GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 17, 2022

Lauren Gowman
Grand Pines Assisted Living Center
1410 S. Ferry St.
Grand Haven, MI 49417

RE: License #: AH700299440
Investigation #: 2022A1028057
Grand Pines 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 responsible party 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 tI am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
Cell (616) 204-4300

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

I. IDENTIFYING INFORMATION

License #:	AH700299440
Investigation #:	2022A1028057
Complaint Receipt Date:	06/29/2022
Investigation Initiation Date:	06/30/2022
Report Due Date:	08/29/2022
Licensee Name:	Grand Pines Assisted Living LLC
Licensee Address:	950 Taylor Ave. Grand Haven, MI 49417
Licensee Telephone #:	(616) 846-4700
Administrator:	Nancy Johnstone
Authorized Representative:	Lauren Gowman
Name of Facility:	Grand Pines Assisted Living Center
Facility Address:	1410 S. Ferry St. Grand Haven, MI 49417
Facility Telephone #:	(616) 850-2150
Original Issuance Date:	07/08/2009
License Status:	REGULAR
Effective Date:	05/12/2022
Expiration Date:	05/11/2023
Capacity:	177

Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility did not provide care consistent with Resident A's service plan.	Yes
The facility is short staffed on Resident A's hallway.	No
Additional Findings	No

III. METHODOLOGY

06/29/2022	Special Investigation Intake 2022A1028057
06/30/2022	Special Investigation Initiated - Letter 2022A1028057
06/30/2022	APS Referral APS made referral to HFA department.
07/11/2022	Contact - Face to Face Interviewed Admin/Nancy Johnstone at the facility.
07/11/2022	Contact - Face to Face Interviewed Employee A at the facility.
07/11/2022	Contact - Face to Face Interviewed Employee B at the facility.
07/11/2022	Contact - Face to Face Interviewed Employee C at the facility.
07/11/2022	Contact - Document Received Received Resident A's service plan with record notes, call light log, June 2022 medication administration record, and working staff schedule from Admin/Nancy Johnstone.

10/17/2022	Exit – Report sent to facility AR/Lauren Gowman and facility Admin/Nancy Johnstone.

ALLEGATION:

The facility did not provide care consistent with Resident A's service plan.

INVESTIGATION:

On 6/29/2022, the Bureau received the allegations from the online complaint system.

On 6/30/2022, Adult Protective Services (APS) made referral to Centralized Intake.

On 7/11/2022, I interviewed administrator, Nancy Johnstone, at the facility. Ms. Johnstone reported Resident A resided at the facility for the month of June 2022 only and that Resident A was their own person and could make needs known. Resident A required one to two person assist with dressing, grooming, toileting, bathing, and transfers. Resident A also had an additional private caregiver who assisted with care at the facility throughout the week. Ms. Johnstone reported it was brought to her attention by family members that Resident A was discovered with a soiled brief by the private duty caregiver on 6/27/22. Ms. Johnstone reported it could not be determined at what time the incident occurred or which care staff was involved, but corrective measures were taken immediately upon the discovery of it. Ms. Johnstone also reported no knowledge of Resident A crawling across the floor to retrieve meals that were left across the room and out of reach. Ms. Johnstone reported to her knowledge Resident A is a two person assist with adaptive equipment and has had no falls. Ms. Johnstone reported there were no concerns voiced by Resident A or Resident A's family other than the incident about the soiled brief during Resident A's stay at the facility. Resident A is no longer at the facility and was discharged per the family's request on 6/30/22. Ms. Johnstone provided me a copy of Resident A's service plan with record notes and June 2022 medication administration record for my review.

On 7/11/22, I interviewed Employee A at the facility. Employee A reported Resident A "was pretty much total care during [their] stay here." Resident A could make needs known but was inconsistent with using the call light. Employee A reported Resident A had a private caregiver that would assist throughout the week, and it was the private duty caregiver that alerted staff on first shift that Resident A was soiled on 6/27/22. Employee A reported the disposable bed pad was rolled over to cover the soiled area and Resident A was sitting on top of the soiled disposable bed pad. Employee A reported "it could not be determined who rolled the disposable bed pad over like that, but we showered [Resident A] immediately and cleaned the bed up." Employee A reported the shift supervisor was also immediately notified of the incident and Resident A was subsequently placed on increased nightly checks. Employee A

reported no knowledge of Resident A crawling on floor to reach meals and/or no knowledge of Resident A falling. Employee A reported Resident A had a poor appetite but could feed self and meals and water were always within reach for Resident A.

On 7/11/22, I interviewed Employee B at the facility. Employee B confirmed there was a soiled disposable bed pad that Resident A was found sitting on top of on 6/27/22. Employee B reported it was discovered by Resident A's private caregiver with the shift supervisor, Ms. Johnstone, and Resident A's family being notified. Resident A was immediately showered, and the bed was cleaned upon the discovery. Employee B reported Resident A was placed on increased night checks due to the incident, but it was never determined what time the incident occurred, or which staff member(s) were involved. Employee B reported Resident A required one to two person assist with all care and mobility. Employee B reported Resident A has fallen out of bed and was witnessed crawling across the floor to reach their food tray that was across the room. Employee B reported Resident A's meal tray was found by care staff on more than three occasions across the room and/or out of reach. Employee B reported even though Resident A could make needs known, Resident A was not consistent with using the call light to ask for assistance.

On 7/11/22, I interviewed Employee C at the facility. Employee C reported Resident A is one to two person assist with all care and mobility. Resident A did not refuse care but was not consistent with using the call light to ask for assistance from care staff either. Employee C reported on Resident A's private caregiver found Resident A sitting on top of a soiled disposable bed pad that had been rolled over by facility staff on third shift. Employee C reported the incident was reported to the first shift care staff immediately, the shift supervisor, management, and Resident A's family. Resident A was showered immediately, and the bed was cleaned with care staff increasing Resident A's supervision to two-hour checks. Employee C reported no knowledge of Resident A crawling on the floor to reach meal trays across the room. Employee C reported Resident A can feed self and meals and water are always left within reach.

On 7/13/22, I reviewed Resident A's service plan which revealed the following:

- Resident A requires one person assist with dressing, grooming, peri-care and is incontinent.
- Resident A requires two person assist with toileting, transfers, and showering.
- Resident A had three nightly visual checks as of 6/12/22 service plan update.
- The facility manages apartment cleaning to include bathroom, laundry, and medications.

Review of Resident A's record notes revealed the following:

- On 6/12/22, Resident A refused to wear O2 at 1:00pm.
- On 6/13/22, Resident A has injury to right elbow, and it is covered with steri strips. No active bleeding and no complaints of pain.

- 6/13/22, Resident A lethargic at 3:15pm with family present in room. Nurse assessed Resident A, EMS services were called, medications were reviewed, and new orders were provided. No further concerns or needs noted by nurse.
- 6/14/22, Resident was alert and used call light for needs. Communicated needs clearly.
- On 6/24/22, Resident A's private caregiver met with Resident A to provide shower and voiced complaint to care staff about needing towels for Resident A.
- On 6/24/22, Resident A's family member voiced a complaint to care staff about Resident A requiring assistance with feeding and *"staff not helping".* Resident A's family member reported "*the food tray is just left in front of [Resident A]".* Care staff reported Resident A's food needs to be cut up by kitchen staff, but Resident A can feed self with special silverware that is provided at meals.

On 7/13/22, I reviewed the departmental facility incident report file. The review revealed the following:

- Resident A incurred a fall out of bed on 6/18/22. Care staff observed Resident A on the floor with Resident A stating [they] were trying to get to the bathroom. The call light was not pushed. Resident A incurred a skin tear to right middle index finger and laceration to left bottom lip. Skin tear and laceration cleaned with steri strip and band-aid applied. Resident A's range of motion was within normal limits and staff completed a two person assist to lift Resident A from the floor. A fall mat and non-slip socks were requested by care staff from Hospice. Resident A is on 2-hour toileting schedule and care plan will be updated to reflect any care changes when fall mat arrives.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.

ANALYSIS:	Resident A was found on 6/27/22 sitting on top of a soiled disposable bed pad. It was alleged care staff rolled the soiled part of the disposable bed over instead of removing it and replacing it with a clean disposable pad. It cannot be determined how long Resident A sat on top of the soiled disposable bed pad or which care staff were involved. While the incident was addressed by facility care staff immediately upon discovery, interviews, on-site inspection, and review of facility documentation revealed evidence that facility care staff did not provide Resident A the dignity or care consistent with the service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility is short staffed on Resident A's hallway.

INVESTIGATION:

On 7/11/22, Ms. Johnstone reported the facility is not understaffed and that while there are call-ins, there is float staff to cover any shift shortages. Ms. Johnstone reported shift supervisors and management will also assist as needed. Ms. Johnstone reported there are staff from other buildings that can be utilized as well. Ms. Johnstone provided me a copy of the staff schedule for June 2022 and the call light log for June 2022 my review.

On 7/11/22, Employee A reported Resident A's hallway and "the facility in general" can be short staffed at times due to call-ins. Employee A reported when call-ins occur, float staff, shift supervisors, and staff from other buildings are called in to fill the shift shortage. Employee A also reported each hall has a med tech in addition to care staff that will assist as needed.

On 7/11/22, Employee B reported Resident A's hallway has been short staffed recently. Employee B reported there has been one care staff to 14 residents on that hallway during second and third shifts. Employee B reported management does attempt to call in other care staff, but care staff do not always pick up the shift shortages. Employee B reported there is some agency in the facility as well and shift supervisors and med techs will help as well.

On 7/11/22, Employee C reported the facility overall can be short staffed at times not just Resident A's hallway due to call-ins. However, Employee C reported float care

staff, shift supervisors, and med techs are utilized when a shift is going to be short staffed.

On 7/11/22, I reviewed the working staff schedule for June 2022 which revealed that while there were multiple call-ins across all shifts, appropriate staff were assigned to fill the shift vacancies. No other concerns noted.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	Interviews with the administrator and care staff along with review of the working staff schedules also reveal a normalization of care staff to appropriately meet the needs of residents at the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the receipt of an approved corrective action plan, I recommend this license remain unchanged.

Julie Viviano

7/14/2022

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Julie Viviano Date
Licensing Staff

Approved By:

Andrea L Moore

10/05/2022

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

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