GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 19, 2022

Donald Trygstad
Robbinswood Assisted Living Community
1125 Robbins Road
Grand Haven, MI 49417

RE: License #: AH700319383
Investigation #: 2022A1028072
Robbinswood Assisted Living Community

Dear Mr. Trygstad:

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 I 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 #:	AH700319383
Investigation #:	2022A1028072
Complaint Receipt Date:	08/03/2022
Investigation Initiation Date:	08/04/2022
Report Due Date:	10/02/2022
Licensee Name:	Robbinswood Operating Co., LLC
Licensee Address:	1125 Robbinswood Road Grand Haven, MI 49417
Licensee Telephone #:	(616) 842-1900
Authorized Representative/Administrator:	Donald Trygstad
Name of Facility:	Robbinswood Assisted Living Community
Facility Address:	1125 Robbins Road Grand Haven, MI 49417
Facility Telephone #:	(616) 842-1900
Original Issuance Date:	05/17/2012
License **Status:**	REGULAR
Effective Date:	12/10/2021
Expiration Date:	12/09/2022
Capacity:	110
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Staff wheeled Resident A into the elevator incorrectly resulting in Resident A's fall with injury.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/03/2022	Special Investigation Intake 2022A1028072
08/04/2022	Special Investigation Initiated - Letter
08/04/2022	APS Referral APS referral sent to Centralized Intake.
08/29/2022	Inspection Completed On-site On-site inspection completed due to investigation.
08/29/2022	Contact - Face to Face Interviewed AR/Administrator, Don Trygstad, at the facility.
08/29/2022	Contact - Face to Face Interviewed Employee A at the facility.
08/29/2022	Contact - Face to Face Interviewed Employee B at the facility.
08/29/022	Contact - Document Received Received Resident A's incident report from Employee A.
08/29/2022	Contact – Document Received Received in-service documentation, Resident A's service plan, and July MAR from AR/Admin/Don Trygstad.
08/29/2022	Contact – Telephone call made Interviewed Employee C by telephone.
10/19/2022	Exited with AR/Admin Don Trygstad via telephone.

ALLEGATION:

Staff wheeled Resident A into the elevator incorrectly resulting in Resident A's fall with injury.

INVESTIGATION:

On 8/4/2022, the Bureau received the allegations through the online complaint system.

On 8/4/2022, an APS referral was made to Centralized Intake.

On 8/29/2022, I interviewed the facility authorized representative/administrator, Don Trygstad, at the facility. Mr. Trygstad reported Resident A was in [their] wheelchair and was pushed forward into the elevator by staff after returning from an activity on the main floor. Mr. Trygstad reported Resident A fell from the wheelchair onto the elevator floor which resulted in injury. Mr. Trygstad reported Resident A's authorized representative and physician were notified and Resident A was sent to the hospital for evaluation due to complaints of pain. Upon return from the hospital, it was revealed Resident A incurred a broken right arm from the fall.

On 8/29/2022, I interviewed Employee A who reported Resident A was being assisted onto the elevator by staff after participating in an activity on the main floor. Resident A was in [their] wheelchair and pushed forward into the elevator but began to resist and put [their] arms and feet out to prevent entering the elevator. Resident A did not have footrests on the wheelchair and attempted to stand from the wheelchair resulting in a fall. Employee A reported the wheelchair wheels got stuck in the gap of the elevator door shaft contributing to the incident. Employee A reported footrests are not always used with Resident A due to Resident A sometimes being able to self-propel the wheelchair. Resident A complained of pain after the fall and was sent to the hospital for evaluation. Resident A returned with a diagnosis of a broken arm. Employee A reported all staff are trained on transfers and to assist residents with ambulation. A recent in-service was completed with all staff on 7/12/2022 prior to this incident. Employee A provided the incident report for my review.

On 8/29/2022, I interviewed Employee B who reported Resident A was assisted by staff onto the elevator after an activity on the main floor. Resident A was pushed in [their] wheelchair forward into the elevator and the wheelchair did not have footrests on at this time. Employee B reported footrests are not always used with Resident A due to Resident A being able to self-propel the wheelchair sometimes. Resident A tried to resist going into the elevator by placing their arms and legs out. Resident A then attempted to stand from wheelchair and fell forward onto the elevator floor. Resident A's wheelchair wheels also got stuck in the gap of the elevator door shaft. Resident A complained of pain and was sent to the hospital. Resident A returned with a diagnosis of a broken arm. Employee B reported all staff are trained on transfers and wheelchair mobility at orientation and receive continual training and

education throughout the year. Employee B reported a recent staff training was held addressing transfers and assisting with mobility.

On 8/29/2022, I interviewed Employee C who reported Resident A incurred a fall while being assisted into the elevator by staff. Resident A's wheelchair wheels got stuck in the gap of the elevator door shaft with Resident A sticking [their] arms and feet out to stand from the wheelchair. Resident A subsequently fell forward onto the elevator floor incurring a broken arm. Staff pushed Resident A in [their] wheelchair forward into the elevator instead of backing the wheelchair into the elevator. Employee C reported all staff are trained on proper transfers and wheelchair mobility at orientation and through monthly continuing education. Employee C reported Resident A's wheelchair should have been backed into the elevator and footrests should have been utilized as well. Employee C reported the staff involved with this incident were re-educated and counseled on appropriate transfer techniques and wheelchair mobility.

On 8/29/2022, I received evidence of staff training and in-service documentation along with Resident A's service plan from Mr. Trygstad.

I reviewed the staff training and in-service documentation which revealed it was completed by care staff on 7/12/2022. The in-service addressed general patient care to include appropriate transfers by a licensed third party.

I reviewed Resident A's service plan which revealed it was last updated on 7/28/2022 with use of Hoyer lift for transfers. Resident also uses a sit to stand and wheelchair with two person staff assist.

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:	Interviews and review of documentation reveal Resident A incurred a fall from [their] wheelchair resulting in injury while being assisted into the elevator by staff. Staff pushed Resident A in the wheelchair forward into the elevator instead of backing the wheelchair into the elevator, which would have prevented the wheelchairs wheels from getting stuck in the elevator door shaft. Wheelchair footrests were not used during the transport either, which could have deterred Resident A from attempting to stand from the wheelchair as well. There is evidence of facility monthly education and training in-services for staff. The in-service addressing general resident care to include appropriate transfers was completed by staff on 7/12/2022, prior to Resident A's fall on 7/26/2022. The staff involved with Resident A's incident completed and signed the in-service document on 7/12/2022. However, on 7/26/2022, the techniques used by the staff did not demonstrate competency of safe and appropriate transfers and wheelchair mobility when assisting Resident A into the elevator, which subsequently contributed to Resident A's fall with injury. Staff did not provide Resident A safety or protection consistent with the service plan or the recent in-service training.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

On 8/29/2022, Employee B reported an incident report was completed internally about Resident A's fall, but it was not initially submitted to the licensing department for review.

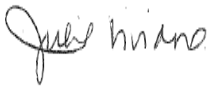
On 8/29/2022, I completed a department file search of the facility incident file to ensure compliance of reporting and the facility did not submit the incident report to the licensing department.

APPLICABLE RULE	
325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.

ANALYSIS:	The facility never reported Resident A's fall with injury to the licensing department.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



8/30/2022

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Julie Viviano Date
Licensing Staff

Approved By:

10/05/2022

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