GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 16, 2022

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

RE: License #: AL700397724
Investigation #: 2022A0467024
AHSL Holland Lakeshore

Dear Mr. Trevathan:

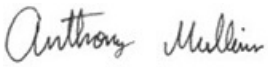
Attached is the Special Investigation Report for the above referenced facility. Due to the violation identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- Specific time frames for the 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,



Anthony Mullins, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL700397724
Investigation #:	2022A0467024
Complaint Receipt Date:	03/01/2022
Investigation Initiation Date:	03/01/2022
Report Due Date:	04/30/2022
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 Lakeshore
Facility Address:	11911 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?
Staff member Crystela Villegas forced Resident A to use the toilet, resulting in him falling and fracturing his ribs.	Yes

III. METHODOLOGY

03/01/2022	Special Investigation Intake 2022A0467024
03/01/2022	Special Investigation Initiated - Telephone
03/04/2022	Inspection Completed On-site
03/16/22	I conducted an exit conference with licensee designee, Chris Trevathan.

ALLEGATION: Staff member Crystela Villegas forced Resident A to use the toilet, resulting in him falling and fracturing his ribs.

INVESTIGATION: On 3/1/22, I reviewed an incident report from the facility, indicating that on 2/26/22, Resident A reported that staff member Annette Weenum physically forced Resident A from his recliner to toilet him. The incident occurred on or around 2/24/22. As a result, Resident A fell and hit his head and fractured his ribs.

On 3/1/22, I spoke to the complainant via phone. He informed me that there is an internal ongoing investigation regarding this matter. Ms. Weenum has been ruled out as the person responsible as she only interacted with Resident A to pass medications in the dining area on the day in question. The complainant also stated that Ms. Weenum's name was mistakenly listed as the person responsible due to a third shift staff member talking to Resident A about what occurred and assuming it was Ms. Weenum without further information. The complainant confirmed that the staff member in question is Crystela Villegas and she is currently suspended. The complainant stated that he has spoken to Ms. Villegas and she has confirmed that she did in fact care for Resident A on the day in question. However, she denies any knowledge of Resident A falling. As a result of Resident A's fall, he sustained rib fractures. Per the complainant, the subdural hematoma that Resident A has is residual from a previous car accident. This was relayed to the complainant from the doctor. However, the rib fractures were only from a few days ago, which the complainant believes is consistent with the explanation provided by Resident A. The complainant confirmed that Ms. Villegas will be terminated today or tomorrow as a result of the outcome of the internal investigation.

On 3/4/22, I made an unannounced onsite investigation to the facility. Upon arrival, I spoke with the licensee designee, Chris Trevathan. Mr. Trevathan informed me that Resident A is aware that the staff member that caused his injuries, Ms. Villegas is no longer employed with American House. Mr. Trevathan again clarified that Ms. Weenum was not the staff member that cared for him on the day he was injured. Instead. Crystela Villegas was the staff member that cared for him. Mr. Trevathan confirmed that Ms. Villegas consistently denied causing Resident A to fall prior to being terminated.

After speaking to Mr. Trevathan, I spoke to Resident A in his room. Resident A stated that he was recently sent to the hospital for broken ribs. When asked how this occurred, Resident A stated, “I got pulled down on the floor by staff. She’s not staff anymore.” Resident A stated that Mr. Trevathan has since fired the staff member that pulled him down to the floor. Resident A was unable to recall the staff member’s name, but he stated that on the day in question, he was in his room wanting to get into his chair from his walker. Resident A stated that he was tired and relayed this information to the staff member. While holding onto his walker, Resident A stated that the staff member pulled it away from him and he fell on the floor. Resident A stated that the staff member told him “screaming isn’t going to do you any good.” According to Resident A, the staff member pulled him up from the floor and took him to the bathroom. While in the bathroom, Resident A stated that the staff member pulled his pants down and told him that he needed to pee. Resident A stated that he told the staff member that he did not need to use the bathroom and she proceeded to pull his pants back up. Resident A then walked back to his walker and the staff member told him that he was lying about not having to go to the bathroom.

Resident A stated that the staff member never apologized for making him fall. Resident A stated that he gets along well with everyone at the facility and he was shocked when this incident occurred as he didn’t understand what was happening. As a result of the fall, Resident A broke his ribs. He also stated that there was a possible head injury. However, he already had 2 holes in his head from years ago when he sustained a subdural hematoma. Resident A stated that doctors were able to confirm that his head injury was from his previous accident. Resident A stated that he told staff about the incident on the same day it occurred.

After speaking to Resident A, I spoke to staff member Annette Weenum. Ms. Weenum stated that she gave Mr. Trevathan her statement regarding this. On the day in question, 2/24/22, Ms. Weenum stated that she was never hands on with Resident A. Ms. Weenum stated she worked approximately 3.5 hours in the facility to pass medication. During Ms. Weenum’s time passing medications, Ms. Villegas helped her identify residents to make sure residents were receiving the appropriate medication. Ms. Weenum stated that after she passed medications, she started helping clear tables. Call lights for room C-14 and B-12 went off and she sent Ms. Villegas to the rooms to assist. Ms. Villegas returned from addressing the call lights and told Ms. Weenum that she made Resident A go to the bathroom although he told her he didn’t have to. Ms. Weenum stated that Ms. Villegas never mentioned

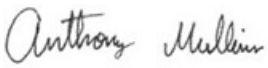
anything about a fall or a distress. Ms. Weenum stated that Ms. Villegas was not in the room long. Ms. Weenum stated that she did not see any signs of distress from Ms. Villegas and that she presented as she normally did. Ms. Weenum has never observed any signs of Ms. Villegas harming other residents when she worked with her previously. The day of the incident was only Ms. Weenum's second time working with Ms. Villegas.

On 03/16/22, I conducted an exit conference with licensee designee, Chris Trevathan. He was informed of the investigative findings and agreed to complete a corrective action plan.

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:	Resident A accused staff of forcing him to use the bathroom although he told her he didn't need to. As a result of this, Resident A fell to floor and hit his head and fractured his ribs. Resident A did not know the name of the staff member that caused him to fall. Staff member Crystela Villegas acknowledged to licensee designee, Chris Trevathan that she cared for Resident A all day on 2/24/22 but denied any knowledge of him falling. Resident A went to the hospital on 2/26/22 after complaining of pain, which is when it was confirmed that he had broken ribs from a recent incident. Although Ms. Villegas denied causing Resident A to fall and there were no witnesses to the incident, Resident A was adamant that staff caused him to fall, and hospital staff confirmed his fractured ribs. Therefore, a preponderance of evidence exists to support the allegation. Ms. Villegas is no longer a threat to Resident A as she has been terminated from American House.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

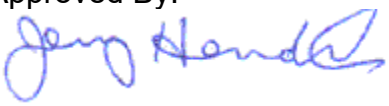
Upon receipt of an acceptable corrective action plan, I recommend no change to the current license status.



03/16/2022

Anthony Mullins Date
Licensing Consultant

Approved By:



03/16/2022

Jerry Hendrick Date
Area Manager