GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 7th, 2021

Kristen Nitz
Grand Village Assisted Living LLC
3939 44th Street SW
Grandville, MI 49418

RE: License #:	AH410384010
Investigation #:	2021A1021033
	Grand Village Assisted Living LLC

Dear Ms. Nitz:

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 authorized representative 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 (517) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410384010
Investigation #:	2021A1021033
Complaint Receipt Date:	05/27/2021
Investigation Initiation Date:	05/27/2021
Report Due Date:	07/26/2021
Licensee Name:	Grand Village Assisted Living, LLC
Licensee Address:	3939 44th Street Grandville, MI 49418
Licensee Telephone #:	(616) 719-5895
Administrator:	Robert Johns
Authorized Representative:	Kristen Nitz
Name of Facility:	Grand Village Assisted Living LLC
Facility Address:	3939 44th Street SW Grandville, MI 49418
Facility Telephone #:	(616) 261-2610
Original Issuance Date:	01/30/2018
License Status:	REGULAR
Effective Date:	07/30/2020
Expiration Date:	07/29/2021
Capacity:	72
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Facility lost personal items of Resident A.	No
Facility did not appropriately contact Relative A1.	Yes
Personal care not provided according to service plan.	Yes
Resident A's room not properly cleaned.	No
Additional Findings	No

III. METHODOLOGY

05/27/2021	Special Investigation Intake 2021A1021033
05/27/2021	Special Investigation Initiated - Letter APS referral sent to centralized intake
06/03/2021	Inspection Completed On-site
06/17/2021	Contact-Document Received Received admission agreement and Authorized Representative paperwork
07/07/2021	Exit Conference Exit conference with authorized representative Kristen Nitz

ALLEGATION:

Facility lost personal items of Resident A.

INVESTIGATION:

On 5/27/27, the licensing department received a complaint with allegations Resident A's personal items were missing. The complainant alleged Resident A's ¾ of the dental bridge was missing. In addition, the complainant alleged Resident A's hair combs were missing.

On 5/27/21, the allegations in this report were sent to centralized intake at Adult Protective Services (APS).

On 6/3/21, I interviewed administrator Robert Johns at the facility. Mr. Johns reported several months ago, caregivers observed Resident A's dental bridge on the table. Mr. Johns reported before the caregivers could secure the dental bridge, it came up missing. Mr. Johns reported caregivers searched for the dental bridge but was unable to locate the item. Mr. Johns reported caregivers and management looked for the dental bridge. Mr. Johns reported eventually the bridge was found in the dishwasher. Mr. Johns reported the facility offered to pay for the dental bridge. Mr. Johns reported caregivers now place the dental bridge in the secure medication cart. Mr. Johns reported he is unaware of any missing hair items of Resident A.

On 6/3/21, I interviewed caregiver Alexis Demaar at the facility. Ms. Demaar reported she was working when the dental bridge was misplaced. Ms. Demaar reported the residents were eating lunch and she observed three teeth on the table. Ms. Demaar reported she called Relative A1 and when she came back the teeth were missing. Ms. Demaar reported caregivers looked for the missing teeth, but they were unable to be located. Ms. Demaar reported caregivers are now responsible for putting the dental bridge in the locked medication cart every night. Ms. Demaar reported she is unaware of any missing hair items.

I reviewed the medication administration record (MAR) for Resident A. The MAR read,

> *"remove both partials clean, and place in locked med cabinet. Never leave partials in her room. Put in container in med cabinet. Put partials in the morning."*

I reviewed *Leisure Living Management Investigation* form dated 9/12/20. The narrative of the incident report read,

> *"While sitting down for lunch staff noticed a set of 3 teeth on the table where (Resident A) had been sitting. Called (Relative A1) to confirm they were hers but when came back they were missing. Checked all of the trash cans but were unable to find them."*

I reviewed correspondence dated 10/13 with Relative A1. The email correspondence read,

> *"As far as the partial goes, I believe that it has been misplaced or accidently thrown away. I looked for it today but was unable to locate it. I will continue to locate it."*

I reviewed Resident A's admission agreement that was signed on 9/26/18. The agreement read,

"The Facility is not responsible or liable for any items that are lost, damaged, or missing. These items include, but are not limited to glasses, dentures, hearing aids, jewelry, electronics, collectibles, cash, credit cards, and check books."

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(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: R 325.1901	**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.
ANALYSIS:	Resident A's partial dental bridge was lost at the facility. The facility attempted to locate the missing items by searching the facility. The staff made reasonable efforts to locate Resident A's items.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Facility did not appropriately contact Relative A1.

INVESTIGATION:

The complainant alleged Relative A1 was not notified of the missing dental bridge as well as Resident A's chipped tooth. The complainant alleged Relative A1 was notified the bridge was taken out of Resident A's mouth but not that it was missing.

Relative A1 reported Resident A has a chipped tooth, and it was not notified to Relative A1.

Mr. Johns reported the facility did not appropriately notify Relative A1 of the missing dental bridge. Mr. Johns reported caregivers contacted Relative A1 to inform him the dental bridge was taken out of Resident A's mouth but not that it was missing. Mr. Johns reported the facility did find part of the partial dental bridge and the facility offered to pay for the repairs of the dental bridge. Mr. Johns reported no knowledge of Resident A's chipped tooth.

Ms. Demaar reported no knowledge of Resident A having a chipped tooth.

I observed Resident A at the facility and did not observe any chipped teeth.

I reviewed the investigation form that was completed when Resident A's dental bridge was lost on 9/12/20. The narrative read,

> "*While sitting down for lunch staff noticed a set of 3 teeth on the table where (Resident A) had been sitting. Called (Relative A1) to confirm they were hers but when came back they were missing. Checked all of the trash cans but were unable to find them."*

I reviewed Resident A's records. Resident A appointed Relative A1 as her authorized representative on 9/26/18.

I reviewed correspondence dated 10/12/20 from Relative A1. The correspondence read,

> *"I came in last week and picked her up for an appointment. I know that when we last spoke about her teeth, you were going to have (Resident A) try to put the partial back in her mouth and if she was unable to do so, you could call me back. I didn't get a call back so my understanding was the issue was resolved."*

I reviewed correspondence dated 10/13/20 with Relative A1. The email correspondence from director of resident care read,

> *"As far as the partial goes, I believe that it has been misplaced or accidently thrown away. I looked for it today but was unable to locate it. I will continue to locate it."*

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in

	writing to the resident's authorized representative, if any, and the resident's physician.
ANALYSIS:	The facility contacted Relative A1 to inform him Resident A's dental bridge was taken out of her mouth. However, the facility failed to inform Relative A1 the dental bridge was missing.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Personal care not provided according to service plan.

INVESTIGATION:

The complainant alleged the facility is not following Resident A's care plan for oral and hair care. The complainant alleged Resident A's oral care is not being provided as Resident A's front tooth is chipped. The complainant alleged Resident A's hair is not to be washed and is to be wrapped at night. The complainant alleged the facility is not following Resident A's service plan regarding the care of Resident A's hair as observed by Resident A's hair is damaged.

Mr. Johns reported caregivers have been educated on the proper way to wash and style Resident A's hair. Mr. Johns reported caregivers are to put treatment/oil in the hair at night and to wrap the hair in a cap. Mr. Johns reported during the day, caregivers are to put Resident A's hair in a bun.

Ms. Demaar reported Resident A receives a shower twice weekly on second shift. Ms. Demaar reported caregivers are not to wash Resident A's hair, per Relative A1 request. Ms. Demaar reported Resident A has prescription shampoo that is to be used once weekly. Ms. Demaar reported at night caregivers are to wrap Resident A's hair in a scarf and during the day Resident A's hair is to be tightly wrapped. Ms. Demaar reported caregivers are to remove both dental bridge partials and place them in the locked medicine cabinet. Ms. Demaar reported caregivers are to put the dental partials back in during morning care.

On 6/3/21, I interviewed caregiver Stephanie Burtin at the facility. Ms. Burtin's statements were consistent with those made by Ms. Demaar.

I reviewed Resident A's service plan. The service plan read,

"provide stand by assistance for oral care throughout task. Hand resident supplies as needed and ready for use. Give short, simple directions to resident. Guide resident through task one step at a time. Clean and put supplies away when complete."

Also, the service plan read,

"prefers AM shower. Do not get hair wet.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	Interviews with management and caregivers Resident A has prescription shampoo, and at night caregivers are to wrap Resident A's hair. In addition, caregivers are to remove Resident A's dental bridge and place in locked medicine cabinet. Resident A's service plan lacked information on hair care and dental care for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A's room not properly cleaned.

INVESTIGATION:

The complainant alleged Resident A's room smelt like urine and the trash bin was overfilled with soiled briefs.

Mr. Johns reported caregivers are responsible for providing daily tidying tasks such as emptying trash and ensuring resident rooms are clean. Mr. Johns reported the facility housekeeper cleans the secure memory care unit every Friday. Mr. Johns reported if an issue arises, the unit can be cleaned again. Mr. Johns reported the facility is clean and denied the allegation Resident A's room smells like urine.

On 6/3/21, I interviewed maintenance director Dave Devires at the facility. Mr. Devires reported resident rooms are cleaned weekly by housekeeping staff. Mr.

Devires reported caregivers are responsible for taking out trash and tidying up resident rooms and common areas. Mr. Devires reported the facility is kept clean.

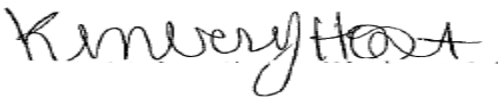
I observed Resident A's room and eight other resident rooms. I observed the trash was emptied in all resident rooms. I observed the resident room and bathroom was clean and did not smell like urine. I observed the common areas in the memory care unit. The common areas were clean as observed by the floor was vacuumed, trash was emptied, and kitchen area was clean.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	Interviews with employees revealed the facility has a housekeeper that cleans common areas and resident rooms. Inspection at the facility revealed the facility is clean.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 7/7/21, I conducted an exit conference with authorized representative Kristen Nitz by telephone. Ms. Nitz had no questions regarding the report.

IV. RECOMMENDATION

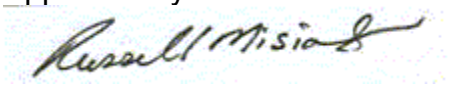
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.



6/22/21

Kimberly Horst Date
Licensing Staff

Approved By:



6/22/21

Russell B. Misiak
Area Manager

Date