GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 9, 2023

Jennifer Herald
Oliver Woods Retirement Village LLC
Suite 200
3196 Kraft Ave SE
Grand Rapids, MI 49512

RE: License #: AL780262260
Investigation #: 2023A0584036
Oliver Woods 2

Dear Jennifer Herald:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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,

Candace Coburn, 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 #:	AL780262260
Investigation #:	2023A0584036
Complaint Receipt Date:	06/13/2023
Investigation Initiation Date:	06/14/2023
Report Due Date:	08/12/2023
Licensee Name:	Oliver Woods Retirement Village LLC
Licensee Address:	Suite 200 3196 Kraft Ave SE Grand Rapids, MI 49512
Licensee Telephone #:	(810) 334-8809
Administrator:	Jennifer Herald
Licensee Designee:	Jennifer Herald
Name of Facility:	Oliver Woods 2
Facility Address:	1312 W. Oliver St. Owosso, MI 48867
Facility Telephone #:	(989) 729-6060
Original Issuance Date:	04/16/2004
License Status:	REGULAR
Effective Date:	08/29/2021
Expiration Date:	08/28/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility is understaffed.	Yes
Staff are not properly trained.	No
Staff did not follow physician order for Resident A.	Yes
Staff withheld food from Resident A	No
Staff did not dispense prescribed medication as directed for Resident A.	No
Resident A was not given care per assessment plan.	Yes
Additional Finding	Yes

III. METHODOLOGY

06/13/2023	Special Investigation Intake 2023A0584036.
06/14/2023	Special Investigation Initiated - Telephone interview with Relative A 1.
06/14/2023	APS Referral made via email to online complaint unit.
06/16/2023	Inspection Completed On-site. I conducted a visual inspection of the entire facility, observed three direct care workers on duty, and observed 7 residents.
07/18/2023	Contact – Documents received via USPS mail from Relative A 1 that consisted of copies of physician orders, screen shots of text contacts, three photographs of Resident A.
08/03/2023	Contact - Face to Face interviews with direct care worker Zoie Martinez, Shelby Root, Wellness Director, Arielle Radick, Wellness Coordinator Chris Weber, Licensee Designee Jennifer Herald, and visual observation of 13 residents. Facility employee files, staff schedules, resident files, and medication administration documents reviewed.
08/03/2023	Exit Conference with Jennifer Herald, licensee designee.
08/04/2023	Contact - Telephone interview with direct care worker Kaylee Graham and Heart to Heart hospice nurse Sarah Nohel.
09/05/2023	Contact – Onsite inspection and unannounced fire drill conducted and observed.

09/13/2023	Contact – Email sent to Cory Irvin, BFS inspector for the facility of timed results of fire drill.
09/14/2023	Conducted exit conference with Licensee Designee, Jennifer Herald.

ALLEGATIONS:

- **The facility is understaffed.**
- **Staff are not properly trained.**
- **Staff did not follow physician orders for Resident A.**
- **Staff withheld food from Resident A**
- **Staff did not dispense prescribed medication as directed for Resident A.**
- **Resident A was not given care per assessment plan.**

INVESTIGATION:

On 6/13/2023, the Bureau of Community and Health Systems (BCHS) received the above allegations via the BCHS on-line complaint system.

On 6/14/2023, I interviewed Relative A 1 via telephone. Relative A 1 stated she observed staff not providing care to Resident A by not helping her rise in the morning hours, assisting her in taking a nap at noon, and then assisting her in getting her up in the afternoon, as directed. Relative A 1 stated that on one afternoon on an unspecified date, she observed Resident A still in her pajamas, soaking wet, and lying in bed. Relative A 1 stated Resident A's required 15-minute checks were also not conducted, as ordered, and Resident A fell twice in two days after she first moved into the facility. Relative A 1 stated staff were not dispensing medication properly to Resident A, nor were they properly caring for Resident A's wound, per medical orders. Relative A 1 also stated it was communicated to her by facility staff members that they were instructed to withhold food from Resident A. However, there was no physician's order to do so. Relative A 1 stated Resident A passed away at the facility on 5/19/2023 while on hospice care.

The facility has been approved by the AFC division to provide personal care, supervision, and protection to the physically handicapped, aged, and Alzheimer's population.

On 6/15/2023, I conducted an onsite visual inspection of the facility's rooms and common areas and also conducted a visual observation of 7 residents who appeared well groomed and well cared for. I also observed three direct care workers on duty.

On 8/3/2023, I conducted a second investigated onsite. While onsite, I observed 13 residents all who appeared well groomed and well care for. I attempted to interview

residents. However, none of the residents present were able or willing to answer my questions.

I interviewed direct care staff member Zoie Martinez, Wellness Coordinator Chris Weber, and Wellness Supervisor Arielle Radick.

Ms. Martinez denied the allegations Resident A did not receive care as indicated in her *Assessment Plan for AFC Residents* (assessment plan) and/or per her physician's orders. However, she also stated she did not recall personally working directly with Resident A. Ms. Martinez also did not recall any time the facility was understaffed, according to the care and supervision needs of the residents.

Mr. Weber stated he is responsible for managing staff records and provided me with 11 employee records to review. I reviewed each employee record and determined all 11 employees satisfactorily completed required training and were deemed competent in all required training areas. Mr. Weber stated he has not had any recent complaints from staff, residents, or family members regarding staff members not being prepared or properly trained to provide care and supervision to the residents, including Resident A.

Ms. Radick provided me with copies of the direct care staff schedules for the months of April and May 2023. According to documentation on the direct care staff schedules, there was a minimum of two direct care staff members working in the facility, on each shift, for the months of April and May. Ms. Radick stated she did have communication with Relative A 1 regarding concerns Relative A 1 had during Resident A's stay at the facility. Ms. Radick stated she communicated all of Relative A 1's concerns to direct care staff members.

I requested and reviewed the facility's *Resident Register*, which indicated the facility's current census is 13.

I reviewed the residents' assessment plans. According to documentation on the assessment plans, as of 08/03/2023, only one resident required one direct care staff member to assist them with transferring, and one resident required two direct care staff members to assist them with transferring, with the assistance of a mechanical lift. According to documentation on the assessment plans, no residents require toileting assistance due to chronic incontinence, however 11 residents were assessed to need staff assistance with regular toileting. 3 residents required assistance by one staff member with bathing, 1 resident require assistance from direct care staff members during mealtimes, 12 residents require medications be administered to them by facility staff members, no residents have aggressive behaviors, no residents are at risk for elopement, no residents require enhanced supervision and no residents have increased anxiety and/or confusion.

I reviewed Resident A's medication administration record (MAR) for 4/7/2023 through 5/19/2023, the date of Resident A's passing. According to documentation on

the MAR, Resident A was administered her prescribed medications as ordered from 4/7/2023 to 5/19/2023, as evidenced by direct care staff members' initials.

Documentation on Resident A's MAR indicated that on 5/3/2023, a "daily flow" began for Resident A, with the following directive: *"Resident is to get up for the day at 9am. Lay down for a nap at 12pm. Get up into Gerri [sic]chair at 4pm. Layed [sic]down for bed at 7pm. Must be toileted at each transfer".* As evidenced by direct care staff members' initials, this "daily flow" was provided to Resident A from 5/3/2023 to the date of her discharge (5/19/2023), however, the "daily flow" for Resident A did not appear to be ordered by a physician, as no physician's order was located for this.

Documentation on Resident A's MAR indicated there was a physician's order, dated 4/25/2023, for the tracking of Resident A's daily bowel movements. There were no initials or exceptions noted on Resident A's MAR indicating this order was followed.

I observed a physician's order, dated 5/4/2023, for wound care and the "repositioning" of Resident A, every two hours. Documentation on Resident A's MAR indicated direct care staff members were to change the dressing on her wound every three days or as needed from 5/4/2023 until 5/12/2023. As evidenced by direct care staff initials, this care was provided to Resident A at 9am on 5/8/2023 and again on 5/11/2023. There were no instructions on Resident A's MAR to reposition Resident A every two hours. Subsequently, no direct care staff initials were on the MAR, indicating that the order for repositioning was followed.

I reviewed Resident A's record and did not locate any other documentation verifying that beginning on 4/25/2023, direct care staff members began tracking Resident A's daily bowel movements and/or documentation verifying that beginning on 5/4/2023, direct care staff members repositioned Resident A every two hours, per physician's orders.

I located a physician's order in Resident A's record, dated 5/5/2023, that directed facility staff members to take Resident A's temperature three times a day. This order was entered on Resident A's MAR. However, there was no documentation entered on the MAR confirming this ordered was followed.

I did not locate a physician's order in Resident A's record to withhold food.

I established Resident A had two assessment plans. The first assessment plan was drafted on 4/7/2023, upon her emergency admission into the facility. In the section that addresses "mobility", documentation on Resident A's assessment plan indicated she was "bedbound" and ambulated with the use of a wheelchair. It also states that Resident A had experienced recent falls at a previous facility. An updated assessment plan for Resident A, dated 4/16/2023, was completed due to Resident A's release from a hospital stay and subsequent admission into a hospice program. On the "mobility" section of the updated assessment plan, documentation indicated Resident A was "bedbound" and was unable to walk. Resident A's assessment

plans stated direct care staff members were to assisted Resident A with toileting, dressing, feeding, and mobility. There was no documentation on either assessment plan instructing direct care staff members to conduct 15-minute room checks on Resident A and/or withhold food from Resident A. There was no documentation on either assessment plan indicating direct care staff members were to track Resident A's bowel movements daily, reposition her every two hours, and take her temperature three times a day. There was also no documentation on Resident A's updated assessment plan specifically addressing her "daily flow".

On 8/4/2023, I conducted a telephone interview with direct care staff member Kaylee Graham. Ms. Graham stated she was familiar with Resident A and provided care to her during the afternoon shifts. Ms. Graham stated there were a couple of times that upon reporting to work in the afternoon, she observed Resident A wearing pajamas and sitting in a soaked brief, as if she was not changed recently. However, she could not recall what days she observed this. Ms. Graham stated she and her coworkers are adequately trained and she did not believe the facility was understaffed. According to Ms. Graham, she did not recall a physician's order to withhold food from Resident A. Ms. Graham stated she did not witness staff withhold food from Resident A, nor did she personally withhold food from Resident A. Ms. Graham stated she followed all of Resident A's physicians' orders and provided care to Resident A, per her assessment plan, and per the requests from Resident A's family members. Ms. Graham confirmed she and her coworkers conducted 15-minute checks on Resident A. Ms. Graham stated she did not recall any medication errors made or medications not administered to Resident A when Resident A resided at the facility.

I conducted a telephone interview with Heart-to-Heart Hospice nurse Sarah Nohel, who confirmed she was the registered nurse who provided hospice care to Resident A at the facility. Ms. Nohel stated that 15-minute checks on Resident A and withholding food from Resident A was never ordered by the Heart-to-Heart Hospice physician. Ms. Nohel stated the facility did obtain a physician's order from her agency for the administration of morphine to Resident A, and to her recollection, direct care staff members administered this medication to Resident A as ordered. Ms. Nohel stated there were "times" when she visited Resident A, and during her visit, direct care staff members did not get Resident A up and out of bed. However, this wasn't specifically "ordered" by a hospice physician. Ms. Nohel stated she recalled a "couple of times" when she visited Resident A in the morning hours and observed Resident A had not been toileted, and her brief was heavily soaked. According to Ms. Nohel, she visited Resident A twice a week in the facility, and most times, she would provide wound care during those visits. Ms. Nohel stated she did not have any other concerns regarding the care of Resident A.

I conducted a telephone interview with direct care worker Shelby Root. Ms. Root stated that during the first two days of Resident A's residence, she had two falls, which were documented and reported to Relative A 1. Ms. Root stated there were communication issues between facility staff members and Resident A's family

members because Resident A's family members would communicate directly with Heart-to-Heart hospice before facility staff members received any medication and/or physician orders for Resident A. Ms. Root stated she was designated to be the main point of contact with Resident A's family members, due to other direct care staff members not relaying information/requests provided to them by family members in a timely manner. Ms. Root stated she dispensed medications, provided wound care, offered food to, and conducted 15-minute checks on Resident A. Ms. Root stated other direct care staff members also conducted 15-minute checks on Resident A. Ms. Root stated 15-minute checks were added to Resident A's MAR due to her family members' request, not as a result of a physician's order. Ms. Root also stated Resident A was moved to a room very close to the facility's care station, so direct care staff members could provide immediate assistance to her, if necessary. Ms. Root stated she and her fellow direct care staff members have been adequately trained, and the facility is adequately staffed to assist residents according to their assessed care needs.

On 9/5/2023, I scheduled a follow up visit at the facility to meet with licensee designee Jennifer Herald and Andrew Green, the facility's new administrator. At this visit, I established the facility's current census was 12 residents. 9 residents were present in the facility, while 3 residents were out of the facility. I established two direct staff members were working at the facility. I requested Ms. Herald conduct an unannounced practice fire drill to determine the facility's evacuation time. During the drill, I observed direct care staff members evacuate 9 residents, 3 of which were transported in wheelchairs, outside to the facility's parking lot in 8 minutes. According to Section R. 400.18103(m) (Definitions) of the Bureau of Fire Services Mich-Admin. Code, "impractical" means that an AFC large group home's evacuation capability is such that the facility cannot be evacuated in less than 8 minutes.

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:	The facility has been approved by the AFC division to provide personal care, supervision, and protection to the physically handicapped, aged, and Alzheimer's population. Based upon my investigation, which consisted of a review of the facility's staff schedules, review of all resident assessment plans, and interviews with facility staff members and Heart-to-Heart Hospice nurse Sarah Nohel, it has been established there were multiple times when Resident A was observed at the facility laying in "soaked" briefs, indicated there was not enough direct care staff members to aid Resident A with toileting in a timely

	manner. During an unannounced practice fire drill on 09/05/2023, it was determined that two direct care staff members evacuated 9 residents outside to the facility's parking lot in 8 minutes. Subsequently, it has been established that on 09/05/2023, staffing ratios in the facility were inadequate, as evidenced by direct care staff members' inability to evacuate the facility's residents safely and in a timely manner.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**
ANALYSIS:	Based upon my investigation, which consisted of interviews with multiple facility staff members, and a review of 11 employee files, it has been established there is no evidence to substantiate the allegation facility staff members are not properly trained.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

R 400.15310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items. **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions**

	and recommendations shall be recorded in the resident's record.
ANALYSIS:	Based upon my investigation, which consisted of interviews with multiple facility staff members, Relative A 1, and Heart-to-Heart Hospice nurse Sarah Nohel, as well as a review of facility documentation pertinent to the allegations, it has been determined that while there isn't enough evidence to established facility staff members did not change Resident A's wound per physician's orders, there was no documentation confirming facility staff members followed physician's orders to track Resident A's bowel movements daily, reposition Resident A every two hours, and to take Resident A's temperature three times a day.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Based upon my investigation, which consisted of interviews with multiple direct care staff members, and hospice nurse Sarah Nohel, as well as a review of facility documentation pertinent to the allegations, it has been established there is no evidence to substantiate the allegation direct care staff members ever withheld food from Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4)(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.

ANALYSIS:	Based upon my investigation, which consisted of interviews with multiple direct care staff members, and hospice nurse Sarah Nohel, as well as a review of Resident A's MAR, there was not enough evidence to substantiate the allegation direct care staff members did not administer prescribed medication to Resident A, as ordered.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
DEFINITION:	"Assessment plan" means a written statement which is prepared in cooperation with a responsible agency or person, and which identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical and behavioral needs and well-being and the methods of providing the care and services, taking into account the preferences and competency of the individual.
ANALYSIS:	Based upon my investigation, which consisted of interviews with multiple facility staff members, Relative A 1, and Heart-to-Heart Hospice nurse Sarah Nohel, as well as a review of facility documentation pertinent to the allegations, it has been determined that per Resident A's assessment plan, direct care staff members were to assist Resident A with toileting, dressing, feeding, and mobility. There is enough evidence to substantiate the allegation direct care staff members did not provide this care, as evidenced by Resident A observed multiple times in the afternoon wearing pajamas and in a soaked brief. Additionally, documentation on Resident A's MAR indicated Resident A required assistance with getting up for the day at 9am, laying down for a nap at 12pm, getting up and into a geriatric chair at 4pm, laying down for bed at 7pm and "toileting at each transfer". According to Relative A 1, Resident A required 15-minute checks. Statements made by multiple direct care staff members indicated they provided 15- minute checks to Resident A. Resident A's most

	current assessment plan did not include directives to follow Resident A's "daily flow", provide Resident A with 15 minutes checks, and reposition Resident A every two hours. While there isn't enough evidence to determine whether or not facility staff members consistently provided this care and supervision to Resident A, these specific directives were not identified in her assessment plan. Subsequently, there is enough evidence to also determine that Resident A's assessment plan did not reflect her current needs.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Upon reviewing the complete facility record for Resident A, I discovered there was no copy of a health care appraisal, a signed resident care agreement, and a copy of the resident funds and valuables record and resident refund agreement.

APPLICABLE RULE	
R 400.15316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: **(d) Health care information, including all of the following:** **(i) Health care appraisals.** **(e) Resident care agreement.** **(i) Resident funds and valuables record and resident refund agreement.**
ANALYSIS:	Based upon my investigation, which consisted of review of Resident A's facility record, there was no copy of a health care appraisal, a signed resident care agreement, and a copy of the resident funds and valuables record and resident refund agreement.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/14/2023, I conducted telephone exit conference with Licensee Designee, Jennifer Herald and shared the findings of this investigation.

IV. RECOMMENDATION

After receiving an acceptable correction action plan, I recommend no changes in the status of this license.

9/14/2023

Candace Coburn Date
Licensing Consultant

Approved By:

09/15/2023

Michele Streeter Date
Area Manager