GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 26, 2022

Lauren Gowman
Appledorn Assisted Living Center
727 Apple Avenue
Holland, MI 49423

RE: License #:	AH700236753
Investigation #:	2022A1021016
	Appledorn Assisted Living Center

Dear Mrs. Gowman:

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 (517) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH700236753
Investigation #:	2022A1021016
Complaint Receipt Date:	12/10/2021
Investigation Initiation Date:	12/13/2022
Report Due Date:	02/09/2022
Licensee Name:	Appledorn Living Center LLC
Licensee Address:	950 Taylor Ave. Grand Haven, MI 49417
Licensee Telephone #:	(616) 842-2425
Administrator:	Jason Bucher
Authorized Representative:	Lauren Gowman
Name of Facility:	Appledorn Assisted Living Center
Facility Address:	727 Apple Avenue Holland, MI 49423
Facility Telephone #:	(616) 392-4650
Original Issuance Date:	03/01/2000
License Status:	REGULAR
Effective Date:	05/12/2021
Expiration Date:	05/11/2022
Capacity:	174
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Call lights are not answered.	Yes
Resident A did not receive medical attention	No
Residents are left in bed soiled.	No
Residents are not fed.	No
Additional Findings	No

III. METHODOLOGY

12/10/2021	Special Investigation Intake 2022A1021016
12/13/2021	Special Investigation Initiated - Letter referral sent to APS
01/10/2022	Inspection Completed On-site
01/12/2022	Contact-Telephone call made Interviewed Holland Hospital Home Care nurse Lisa Vandenberg
01/14/2022	Contact-Telephone call made Interviewed shift supervisor Soubanh Synha
01/26/2022	Exit Conference Exit Conference with authorized representative Lauren Gowman

The complainant identified some concerns that were not related to home for the aged licensing rules and statutes. Therefore, only specific items pertaining to homes for the aged provisions of care were considered for investigation. The following items were those that could be considered under the scope of licensing.

ALLEGATION:

Call lights are not answered.

INVESTIGATION:

On 12/10/21, the licensing department received an intake with allegations call lights are not answered at the facility. The complainant alleged staff members do not answer call lights and assist the residents.

On 12/13/21, the allegations in this report were sent to centralized intake at Adult Protective Services (APS).

On 1/10/21, I interviewed the administrator Jason Bucher at the facility. Mr. Bucher reported residents have a pull cord in their bathroom and the residents also wear a call pendent. Mr. Bucher reported the notification goes to an iPad or phone that the staff member carries. Mr. Bucher reported if the call is not answered, it will accelerate to the care station located on each unit. Mr. Bucher reported the caregiver must physically report to the resident's room to turn off the call light. Mr. Bucher reported the facility has a goal to answer call lights within seven to 10 minutes. Mr. Bucher reported at times residents do have to wait for their light to be answered. Mr. Bucher reported no concerns about call lights not being answered have been brought to his attention.

On 1/10/21, I interviewed Resident B at the facility. Resident B reported it does take increased time for caregivers to respond to his call pendent. Resident B reported in the morning he requires assistance with his socks, and it will take a long time for caregivers to respond to his call pendent.

On 1/10/21, I interviewed Resident C at the facility. Resident C reported it takes a long time for caregivers to respond to his call pendent. Resident C reported he has been transferred to the bathroom and then caregivers leave him for upwards of 20 minutes. Resident C reported he has also had to leave the bathroom and get a new incontinence product himself because caregivers were not responsive to his call pendent.

On 1/10/21, I interviewed Resident D at the facility. Resident D reported it takes a long time for caregivers to respond to the call pendants. Resident D reported at times caregivers will come in, turn off the call pendent, say they will be right back, and never return.

On 1/10/21, I interviewed caregiver Kendra Grandy at the facility. Ms. Grandy reported call lights are to be answered within five minutes but at times residents do have to wait for staff assistance.

On 1/10/21, I interviewed caregiver Shawn Smith at the facility. Ms. Smith reported call lights should be answered within 10 minutes.

I reviewed call light response times for 12/27-1/10 for Resident B, Resident C, and Resident D. The report revealed Resident B had to wait on average 25 minutes, Resident C had to wait average of 24 minutes, and Resident D had to wait average of 15 minutes.

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.**
For Reference: R 325.1901	**Definitions.**
	(4) "Assistance" means help provided by a home or an agent or employee of a home to a resident who requires help with activities of daily living.
ANALYSIS:	Interviews with residents and review of call light response times revealed on average residents must wait between 15-25 minutes. This practice results in residents not receiving the assistance they require such as assistance in toileting and dressing.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A did not receive medical attention

INVESTIGATION:

The complainant alleged Resident A was showing signs of a stroke and the facility did nothing. The complainant alleged the facility was aware of Resident A's change in condition, but no medical attention was provided until Resident A fell and was transported to the hospital where she was diagnosed with a stroke.

Mr. Bucher reported in November 2021, Resident A had a few falls, 11/17, 11/18, and 11/19, at the facility. Mr. Bucher reported following the falls, the facility would complete post fall monitoring and evaluate Resident A. Mr. Bucher reported on 11/19, Resident A fell and hit her head which resulted in a hospitalization for Resident A. Mr. Bucher reported when Resident A fell on 11/19, Resident A had left side weakness and facial dropping. Mr. Bucher reported prior to this fall, Resident A was at baseline and had no signs or symptoms of a stroke. Mr. Bucher reported Resident A was very independent and would not request assistance from staff. Mr. Bucher reported there was no indication prior to the fall on 11/19 that Resident A was having or had a stroke.

Resident A was no longer at the facility and therefore I was unable to interview Resident A.

On 1/14/22, I interviewed shift supervisor Soubanh Synha by telephone. Ms. Synha reported she worked the morning Resident A was sent to the hospital. Ms. Synha reported prior to fall Resident A was at baseline and had no signs or symptoms of a stroke. Ms. Synha reported she was paged to Resident A's room due to a fall. Ms. Synha reported Resident A was on the floor and reported she was in pain but denied hitting her head. Ms. Synha reported due to the positioning of Resident A, caregivers were unable to get Resident A off the floor and contacted emergency medical services, EMS. Ms. Synha reported when Resident A was assisted off the floor, Resident A was then observed to have left side weakness. Ms. Synha reported the facility acted in a timely manner to arrange medical care for Resident A.

I reviewed observation notes for Resident A. The notes read,

"11/17: The medication technician heard this resident calling for help, so she went to her room and observed her holding onto the bed and her nightstand, starting to slip. The (medication technician) lowered her to the floor. Vitals and range of motion were done/taken. POA and PCP notified.
11/17: 2nd fall: The (medication technician) head this resident calling for help, so she went to her room and observed her laying on the floor near her bed. The (medication technician) paged her. Vitals and (range of motion) were done/taken. No injuries. POA notified.
11/18: Respond to a code while 4:45pm, upon arrival observed the resident in front of the bed. The resident was trying to self-transfer and fell. (Range of motion) was done with no pain or injuries. The resident was able to bend her knee, with help b two staff using a gait belt, stand-up hold on to the walker. PCP, Family, and Management were notified. Vitals are T 97.5 BP 163/93 P 84 O2 9
11/19: At 10:45am one of the staff observed the resident was laying face down on the floor next to her bed. Both of her legs were under the bed and her body is by the nightstand. RSA paged for (shift supervisor). (Shift supervisor) arrived promptly. (Shift supervisor) asked the resident if she was in pain. The resident stated, "My right toe hurts and my back." (Shift supervisor) was going to use the camel device but we were unable to slide the green sheet under her d/t the way she was

positioned. The left side of her face is droopy and the left side of her body weakness. Unable to do a range of motion. This (Shift supervisor) called AMR to transport her to the hospital. POA and PCP notified."

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: **(c) Assure the availability of emergency medical care required by a resident.**
ANALYSIS:	Interview with Mr. Bucher, interview with Soubanh Synha, and document review revealed Resident A received appropriate medical treatment after staff observed her to have stroke like symptoms.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents are left in bed soiled.

INVESTIGATION:

The complainant alleged residents have skin breakdown and are not toileted appropriately. The complainant alleged Resident B was found with a dirty brief that was overflowing with feces.

On 1/10/22, I interviewed clinical coordinator Mary Overway at the facility. Ms. Overway reported there are no residents with wounds that are stageable. Ms. Overway reported a few residents have redness on their bottom and are prescribed ointments to assist with healing. Ms. Overway reported there are no residents that are bed bound. Ms. Overway reported Resident B is active with Holland Hospital Home Care for catheter care. Ms. Overway reported Resident B has some skin breakdown on his groin area and is prescribed A&D ointment. Ms. Overway reported at times Resident B will go in his Depend instead of requesting assistance. Ms. Overway denied allegation residents are left soiled and are not toileted appropriately.

Resident B reported caregivers provide good care to him. Resident B reported caregivers assist him when requested. Resident B reported no concerns with not being changed appropriately.

On 1/10/22, I interviewed caregiver Kendra Grandy at the facility. Ms. Grandy reported she has no concerns with skin breakdown at the facility. Ms. Grandy reported residents are changed appropriately.

On 1/10/22, I interviewed caregiver Shawn Smith at the facility. Ms. Smith reported there are not many residents with skin breakdown. Ms. Smith reported the residents that do have some skin breakdown it is very minor. Ms. Smith reported residents are changed appropriately.

At the facility I observed multiple residents in common areas and within their rooms. I did not observe any residents left in bed nor residents not changed appropriately. I did not detect any foul odors throughout the facility.

On 1/12/22, I interviewed Holland Hospital home care nurse Lisa Vandenberg by telephone. Ms. Vandenberg reported she has treated and cared for Resident B at the facility. Ms. Vandenberg reported Resident B has had some redness in his groin area but has had no skin breakdown. Ms. Vandenberg reported Resident B has gone to the bathroom in his Depend instead of requesting assistance. Ms. Vandenberg reported she has no concerns with care provided at the facility.

APPLICABLE RULE	
R 325.1933	**Personal care of residents.**
	(1) A home shall provide a resident with necessary assistance with personal care such as, but not limited to, care of the skin, mouth and teeth, hands and feet, and the shampooing and grooming of the hair as specified in the resident's service plan.
ANALYSIS:	The interviews with Mr. Bucher, Ms. Vandenberg, and Resident B revealed resident care needs are met by the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents are not fed.

INVESTIGATION:

The complainant alleged residents that are on hospice services that require assistance with eating are not fed because staff members report the residents will not eat.

Mr. Bucher reported there are a few residents that are on hospice services that required assistance with feeding. Mr. Bucher reported if a resident requires assistance with eating, a caregiver will assist the resident. Mr. Bucher reported if a resident refuses to eat, the facility will not force the resident to eat. Mr. Bucher reported the facility will work to accommodate resident preferences on food choices. Mr. Bucher reported for residents that are near end of life, their food intake will decrease but the facility will still offer food choices.

On 1/14/22, I interviewed caregiver Veronica Ybarra by telephone. Ms. Ybarra reported on “C” hallway there used to be quite a few residents that required assistance with eating. Ms. Ybarra reported these residents were near end of life and slept most of the day. Ms. Ybarra reported if a resident is sleeping, caregivers would attempt to wake up the resident but would not force the resident to eat. Ms. Ybarra reported residents are fed appropriately and do not go without food.

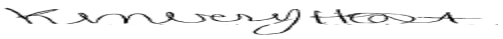
Ms. Synha reported she typically cares for three residents that require assistance with feeding. Ms. Synha reported if a resident is sleeping, caregivers will attempt to wake the resident up. Ms. Synha reported if the resident does not wake up, then the caregiver will attempt later. Ms. Synha reported residents do not go without food.

APPLICABLE RULE	
R 325.1952	**Meals and special diets.**
	(1) A home shall offer 3 meals daily to be served to a resident at regular meal times. A home shall make snacks and beverages available to residents.
ANALYSIS:	Interviews with employees revealed lack of evidence to support the allegation residents do not receive meals.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 2/10/21, I conducted an exit conference with authorized representative Lauren Gowman by telephone. Ms. Gowman reported it is not the standard for residents to wait 15-25 minutes for staff assistance. Ms. Gowman agreed with the findings in this report.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.



1/20/22

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Kimberly Horst — Date
Licensing Staff

Approved By:

01/26/2022

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Andrea L. Moore, Manager — Date
Long-Term-Care State Licensing Section