GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 23, 2021

Paul Buchholz
Spring Arbor Assisted Living Center
3700 S. Dearing Rd.
Spring Arbor, MI 49283

RE: License #: AH380237409
Investigation #: 2021A1027037
Spring Arbor Assisted Living Center

Dear Mr. Buchholz:

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 by the home for the aged authorized representative 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,

Jessica Rogers

Jessica Rogers, Licensing Staff
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 #:	AH380237409
Investigation #:	2021A1027037
Complaint Receipt Date:	06/24/2021
Investigation Initiation Date:	06/28/2021
Report Due Date:	08/24/2021
Licensee Name:	Ganton Retirement Centers, Inc.
Licensee Address:	7925 Spring Arbor Rd. Spring Arbor, MI 49283
Licensee Telephone #:	(517) 750-0500
Administrator:	Karol Buchholz
Authorized Representative:	Paul Buchholz
Name of Facility:	Spring Arbor Assisted Living Center
Facility Address:	3700 S. Dearing Rd. Spring Arbor, MI 49283
Facility Telephone #:	(517) 750-2700
Original Issuance Date:	07/16/2001
License Status:	REGULAR
Effective Date:	08/20/2020
Expiration Date:	08/19/2021
Capacity:	88
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The facility blocked exits with furniture and roped hallways off to prevent residents from exiting.	Yes
The facility is understaffed.	No
Residents are not receiving their showers.	Yes
The facility has bed bugs.	No
The facility has an employee with a history of abuse working.	No
The facility is not reporting falls.	Yes
Additional Findings	No

III. METHODOLOGY

06/24/2021	Special Investigation Intake 2021A1027037
06/28/2021	Special Investigation Initiated - On Site Observations made, documentation obtained, staff and resident interviews conducted
07/06/2021	Contact - Document Received Requested documentation received by fax from Director of Nursing S. Stubbins
07/12/2021	Contact - Document Received Requested documentation received by fax from Director of Nursing S. Stubbins
07/13/2021	Contact - Document Sent Requested documentation from S. Stubbins
07/15/2021	Contact - Document Received Received requested documentation from S. Stubbins
07/20/2021	Contact - Telephone call made

	Telephone interview conducted with Director of Nursing Susan Stubbins
08/19/2021	Exit Conference Conducted with authorized representative Paul Buchholz

ALLEGATION:

The facility blocked exits with furniture and roped hallways off to prevent residents from exiting.

INVESTIGATION:

On 6/24/21, the department received an anonymous complaint alleging the facility blocked doorways with furniture and roped off areas within the facility to prevent residents from exiting.

On 6/28/21, I conducted an on-site inspection at the facility. I observed a white rope through two eye hooks along one side the hallway and another eye hook on the opposite side. The rope was long enough to reach across the hallway and hook to the other side. There were two separate areas of the facility with a rope and hooks that would block an area of the facility from rooms 121 through 131. I conducted facility staff interviews. Employee #1 stated the ropes were used during quarantine to keep residents in certain locations but not used now. Employee #2 stated the ropes are used intermittently to divide the back hall area where residents with dementia wander into the assisted living area. Employee #3 stated the back hall, where the ropes are located, is called the “A-2” unit. Employee #3 stated the “A-2” unit has residents that have moved from the “Willows” (memory care) unit and the ropes prevented residents from wandering. Employee #4 statements were consistent with statements from Employee #2. Employee #7’s statements were consistent with statements from Employee #2 and #3. Employee #8 statements were consistent with statements from Employee #3. I observed the “Willows” unit, a locked unit for residents with dementia. Near the center of the “Willows” unit were two doors leading to a foyer area with two additional doors that exit the building. In front of the two doors leading to the foyer area, I observed a couch with two wheelchairs located directly in front of doors. The doors would not be able to open due to the furniture placement. At the end of each hallway on the “Willows” unit were exit doors. I observed one exit door with three wheelchairs parked in front of it in which the door could not be accessed nor opened. The other exit door had one wheelchair folded in front it in which the door could not be opened. Residents or staff would have to remove the equipment and/or furniture to exit the facility. Interviews with Employee #6 and #7 revealed the equipment and furniture were in front of the exit doors due to a resident exit seeking and wandering.

On 7/20/21, I conducted a telephone interview with director of nursing Susan Stubbins. Ms. Stubbins stated the ropes in “A-2” or “Alzheimer’s 2” unit were used during the COVID-19 pandemic as a “visual” reminder to residents with dementia to stay quarantined to that area. Ms. Stubbins stated the ropes were a trial during COVID-19 and did not work. Ms. Stubbins stated the ropes should have been removed. Ms. Stubbins stated two residents who were non-ambulatory were moved from the “Willows” unit to the “A-2” hallway due to the “Willows” unit being full. Ms. Stubbins stated residents in the “A-2” unit have dementia and require additional care. In addition, Ms. Stubbins stated facility staff do not usually store equipment or furniture in front of the doors in the “Willows” unit. Ms. Stubbins stated the facility has a storage room with extra equipment that is utilized.

I reviewed resident service plans. Service plans for Resident E and F read the resident resided in the “Willows” unit receiving a Willows level of care. The service plans for both residents read they had moved to rooms in “A-2” hallway in the assisted living on 10/21/20.

APPLICABLE RULE	
R 325.1964	**Interiors.**
	(11) A doorway, passageway, corridor, hallway, or stairwell shall be kept free from obstructions at all times.
ANALYSIS:	Observations at the time of inspection and interviews with facility staff revealed the facility utilized ropes and furniture to physically restrict movement of residents within the facility. In addition, furniture located in front of exit doors would prevent safe exiting of the facility in the event of a fire or emergency.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility is understaffed.

INVESTIGATION:

On 6/24/21, the department received an anonymous complaint alleging lack of resident care due to staffing.

On 6/28/21, I conducted an on-site inspection at the facility. I observed staff two staff at the front office of the facility, two staff assigned to the “Willows” unit and observed four staff assigned to the assisted living unit. At the time of inspection, there were 14

residents in the “Willows” unit and 44 residents in the assisted living. I observed many residents in the assisted living area and all residents in the “Willows” unit. The residents appeared well groomed, dressed, and were sitting in commons areas within each area of the facility. I interviewed Employee #7 who stated the number of staff has decreased on the weekends on the “Willows” unit. I interviewed Employee #8 who stated she felt the facility was understaffed but management was working to hire more staff. I interviewed Employee #9 who stated the facility is understaffed. I interviewed Resident D who stated the facility has had a decrease in staff and ability to provide resident care.

On 7/15/21, I received documentation from director of nursing Susan Stubbins. I reviewed a list of 20 employees who were hired in April and May 2021, however two employees never started their employment, and seven employees were no longer employed with the facility.

On 7/20/21, I conducted a telephone interview Ms. Stubbins. Ms. Stubbins stated the facility tries to staff 3-4 charge aides or nurses and 4-5 resident aides on both first and second shifts, as well as 1-2 charge aides with 2-3 resident aides on third shift. Ms. Stubbins stated staff work together as a team and communicate by walkie talkies if they need assistance. Ms. Stubbins stated she is currently interviewing and hiring additional staff.

I reviewed the staffing schedule from May and June 2021. The schedule read consistent with statements from Ms. Stubbins. The “Willows” unit schedule read one nurse or charge aide and two resident aides was assigned to the unit on most days.

I reviewed the facility’s levels of care. Level 1 read the resident will receive basic services with medication administration and is independent with all personal care. Level 2 read the resident will receive basic services with medication administration, apartment to be straightened daily and verbal cueing for activities of daily living. Level 3 read the resident will receive basic services with medication administration, shower assistance and is independent with personal care. Level 4 read the resident will receive basic services with medication administration, assistance with all personal care and one person assist with transfers and mobility along with assistance with feeding. Level 5 read the resident will receive basic services with medication administration, assistance with all personal care and two person assists with transfers and mobility along with assistance with feeding. Willows level of care requires all care plus a higher staff to resident ratio in a secure unit. Review of the residents’ levels of care record revealed four residents received Level 1 care, 11 residents received Level 2 care, 13 residents received Level 3 care, 12 residents received Level 4 care, and two residents received Level 5 care. There were two residents in the assisted living receiving “Willows” level of care. There were 14 residents in the “Willows” unit receiving the Willows level of care.

I reviewed seven resident service plans. The service plans read consistent with the level of care assigned to each resident.

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:	Interviews with staff and residents along with review of documentation revealed the facility staff the units according to the residents' assigned levels of care and consistent with their service plans. Facility documentation revealed Ms. Stubbins has hired additional staff. Based on this information, this allegation cannot be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents are not receiving their showers.

INVESTIGATION:

On 6/24/21, the department received an anonymous complaint alleging residents were not receiving assistance with their scheduled showers.

On 6/28/21, I conducted an on-site inspection at the facility. I observed approximately 30 residents in the facility. The residents appeared to be groomed and dressed in clean clothing. I interviewed Employee #3 who stated staff are to initial on the Daily Flow Sheet that they have provided resident care such as bathing, grooming, and dressing for each assigned resident on their shift. I interviewed Resident A, Resident B, Resident C and Resident D who stated facility staff assist with their showers on their assigned shower days along with any additional care needs.

I reviewed the June 2021 resident daily flow sheets in which staff sign their initials as they provided care for morning and night shift. The Hall 4 resident daily flow sheet for morning care was not marked with staff initials on the following dates: 6/2, 6/3, 6/7, 6/16, 6/21, 6/26, 6/28, 6/29, and 6/30. The Hall 4 resident daily flow sheet for night care was not marked with staff initials on the following dates: 6/4, 6/7, 6/8, 6/15, 6/21, 6/24, 6/25, 6/28, 6/29, and 6/30. The Hall 2 resident daily flow sheet for night care for was not marked with staff initials on the following dates: 6/4,6/7, 6/8, 6/11, 6/15, 6/21, 6/24, 6/25, 6/26, 6/28, 6/29, and 6/30. The Hall 3 resident daily flow sheet for night care for was not marked with staff initials on the following dates: 6/3, 6/5,

6/7, 6/12, 6/16, 6/19, 6/27, 6/28, 6/29, and 6/30. The Willows unit resident daily flow sheet for morning care for the was not marked with staff initials on the following dates: 6/29 and 6/30. The Willows unit resident daily flow sheet for night care was not marked with staff initials on the following dates: 6/26, 6/27, 6/28, 6/29 and 6/30.

On 7/20/21, I conducted a telephone interview Ms. Stubbins. Ms. Stubbins stated the resident Daily Flow Sheets are to be initialed by staff daily for each resident to verify care such as showers, grooming and oral care was provided. Ms. Stubbins stated the Daily Flow Sheets are not a written requirement and resident aides have left their shift without initialing the documentation. Ms. Stubbins stated staff provided resident care but may not always initial that the care was provided.

APPLICABLE RULE	
R 325.1933	**Personal care of residents.**
	(1) A home shall afford a resident the opportunity and instructions when necessary for daily bathing, oral and personal hygiene, daily shaving, and hand washing before meals. A home shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Observation, interviews with facility staff and residents, along with review of facility documentation revealed the facility has a procedure staff are trained on to account for care provided to residents. However, review of this document establishing resident care revealed many dates on Daily Flow Sheets were left blank. It cannot be determined if residents received their showers or not. Given the training provided and the availability of the sheets to complete this task, it minimally reflects the possibility of care not provided.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility has bed bugs.

INVESTIGATION:

On 6/24/21, the department received an anonymous complaint alleging the facility had an infestation of bed bugs.

On 6/28/21, I conducted an on-site inspection at the facility. I observed the furniture including multiple chairs and couches throughout the assisted living. I interviewed facility staff. Employee #1 stated the facility has monthly visits from Rose Pest Solutions and they also bring in their dog. Employee #2 stated she thought rooms 114 and 153 had bed bugs a few months ago but that the facility sprayed for them. I observed seven resident rooms and did not observe bed bugs or any type of bug. I lifted and observed under the mattresses of resident rooms 114 and 153 and did not observe bed beds or any signs of bed bugs. I interviewed five residents who denied observing any bugs within the facility or bugs in their rooms. I interviewed two contracted Genesis therapists in the facility who denied any observations of an insect infestation or bed bugs in resident rooms.

On 7/20/21, I conducted a telephone interview with Ms. Stubbins. Ms. Stubbins stated the facility had bed bugs around July 2018. Ms. Stubbins stated the facility does not currently have bed bugs, but occasionally they have sand ants in the front lobby area. Ms. Stubbins stated Rose Pest Solutions conducts inspections every other month but may inspect the facility monthly if needed.

I reviewed the facility's Rose Pest Solutions Service Inspections Reports. The service inspection report from January 2021 read the Rose Pest Solution K9 team visited, and no bed bugs were identified. The service inspection report from February 2021 read no pest activity was noted during their service. The service inspection report from March 2021 read the inspection was completed by the K9 unit and no live bed bugs were identified. The service inspection report from May 2021 read the front lobby was treated for ants on 5/14 and the K9 team inspected the facility on 5/20 in which no bed bugs were identified. The service inspection report from June 2021 read there were no bed bugs at that inspection.

APPLICABLE RULE	
R 325.1978	**Insect and vermin control.**
	(1) A home shall be kept free from insects and vermin.
ANALYSIS:	Observations at the time of inspection, staff and resident interviews along with review of facility documentation revealed the facility does not have an infestation of bed bugs. Based on these findings, this allegation cannot be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility has an employee with a history of abuse working.

INVESTIGATION:

On 6/24/21, the department received an anonymous complaint alleging the facility an employee who was re-hired had a history of abusing residents.

On 7/15/21, I received hired staff documentation from Ms. Stubbins. I reviewed a list of employees who were hired from April and May 2021. There were 19 new employees hired. Per written correspondence with Ms. Stubbins, two of those employees were re-hired back to the facility. I reviewed the background checks for the 19 employees which revealed they all were eligible for hire; however some no longer work at the facility.

I reviewed the facility's file from January 2020 to July 2021. I reviewed the exclusionary notices submitted to the department and the applicants were not employed with the facility.

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: **(a) Assume full legal responsibility for the overall conduct and operation of the home.**
ANALYSIS:	Review of facility documentation revealed the facility did not have excluded employees hired.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility is not reporting falls.

INVESTIGATION:

On 6/24/21, the department received an anonymous complaint alleging a resident had fallen which resulted in a head injury and the department was not notified.

On 6/28/21, I conducted an on-site inspection at the facility. I interviewed eight staff members who could not recall a resident who had fallen with a head injury.
I interviewed two contracted Genesis therapists who stated Resident H had a fall about a month ago but could not recall an injury.

On 7/20/21, I conducted a telephone interview Ms. Stubbins. Ms. Stubbins stated Resident H had a fall with head injury and it was reported to the department. Ms. Stubbins stated Resident H is doing well and did not require emergency care.

I reviewed the department's facility file which read consistent with statements from Ms. Stubbins. Resident H's incident report read she had a fall on 6/4/21 with a laceration to the back right side of her head. The report read Resident H's authorized representative and physician were notified, was well as the department.

I reviewed Resident H's service plan which was consistent with statements from Ms. Stubbins.

I reviewed the facility's internal incident reports which reported incidents to the resident's authorized representatives and physician, but not to the department. Three incident reports read Resident C had falls without injury on 5/4/21, 5/5, and 5/18. Incident report for Resident F read he fell on 5/5 resulting in a skin tear to his left upper arm. Incident report for Resident G read he fell on 5/25 resulting in a skin tear to his left hand between his fingers. Incident report for Resident K read she had an incident resulting in a skin tear to the right wrist. Incident report for Resident J read staff observed an open area on his right forearm with drainage after being outside the facility.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(2) 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.
For Reference: R325.1901	**Definitions.**
	(17) "Reportable incident/accident" means an intentional or unintentional event in which a resident suffers harm or is at risk of more than minimal harm, such as, but not limited to, abuse, neglect, exploitation, or unnatural death.

ANALYSIS:	Interviews with staff and review of facility documentation revealed Resident H's fall with injury was reported to the department. Review of the facility's internal incident reports revealed Resident C had multiple falls within a short time frame. Review of internal incident reports for Residents F, G, K and J revealed all had falls with injuries not reported to the department. Multiple falls, as well as falls with injuries, place a resident at risk for more minimal harm therefore should be reported to the department. Based on this information, this allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 8/19/2021, I shared the findings of this report with licensee authorized representative Paul Buchholz. Mr. Buchholz verbalized understanding of the findings.

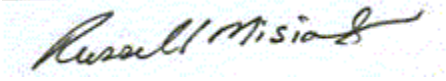
IV. RECOMMENDATION

Contingent upon a receipt of an acceptable correction action plan, I recommend the status of the license remain unchanged.

7/28/21

Jessica Rogers Date
Licensing Staff

Approved By:



8/19/21

Russell B. Misiak Date
Area Manager