Contact - Document Received Relative A
09/03/2024	Inspection Completed On-site Heather Reno
09/06/2024	Exit Conference Kory Feetham

ALLEGATION:

Resident A's two-hour checks were not completed.

INVESTIGATION:

On 7/10/24, I conducted an unannounced onsite inspection at the facility. I interviewed direct care staff (DCS) Dani Lin Marcinkowski. Ms. Marcinkowski stated Resident A's family had reported to the administrator Heather Reno, that they were concerned Resident A's two-hour checks were not being conducted. Ms. Marcinkowski stated that she is not aware of any missing checks. She stated Resident A is ordered to have two-hour checks through hospice. Ms. Marcinkowski provided me with a bed check logbook for Resident A. On 7/1/24 there was a bed check noted at 9:46 p.m., the next note indicated that a bed check was done on 7/1/24 at 2:19 p.m. The next note indicated a bed check was done on 7/2/24 at 4 a.m. Ms. Marcinkowski stated she believes the 7/1/24 bed check at 2:19 p.m. should have been documented as 7/2/24. She stated that the midnight check was probably done however it must not have been documented.

On 7/10/24, while at the facility, I attempted an interview with Resident A. Resident A was not oriented to time, place, or person.

On 7/10/24, while at the facility, I interviewed Harmony Hospice Nurse, Karyn Witte. Ms. Witte stated she has been working with Resident A since September 2023. She stated due to past pressure ulcers from Resident A's chair, they ordered Resident A have two hour checks to prevent skin breakdown. She stated each two-hour check should be to check for a soiled brief and repositioning. Ms. Witte stated that Resident A does not currently have any skin breakdown and her skin is in really good condition.

On 7/10/24, while at the facility, I interviewed Guardian A. She stated she received a 30-day written discharge notice yesterday after she reported to the facility that she thought the two-hour bed check log was being falsified. She stated she has a camera in Resident A's bedroom and there were logs that Resident A's bed checks were completed on 7/7/24 and 7/2/24 however there was no camera activation in Resident A's bedroom. Guardian A stated hospice has ordered two-hour bed checks that should include a brief check and repositioning. Guardian A stated after she made a complaint about the two-hour checks being falsified, the camera was unplugged from Resident A's bedroom by one of the staff members. Guardian A stated the camera has now been plugged back in. I then observed the camera in Resident A's bedroom plugged in.

On 7/11/24, I interviewed the facility administrator Heather Reno by telephone. Ms. Reno stated she received a phone call from Guardian A on 7/4/24 regarding concerns that two-hour checks were not being completed. Ms. Reno stated she has addressed this concern in the past with Guardian A. Ms. Reno stated the family observed a staff vaping in Resident A's bedroom in January 2024 on the surveillance camera and that staff was fired. Ms. Reno stated she has reviewed the bed check logbook for Resident A and that she is aware they did not document a bed check on 7/2/24 at midnight. She stated that she has also reviewed the logbook for Resident

A’s bed checks on 7/7/24 and cross referenced it with the surveillance camara footage of the hallway outside of Resident A’s bedroom and staff can be observed entering Resident A’s bedroom every two hours. She stated she conducted a staff in-service training on 7/9/24 to educate all staff on making sure that the two-hour checks are completed properly and documented. Ms. Reno stated she did not have video surveillance of the 7/2/24 bed check at midnight to verify that it was completed. She stated she has educated her staff that this is why documentation is so important.

On 7/11/24, I conducted another onsite inspection at the facility. I interviewed the administrator, Heather Reno. Ms. Reno provided me with a copy of Resident A’s Resident Care Agreement, Hospice Plan of Care, and Resident Written Assessment Plan. The written assessment plan dated 5/3/24 documented that Resident A requires 2-hour checks for needs. Ms. Reno stated the police came to the facility on 7/9/24 because the camera in Resident A’s room was unplugged and someone requested a welfare check. She stated the camera has been plugged back in and will remain plugged in for the family.

On 7/11/24, I received written documents from Guardian A dropped off at the office. The documents included a screen shot of the video recording activations for Resident A’s bedroom on 7/1/24, 7/7/24 and 7/8/24. Also included was a copy of the 30-day discharge notice dated 7/9/24.

On 7/11/24, I received an email from Heather Reno with video surveillance of staff entering Resident A’s bedroom on 7/7/24 at 12:45 a.m., 2:21 a.m., 4:48 a.m., and 7:22 a.m.

On 7/11/24, I received an email from Relative A. The email included video recording of staff entering Resident A’s bedroom for a bed check on 7/1/24 at 9:47 p.m., on 7/2/24 at 4:05 a.m., and then 6:51 a.m. There was no video activation for the 2:19 a.m. bed check that was documented on the logbook and no activation for a midnight bed check. Video recording of 7/7/24 was also provided and there was no recording activation between 1 a.m. and 7 a.m.

On 9/3/24, I conducted another unannounced onsite inspection at the facility. Ms. Reno stated Resident A was moved by her family on 7/18/24 to a facility in Traverse City. She stated they worked closely with the family to make sure that it was an easy move.

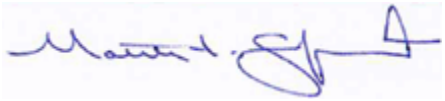
APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	Resident A was ordered through hospice, and it was documented on her written assessment plan that she was to have two-hour checks. Ms. Witte reported the checks should include a brief check and repositioning. Interviews with Ms. Marcinkowski, Ms. Reno, and Ms. Witte revealed that staff have been conducting two-hour checks and Resident A's skin remained in good condition. However, documentation in Resident A's two-hour check logbook failed to document a two-hour check had been completed on midnight of 7/2/24 and it was unable to be verified by video surveillance.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 09/06/2024 I conducted an exit conference with licensee designee Kory Feetham. Mr. Feetham stated he would submit a corrective action plan for approval.

IV. RECOMMENDATION

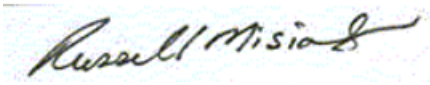
Upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.



9/3/24

Matthew Soderquist Date
Licensing Consultant

Approved By:



9/6/24

Russell B. Misiak Date
Area Manager