GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 19, 2021

Jessica Boucher
Pinecrest MCF Board
PO Box 603
Powers, MI 49874

RE: License #: AS210278290
Investigation #: 2021A0221014
Whispering Pines Gladstone

Dear Ms. Boucher:
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 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 (906) 226-4171.

Sincerely,

Theresa Norton, Licensing Consultant
Bureau of Community and Health Systems
234 West Baraga
Marquette, MI 49855
(906) 280-2519

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS210278290
Investigation #:	2021A0221014
Complaint Receipt Date:	07/23/2021
Investigation Initiation Date:	07/26/2021
Report Due Date:	09/21/2021
Licensee Name:	Pinecrest MCF Board
Licensee Address:	Main Street Powers, MI 49874
Licensee Telephone #:	(906) 497-2551
Administrator:	Jessica Boucher
Licensee Designee:	Jessica Boucher
Name of Facility:	Whispering Pines Gladstone
Facility Address:	416 S 17th Street Gladstone, MI 49837
Facility Telephone #:	(906) 428-3012
Original Issuance Date:	11/10/2005
License **Status:**	REGULAR
Effective Date:	05/10/2020
Expiration Date:	05/09/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
A staff member of the facility is being verbally abusive to Resident A.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/23/2021	Special Investigation Intake 2021A0221014
07/26/2021	Special Investigation Initiated - On Site
07/26/2021	Contact - Face to Face Interview with Staff Didgett Weber and Staff Richard Campbell.
07/27/2021	Contact - Telephone call made Phone call to Bernie Bouty, Asst. Administrator.
07/27/2021	Contact - Telephone call made Phone call to Recipient Rights Officer Faye Witte.
08/02/2021	Inspection Completed On-site Interviews with Staff Kathy Lindholm, Staff Nikki Syverston and Home Manager Jamie Dabney with Recipient Rights Officer Faye Witte.
08/05/2021	Contact - Document Received St. Francis Hospital discharge orders for Resident A received.
08/10/2021	Exit Conference Exit interview with Administrator Jessica Boucher.
08/19/2021	APS Referral Telephone call to Delta County APS worker Shawn Maki.

ALLEGATION: A staff member of the facility is being verbally abusive to Resident A.

INVESTIGATION: On 07/23/2021 a complaint was received in this office. The anonymous complainant reported: “There is an unknown staff member is verbally abusive to the patients at the home. She is constantly heard to be yelling and cursing at the patients. On 7/22/21 She was heard to tell one of the residents to "Get your ass out of that chair" and to tell someone else to "brush your f'ing teeth". The unknown staff has been verbally abusing the patients for at least 10 months. It is unknown if the staff member is physically abusive to the patients.” The complainant is anonymous and could not be contacted for further information.

An unannounced inspection was conducted at the facility on 07/26/2021. Staff Didgett Weber and Staff Richard Campbell were interviewed. It was discovered that Resident A was currently in the hospital with a muscular issue. On 08/02/2021, interviews were conducted in conjunction with Recipient Rights Officer Faye Witte. Interviews were conducted with Staff Nikki Syverston and Home Manager Jamie Dabney. When questioned concerning the allegations, two staff reported that Staff Kathy Lindholm has been heard being “rude” or “using a loud voice” to two of the residents. One example was reported that Staff Kathy Lindholm is “very loud and demanding with two female residents.” (Resident A and B). i.e. “Go clean up!!” and “Hurry up!”.

Home Manager Jamie Dabney stated that Staff Kathy Lindholm has a “stern/parental voice”. Ms. Dabney stated that Ms. Lindholm has been disciplined in the past for using a “harsh voice” toward residents. Ms. Dabney stated she has never heard that Ms. Lindholm has sworn at residents, but stated she has been told by other staff that Ms. Lindholm uses a “loud voice” when speaking to particularly Resident A and Resident B.

It was determined that Resident A is the only resident in the home that brushes her own teeth/dentures. Resident A has limited verbal skills and was not interviewed due to the fact she is an unreliable reporter. The other residents that reside in the home are all nonverbal.

Staff Kathy Lindholm was interviewed on 08/02/2021. Ms. Lindholm was told of the allegations. Ms. Lindholm stated, “I do have a loud voice and I have raised my voice at (Resident A) to get her attention.” Ms. Lindholm continues as and stated, “I do curse and it (a word) could have slipped out.” When asked what she does when Resident A does not respond to the ‘loud voice’, Ms. Lindholm stated, “I just walk away and then come back and try again.” When asked about telling Resident A to ‘go brush her f’ing teeth’, Ms. Lindholm stated “I could have”.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(f) Subject a resident to any of the following:** **(ii) Verbal abuse.**
ANALYSIS:	Information gathered through interviews concur that Staff Kathy Lindholm had subjected Resident A to verbal abuse. Two staff have witnessed Staff Kathy Lindholm using a "loud voice" with Resident A and Resident B. Ms. Lindholm has been disciplined for using a "harsh voice" with residents in the past. Ms. Lindholm admitted to using a "loud voice" with Resident A and stated, "a curse word may have slipped out."
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: During the course of the investigation, it was discovered that Resident A was admitted to the hospital on 07/22/2021 for a condition called rhabdomyolysus. Upon further review, it was discovered that Resident A had slept on the hard floor of her bedroom the night before.

Resident A suffers from Downs Syndrome and is clinically obese and has limited vocabulary. There is only one staff on per night shift due to no necessary two-person transfers or residents assessed to need additional care/aid.

Staff Kathy Lindholm had worked alone the evening on 07/21-07/22. The following information was taken from interviews with staff, incident reports, St. Francis Hospital records, and the "communication log" from the facility:

In the 08/02/2021 interview with Staff Kathy Lindholm, she stated that Resident A had been 'having behaviors' the evening of 07/21-07/22. Ms. Lindholm stated that Resident A was in the bathroom and refused to get up before going to bed. Ms. Lindholm stated Resident A "crawled" to her bedroom and 'chose' to sleep on the floor. Ms. Lindholm stated she asked Resident A if she wanted to sleep on the hard floor, and Resident A stated she did. Ms. Lindholm stated, "We are told it is the residents right to sleep wherever they want." Ms. Lindholm stated she gave Resident A a blanket and pillow and closed her door. Ms. Lindholm stated she

would check on Resident A every 15 minutes and she was sleeping on the floor. Ms. Lindholm stated, “We are told not to wake up the residents.” Ms. Lindholm stated, “In hindsight, I would have given her a mattress on the floor.”

Ms. Lindholm worked until 7:00AM on 07/22/21 and Staff Didgette Weber came in the morning to relieve Ms. Lindholm to find Resident A on the floor. Ms. Weber stated she tried to get Resident A off the floor and was successful to get her to sit on her bench in her room. Ms. Weber stated that Resident A wanted to continue to lay on the floor. Ms. Weber stated that when the Home Manager, Jamie Dabney came into the facility, she and Ms. Dabney were able to get Resident A to the bathroom and cleaned up for the day. However, Resident A was weak and having a hard time walking and balancing on her feet. Ms. Dabney stated she called 911 and Resident A was admitted to St. Francis Hospital for observation.

Resident A’s hospital records written by Nicole Linder MD, OSF Hospital, indicate high levels of CK (Creatine Kinase) due to ‘inactivity laying on a hard surface’, resulting in the muscle diagnosis of rhabdomyolysus.

On 08/10/2021, an exit interview was conducted with Administrator Jessica Boucher informing her of the findings of this report and the expectation of an acceptable corrective action plan.

On 08/17/2021, a phone call was received from Administrator Jessica Boucher informing this consultant that Staff Kathy Lindholm had been terminated. Ms. Boucher also stated that Resident A had returned to the facility and is doing well.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Staff Lindholm failed to protect Resident A by allowing Resident A to sleep for hours on the hard floor without a mat or padded area. Ms. Lindholm stated, “It is their (the residents) right to sleep where they want.” This action resulted in a hospital visit and diagnosis of rhabdomyolysus.
CONCLUSION:	**VIOLATION ESTABLISHED**

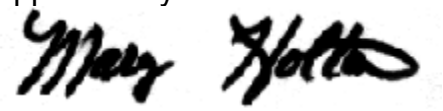
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change to the status of this license.

08/19/2021

Theresa Norton — Date
Licensing Consultant

Approved By:



08/19/2021

Mary E Holton — Date
Area Manager