STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

December 7, 2021

Christopher Trevathan
AH Holland Subtenant LLC
6755 Telegraph Rd Ste 330
Bloomfield Hills, MI 48301

RE: License #: AL700397730
Investigation #: 2022A0583006
AHSL Holland Beachside

Dear Mr. Trevathan:

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) 356-0183.

Sincerely,

Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL700397730
Investigation #:	2022A0583006
Complaint Receipt Date:	11/29/2021
Investigation Initiation Date:	11/29/2021
Report Due Date:	12/29/2021
Licensee Name:	AH Holland Subtenant LLC
Licensee Address:	One SeaGate, Suite 1500 Toledo, OH 43604
Licensee Telephone #:	(248) 203-1800
Administrator:	Christopher Trevathan
Licensee Designee:	Christopher Trevathan
Name of Facility:	AHSL Holland Beachside
Facility Address:	11821 James Street Holland, MI 49423
Facility Telephone #:	(616) 393-2174
Original Issuance Date:	03/21/2019
License Status:	REGULAR
Effective Date:	09/21/2021
Expiration Date:	09/20/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Facility staff do not provide Resident A with adequate fluids daily.	No
Facility staff do not assist Resident A with putting his compression stockings on daily.	No
Facility staff do not check on Resident A often enough.	No
Facility staff removed Resident A's soda pop from his personal in-room refrigerator without his permission.	No
Additional Findings	Yes

III. METHODOLOGY

11/29/2021	Special Investigation Intake 2022A0583006
11/29/2021	Special Investigation Initiated - Telephone Relative 1
11/30/2021	Inspection Completed On-site Licensee Designee Christopher Trevathan, Staff Kerrie Flores, Staff Zachary Fickel, Staff Nicole Grotler, Resident A, Resident B, Resident C
12/07/2021	Exit Conference Licensee Designee Christopher Trevathan

ALLEGATION: Facility staff do not provide Resident A with adequate fluids daily.

INVESTIGATION: On 11/29/2021 I received complaint allegations from Adult Protective Services centralized intake. The allegations were screened out for formal Adult Protective Services investigation. The complaint alleged that facility staff do not provide Resident A with adequate fluids daily.

On 11/29/2021 I interviewed Relative 1 via telephone. Relative 1 stated Resident A exhibits confusion and memory loss as a result of a history of "severe brain damage". Relative 1 stated Resident A currently suffers from hydrocephalus and utilizes a brain shunt. Relative 1 stated Resident A is his own decision maker despite his history of confusion. Relative 1 stated Resident A refuses to drink water but will drink juice and soda pop. Relative 1 stated facility staff offer Resident A water, but rarely offer Resident A soda pop or juice. Relative 1 stated within the past week Relative 1 observed that Resident A appeared more confused than his baseline. Relative 1 stated she suspected Resident A was "dehydrated" because

after Resident A was supplied soda pop or other fluid Resident A's confusion improved.

On 11/30/2021 I completed an unannounced onsite investigation at the facility and privately interviewed Licensee Designee Christopher Trevathan, Staff Kerrie Flores, Staff Zachary Fickel, Staff Nicole Grotler, Resident A, Resident B, and Resident C.

Licensee Designee Christopher Trevathan stated facility staff offer Resident A water at every meal and multiple times during the day. Mr. Trevathan stated Resident A has the capacity to request soda pop and/or juice when he prefers, and facility staff provide it upon his request. Mr. Trevathan stated he has no knowledge of Resident A displaying symptoms of dehydration and he has never observed such behaviors.

Staff Kerrie Flores, Nicole Grotler, and Zachary Fickel each stated they have never observed Resident A to display symptoms of dehydration. Staff Kerrie Flores, Nicole Grotler, and Zachary Fickel each stated facility staff provide Resident A with water at every meal, during shift changes, during facility staff's "two-hour" resident checks, and at any other time Resident A requests with his bedroom pull cord. Staff Kerrie Flores, Nicole Grotler, and Zachary Fickel each stated Resident A has the ability to request soda pop or juice when he prefers, and facility staff provide it upon his request.

Resident A stated he has not exhibited symptoms of hydration recently and facility staff provide him with water or any other fluid he requests at meals and regularly throughout the day. Resident A stated he can pull his bedroom pull cord whenever he requests something to drink. Resident A stated facility staff are responsive to his needs and he is happy with the quality of care provided. While interviewing Resident A in his private bedroom, I observed a Styrofoam cup of water sitting next to Resident A on a table.

Resident B and Resident C both stated facility staff provide residents with water or any other fluid requested at meals and regularly throughout the day. I observed Resident B and Resident C each had a full Styrofoam cup of water located on the tables next to each of them.

While onsite I reviewed Resident A's "Uniform Evaluation Tool – 2020" completed 05/02/2021 and signed by Relative 1 and Staff Carrie Flores on 05/11/2021. The form is not signed by Resident A or the Licensee Designee Christopher Trevathan. The document states Resident A requires "no assistance with eating" and receives a "regular diet".

On 12/07/2021 I completed an Exit Conference with Licensee Designee Christopher Trevathan via telephone and informed him of the Special Investigation findings. Mr. Trevathan stated he agreed with the findings.

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:	Resident A stated he has not exhibited symptoms of dehydration and facility staff provide him with water or any other fluid he requests at meals and regularly throughout the day. While onsite I observed a Styrofoam cup of water sitting next to Resident A on a table in his private bedroom. Resident B and Resident C both stated facility staff provide residents with water or any other fluid requested at meals and regularly throughout the day. I observed Resident B and Resident C each had a full Styrofoam cup of water located on the tables next to each of them. I reviewed Resident A's "Uniform Evaluation Tool – 2020" completed 05/02/2021 and signed by Relative 1 and Staff Carrie Flores on 05/11/2021. The form is not signed by Resident A or the Licensee Designee Christopher Trevathan. The document states Resident A requires "no assistance with eating" and receives a "regular diet". A preponderance of evidence does not support violation of the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Facility staff do not assist Resident A with putting his compression stockings on daily.

INVESTIGATION: On 11/29/2021 I received complaint allegations from Adult Protective Services centralized intake. The complaint alleged Resident A suffers from swollen ankles which require the use of compression stockings. The complaint alleged that facility staff do not assist Resident A with putting his compression stockings on daily.

On 11/29/2021 I interviewed Relative 1 via telephone. Relative 1 stated Resident A requires the use of daily compression stockings due to swollen ankles. Relative 1 stated she was unsure if a physician's script was written for use of the compression stockings. Relative 1 stated she visited the facility and observed that Resident A was not wearing his compression stockings on 11/26/2021 and 11/27/2021.

Relative 1stated she visited the facility on 11/28/2021 and observed Resident A call a facility staff to assist him with putting the compression stockings on.

On 11/30/2021 I completed an unannounced onsite investigation at the facility and privately interviewed Licensee Designee Christopher Trevathan, staff Kerrie Flores, Zachary Fickel, Nicole Grotler, and Resident A.

Licensee Designee Christopher Trevathan stated he had no knowledge regarding Resident A not receiving facility staff assistance daily with putting his compression stockings on.

Staff Kerrie Flores stated she has never observed a physician's script requiring the daily use of compression stockings for Resident A. Ms. Flores stated facility staff do assist Resident A daily with dressing into his compression stockings.

Staff Nicole Grotler stated Resident A utilizes his pull cord daily at approximately 10:00 am and requests staff assistance with dressing. Ms. Grotler stated she assists Resident A with putting on his compression stockings routinely and assisted him with dressing into his compression this morning. Ms. Grotler stated Resident A does object to wearing his compression stockings sporadically such as in the summer when they make his legs hot.

Staff Zachary Fickel stated Resident A utilizes his pull cord daily at approximately 11:00 am and requests staff assistance with dressing. Ms. Grotler stated he assists Resident A often with dressing into his compression stockings and has no knowledge of Resident A not wearing his compression stockings daily.

Resident A stated facility staff assist him daily with dressing into his compression stockings. Resident A stated facility staff assisted him this morning with dressing into his compression stockings.

While onsite I reviewed Resident A's "Uniform Evaluation Tool – 2020" completed 05/02/2021 and signed by Relative 1 and Staff Carrie Flores on 05/11/2021. The form is not signed by Resident A or the Licensee Designee Christopher Trevathan. The document states Resident A "is able to complete cares independently with set up and some cuing, staff to return to reassure cares are completed".

On 12/07/2021 I completed an Exit Conference with Licensee Designee Christopher Trevathan via telephone and informed him of the Special Investigation findings. Mr. Trevathan stated he agreed with the findings.

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:	Resident A stated facility staff assist him daily with dressing into his compression stockings. Resident A stated facility staff assisted him this morning with dressing into his compression stockings. I reviewed Resident A's "Uniform Evaluation Tool – 2020" completed 05/02/2021 and signed by Relative 1 and Staff Carrie Flores on 05/11/2021. The form is not signed by Resident A or the Licensee Designee Christopher Trevathan. The document states Resident A "is able to complete cares independently with set up and some cuing, staff to return to reassure cares are completed". A preponderance of evidence does not support violation of the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Facility staff do not check on Resident A often enough.

INVESTIGATION: On 11/29/2021 I received complaint allegations from Adult Protective Services centralized intake. The complaint alleged facility staff do not regularly check on Resident A therefore he is left unattended for hours at a time.

On 11/29/2021 I interviewed Relative 1 via telephone. Relative 1 stated "I don't know how often staff check on" Resident A. Relative 1 stated she had "no idea" of the schedule staff keep when checking on Resident A. Relative 1 stated she found it "curious" that there have been times Relative 1 has visited Resident A at the facility for up to "three hours" however facility staff never checked on Resident A's wellbeing.

On 11/30/2021 I completed an unannounced onsite investigation at the facility and privately interviewed Licensee Designee Christopher Trevathan, Staff Kerrie Flores, Zachary Fickel, Nicole Grotler, Resident A, Resident B, and Resident C.

Licensee Designee Christopher Trevathan stated facility staff check on Resident A at least once every two hours and he has observed no indication that facility staff are not completing the resident checks.
Staff Kerrie Flores, Nicole Grotler, and Zachary Fickel each stated facility staff check on Resident A at least once every two hours unless a resident has a visitor. Staff Kerrie Flores, Nicole Grotler, and Zachary Fickel each stated facility staff often allow

residents privacy during family and friend visits which can result in less than two-hour visual checks.

Resident A, Resident B, and Resident C each stated facility staff complete resident checks once every two hours. Resident A, Resident B, and Resident C each stated facility staff are responsive when they ring their in-room pull cords.

While onsite I reviewed Resident A's "Uniform Evaluation Tool – 2020" completed 05/02/2021 and signed by Relative 1 and Staff Carrie Flores on 05/11/2021. The form is not signed by Resident A or the Licensee Designee Christopher Trevathan. The document states Resident A "is able to complete cares independently with set up and some cuing, staff to return to reassure cares are completed".

On 12/07/2021 I completed an Exit Conference with Licensee Designee Christopher Trevathan via telephone and informed him of the Special Investigation findings. Mr. Trevathan stated he agreed with the findings.

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:	Resident A, Resident B, and Resident C each stated facility staff complete resident checks once every two hours. I reviewed Resident A's "Uniform Evaluation Tool – 2020" completed 05/02/2021 and signed by Relative 1 and Staff Carrie Flores on 05/11/2021. The form is not signed by Resident A or the Licensee Designee Christopher Trevathan. The document states Resident A "is able to complete cares independently with set up and some cuing, staff to return to reassure cares are completed". A preponderance of evidence does not support violation of the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Facility staff removed Resident A's soda pop from his personal in-room refrigerator without his permission.

INVESTIGATION: On 11/29/2021 I received complaint allegations from Adult Protective Services centralized intake. The complaint alleged facility staff removed Resident A's soda pop from his personal in-room refrigerator without his permission.

On 11/29/2021 I interviewed Relative 1 via telephone. Relative 1 stated on approximately 11/23/2021 she purchased and supplied Resident A with a twelve pack of soda pop that was placed by an unknown facility staff into Resident A's personal refrigerator located in Resident A's private bedroom. Relative 1 stated on approximately 11/26/2021 she visited the facility and observed that Resident A's soda pop was no longer in his personal refrigerator. Relative 1 stated facility staff located Resident A's soda pop unopened in the facility's main refrigerator.

On 11/30/2021 I completed an unannounced onsite investigation at the facility and privately interviewed Licensee Designee Christopher Trevathan, Staff Kerrie Flores, Zachary Fickel, Nicole Grotler, and Resident A.

Licensee Designee Christopher Trevathan, staff Nicole Grotler, and Zachary Fickel each stated they had no knowledge regarding Resident A's missing soda pop.

Staff Kerri Flores stated that on approximately 11/26/2021 Relative 1 reported that Resident A's personal soda pop was missing from his in-room refrigerator. Ms. Flores stated Resident A's soda pop was discovered in the facility's main refrigerator. Ms. Flores stated she does not know how the soda pop ended up in the facility's main refrigerator however several other residents store their personal items in the facility's main refrigerator because they do not have in-room refrigerators. Ms. Flores stated facility staff supply residents with their personal food items when requested by residents.

Resident A stated he has a personal refrigerator located in his private bedroom. Resident A stated Relative 1 recently purchased him a twelve pack of soda pop which was initially placed by an unknown staff in his personal refrigerator. Resident A stated at some point his soda pop was subsequently placed in the facility's main refrigerator by an unknown staff. Resident A stated he can request that a facility staff bring him a can of soda pop from the facility's main refrigerator at any time. Resident A stated it did not bother him that his soda pop was placed in the facility's main refrigerator because he always had access to it.

On 12/07/2021 I completed an Exit Conference with Licensee Designee Christopher Trevathan via telephone and informed him of the Special Investigation findings. Mr. Trevathan stated he agreed with the findings.

APPLICABLE RULE	
R 400.15304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated

	representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(j) The right of reasonable access to and use of his or her personal clothing and belongings.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Resident A stated he has a personal refrigerator located in his private bedroom. Resident A stated Relative 1 recently purchased him a twelve pack of soda pop which was initially placed by an unknown staff in his personal refrigerator. Resident A stated at some point his soda pop was subsequently placed in the facility's main refrigerator by an unknown staff. Resident A stated he can request that a facility staff bring him a can of soda pop from the facility's main refrigerator at any time. Resident A stated it did not bother him that his soda pop was placed in the facility's main refrigerator because he always had access to it. A preponderance of evidence does not support violation of the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS: Resident A's Assessment Plan lacks Resident A and Licensee Designee Christopher Trevathan's signatures.

INVESTIGATION: On 11/30/2021 I completed an unannounced onsite investigation at the facility and privately interviewed Licensee Designee Christopher Trevathan.

Mr. Trevathan stated Resident A is his own legal decision maker and should be signing his own "Uniform Evaluation Tool – 2020". Mr. Travathan stated he did not sign Resident A's "Uniform Evaluation Tool – 2020". Mr. Travathan stated the facility's "Uniform Evaluation Tool" is utilized as a Resident Assessment Plan.

I reviewed Resident A's "Uniform Evaluation Tool – 2020" completed 05/02/2021 and signed by Relative 1 and Staff Carrie Flores on 05/11/2021. The form is not signed by Resident A or the Licensee Designee Christopher Trevathan.

On 12/07/2021 I completed an Exit Conference with Licensee Designee Christopher Trevathan via telephone and informed him of the Special Investigation findings. Mr. Trevathan stated he agreed with the findings and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(9) A licensee shall review the written resident care agreement with the resident or the resident's designated representative and responsible agency, if applicable, at least annually or more often if necessary.
ANALYSIS:	I reviewed Resident A's "Uniform Evaluation Tool – 2020" completed 05/02/2021 and signed by Relative 1 and Staff Carrie Flores on 05/11/2021. The form is not signed by Resident A or the Licensee Designee Christopher Trevathan. Licensee Designee Trevathan stated Resident A is his own legal decision maker and should be signing his own "Uniform Evaluation Tool – 2020". Mr. Trevathan stated he did not sign Resident A's "Uniform Evaluation Tool – 2020". Mr. Trevathan stated the facility's "Uniform Evaluation Tool" is utilized as a Resident Assessment Plan. A preponderance of evidence does support violation of the applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend the license remain unchanged.

12/07/2021

Toya Zylstra, Licensing Consultant Date

Approved By:

12/07/2021

Jerry Hendrick, Area Manager Date