GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 1, 2022

Troy Vugteveen
Holland Home Raybrook Manor
2121 Raybrook Avenue, SE
Grand Rapids, MI 49546-5793

RE: License #: AH410236821
Investigation #: 2023A1010004
Holland Home Raybrook Manor

Dear Mr. Vugteveen:

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 that I am not available and you need to speak to someone immediately, please contact the local office at (517) 241-1970.

Sincerely,

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa NW Unit 13, 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410236821
Investigation #:	2023A1010004
Complaint Receipt Date:	10/13/2022
Investigation Initiation Date:	10/14/2022
Report Due Date:	12/12/2022
Licensee Name:	Holland Home
Licensee Address:	Suite 300 2100 Raybrook Ave. SE Grand Rapids, MI 49546
Licensee Telephone #:	(616) 643-2501
Administrator:	Timothy Myers
Authorized Representative:	Troy Vugteveen
Name of Facility:	Holland Home Raybrook Manor
Facility Address:	2121 Raybrook Avenue, SE Grand Rapids, MI 49546-5793
Facility Telephone #:	(616) 235-5002
Original Issuance Date:	11/10/1996
License Status:	REGULAR
Effective Date:	12/21/2021
Expiration Date:	12/20/2022
Capacity:	236
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was observed with multiple bruises on 9/27/22. Resident A's responsible person was not notified of the bruises.	Yes

III. METHODOLOGY

10/13/2022	Special Investigation Intake 2023A1010004
10/14/2022	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
10/14/2022	APS Referral APS referral emailed to Centralized Intake
10/27/2022	Inspection Completed On-site
10/27/2022	Contact - Document Received Received resident service plan, staff notes, and pendant response times
12/01/2022	Exit Conference A voicemail was left for licensee authorized representative Troy Vugteveen

ALLEGATION:

Resident A was observed with multiple bruises on 9/27/22. Resident A's responsible person was not notified of the bruises.

INVESTIGATION:

On 10/13/22, the Bureau received the allegations from the online complaint system. The complaint read on 9/27/22, a family member observed Resident A was "covered in bruises. What is most disturbing is that family had never been informed about this, and there was nothing noted in medical records about the bruises or about any other concerns (other than a medical note written on 9/22 by [Staff Person 1 (SP1)] at 12:07pm." The complaint also read when confronted about the bruises, staff reported they did not know how Resident A got them. Resident A's family requested she be sent to the hospital for further evaluation.

10/14/22, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 10/27/22, I interviewed administrator Tim Myers at the facility. Mr. Myers stated Relative A1 went to visit Resident A on 9/27/22. Mr. Myers reported Relative A1 notified staff she observed multiple bruises on Resident A. Mr. Myers stated Resident A resided in the Verblaauw secured memory care unit in the facility. Mr. Myers said Relative A1 spoke with Verblaauw unit manager Staff Person 1 (SP1) regarding the bruises she observed on Resident A. Mr. Myers stated after he was informed of the bruises, he went to talk to Resident A.

Mr. Myers reported it was difficult to engage Resident A in meaningful conversation due to her memory loss. Mr. Myers stated Resident A told him she fell; however, she was unable to answer additional questions. Mr. Myers explained Resident A had a dresser in her bathroom in front of her toilet. Mr. Myers said Resident A had a scrape with a bruise on her knee, a bruise on her arm, and a bruise on her forehead. Mr. Myers stated the bruises appeared to be more consistent with an unwitnessed fall.

Mr. Myers stated staff first observed and documented Resident A's bruises on 9/22/22. Mr. Myers reported the bruises that Relative A1 observed on 9/27/22 were the same that staff documented about on 9/22/22. Mr. Myers said the bruises appeared to be getting worse rather than healing. Mr. Myers explained Resident A was tested positive for COVID-19 and was prescribed Paxlovid at the time the bruises were observed. Mr. Myers stated this, along with Resident A's other prescribed medications, may have led to the inability of Resident A's bruises to heal.

Mr. Myers reported it was the facility's procedure for staff to complete an "interdisciplinary note" and complete an incident report anytime a bruise or injury is observed on a resident. Mr. Myers stated an "interdisciplinary note" was completed on 9/22/22, however an incident report was not completed. Mr. Myers reported the completion of an incident report would have involved notifying Resident A's responsible person and her physician of the bruises observed. Mr. Myers said because a formal incident report was not completed on 9/22/22, these notifications were not made.

Mr. Myers stated Resident A also expressed some discomfort in her genital area. Mr. Myers said this was brought to SP1's attention and addressed with Resident A's physician due to concerns regarding a possible urinary tract infection (UTI). Mr. Myers reported an incident report was completed on 9/27/22 and contact was made with Resident A's physician. Mr. Myers said Resident A was sent to the hospital on 9/28/22.

Mr. Myers reported Resident A required the assistance from one staff person to transfer and use the toilet. Mr. Myers stated he interviewed staff that worked 9/22/22 through 9/27/22. Mr. Myers said staff did not report seeing Resident A fall. Mr. Myers provided me with copies of the staff written statements. I observed the written statements were consistent with Mr. Myers' statements. Mr. Myers said he also

watched video surveillance footage and did not observe any events that caused injury to Resident A.

Mr. Myers provided me with a copy of Resident A's service plan for my review. The *Ambulation/Mobility* section of the plan read, "Resident 1-2 assist, staff will monitor for changes in mobility status. 1-2 assist as needed, w/c for distance." The *Fall Risk Management* section of the plan read, "Staff will identify and monitor for fall risks. Keeps call light, water, TV remote, walker in reach at all times."

Mr. Myers provided me with a copy of Resident A's *Interdisciplinary Notes* for my review. A note dated 9/22/22 read, "It was observed today at 1130 that resident has bruising on left side of forehead, new bruising on upper left arm, and scrape on right knee. There was nothing passed along from previous shift what had happened to resident – and no note in communication sheet. Resident is less lethargic than she was yesterday. Woke up at 1130 am an was alert and talking with aides. She explained that her head hurts, hovering her hand over where bruising is on forehead. Resident was unable to explain how or when she got bruising." Follow up to previous note: manager has been notified."

Mr. Myers said after Resident A was admitted to the hospital on 9/28/22, she was discharged to the skilled nursing area of the facility. Mr. Myers reported Resident A passed away in the skilled nursing area.

On 10/27/22, I interviewed SP1 at the facility. SP1's statements were consistent with Mr. Myers. SP1 reported she was informed by care staff on 9/22/22 that bruises were observed on Resident A's knee, face, and arm. SP1 stated the staff person who observed the bruises on 9/22/22 did write an "interdisciplinary note" regarding the bruises, however she did not complete an incident report. SP1 reported the staff person did not follow the facility's procedure and complete the incident report or make the required contacts to the resident's responsible person or physician.

SP1 reported Resident A's vitals were being monitored after her bruises were observed on 9/22/22. SP1 stated it was observed that Resident A's bruises were getting worse, rather than healing. SP1 said that as a result, on 9/27/22, she contacted Resident A's physician. SP1 explained at that time, Resident A's physician changed some of Resident A's medications due to concern they were causing her to bruise easily and not heal. SP1 reported after she contacted Resident A's physician, he made no recommendation that Resident A be sent to the hospital. SP1 stated Resident A's vitals were stable at that time. SP1 said Resident A was transported to the hospital on 9/28/22 after she was observed to be more lethargic and required more assistance from staff.

I reviewed Resident A's physician note that was dated 9/27/22. The note read, "Notified by nursing staff of patient with bruising apparently initially started on her forehead but now noted to be below both eyes as well as right arm, apparently started a few days ago around September 21 or 22. At that time patient apparently

was flailing her arms through no apparent falls. Patient does have advanced dementia, unable to provide any details. She was recently increased on Depakote due to behavioral issues though concerned this may be contributing to some side effects of increasing bleeding and bruising. Recommend decreasing Depakote from 500 mg twice daily back to 250 mg twice daily as behaviors also seem better controlled. Also concerned that Celexa may be contributing to some easy bruising as well, recommend holding this for at least a week. Recommend rechecking labs including CBC and BMP. Have been attempting to obtain a urinalysis though so far unable to obtain. Apparently does have some history of some hematuria. Continue to monitor closely and will try to follow-up with patient again in a few days. Discussed with [Relative A1] as well today. If condition continues to decline, she may be appropriate for hospice care to focus on comfort care. Discussed with clinical care mangers."

APPLICABLE RULE	
R 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 interviews with Mr. Myers and SP1 revealed an incident report was not completed after care staff observed Resident A had bruising on her face, arm, and knee on 9/22/22. Resident A's responsible person, physician, and licensing staff were not notified of the bruises.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/1/22, I left voicemails for licensee authorized representative Troy Vugteveen and administrator Tim Myers regarding this investigation.

IV. RECOMMENDATION

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

11/22/2022

Lauren Wohlfert — Date
Licensing Staff

Approved By:

11/28/2022

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