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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 11, 2021

Paul Wyman
Living Management of Allendale, LLC
1845 Birmingham S.E.
Lowell, MI 49331

RE: License #: AL700380147
Investigation #: 2021A0350052
Green Acres of Allendale

Dear Mr. Wyman:

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.

If you desire technical assistance in addressing these issues, please 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 (616) 356-0100.

Sincerely,

Ian Tschirhart, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 644-9526

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL700380147
Investigation #:	2021A0350052
Complaint Receipt Date:	08/02/2021
Investigation Initiation Date:	08/02/2021
Report Due Date:	09/01/2021
Licensee Name:	Living Management of Allendale, LLC
Licensee Address:	1845 Birmingham S.E. Lowell, MI 49331
Licensee Telephone #:	(616) 897-8000
Administrator:	Paul Wyman
Licensee Designee:	Paul Wyman
Name of Facility:	Green Acres of Allendale
Facility Address:	11289 Commerce Drive Allendale, MI 49401
Facility Telephone #:	(616) 892-1200
Original Issuance Date:	07/28/2016
License Status:	REGULAR
Effective Date:	01/28/2021
Expiration Date:	01/27/2023
Capacity:	20
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
On 5/10/2021, Resident A was dropped by staff while being assisted into a Hoyer Lift, but there was no doctor's order for the use of a Hoyer Lift for Resident A.	Yes
Resident A's DPOA (Durable Power of Attorney) was not notified about the fall Resident A had on 05/10/2021.	No
Medical attention was not sought until several weeks later for Resident A after the fall she had on 05/10/2021.	Yes

III. METHODOLOGY

08/02/2021	Special Investigation Intake 2021A0350052
08/02/2021	Special Investigation Initiated - Letter I sent an email to Relative 1 requesting documents
08/02/2021	Contact - Document Received I received an email from Relative 1 with the documents attached
08/03/2021	Contact - Document Sent I sent an email to Loren Duemler, Administrator requesting information and informing her of my visit on 08/04
08/03/2021	Contact - Document Received I received an email from Ms. Duemler with the requested information and confirming my inspection on 08/04
08/03/2021	Contact - Telephone call made I called and spoke with Lindsey Matsumoto, DCW
08/03/2021	Contact - Document Sent I sent Ms. Duemler another email
08/03/2021	Contact - Document Received I received another email from Ms. Duemler
08/04/2021	Contact - Face to Face I met with Ms. Duemler, and spoke with Resident A privately
08/06/2021	Contact – Telephone call made

	I spoke with Relative 2/DPOA
08/11/2021	Exit conference – Held with Paul Wyman, Licensee Designee

ALLEGATION: On 5/10/2021, Resident A was dropped by staff while being assisted into a Hoyer Lift, but there was no doctor's order for the use of a Hoyer Lift for Resident A.

INVESTIGATION: On 08/02/2021, I sent an email to Relative 1, requesting the x-rays, medical report, and Incident Report regarding this matter. It was stated in the Online Complaint form that Relative 1 offered to send these to the person investigating this alleged incident.

On 08/02/2021, I received an email from Relative 1 with the above-mentioned documents attached.

On 08/03/2021, I sent an email to Loren Duemler, Administrator, informing her that a complaint was made and regarding which resident. I also requested the names and cell phone numbers of the staff members who worked the shift on 05/10 during which Resident A either fell or was dropped. I further requested for Ms. Duemler to meet with me at this facility on 08/04 between 10:45 and 11:00 a.m.

On 08/03/2021, Ms. Duemler sent me an email containing the requested names of the staff members and their phone numbers. There were also two Incident Reports (IR) attached, both dated 05/10/2021.

The IR with the time of 6:28 a.m. states, *"While assisting (Resident A) to toilet using 2 person assist and hoyer, resident slide off toilet. Resident was sitting up in front of the toilet…Resident was assisted up with 2 person assist and hoyer to bed -Notified on call [sic]."* In the section titled "Corrective Measures Taken to Remedy and/or Prevent Recurrence" this IR states, *"Encourage resident to follow physician order, obtain order for hoyer chair use, staff reeducation on care plan guidelines [sic]."* This IR indicates that Lindsey Matsomoto was the assigned staff person for Resident A at the time of this incident

On 08/03/2021, I called and spoke with Ms. Matsumoto who reported that Resident A was not dropped during her shift but did slide off the toilet once and fell from a standing position a little bit later. Ms. Matsumoto explained that she and Ms. Jackson used a Hoyer Lift to transfer Resident A onto the toilet and that Resident A must have leaned forward causing the clip-on toilet seat to break and she fell off. Ms. Matsumoto informed me that Ms. Jackson called Ms. Duemler, who was the on-call person, but she wasn't sure what was said. Ms. Matsumoto told me that at about 6:28 a.m., she was transferring Resident A using an ETAC, a device she informed me is used to help a person stand and transfer, and she was also holding Resident A with a gait belt. She stated that Resident A then fell, but Ms. Matsumoto said it

was a “controlled fall” because she was still holding the belt, easing the fall somewhat. She said that Resident A hit part of her wheelchair and then landed on her “rear end.” Ms. Matsumoto told me that she was trained on how to use a Hoyer Lift but couldn’t remember if it was before or after this incident. Ms. Matsumoto stated that she didn’t contact either Von Vitto, NP or Relative 2 because the standard procedure was for someone on 1st shift to make these kinds of contacts.

On 08/03/2021, I sent Ms. Duemler another email requesting the following information: Proof of Hoyer Lift training for Lindsey Matsumoto and Sidnie Jackson, Medical document approving Resident A for Hoyer Lift use, phone numbers for Relative 2 and Von Vitto, NP, and sections of Resident A’s Assessment Plan about her need of staff assistance (or complete Assessment Plan).

On 08/03/2021, I received another email from Ms. Duemler stating she will have the requested information ready for me at our meeting on 08/04. She added that she would have ready “all notes/observations from the days surrounding the day and all notes and steps taken since recent reports of protrusion on left hip area.”

On 08/04/2021, I made an onsite inspection and met with Ms. Duemler. We discussed the allegations further and she provided me with several documents. I then requested to speak with Resident A and Ms. Duemler took me to her apartment. Ms. Duemler showed me Resident A’s ETAC and explained how it is used. We also looked at the clip-on toilet seat in Resident A’s bathroom. Ms. Duemler lifted it and it came off very easily. We looked to see if it was broken, but it wasn’t, it just doesn’t secure very tightly. At this point, Ms. Duemler left and I spoke with Resident A alone.

Resident A stated that while a Ms. Matsumoto was transferring her from the ETAC to her wheelchair in her bathroom, she “let go” and fell. Resident A informed me that then two staff members, Ms. Matsumoto and Ms. Jackson, used a gait belt, one holding the front of the belt, the other the back, and they tried lifting her onto the seat of a Hoyer Lift. They couldn’t do it and dropped her onto the floor. One of the staff members asked her if she was hurt, and she said, “Yes, my rear end.” Resident A said that staff got the Hoyer Lift out and called for a third staff and they were able to get her into her wheelchair.

On 08/04/2021, while still onsite, I spoke further with Ms. Duemler, who said that Resident A has COPD (Chronic Obstructive Pulmonary Disease) and has gotten pneumonia a few times. Ms. Duemler stated that when these conditions “act up”, Resident A gets weak. She added that Resident A had pneumonia at the time of this incident. Ms. Duemler informed me that prior to this incident there wasn’t a physician’s order for a Hoyer Lift to be used with Resident A, but an order was obtained the same day, after this incident. Ms. Duemler reported that the use of a Hoyer Lift was not in Resident A’s Care Plan, but her plan will be updated to reflect this change. Ms. Duemler told me that all staff members had been trained on how to use a Hoyer Lift before this incident occurred, but because the use of one was not in

Resident A's Care Plan, the staff members handling this situation should have called 9-1-1.

On 08/05/2021, I reviewed the documents that Ms. Duemler provided me. I observed training records for Ms. Matsumoto and Ms. Jackson, which showed they were both trained on how to use a Hoyer Lift (Ms. Matsumoto on 02/15/2021 and 02/26/2021; and Ms. Jackson on 08/19/2020). Resident A's Level of Care Assessment states that she is a one-person assist getting in and out of the spa tub, and "minor asst needed getting into w/c (wheelchair)" and "min assist needed w/ prep and mobility." The plan also states that Resident A requires one-person assistance with the ETAC and getting her in and out of her wheelchair. There was no mention of a Hoyer Lift in her Care Plan. I saw a script written by Mr. Vitto, NP, which was dated 05/10/2021, ordering that Resident A be sent to the ED for further evaluation and management, and approving the use of a Hoyer Lift with Resident A.

On 08/11/2021, I called and held an exit conference with Paul Wyman, Licensee Designee and informed him that I was citing violation of this rule and why. Mr. Wyman agreed with this finding and had no further comments.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Two staff members, Lindsey Matsumoto and Sidnie Jackson, attempted to use a Hoyer Lift with Resident A. There was no doctor's order authorizing the use of a Hoyer Lift for Resident A at that time. Even though Ms. Matsumoto and Ms. Jackson were trained on how to use a Hoyer Lift, they were not successful in getting Resident A in it, and she fell on her buttocks onto the bathroom floor. Loren Duemler, Administrator, stated that it was not in Resident A's Care Plan for a Hoyer Lift to be used with her and that one of these staff members should have called 9-1-1 to assist in lifting and transferring Resident A. My findings support that this rule had been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A's DPOA (Durable Power of Attorney) was not notified about the fall Resident A had on 05/10/2021.

INVESTIGATION: On 08/03/2021, I reviewed the documents sent to me from Relative 1. The “Fall Incident Checklist” shows that Resident A fell or was dropped two times on 05/10/2021, once at 6:00 a.m. and again at 6:28 a.m. This checklist does not have a check next to the box that says, “Notified resident’s DPOA via phone.”

On 08/03/2021, Ms. Duemler sent me an email containing the requested names of the staff members and their phone numbers. There were also two Incident Reports (IR) attached, both dated 05/10/2021.

On 08/03/2021, I reviewed the two IRs pertaining to this matter. They both state, “Notified on call” and show that Von Vitto, NP and Relative 2/Legal Guardian were notified at 12:00 p.m. on 05/10 of this incident, but they do not state how they were notified (i.e., phone, Email, etc.).

On 08/03/2021, I called and spoke with Ms. Matsumoto who stated that she didn’t contact either Von Vitto, NP or Relative 2 because the standard procedure was for someone on 1st shift to make these kinds of contacts.

Resident A stated that Relative 2, who is also her DPOA, and a nurse were notified immediately after this incident occurred.

On 08/04/2021, I made an onsite inspection and met with Ms. Duemler, who said she was the one who contacted Relative 2 and Von Vitto, NP; however, she spoke with Relative 2’s spouse, Relative 3, who is involved in Resident A’s life and she (Relative 3) said she would tell Relative 2 what had happened.

On 08/05/2021, I reviewed the documents that Ms. Duemler provided me. I observed a script written by Mr. Vitto, NP, which was dated 05/10/2021, ordering that Resident A be sent to ED for further evaluation and management.

On 08/06/2021, I called and spoke with Relative 2, who is also Resident A’s DPOA. Relative 2 stated that his wife, Relative 3, was contacted about these incidents on the day they happened, and she told him about them “almost immediately." Relative 2 informed me that Relative 3 is very involved in Resident A’s life and visits her “very often.”

On 08/11/2021, I called and held an exit conference with Paul Wyman, Licensee Designee and informed him that I was not citing violation of this rule and why. Mr. Wyman thanked me for informing him of this and had no further comments.

APPLICABLE RULE	
R 400.15311	**Investigating and reporting of incidents, accidents, illnesses, absences, and death.**

	A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensee division within 48 hours of any of the following: **(b) Any accident or illness that requires hospitalization.**
ANALYSIS:	Loren Duemler attempted to contact Relative 2, who is Resident A's DPOA, on the day of these incidents (05/10/2021). She was unable to make contact with Relative 2, but she informed Relative 3, who is Relative 2's spouse, of these incidents, and Relative 3 said she would inform Relative 2. Relative 2 confirmed that his wife, Relative 3, was contacted the day of these incidents and that she relayed the information to him "almost immediately." My findings do not support that this rule had been violated.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Medical attention was not sought until several weeks later for Resident A after the fall she had on 05/10/2021.

INVESTIGATION: On 08/03/2021, I reviewed the documents sent to me from Relative 1. A document called "Fall Incident Checklist" shows that Resident A fell or was dropped two times on 05/10/2021, once at 6:00 a.m. and again at 6:28 a.m. This document and a "Fall Evaluation Form" show that a Range of Motion check was done and vital statistics were taken on Resident A. There is no mention of Resident A being examined by a medical professional in these documents.

On 08/03/2021, I reviewed the two IRs regarding these incidents. Both show that Von Vitto, NP, was notified on 05/10/2021. The IR for the second incident that happened at 6:28 a.m. states that Resident A said she "didn't want to be sent to the hospital."

On 08/03/2021, I called and spoke with Ms. Matsumoto who reported that she didn't contact Von Vitto, NP because the standard procedure was for someone on 1st shift to make these kinds of contacts.

On 08/04/2021, I made an onsite inspection and spoke with Resident A who stated that a nurse was notified immediately after this incident occurred, but she was not seen by a medical professional, either a nurse or doctor, until several weeks after this incident. She reported that about three weeks after this incident, a male staff

member noticed a “knob” on her hip; and then, upon a routine examination by a visiting nurse and that nurse took an x-ray of her hip.

On 08/04/2021, while still onsite, I spoke further with Ms. Duemler, who said she contacted Von Vitto, NP on 05/10/2021 by phone and that Mr. Vitto sent an order the same day.

On 08/05/2021, I reviewed the script written by Mr. Vitto, NP, which was dated 05/10/2021. Mr. Vitto ordered that Resident A “…be sent to ED (Emergency Department) for further evaluation and management” and approved the use of a Hoyer Lift with Resident A. As stated in one of the IRs, Resident A refused to go to the ED at that time. A Progress Note dated 05/13/2021 shows that Mr. Vitto, NP, examined Resident A at Green Acres on that date. Mr. Vitto ordered Oxycodone for Resident A and for staff members to “apply cool compress to right shin for 15 to 20 minutes for 3 days”, he did not order her to be seen by a specialist or her Primary Care Physician.

I looked through a document called Observations of (Resident A), which is equivalent to staff or progress notes. I noticed on 07/13/2021 an entry was made by Glenda Van Beek, PTA from At Home Rehab that states a staff member told Ms. Van Beek that Resident A had a *“bump” on her left hip and Ms. Van Beek inspected it and noted: “Nodule on L hip just post to old incision, non tender but prominent. No redness currently but should be seen by PA/MD. Lauren, RN, is aware and will have MD see her at next visit here [sic].”* A fax was sent by Ms. Duemler on 07/16/2021 to HTP, Resident A’s doctor’s office, requesting an x-ray and evaluation of Resident A’s left leg. The Order Form from Careline Physician Services regarding an examination of Resident A on 07/20/2021 states that she was diagnosed with “Other specified complication of internal orthopedic prosthetic devices, implants and grafts, subsequent encounter” and “Pain in left hip.” This document shows that the services ordered were “Non-weight bearing status with use of hoyer lift, unless (Resident A) indicates otherwise. (Resident A) will f/u with Ortho on 07/26/2021.” I also reviewed an entry made on 07/26/2021 from the Observations document, which states, “Resident returned from doctor’s appointment this afternoon.” In Resident A’s information sheets generated by Green Acres, it shows that she had previously been diagnosed with a “Periprosthetic fracture around internal prosthetic left hip joint, sequela” on 01/17/2019, when she resided at another facility.

On 08/10/2021, I called and spoke with Resident A. I reminded Resident A of who I was and that we met and spoke last week at Green Acres. Resident A remembered who I was. I asked Resident A if staff offered to call 9-1-1 and have her sent to the ED, but she said no one offered that to her. Resident A informed me that she “thought her leg was broken,” and that she had a hand-sized bruise on her right leg after these incidents (falls to the floor). She said that if she were offered to go to the hospital, she would have said “Yes” because she was in a lot of pain.

On 08/10/2021, I called and spoke with direct care worker Sidnie Jackson, who worked with Ms. Matsumoto the shift these incidents occurred. I asked Ms. Jackson if either she or Ms. Matsumoto asked Resident A if she wanted to go to the hospital, and she said that she asked Resident A, but she didn't want to go. Ms. Jackson reported that Ms. Matsumoto checked Resident A over for injuries, did a ROM test with her, and took her vitals.

On 08/11/2021, I called and held an exit conference with Paul Wyman, Licensee Designee and informed him that I was citing violation of this rule and why. Mr. Wyman said that although he believes his staff do a very good job, "sometimes we hit a foul ball." I informed him that a corrective action plan was due in 15 days, and he stated that he would get that to me as soon as possible

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Loren Duemler, Administrator, called Von Vitto, NP, on 05/10/2021, the date of these incidents. Mr. Vitto sent an order stating that Resident A should be taken to the ED (Emergency Department). Immediately after both incidents of Resident A falling to the floor on 05/10/2021, staff reportedly asked Resident A her about pain, assessed her ROM (Range of Motion) and took her vital statistics. Staff reported that no injuries were observed. In addition, Ms. Jackson reportedly asked Resident A if she wanted to go to the ED, but Resident A refused. Resident A was not examined by medical personnel after her 05/10/2021 falls until 05/13/2021, when Mr. Vitto examined her at the facility. Mr. Vitto found that Resident A had "Limited left leg movement," and "Maroonish bruising on right anterior leg secondary to recent fall." Mr. Vitto, NP, ordered Oxycodone for Resident A and for staff members to "apply cool compress to right shin for 15 to 20 minutes for 3 days." In my first interview of Resident A, she said that a nurse was contacted immediately after her second fall. However, upon the second interview, she said that no staff member asked her if she wanted to go to the hospital.

	I am citing a violation of this rule because medical staff advised that Resident A be sent to the ED but she was not taken. In addition, Resident A reported that she was hurt and would have gone to the hospital if it had been offered.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon an acceptable corrective action plan, I recommend that the status of this facility's license remain unchanged, and that this special investigation be closed.

August 11, 2021

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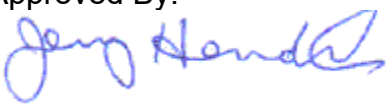
Ian Tschirhart — Date
Licensing Consultant

Approved By:



August 11, 2021

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Jerry Hendrick — Date
Area Manager