GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 12, 2021

Troy Vugteveen
Holland Home Raybrook Manor
2121 Raybrook Avenue, SE
Grand Rapids, MI 49546-5793

RE: License #: AH410236821
Investigation #: 2021A1010049
Holland Home Raybrook Manor

Dear Mr. Vugteveen:

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 (616) 356-0100.

Sincerely,
Lauren Wohlfert

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410236821
Investigation #:	2021A1010049
Complaint Receipt Date:	08/25/2021
Investigation Initiation Date:	08/25/2021
Report Due Date:	10/24/2021
Licensee Name:	Holland Home
Licensee Address:	Suite 300 2100 Raybrook Ave. SE Grand Rapids, MI 49546
Licensee Telephone #:	(616) 235-5000
Administrator:	Timothy Myers
Authorized Representative:	Troy Vugteveen, Designee
Name of Facility:	Holland Home Raybrook Manor
Facility Address:	2121 Raybrook Avenue, SE Grand Rapids, MI 49546-5793
Facility Telephone #:	(616) 235-5002
Original Issuance Date:	11/10/1996
License Status:	REGULAR
Effective Date:	12/21/2020
Expiration Date:	12/20/2021
Capacity:	236
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident D was diagnosed with an acute distal fibula fracture on 7/29. Resident D sustained the fracture approximately four to five days before she received medical treatment.	No
Additional Findings	Yes

III. METHODOLOGY

08/25/2021	Special Investigation Intake 2021A1010049
08/25/2021	Special Investigation Initiated - Letter Interviewed the complainant by telephone
09/02/2021	Inspection Completed On-site
09/02/2021	Contact - Document Received Received Resident E's service plan, staff notes, and facility incident reports
09/14/2021	Contact – Telephone call made Interviewed direct care staff person Cordeidra Powell by telephone
09/21/2021	Contact – Telephone call made Message left for care staff person Diana Nichols
10/05/2021	Contact – Telephone call made Interviewed nurse Karen Uherek by telephone
10/12/2021	Exit Conference Completed with licensee authorized representative Troy Vugteveen

ALLEGATION:

Resident D was diagnosed with an acute distal fibula fracture on 7/29. Resident D sustained the fracture approximately four to five days before she received medical treatment.

INVESTIGATION:

On 8/25/21, the Bureau received the allegations by telephone from the complainant.

On 8/25/21, I interviewed the complainant by telephone. The complainant reported Resident D fell multiple times when she resided in the facility. The complainant stated Resident D was sent to the hospital on 7/29 and was diagnosed with a fractured left ankle. The complainant expressed concern that Resident D fell and fractured her ankle several days before 7/29 and did not get proper medical attention. The complainant stated hospital staff observed blood in Resident D's lower left foot and her foot was blue in color. The complainant said hospital staff reported these were signs the fracture occurred several days prior to 7/29.

The complainant reported Resident D was unable to make her needs known and could have walked on the fracture for several days without alerting staff to the fact that she was in pain. The complainant stated Resident D also had significant drywall damage in her bathroom that was not reported to Resident D's family. The complainant expressed concern that Resident D fell in her bathroom, hit her head, and may have suffered harm as a result. The complainant expressed concern that staff at the facility did not accurately report information to Resident D's family.

The complainant stated there was also an incident in which a brake on Resident D's walker was broken and in need of repair. The complainant reported Resident D's family brought the broken brake to staff's attention, however staff did not follow through with having the brake fixed. The complainant said Resident D's family contacted Carelink themselves to have the brake repaired.

On 8/25/21, I re-reviewed Resident D's incident report that I received on 8/3. The report was dated 8/3 and the *Description of Accident/Incident* section of the plan read, "Family is indicating an allegation of neglect based on a Physician Assistant's and Orthopedic clinician's report at the hospital. Family reporting fracture 4-5 days old based on bruising and staff did not detect or complete range of motion. The *Effect on Resident and/or Type/Description and Extent of Injury* section of the plan read, "[Resident D] sustained an acute distal fibula fracture with misalignment on July 29, 2021. Observations of ambulating well on July 28 and morning of July 29 in the interdisciplinary notes prior to the fall." The *Action Taken to Prevent Recurrence* section of the report read, "Hospital records reviewed. IDT notes reviewed. Timeline of falls and range of motion observations established. Dr. Reikse, PCP to review chart."

On 9/2/21, I interviewed administrator Tim Myers at the facility. Mr. Myers reported Resident D "stumbled" in the dining room on 7/28 when she attempted to stand up from her chair. Mr. Myers stated Resident D ambulated independently and used a walker for assistance. Mr. Myers said after Resident D "stumbled" out of her chair in the dining room, staff then helped her to her room and contacted the response nurse.

Mr. Myers stated the response nurse on the evening of 7/28 was Karen Uherek. Mr. Myers reported Ms. Uherek assessed Resident D and observed some swelling in

her ankle, however Resident D was able to ambulate and bear weight. Mr. Myers explained Ms. Uherek also evaluated Resident D's range of motion and found she was within her normal limits. Mr. Myers stated after the incident in the dining room on 7/28, Resident D gave staff a pain rating of three and asked for Tylenol. Mr. Myers said the Tylenol was effective. Mr. Myers said staff observed the swelling in Resident D's ankle went down as the night went on.

Mr. Myers explained medication technician Diana Nichols observed Resident D in the doorway of her room the morning of 7/29. Mr. Myers reported after this incident, Resident D could no longer bear weight. Mr. Myers said Resident D's physician was contacted and he ordered a mobile x-ray. Mr. Myers stated the x-ray showed Resident D fractured her ankle, therefore she was transported to the hospital.

Mr. Myers reported after the incident on 7/29, he reviewed video surveillance of the hallways in the secured memory care prior to 7/29. Mr. Myers stated Resident D ambulated within her normal limits. Mr. Myers said Resident D's gait was normal and she did not exhibit any symptoms of being in pain or distress.

Mr. Myers stated Resident D did not return to the facility after she was admitted to the hospital. Mr. Myers reported Resident D was admitted to the skilled nursing area on the facility's campus. Mr. Myers said it was not likely Resident D would return to the secured memory care unit in the facility.

Mr. Myers reported when Resident D's family cleaned out her room, they reported damage to the drywall in Resident D's bathroom to staff. Mr. Myers said he completed an internal investigation into the incidents on 7/28 and 7/29. Mr. Myers stated there were no reports from staff regarding damage to the drywall in Resident D's bathroom. Mr. Myers reported maintenance staff also had no knowledge regarding the damaged drywall. Mr. Myers said Resident D may have fallen in her bathroom on 7/29 and somehow got herself to the doorway of her room.

Mr. Myers said Resident D's husband informed staff that one of the brakes on Resident D's walker was broken on 6/29. Mr. Myers reported after resident services manager Julie Adelberg was made aware of the broken brake, she submitted an order to Resident D's physician regarding the brake repair. Mr. Myers stated after the order was sent, Ms. Adelberg did not follow up on it. Mr. Myers explained Resident D's husband contacted Carelink himself on 7/13 and they provided Resident D with a walker to use until they fixed her brake. Mr. Myers said Carelink fixed Resident D's brake and returned the walker to her on 7/19.

Mr. Myers stated it was the facility's procedure to contact any assistive device provider directly if there were an issue with a resident's equipment. Mr. Myers reported the facility's maintenance staff would also be notified. Mr. Myers said this procedure was not followed regarding the broken brake on Resident D's walker. Mr. Myers provided me with a copy of Resident D's *Physician's Telephone Orders* document for my review. The *MEDICATION/Order section* of the document read, "4-

wheeled walker (unsteady gait) brakes are not working properly." The document was dated 6/29 and signed by Ms. Adelberg.

Mr. Myers reported Resident D was diagnosed with progressive supranuclear palsy (PSP) which has affected her memory and ability to express herself. Mr. Myers stated Resident D experienced falls prior to 7/28 and 7/29, however none resulted in serious injury. Mr. Myers said Resident D previously fractured her ankle in 2016 when she was not a resident living in the facility.

Mr. Myers provided me with a copy of Resident D's service plan for my review. The *BED MOBILITY* section of the plan read, "Resident independent." The *TRANSFER* section of the plan read, "Resident independent." The *LOCOMOTION* section of the plan read, "Resident independent. Assistive device required walker." The *TOILETING* section of the plan read, "Resident independent." The *FALL RISK* section of the plan read, "Fall risk. Less than 2 per month. Loses balance due to PSP."

Mr. Myers provided me with a copy of Resident D's staff notes for my review. A note dated 7/28 at 6:31 pm read, "Observed 3cm/3cm old bruise on L-upper arm. fresh abrasion on L-elbow and 4cm long scratct [sic] on left wrist from resident watch. Not bleeding at this time, Also observed some old bruise on buttock. Will continue to monitor." A note dated 7/29 at 9:18 a read, "Res found laying on the floor on her rt. side in her room – unable to state if she bumped her head. Stated that she had gotten up from her chair and fell. Walker sitting next to her chair – res across room near entrance door. ROM done WNL – complaints of pain in her left ankle and stated it ha been this way – this was also documented in ID notes, possibly from previous falls. Res limping back to her chair when assisted up. Able to point and flex ankle – brusing and swelling noted. No other injuries noted from this fall. Contacted Dr. Riekse. Orders for x-ray of ankle and Homecare."

A note dated 7/29 at 1:29 pm read, "Resident has complained of left rib pain since this morning. Dr. Riekse notified and gave new orders. Chest xray – 2 views – attention to left rib area. Schedule Tylenol ES 1000mg by mouth TID, and obtain CBC & BMP today. Resident's husband, [Relative D1], notifed of oreders [sic] and agrees. Dr. Riekse wiill [sic] follow up with Resident next visit. A note dated 7/29 at 1:55 pm read, "Resident pushing call light every 5 to 10 minutes all shift. Most of the time stating she didn't need anything. Other times letting rca know of pain in her ankle and right rib."

A note dated 7/29 at 6:04 pm read, "Resident had xrays completed and results of her left ankle returned positive for a fracture. Dr. Riekse notified at 1728, and he gave order to send to ER for further evaluation. Resident's husband, [Relative D1], notified at 1739, of xray results and order for ER to eval. [Relative D1] will meet resident at Mercy Health St. Mary's ED. Life EMS contacted at 1757 for tranport [sic] to ED. Resident notified of transfer to hospital."

Mr. Myers provided me with a copy of his *INVESTIGATION/FOLLOW-UP* document for my review. The *Notes* section of the document read, “In a statement provided by Resident Care Aid (RG) [Resident D] was complaining of left ankle pain the evening shift of 7-28-21. At approximately 9:30 p.m. on 7-28-21 (RG) noticed [Resident D] left ankle swollen and alerted the response nurse for review. When (RG) observed the skin of the left ankle, she did not observe bruising. [Resident D] was given Tylenol at 3:36 p.m., at 6:00 p.m. and 10:19 p.m. for ankle pain on 7-28-21. In a statement provided by the Life Enrichment (AS) after supper at approximately 5:00 p.m. on 7-28-21 [Resident D] struggled to get up from the table. (AS) and resident care aid help support [Resident D] until she could stand. Resident was assisted back to her room sitting on her wheeled walker as she complained of ankle pain. The medication tech (RG) and the Unit Manager (JA) was notified of this event. At 4:15 p.m. on 7-28-21 the video surveillance shows [Resident D] walking to the dining room with normal gait, weight bearing on both feet with no limping observed. Interviews with staff did not indicate further observations of ankle swelling, bruising or abnormal walking or gait. Interviews and surveillance video of the Cook unit confirm [Resident D] is ambulating well, fully weight bearing with no limping or abnormal gait prior to 5:00 pm on 7-28-21.”

On 9/2/21, I interviewed Ms. Adelberg at the facility. Ms. Adelberg’s statements regarding Resident D’s care needs were consistent with her service plan and Mr. Myers. Ms. Adelberg reported Resident D knew where her call light was and knew how to use it.

Ms. Adelberg said she was not present during the incident on 7/28 or when Resident D was found in her doorway on 7/29. Ms. Adelberg reported staff informed her of the incident when she arrived to the facility on 7/29. Ms. Adelberg’s statements were consistent with Mr. Myers.

Ms. Adelberg was unable to recall when Relative D1 informed her that the brake on Resident D’s walker was broken. Ms. Adelberg reported she sent Resident D’s physician an order regarding the broken brake. Ms. Adelberg’s statements regarding Carelink and Resident D’s walker repair were consistent with Mr. Myers.

On 9/2/21, I interviewed Resident D in the skilled nursing area on the facility’s campus. I was unable to engage Resident D in meaningful conversation. I observed Resident D in a common area sitting in her wheelchair.

On 9/14/21, I interviewed direct care staff person Cordeidra Powell by telephone. Ms. Powell reported she worked the third shift overnight after Resident D fell during second shift. Ms. Powell stated during shift change, second shift staff informed her and the other third shift staff persons that Resident D fell earlier in the day. Ms. Powell said staff were informed Resident D had some swelling in her ankle, however she did not express pain and ambulated within her normal limits. Ms. Powell reported this occurred at the end of July, however she was unable to recall the exact date.

Ms. Powell explained Resident D was “off” and “not her usual self” during her entire third shift. Ms. Powell reported at the beginning of her shift, Resident D asked for a second shift staff person that she favored. Ms. Powell stated she had to explain to Resident D that the staff person was not available because she went home for the night. Ms. Powell said Resident D then began to use her call light every few minutes throughout her shift.

Ms. Powell reported when she initially responded to Resident D’s room after she used her call light, Resident D did not need any assistance. Ms. Powell stated Resident D just wanted someone to stay in her room with her. Ms. Powell said during one incident when she responded to Resident D’s call light, Resident D asked for a pair of shoes on one of her chairs. Ms. Powell reported there were no shoes on any of the chairs in Resident D’s room.

Ms. Powell stated she informed her “team leader” that Resident D continuously pushed her call light and didn’t need assistance. Ms. Powell reported she was unable to complete her “rounds” because she had to keep responding to Resident D’s room. Ms. Powell explained after she talked to her “team leader” she passed Resident D’s room and observed her standing in her doorway without her walker. Ms. Powell said Resident D told her she was going to “go back to bed.”

Ms. Powell reported not long after she observed Resident D in her doorway, Resident D pushed her call light again. Ms. Powell said when she responded to Resident D’s room, she was on the floor by her recliner chair. Ms. Powell reported Resident D told her, “well you wouldn’t help me so I put myself on the floor.” Ms. Powell stated she notified the response nurse that Resident D lowered herself on the floor.

Ms. Powell explained the response nurse during that shift was Ms. Uherek. Ms. Powell stated Ms. Uherek assessed Resident D and found she had no injuries. Ms. Powell reported Resident D lowered herself onto the floor several times during her shift to get attention. Ms. Powell said Resident D got up by herself after each incident and was assessed by Ms. Uherek. Ms. Powell stated Resident D did not suffer any injuries after she lowered herself to the floor. Ms. Powell said after each time she and Ms. Uherek responded to Resident D’s room after she lowered herself to the floor, Resident D told them she didn’t fall.

Ms. Powell reported she and her “team leader” decided it was best to have Resident D sit in a common area so she could be supervised closely. Ms. Powell stated when Resident D sat in the common area near the nurse’s station, she asked why she couldn’t sit with her in her room. Ms. Powell said she did not know why Resident D exhibited attention seeking behavior throughout her shift.

Ms. Powell stated she observed Resident D ambulated without pain and had a normal gait. Ms. Powell reported Resident D never complained of being in pain

during her shift, nor did she grimace when she ambulated or got herself up off the floor. Ms. Powell said Resident D's range of motion was normal and Ms. Uherek didn't find injuries when she assessed her.

Ms. Powell reported there were some instances when Resident D said she had to go to the bathroom when she responded to her call light. Ms. Powell explained she then observed Resident D walk to her bathroom with her walker. Ms. Powell stated Resident D was able to toilet herself independently and did not need assistance from staff. Ms. Powell said as a result, she stood outside of Resident D's bathroom while Resident D toileted herself. Ms. Powell reported she did not observe any damage to the drywall in Resident D's bathroom during her shift. Ms. Powell said she observed the swelling in Resident D's ankle went down as her shift progressed.

On 9/21/21, I attempted to interview care staff person Diana Nichols by telephone. The telephone number was disconnected. Mr. Myers reported Ms. Nichols resigned and was no longer employed by the facility.

On 10/6/21, I interviewed Ms. Uherek by telephone. Ms. Uherek reported she worked third shift the night Resident D was up throughout the night. Ms. Uherek was unable to recall the exact night this occurred in July. Ms. Uherek reported she was notified by care staff in the secured memory care unit that Resident D was up all night and ambulating around her room. Ms. Uherek said she could not recall whether staff notified her Resident D was intentionally lowering herself onto the floor. Ms. Uherek stated staff did tell her they had Resident D sit near them at the nurse's station because she was attention seeking all night.

Ms. Uherek reported she observed Resident D ambulate within her normal limits during her shift. Ms. Uherek said Resident D did not state she was in pain at any time. Ms. Uherek explained when she arrived for her shift, second shift staff informed her Resident D had a fall earlier that day. Ms. Uherek stated she did not know the details of the fall, however she assessed Resident D during the shift change. Ms. Uherek said Resident D's range of motion was within her normal limits. Ms. Uherek stated the only time Resident D expressed some discomfort during her assessment was when she "hyper flexed" Resident D's ankle. Ms. Uherek said she did observe some minor swelling in Resident D's ankle, however it did not cause Resident D pain, there was no bruising, and she was able to bear weight on it and ambulate without pain.

Ms. Uherek reported as she assessed Resident D's ankle during that shift, she observed the minor swelling had gone down. Ms. Uherek stated this led her to believe Resident D had fluid retention in her ankle. Ms. Uherek said she was informed Resident D fell the following morning and was no longer able to bear weight. Ms. Uherek reported it was believed the fall the following morning was the cause of her fracture.

Ms. Uherek stated she did not observe the bathroom in Resident D's room the night Resident D was up and ambulating all night. Ms. Uherek reported care staff in the secured memory care unit did not report any drywall damage to her. Ms. Uherek explained the care staff in the memory care unit were "very good" staff and would have alerted her if there was damage to the drywall in Resident D's room. Ms. Uherek reported care staff were trained to report any significant damage they observed in 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: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	The interviews with Mr. Myers, Ms. Powell, Ms. Uherek, along with my review of the staff notes and Resident D's service plan revealed she received care consistent with her service plan. Staff observed Resident D ambulate within her normal limitations on 7/28 and there was no indication she had a fractured ankle. When staff observed Resident D had a change in condition after she was found on the ground on 7/29, they contacted her physician and followed his instructions after a mobile x-ray was completed and found a fracture.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 9/2/21, Mr. Myers reported Resident D had previous falls at the facility with minor injuries. Mr. Myers provided me with incident reports dated 5/14, 6/17, 6/29, 7/21, and 7/23 that read Resident D sustained skin tears and abrasions after she had fallen. Mr. Myers stated these incidents were not reported to the department.

On 9/3/21, I reviewed the facility file and confirmed Resident D's incident reports that were dated 5/14, 6/17, 6/29, 7/21, and 7/23 were not received.

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 interview with Mr. Myers, along with review of the facility file, revealed Resident D had several reportable incidents that were not reported to the department.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Troy Vugteveen by telephone on 10/12. Mr. Vugteveen stated staff have been re-educated regarding incident reporting requirements.

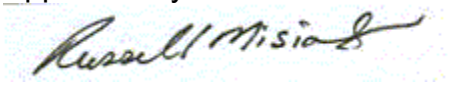
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

10/6/21

Lauren Wohlfert — Date
Licensing Staff

Approved By:



10/6/21

Russell B. Misiak — Date
Area Manager