GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 20, 2022

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

RE: License #: AH700299440
Investigation #: 2022A1028079
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 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 #:** | AH700299440 |
| | |
| **Investigation #:** | 2022A1028079 |
| | |
| **Complaint Receipt Date:** | 09/01/2022 |
| | |
| **Investigation Initiation Date:** | 09/06/2022 |
| | |
| **Report Due Date:** | 11/01/2022 |
| | |
| **Licensee Name:** | Grand Pines Assisted Living LLC |
| | |
| **Licensee Address:** | 950 Taylor Ave.<br>Grand Haven, MI 49417 |
| | |
| **Licensee Telephone #:** | (616) 846-4700 |
| | |
| **Administrator:** | Nancy Baar-Johnstone |
| | |
| **Authorized Representative:** | Lauren Gowman |
| | |
| **Name of Facility:** | Grand Pines Assisted Living Center |
| | |
| **Facility Address:** | 1410 S. Ferry St.<br>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<br>ALZHEIMERS |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Staff did not follow Resident A's service plan contributing to Resident A's death. | Yes |
| The facility continues to be understaffed. | No |
| Additional Findings | No |

## III. METHODOLOGY

| | |
|---|---|
| 09/01/2022 | Special Investigation Intake<br>2022A1028079 |
| 09/06/2022 | Special Investigation Initiated - Letter |
| 09/06/2022 | APS Referral<br>No APS referral needed due to resident being deceased. |
| 09/22/2022 | Inspection Completed On-site<br>On-site inspection completed due to special investigation. |
| 09/22/2022 | Contact - Face to Face<br>Interviewed Admin/Nancy Baar-Johnstone at the facility. |
| 09/22/2022 | Contact - Face to Face<br>Interviewed Employee A at the facility. |
| 09/22/2022 | Contact - Face to Face<br>Interviewed Employee B at the facility. |
| 09/22/2022 | Contact - Face to Face<br>Interviewed Employee C at the facility. |
| 09/22/2022 | Contact - Document Received<br>Received Resident A's service plan, record with notes, working staff schedules, and adaptive equipment policy from Admin/Nancy Baar-Johnstone. |
| 10/20/2022 | Exited with Admin/Nancy Johnstone via telephone. Report sent to AR/Lauren Gowman and Admin/Nancy Johnstone. |

**ALLEGATION:**

**Staff did not follow Resident A's service plan contributing to Resident A's death.**

**INVESTIGATION:**

On 9/1/2022, the Bureau received the allegations anonymously from the online complaint system.

On 9/22/2022, I interviewed the facility administrator, Nancy Baar-Johnstone, at the facility. Ms. Baar-Johnstone reported Resident A was receiving hospice services at the time of death and Resident A had a do not resuscitate (DNR) order as well. Resident A was declining in health days prior to [their] death. Ms. Baar-Johnstone reported on 7/17/2022, the morning shift supervisor entered Resident A's room and found Resident A on the floor with [their] arm wedged between the halo bar and the mattress. Resident A's halo bar did not have a cover to prevent entanglement. Ms. Baar-Johnstone reported staff immediately assessed Resident A, alerted Resident A's physician, authorized representative, and emergency services were called. Staff were unable to safely assist Resident A from the floor, so staff made Resident A as comfortable as possible while until emergency services arrived. Ms. Baar-Johnstone reported prior to emergency services arriving, Resident A stop responding to staff and expired. A second phone call was made to Resident A's physician reporting Resident A's death with emergency services and a police officer arriving at the facility shortly after Resident A expired. Staff presented the emergency services personnel and the police officer Resident A's DNR order. Ms. Baar-Johnstone reported an internal facility investigation was opened immediately revealing the third shift staff member assigned to Resident A completed documentation that the two-hour service checks for Resident A were completed. The third shift staff member was suspended pending the investigation results. Ms. Baar-Johnstone reported she compared the third shift staff member's documentation with the facility video surveillance, and it did not support the third shift staff member's documentation. Ms. Baar-Johnstone reported the third shift staff member did not complete the two-hour service checks for Resident A as required. Ms. Baar-Johnstone reported the third shift staff member was terminated immediately due to this incident and the results of the investigation were provided to the police as well. The facility also informed the licensing department of this incident as well in accordance with the reporting requirements. Ms. Baar-Johnstone provided me a copy of Resident A's service plan, DNR order, the facility internal investigation, adaptive equipment policy, and staffing schedules.

On 9/22/2022, Employee A reported Resident A incurred a fall out of bed on 7/17/2022. Resident A had been declining in health prior to the fall and was receiving hospice services. Resident A also had a DNR order in place which staff were aware of and had access to. Employee A reported Resident A was found on the floor in

[their] apartment with [their] arm wedged between the halo bar and the mattress. Resident A's physician and emergency services were called. Employee A reported Resident A expired before emergency services arrived and that Resident A's DNR order was provided to emergency services and the police officer who arrived shortly after. Employee A reported an investigation was opened and it was revealed the third shift staff member fraudulently completed documentation that [they] had completed a recent check on Resident A. Employee A reported the facility is video monitored and the third shift staff member was terminated immediately. Employee A reported the facility provided education on completing service checks appropriately and completing documentation correctly.

On 9/22/2022, I interviewed Employee B and Employee C at the facility, whose statements are consistent with Ms. Baar-Johnstone's and Employee A's statements.

On 9/27/2022, I reviewed Resident A's service plan which revealed Resident A was receiving hospice services, was an increased fall risk, and required one to two person assist with care. Resident A was to also be provided a service check every 1.5 hours to 2 hours for repositioning.

I reviewed Resident A's DNR order which revealed it was signed by Resident A's authorized representative on 6/10/2022 and Resident A's physician on 6/13/2022.

I reviewed the incident report with record notes which revealed the facility completed an internal investigation resulting in the termination of the third shift staff member assigned to Resident A on 7/16/22 to 7/17/22.

I reviewed facility adaptive equipment policy for the facility which revealed bedrails are to be checked quarterly by the facility to ensure safety.

| **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:**<br>**(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.** |

| | |
|---|---|
| **ANALYSIS:** | Resident A was declining in health and receiving hospice services prior to the incident that occurred on 7/17/22. Resident A also had DNR order in place with staff aware of the order.<br><br>On 7/17/22, Resident A was found on the floor by first shift staff. Resident A's physician, emergency services, and authorized representative were immediately notified by the facility. However, prior to emergency services arriving, Resident A expired.<br><br>Due to the nature of the incident the facility completed an internal investigation and subsequently suspended the third shift staff member in question until the investigation was complete. The investigation revealed the third shift staff member assigned to Resident A from 7/16/22 to 7/17/22, did not provide Resident A care consistent with the service plan. The third shift staff did not complete the 1.5-hour to 2-hour service check as required by the service plan but documented as completing the service check. The facility immediately terminated the third shift staff member and provided the investigation results to the police as well.<br><br>While facility took immediate action and appropriate measures to address this incident, there is evidence the facility did not follow their adaptive equipment policy. Resident A's arm was found wedged between the halo bar and the mattress and the halo bar did not have a cover to prevent entanglement. There is no evidence to support the facility completes the quarterly bedrail checks in accordance with their policy. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION:**

**The facility continues to be understaffed.**

**INVESTIGATION:**

On 9/22/2022, Ms. Baar-Johnstone reported the facility continues to struggle with staffing, but all shifts are covered by facility staff, float staff, and management. Ms. Baar-Johnstone reported med-techs are also assisting with care and the facility is also using agency again due to call-ins. Ms. Baar-Johnstone reported the facility continues to actively hire, provide incentives to pick up shifts, and provide shift premiums as well. Ms. Baar-Johnstone reported the facility has paused all resident

admissions above a certain level of care due to staffing issues as well. Ms. Baar-Johnstone reported she wants to ensure there is enough staff and that the current staff can meet the needs of the current residents before admitting new residents. Ms. Baar-Johnstone reported that while the facility continues to experience call-ins and no-shows from staffing, the facility continues to ensure all shifts are covered. Ms. Baar-Johnstone provided me the working staff schedules from July 2022 to September 2022 for my review.

On 9/22/2022, Employee A reported the facility continues to struggle with staffing and call-ins but ensures all shifts are covered. Employee A reported the facility utilizes facility staff, float staff, management, and agency to cover short shifts. Employee A reported the facility is actively hiring but some of the new hires either did not show up or completed orientation and then did not show up for their first day of training. Employee A also reported the facility offers incentives, shift premiums, and med techs are required to assist with care when needed as well. Employee A reported the facility "is doing everything they can but they can't make people work. No shift goes uncovered though".

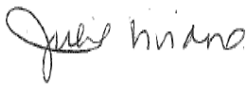
On 9/22/2022, Employee B and Employee C's statements are consistent with Ms. Baar-Johnstone's and Employee A's statements.

On 9/27/2022, I reviewed the working staff schedules from July 2022 to September 2022 which revealed that while there were multiple call-ins across all shifts, appropriate staff to include management and agency were assigned to fill the shift vacancies.

| **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 reveal that while the facility continues to experience call-ins, the facility continues to take appropriate measures to meet the needs of residents at the facility. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

## IV. RECOMMENDATION

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



9/27/2022

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Julie Viviano Date
Licensing Staff

Approved By:

10/06/2022

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