GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 30, 2021

Lauren Gowman
Grand Pines Assisted Living Center
1410 S. Ferry St.
Grand Haven, MI 49417

RE: License #:	AH700299440
Investigation #:	2021A1021030 Grand Pines Assisted Living Center

Dear Mrs. Gowman:

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.

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
REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AH700299440
Investigation #:	2021A1021030
Complaint Receipt Date:	05/10/2021
Investigation Initiation Date:	05/11/2021
Report Due Date:	07/09/2021
Licensee Name:	Grand Pines Assisted Living LLC
Licensee Address:	950 Taylor Ave. Grand Haven, MI 49417
Licensee Telephone #:	(616) 846-4700
Administrator:	Kelly Miller
Authorized Representative:	Lauren Gowman
Name of Facility:	Grand Pines Assisted Living Center
Facility Address:	1410 S. Ferry St. Grand Haven, MI 49417
Facility Telephone #:	(616) 850-2150
Original Issuance Date:	07/08/2009
License Status:	REGULAR
Effective Date:	05/12/2020
Expiration Date:	05/11/2021
Capacity:	177
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Staff Person 1 (SP) vapes in the facility.	No
Resident A was called a bitch	No
Insufficient staff on 5/9 on third shift	Yes
Additional Findings	No

III. METHODOLOGY

05/10/2021	Special Investigation Intake 2021A1021030
05/11/2021	Special Investigation Initiated - Letter Referral sent to APS centralized intake
05/14/2021	Inspection Completed On-site
05/14/2021	Contact-Telephone call made Interviewed medication technician Alicia Turley
05/17/2021	Contact - Telephone call made Interviewed SP1
05/17/2021	Contact-Telephone call made Interviewed caregiver Pat Canning
05/17/2021	Contact-Telephone call made Interviewed shift supervisor Arthur Evans
05/19/2021	Contact-Telephone call made Interviewed caregiver Stephanie McFarland
05/20/2021	Contact-Telephone call made Interviewed caregiver Kaylynn Melgoza
05/20/2021	Contact-Telephone call made Interviewed medication technician Bobbi DeFeyer
	Exit Conference

ALLEGATION:

Staff Person 1 (SP) vapes in the facility.

INVESTIGATION:

On 5/10/21, the licensing department received a complaint with allegations SP1 vapes in the spa bathroom on second and third shift.

On 5/11/21, the allegations in this report were sent to centralized intake at Adult Protective Services (APS).

On 5/13/14, I interviewed the complainant by telephone. The complainant alleged SP1 vapes in the spa bathroom while working at the facility.

On 5/14/21, I interviewed resident services coordinator Maria Busch at the facility. Ms. Busch reported she is aware that SP1 vapes but only does so on breaks. Ms. Busch reported the facility policy allows for employees to smoke and/or vape but only so in designated areas or in their cars. Ms. Busch reported employees are not allowed to smoke in the facility.

On 5/14/21, I interviewed administrator Kelly Miller at the facility. Ms. Miller reported a few years ago an employee was terminated due to vaping in the facility. Ms. Miller reported no allegations of employees vaping in the facility have been brought to her attention.

On 5/17/21, I interviewed SP1 by telephone. SP1 reported she does vape and has vaped on her breaks at the facility. SP1 reported employees can vape in the designated smoking area or in their cars. SP1 reported she has never vaped in the facility.

On 5/19/21, I interviewed caregiver Stephanie McFarland by telephone. Ms. McFarland reported she has heard rumors that caregivers vape inside the facility while working but she has never seen anyone vaping.

On 5/20/21, I interviewed Kaylynn Melgoza by telephone. Ms. Melgoza reported she has heard rumors of caregivers vaping inside the facility while working but has never seen anyone vaping.

On 5/20/21, I interviewed medication technician Theresa Groh by telephone. Ms. Groh reported she has never seen any caregivers vaping in the facility.

On 5/24/21, I interviewed caregiver Bobbi DeFeyer by telephone. Ms. DeFeyer reported has not heard rumors of caregivers vaping nor seen any caregivers vaping in the facility.

I reviewed SP1's *Grand Pines Assisted Living Center Employee Handbook* acknowledgement form. The form revealed SP1 received and read the employee handbook and the facility smoking policy.

APPLICABLE RULE	
R 325.1917	**Compliance with other laws, codes, and ordinances.**
	(2) A home shall comply with the department's health care facility fire safety rules being R 29.1801 to R 29.1861 of the Michigan Administrative Code.
ANALYSIS:	Interviews with multiple caregivers revealed lack of evidence to support the allegation that SP1 vapes while working in the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was called a bitch.

INVESTIGATION:

The complainant alleged Resident A was called a bitch by SP2. The complainant alleged SP2 called Resident A, a bitch because she was not cooperating.

Ms. Busch reported Resident A has frontal lobe dementia and has been known to be verbally aggressive with employees. Ms. Busch reported she has not heard of any employees calling Resident A, a bitch.

On 5/14/21, I interviewed resident care associate Jandi Foster at the facility. Ms. Foster reported Resident A has outbursts and will yell at the employees. Ms. Foster reported she has never heard of an employee calling Resident A, a bitch.

On 5/14/21, I interviewed administrator Maria Busch at the facility. Ms. Busch reported Resident A has behavior difficulties and can be very mean to employees. Ms. Busch reported no complaints of employees calling Resident A, a bitch have been brought to her attention.

On 5/18/21, I interviewed medication technician Stephanie McFarland by telephone. Ms. McFarland reported Resident A has behaviors and will call staff names. Ms. McFarland reported she has never witnessed staff call Resident A, a bitch to her face.

On 5/20/21, I interviewed SP2 by telephone. SP2 reported Resident A is known to be verbally aggressive with employees. SP2 reported if Resident A is combative with staff, the employee will leave the room and try again after the resident has calmed down. SP2 reported she has never called Resident A, a bitch.

I reviewed SP2 employee file. The file revealed SP2 completed Resident Rights and Responsibilities training.

I reviewed observation notes for Resident A. The notes read,

> *"RSA stated that right before dinner, resident passed by two other female residents who were sitting at the dining room table and called on a "bitch" unprovoked. RSA explained that it was inappropriate to call people names and resident replied, "She called me a bitch first" which was untrue. Also, shortly after that, resident requested to go to the bathroom. She had a BM and RSA stated that while she was cleaning her with a baby wipe, resident called her a "bitch" out of nowhere. RSA asked what happened and resident stated she didn't want to be cleaned. RSA reminded her that she had a BM and she was just trying to make sure she was cleaned well and resident, "okay, I'm sorry" then allowed her to finish."*

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 caregivers and review of Resident A's chart, revealed Resident A is known to be verbally aggressive towards staff members. There is lack of evidence to support the allegation that Resident A was called a bitch.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

There is insufficient staff.

INVESTIGATION:

The complainant alleged on 5/9, there was insufficient staff on third shift. The complainant alleged there was only five people working for 75 residents.

Ms. Miller reported there is adequate staff to care for the residents. Ms. Miller reported the facility offers incentives for staff members to pick up additional hours. Ms. Miller reported staffing is based on resident care needs in their service plans.

Ms. Busch reported that was five people working on 5/9. Ms. Busch reported one caregiver stayed over from the previous shift and left at 5:00am. Ms. Busch reported there was also a housekeeper that is also trained as a caregiver. Ms. Busch reported this caregiver was responsible for housekeeper tasks but also can assist with resident care and cover breaks for the employees. Ms. Busch reported the facility staffs one caregiver for Terrace which is a secure memory care unit and has 12 residents; two caregivers for Courtyard which is a secure memory care unit and has 12 residents; one caregiver for north pines with 16 residents; one caregiver for South Pines with 22 residents. Ms. Busch reported in Courtyard unit there is one resident that attempts to exit seek, and two residents that are changed in bed. Ms. Busch reported in South Pines there is one resident that is a two person assist. Ms. Busch reported caregivers use walkie-talkies to communicate with each other. Ms. Busch reported resident call lights alert the caregiver on their phone so that the caregiver does not have to be in the unit to see where the call light is activated.

While at the facility I observed the layout of the facility. The facility has two secure memory care units at each end of the building. Within the facility there is two assisted living units, North and South. These units are in the middle of the building. The building is ¼ mile long from Terrace Unit to the Courtyard unit.

On 5/14/21, I interviewed medication technician Alicia Turley by telephone. Ms. Turley reported there is lack of staff on third shift. Ms. Turley reported on 5/9 there was five employees working. Ms. Turley reported of the five employees there was two medication technicians. Ms. Turley reported the medication technicians were staffed in assisted living and had to leave their units to go to the secure memory care units to administer medications. Ms. Turley reported by doing so, this left units unattended. Ms. Turley reported caregivers use walkie-talkies to communicate but the facility is big and it takes time for caregivers to receive assistance.

On 5/17/21, I interviewed resident service associate Pat Canning by telephone. Ms. Canning reported she worked on 5/9 in Terrace memory care unit. Ms. Canning reported there was another caregiver in the unit but there were scheduled as a housekeeper. Ms. Canning reported within the unit there is three residents with behaviors and two residents that are a two-person assist. Ms. Canning reported at times caregivers can meet the needs of the residents but typically the facility works short which results in resident needs not met.

On 5/17/21, I interviewed shift supervisor Arthur Evans by telephone. Mr. Evans reported he is the shift supervisor on third shift but due to lack of staff he is usually assigned to work the floor. Mr. Evans reported if there is any emergency or resident fall he is to assist in the follow up which results in him leaving the residents

unattended. Mr. Evans reported on 5/9 he was assigned to the north unit yet had to leave his unit to administer medications in the secure memory care units.

On 5/24/21, I interviewed resident service associate Bobbi DeFeyter by telephone. Ms. DeFeyter reported she was working on 5/9 and there was lack of staff. Ms. DeFeyter reported she was Courtyard, the secure memory care unit. Ms. DeFeyter reported in Courtyard there was another resident care associate, but she left the unit at 5:00am. Ms. DeFeyter reported a medication technician came to administer medications and left her unit to do so. Ms. DeFeyter reported there is two residents that are a two person assist in Courtyard, one resident that attempts to exit, two residents that have behavior difficulties, and two residents that are changed in bed. Ms. DeFeyter reported resident needs are not met as two-person assist transfers are done with only one person due to lack of staff available to assist in the transfers.

I reviewed the staff schedule for 5/9 for third shift. The schedule revealed there was two medications technician scheduled and three resident service associates. There was one housekeeper scheduled. In addition, one resident service associate ended her shift at 5:00am.

I reviewed a random sample of service plans for courtyard residents. The service plans revealed there was six residents that were on a toileting schedule, six residents were a higher fall risk, one resident was incontinent, and three residents that were a two-person assist transfer,

I reviewed a random sample of service plans for Terrace residents. The service plans revealed three residents required assistance with toileting, one resident is incontinent, one resident required two-person assist with toileting, three residents had behaviors, and one resident was a two person assist transfer.

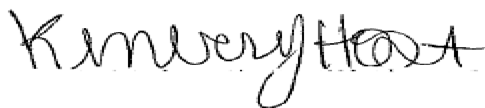
APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	On 5/9, there was five direct care employees scheduled with two medication technicians scheduled. Due to low staffing, the medication technicians left their units to administer medications in other units. This practice resulted in residents left unattended. In addition, the secure memory care units had one caregiver scheduled for each unit and there were multiple residents that required two-person assistance. The supervisor of resident care, who is typically able to assist in covering, was already assigned to an area.

CONCLUSION:	VIOLATION ESTABLISHED

On 6/30/21, I conducted an exit conference with authorized representative Lauren Gowman by telephone. Ms. Gowman reported the facility is attempting to hire and retrain staff to their best of their ability.

IV. RECOMMENDATION

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



6/28/21

Kimberly Horst Date
Licensing Staff

Approved By:

6/28/21

Russell B. Misiak Date
Area Manager