GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 16, 2021

Theresa Bursley
AH Jenison Subtenant LLC
6755 Telegraph Rd Ste 330
Bloomfield Hills, MI 48301

RE: License #: AL700397747
Investigation #: 2021A0355041
AHSL Jenison Cottonwood

Dear Mrs. Bursley:

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,

Grant Sutton, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4437

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL700397747
Investigation #:	2021A0355041
Complaint Receipt Date:	05/19/2021
Investigation Initiation Date:	05/19/2021
Report Due Date:	07/18/2021
Licensee Name:	AH Jenison Subtenant LLC
Licensee Address:	One SeaGate, Suite 1500, Toledo, OH 43604
Licensee Telephone #:	(248) 203-1800
Administrator:	Theresa Bursley
Licensee Designee:	Theresa Bursley
Name of Facility:	AHSL Jenison Cottonwood
Facility Address:	834 Oak Crest Lane, Jenison, MI 49428
Facility Telephone #:	(616) 457-3576
Original Issuance Date:	03/11/2019
License Status:	REGULAR
Effective Date:	09/11/2019
Expiration Date:	09/10/2021
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Staff Wendy Hartman made statements about residents dying whenever that particular staff was around in front of Resident A.	Yes
Staff Keri Quist “bullied” Resident A into eating in the dining room when Resident A was in pain.	Yes
Staff Wendy Hartman implied she was untrained to give an insulin shot to Resident A prior to giving the shot and passed Resident A oral medications in a demoralizing manner.	No
The bathroom in Resident A’s room was “teeming” with ants.	No

The complainant outlined multiple instances in which she feels she and Resident A’s family were not treated in a respectful manner when they were in the facility by the staff. The situations described between staff and Resident A’s family are not regulated by Adult Foster Care Licensing. I did, however, share these situations as described with the licensee designee, Theresa Bursley, for follow up.

III. METHODOLOGY

05/19/2021	Special Investigation Intake 2021A0355041
05/19/2021	APS Referral
05/19/2021	Special Investigation Initiated - Telephone Licensee designee, by telephone
05/24/2021	Inspection Completed On-site Interviewed staff; reviewed facility file, reviewed staff schedule, inspected Resident A’s room
05/25/2021	Contact - Document Received Receipts for Rose Exterminators
05/25/2021	Contact - Telephone call made Family member #1
05/27/2021	Contact - Telephone call made Interviewed staff
06/24/2021	Inspection Completed On-site For the purpose of the upcoming license renewal
07/13/2021	Contact - Telephone call made Family member #2

07/14/2021	Exit Conference Licensee designee by telephone

ALLEGATION: Staff Wendy Hartman made statements about residents dying whenever that particular staff was around in front of Resident A.

INVESTIGATION: On 05/19/2021, I received a complaint alleging that on 03/15/2021, staff Wendy Hartman shared a story in front of Resident A in which Ms. Hartman stated that because many residents have died during her shift, co-workers jokingly refer to Ms. Hartman as the 'Angel of Death'. Resident A was on Hospice and passed away on 04/17/2021.

On 05/24/2021, I conducted an on-site investigation and interviewed staff Wendy Hartman. The licensee designee, Theresa Bursley, and wellness director, Jennifer Hicks, sat in on the interview.

Ms. Hartman acknowledged that she told the story of residents dying during her shift and how co-workers joke that Ms. Hartman is the 'Angel of Death' because she often is working when residents die. Ms. Hartman stated that she didn't recall saying it in front of Resident A but did do so to Resident A's family. Ms. Hartman described that she felt she had a good working relationship with Resident A's family and laughed with the family at the jokes they made. Ms. Hartman stated she enjoyed working with Resident A and her family.

On 05/25/2021, I interviewed by telephone Family member #1. Family member #1 stated that Ms. Hartman told family members that so many residents had died during Ms. Hartman's shift that co-workers referred to Ms. Hartman as the 'Angel of Death'. Family member #1 stated that this story was told in front of Resident A.

On 07/13/2021, I interviewed by telephone Family member #2. Family member #2 described the statement in the allegation to me before I specifically asked about it. Family member #2 stated that Resident A was already afraid of dying and the statement did nothing to assuage those feelings.

On 07/14/2021, I completed by telephone an exit conference with the licensee designee, Theresa Bursley. Mrs. Bursley accepted the findings of my investigation.

APPLICABLE RULE	
R 400.15305	**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 Wendy Hartman acknowledged that she made statements about co-workers calling her the 'Angel of Death' because residents have died during her shift. Ms. Hartman was not sure she had made the statements in front of Resident A. Family member #1 and #2 each heard Ms. Hartman make the statement about being referred to by co-workers as the 'Angel of Death' in front of Resident A. I find a preponderance of evidence to support that a rule violation has occurred.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff Kerri Quist "bullied" Resident A into eating in the dining room when Resident A was in pain.

INVESTIGATION: On 05/19/2021, I received a complaint alleging that staff Kerri Quist bullied Resident A into having lunch in the dining room on 04/10/2021. This was of particular concern since Resident A had experienced a significant fall the day before on 04/09/2021 and was experiencing a great deal of pain.

On 05/24/2021, I conducted an on-site investigation and interviewed staff Kerri Quist and staff Wendy Hartman. Mrs. Bursley and Ms. Hicks sat in on the interviews and offered information following the interviews. While on-site, I also reviewed Resident A's facility file.

Ms. Quist denied that she had ever bullied Resident A, a Hospice patient, to eat any meals in the dining room. Ms. Quist stated that since Resident A had moved into the facility in March of this year, Resident A was not steady on her feet and had experienced a number of falls in the facility. Ms. Quist stated that after the first fall, she had encouraged Resident A to allow staff to assist Resident A into her wheelchair before leaving Resident A's room. Ms. Quist stated that staff always encourage residents to eat in the dining room if they are able so that they don't isolate in their rooms. Ms. Quist stated that no resident, especially one on Hospice, is forced to eat in the dining room.

Mrs. Bursley stated that she reviewed the staff schedule and pointed out that Ms. Quist was using annual leave on 04/09, 04/10, and 04/11/2021 which Ms. Quist confirmed while still present.

Ms. Hartman was the designated med tech at the facility on 04/10/2021. Ms. Hartman denied that she or any staff forced Resident A or any resident to go to the dining room, certainly not a resident who was on Hospice.

On 05/25/2021, I interviewed by telephone Family member #1. Family member #1 stated that Resident A telephoned her on 04/10/2021 upset to the point of crying, stating to Family member #1 that Ms. Quist had forced Resident A to eat lunch in the dining room that day and Resident A complained of still being very sore after her fall on 04/09/2021.

On 05/27/2021, I interviewed by telephone staff Julie Lewis. Mrs. Bursley had identified that Ms. Lewis was the designated aide staff working with Ms. Hartman on 04/10/2021. Ms. Lewis stated that residents, even Hospice patients, are encouraged to eat in the dining room. Ms. Lewis stated that Hospice patients, in particular, tend to eat in their rooms if they don't feel like going to the dining room or if they are unable to do so.

Present in Resident A's file were observation notes completed by staff on each shift. I reviewed the following notes; staff Yahira Zamora wrote at 6:38 a.m. on 04/10/2021, "Resident asleep during rounds, no concerns voiced." Ms. Hartman wrote at 2:37 p.m. on 04/10/2021 that, "Resident (A) was painful throughout the day. Staff called Hospice to ask to advise. The on-call nurse stated to give Morphine and monitor her (Resident A's) pain. If the pain gets worse, to call for a Hospice nurse visit. At this time, the resident is resting with her feet up and seems to be in some pain but seems to be easing up a bit." At 7:57 p.m. on 04/10/2021 Ms. Hartman wrote, "Resident (A) in room most of the shift and medications taken as ordered. Vitals within normal range. In dining room for dinner. Voiced no concerns." At 6:21 a.m. on 04/11/2021, staff Deborah Link wrote, "Resident slept in bed all shift. All medications taken as prescribed. No issues and/or concerns addressed during shift."

On 07/13/2021, I interviewed by telephone Family member #2. Family member #2 resides close to the facility and stated that there were times that she would find Resident A sitting in the dining room eating when Resident A complained of being in a great deal of pain and indicating that the staff made her come to the dining room. Family member #2 stated that when she encountered Resident A in the dining room having dinner on 04/10/2021, Resident A told Family member #1, "get me out of here."

On 07/14/2021, I conducted by telephone an exit conference with the licensee designee, Theresa Bursley. Mrs. Bursley accepted the findings of my investigation.

APPLICABLE RULE	
R 400.15305	**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 Kerri Quist, Wendy Hartman, and Julie Lewis denied that they forced Resident A or any resident, in particular a resident on Hospice, to eat in the dining room. Each stated that all residents are encouraged to eat in the dining room. Family members #1 & #2 both stated that they observed that Resident A communicated to them that she felt bullied into eating in the dining room for meals. Family member #2 observed Resident A sitting in the dining room in person complaining of pain. While it is not the stated intent of the staff to force residents to eat in the dining room, in the case of Resident A, the perception of Resident A and her family was that Resident A was forced to eat in the dining room.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff Wendy Hartman implied she was untrained to give an insulin shot to Resident A prior to giving the shot and passed Resident A oral medications in a demoralizing manner.

INVESTIGATION: On 05/19/2021, I received a complaint alleging that staff Wendy Hartman implied she was untrained when giving an insulin shot to Resident A because Ms. Hartman stated to family members and Resident A that Ms. Hartman, "wasn't very good at giving shots and probably shouldn't be giving them." This occurred on 03/15/2021. On this same date, Ms. Hartman administered Resident A's oral medications by telling Resident A, "Open up" and dumped the medications in Resident A's mouth.

On 05/24/2021, I conducted an on-site investigation and interviewed staff Wendy Hartman. Mrs. Bursley and Ms. Hicks sat in on the interview. While on-site, I reviewed Ms. Hartman's training records.

Ms. Hartman stated that she is trained but did not have a lot of experience in administering shots of insulin. Ms. Hartman acknowledged telling the family she hadn't had much experience and acknowledged that this communication probably did not inspire confidence in Resident A and her family. Ms. Hartman acknowledged asking Resident A to, "open up" and dumped the medications in Resident A's mouth. Ms. Hartman stated that she didn't realize how this might come across to others. When she demonstrated to me what she had done, it was with a cheerful demeanor.

Ms. Hartman's training records indicated that she is fully trained in medication passing, including giving injections. Ms. Hicks stated that while there was no intent

in offending Resident A, the approach used in passing Resident A her oral medications is not an approach trained in medication administration.

On 05/25/2021, I contacted Family member #1 by telephone. Family member #1 stated she was present when Ms. Hartman passed Resident A's oral medications and when Ms. Hartman made the statements about being inexperienced in giving insulin shots. Family member #1 supported the statement that the approach used in passing Resident A's oral medications by Ms. Hartman was demoralizing as it appeared Ms. Hartman was treating Resident A like a child. Family member #1 supported the allegation that Ms. Hartman's statements about her inexperience in giving insulin shots was "unsettling."

On 07/13/2021, I interviewed by telephone Family member #2. Family member #2 was present when Ms. Hartman communicated her inexperience and relative discomfort in administering Resident A's insulin. Family member #2 agreed with Family member #1 that the experience was unsettling.

On 07/14/2021, I conducted by telephone an exit conference with the licensee designee, Theresa Bursley. Mrs. Bursley concurred with the findings of my investigation and she and Ms. Hicks will review approaches used with residents when passing medications with the staff at the facility.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4)(a) Be trained in the proper handling and administration of medication.
ANALYSIS:	Staff Wendy Hartman was fully trained when administering Resident A's insulin shot and Resident A's oral medications. While the statements made and the approach used did not fit the licensee's protocol for a medication tech's behavior, it does not rise to the occasion of a licensing rule violation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: The bathroom in Resident A's room was "teeming" with ants.

INVESTIGATION: On 05/19/2021, I received an allegation that Resident A's bathroom was "teeming" with ants. This was observed in the bathroom on 04/15-17/2021. 'Ant traps' were reportedly observed in the bathroom but did not seem to have an effect.

On 05/24/2021, I conducted an on-site investigation and interviewed the licensee designee, Theresa Bursley and inspected Resident A's room, in particular, the bathroom and surrounding bedrooms/bathrooms.

Mrs. Bursley stated that because the facility is built on a slab which is on sandy soil, ants can be an issue, however, the licensee has a contract with a professional exterminator who regularly sprays for the ants. Mrs. Bursley stated that this year has actually not been as big a problem as some years in the past. Mrs. Bursley stated that it was not brought to her attention that ants were a problem in Resident A's bathroom.

Resident A's room is still unoccupied following Resident A's death. I did not find evidence of ants in the room or the bathroom. There were no ant traps present. I did not observe ants in the bedrooms or bathrooms around Resident A's room.

On 05/25/2021, Mrs. Bursley sent me copies of receipts from Rose Exterminators documenting the most recent spraying in the facility. One receipt was dated 03/22/2021 and the other 04/27/2021.

On 05/27/2021, I interviewed by telephone Family member #1. Family member #1 stated that she observed the ants in Resident A's bathroom to be in fact, "teeming" out of the toilet area.

On 06/24/2021, I completed an inspection of the facility for the upcoming license renewal. I did not observe ants in the resident rooms, in particular the resident bathrooms in their rooms, in the main areas or in the 'spa' bathrooms where I have observed a few ants in past years. Mrs. Bursley offered receipts for review from Rose exterminators for the past year.

On 07/13/2021, I interviewed by telephone Family member #2. Family member #2 confirmed that there were a great deal of ants coming out around Resident A's toilet when Family member #2 visited and was assisting Resident A in the bathroom. Family member #2 stated that the ants bit her feet.

On 07/14/2021, I conducted by telephone an exit conference with the licensee designee, Theresa Bursley. Mrs. Bursley observed that they have experienced an increase in ants being observed in some of the rooms in which residents are taking their meals in the rooms. Mrs. Bursley indicated that in the 'ant season', the licensee will communicate the possibility of this with residents and their families, encouraging them to notify her if there is an uptick in activity so that she can contact Rose Exterminators.

APPLICABLE RULE	
R 400.15401	**Environmental health.**
	(5) An insect, rodent, or pest control program shall be maintained as necessary and shall be carried out in a manner that continually protects the health of residents.
ANALYSIS:	While ants were observed in Resident A's bathroom on 04/15-17/2021, the licensee regularly has the facility sprayed for ants and there were none present during my on-site investigation. The licensee provided receipts from Rose Exterminators documenting the intervention provided on a regular, monthly basis. I did not observe ants in the building, including in Resident A's room, when I conducted my inspection recently for the upcoming renewal of the facility license. I do not find a rule violation on this issue.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend that the license remain unchanged.

07/14/2021

Grant Sutton — Date
Licensing Consultant

Approved By:

07/16/2021

Jerry Hendrick — Date
Area Manager