GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 24, 2021

Shannon VanHouten
Boulder Creek Assisted Living
6070 Northland Drive
Rockford, MI 49341

RE: License #: AH410336370
Investigation #: 2021A1028020
Boulder Creek Assisted Living

Dear Ms. VanHouten:

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.

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,

Julie Viviano

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
Cell Phone (616) 204-4300

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

I. IDENTIFYING INFORMATION

License #:	AH410336370
Investigation #:	2021A1028020
Complaint Receipt Date:	04/02/2021
Investigation Initiation Date:	04/02/2021
Report Due Date:	06/02/2021
Licensee Name:	Boulder Creek Assisted Living, LLC
Licensee Address:	Suite 200 3196 Kraft Ave. Grand Rapids, MI 49512
Licensee Telephone #:	(616) 464-1564
Administrator:	Lauren Wu
Authorized Representative:	Shannon VanHouten
Name of Facility:	Boulder Creek Assisted Living
Facility Address:	6070 Northland Drive Rockford, MI 49341
Facility Telephone #:	(616) 866-2911
Original Issuance Date:	10/03/2014
License **Status:**	REGULAR
Effective Date:	05/15/2020
Expiration Date:	05/14/2021
Capacity:	108
Program Type:	AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Employee #1 is neglectful with resident care.	No
Resident A incurred a black eye from an unwitnessed fall.	Yes

III. METHODOLOGY

04/02/2021	Special Investigation Intake 2021A1028020
04/02/2021	Special Investigation Initiated - Letter APS referral emailed to centralized intake
04/02/2021	APS Referral APS referral emailed to centralized intake
04/08/2021	Contact - Face to Face Interviewed executive director, Lauren Wu, in person at facility
04/15/2021	Contact - Telephone call made Interviewed staff, Kaylyn Holden, by telephone
04/15/2021	Contact - Telephone call made Interviewed staff, Ashley Lee, by telephone
04/15/2021	Contact - Telephone call made Interviewed Resident A's AR, Deborah Dubey, by telephone
4/21/21	Contact – Telephone call made Attempted to contact staff members, Chandler Becker and Melody Wagner, for third time with no success
4/27/21	Contact – Email sent Sent follow up email to Lauren Wu requesting fall prevention documents

ALLEGATION:

Employee #1 is neglectful with resident care.

INVESTIGATION:

On 4/2/21, the Bureau received the allegations from the online compliant system. The complainant wished to remain anonymous. Therefore, I was unable to contact them to clarify their concerns or gather additional information.

On 4/2/21, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 4/8/21, I interviewed executive director Lauren Wu at the facility. Ms. Wu reported that employee #1 was recently hired and is on a 90-day probationary period. Ms Wu stated that employee #1 completed the "on-line training with success, but struggled with the hands-on training, requiring additional training". Ms. Wu reported that it appears that employee #1 "presented a false skill level set during the interview and hiring process". Ms Wu reported facility care staff voiced concerns to her within the past 30 days about the care employee #1 was providing to residents on third shift. Third shift care staff reported employee #1 does not complete resident care or relies on other staff to complete resident care. Ms. Wu reported she questioned employee #1 about completion of resident care, with employee #1 reporting a prior shoulder injury is interfering with ability to complete transfers, toileting, and bathing. Ms. Wu reported she asked employee #1 for medical documentation of the shoulder injury so the facility could make workload accommodations for employee #1, but employee #1 did not provide any medical documentation. Ms. Wu reported that employee #1 was placed with another care staff member on third shift to ensure resident care was completed and for additional training purposes. Ms. Wu reported she and the director of resident care, Mercedes Eggleston, also provided employee #1 continuing education and training, but decided to remove employee #1 from the schedule on 4/5/21 due to employee #1 being unable to complete resident care without assist. Ms. Wu reported employee #1 is not currently on the staff schedule and the facility is exiting employment with employee #1 due to inability to complete job tasks safely and efficiently. Ms. Wu provided employee #1's training record and staff schedule for my review.

On 4/15/21, I interviewed care staff person (CSP) Kaylyn Holmden by telephone. Ms. Holmden reported that she worked third shift with employee #1 and that employee #1 "was difficult to work with". Ms. Holmden reported employee #1 "would often not leave the care station to attend to residents, would take too long to answer call lights, or would complain of a shoulder injury and not complete resident care because of it". Ms. Holmden reported employee #1 would ask for help from other staff but would then leave all the resident care for the other staff to complete. Ms. Holmden reported employee #1 received on-line and in-person training from management and care

staff. Ms. Holden reported employee #1 also received additional training from management and care staff due to demonstrating difficulty with simple job tasks. Ms. Holmden reported that care staff voiced concerns about employee #1 to Ms. Wu and Ms. Eggleston resulting in employee #1 being removed from the staff schedule. Ms. Holmden reported employee #1 "has not been on the staff schedule for a few weeks".

On 4/15/21, I interviewed CSP Ashley Lee by telephone. Ms. Lee's statements are consistent with Ms. Holmden's statements. Ms. Lee reported that employee #1 "doesn't complete tasks correctly and is not safe with resident's care". Ms. Lee reported that employee #1 "relies on other staff to do the job" and that staff voiced concerns about employee #1 to management. Ms. Lee reported employee #1 is not on the staff schedule.

On 4/19/21, I reviewed employee #1's training record which revealed employee #1 completed 20 on-line training courses with a passing score. Review of the staff schedule revealed employee #1 has not been on the schedule since 4/5/21.

On 4/21/21, I attempted to contact care staff members, Chandler Becker and Melody Wagner, for third time with no success.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff. Patients and residents shall be treated in accordance with the policy.
For Reference:	**2 (e) A patient or resident is entitled to receive adequate and appropriate care, and to receive, from the appropriate individual within the health facility or agency, information about his or her medical condition, proposed course of treatment, and prospects for recovery, in terms that the patient or resident can understand, unless medically contraindicated as documented in the medical record by the attending physician or a physician's assistant to whom**

	the physician has delegated the performance of medical care services.
ANALYSIS:	Interviews with facility staff along with review of employee #1 training record reveal that employee #1 demonstrated difficulty with resident care. Care staff voiced concerns to management about employee #1's behavior resulting in management providing employee #1 additional training. After additional training was provided, employee #1 still demonstrated difficulty with safe job completion resulting in management removing employee #1 from the facility staff schedule. While the allegation is in fact substantiated, administration recognized the isolated issue and took reasonable steps to ensure adequate resident care was ensured and there is no ongoing systemic issue.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident incurred a black eye from an unwitnessed fall.

INVESTIGATION:

Ms. Wu reported that Resident A recently incurred a fall, resulting in a black eye. Ms. Wu reported that the black resulted from Resident A's "glasses being pushed into the face during the fall". Ms. Wu reported Resident A is inconsistent with use of the call light despite reminders from staff. Ms. Wu reported Resident A has a history of falls and that falls along with any other incident are reported to Resident A's authorized representative, physician, and the department of LARA. Ms. Wu provided a copy of Resident A's service plan, record notes, and incident reports for my review.

Ms. Holmden reported that Resident A has a history of falls and is not consistent with use of the call light. Ms. Holmden reported Resident A incurred a black eye from a recent fall because Resident A "wears glasses and the glasses caused bruising around the eye due to the fall". Ms. Holmden was able to state Resident A's level of care required by the service plan and reported staff follow the service plan. Ms. Holmden also reported all falls and incidents are documented in Resident A's record and Resident A's "guardian, physician, and the state are notified immediately".

Ms. Lee's statements are consistent with Ms. Holmden's statements. Ms. Lee reported that Resident A's authorized representative is aware of Resident A's history

of falls and that the current care plan reflects fall prevention techniques for Resident A.

On 4/15/21, I interviewed Resident A's authorized representative by telephone. Resident's A authorized representative reported she is aware of Resident A's history of falls and is aware of Resident A's recent fall resulting in a black eye. The authorized representative reported the facility is in consistent communication with her about Resident A's care and there are no concerns with Resident A's care at the facility at this time.

On 4/19/21, I reviewed Resident A's care plan which revealed Resident A requires stand by assist to one person assist for cares and that Resident A requires reminders with stand by assist to use walker or wheelchair. Resident A requires one person assist for safe transfers. Resident A demonstrates confusion and disorientation intermittently, requiring reminders or redirection from care staff.

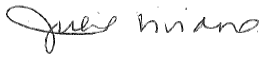
I reviewed Resident A's record and incident reports which revealed a documented history of falls, confusion intermittently with Resident A receiving reminders and redirection from care staff, and good communication with Resident A's authorized representative, physician, and the department of LARA.

On 4/26/21, I requested the facility protocol and policy for fall prevention. Ms Wu reported that staff receives fall prevention training upon hire and annually, but the facility does not have a fall prevention policy or protocol.

APPLICABLE RULE	
R325.1921	**Governing bodies, administrators, and supervisors.**
	(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.
For Reference: R325.1901	**Definitions**
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision. **(21) "Service Plan" means a written statement prepared by the home in a cooperation with a resident and/or the resident's authorized representative or agency responsible for a resident's placement, if any, and that identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical, social, and behavioral needs and well-being and the methods of providing the care and services while taking into account the preferences and competency of the resident.**
ANALYSIS:	Interviews with facility staff and Resident A's authorized representative, along with review of documentation reveal Resident A has a history of falls, confusion, and disorientation. There is evidence that the facility is in routine communication with Resident A's authorized representative, physician, and the department about Resident A's history of falls. However, Resident A's service plan demonstrates inadequate plan development related to the prevention of falls and protection from harm. The most recent service plan dated 4/16/21continues to lack reasonable fall preventative measures. For instance, the plan lacks the frequency or type of staff monitoring required for a resident with dementia and inconsistent with remembering to summon staff for assistance.
CONCLUSION:	**VIOLATION ESTABLISHED.**

IV. RECOMMENDATION

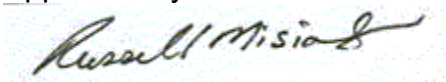
Upon receipt of an acceptable corrective action plan, I recommend the status of this license remained unchanged.



4/30/21

Julie Viviano — Date
Licensing Staff

Approved By:



5/24/21

Russell B. Misiak — Date
Area Manager