GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 28, 2023

Rochelle Lyons
Grandhaven Living Center LLC
Suite 200
3196 Kraft Avenue SE
Grand Rapids, MI 49512

RE: License #: AL330268975
Investigation #: 2023A0790033
Grandhaven Living Center 4 (Cottage)

Dear Ms. Lyons:

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 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. If I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Rodney Gill, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL330268975
Investigation #:	2023A0790033
Complaint Receipt Date:	03/09/2023
Investigation Initiation Date:	03/10/2023
Report Due Date:	05/08/2023
Licensee Name:	Grandhaven Living Center LLC
Licensee Address:	Suite 200 3196 Kraft Avenue SE Grand Rapids, MI 49512
Licensee Telephone #:	(517) 420-3898
Administrator:	Rochelle Lyons
Licensee Designee:	Rochelle Lyons
Name of Facility:	Grandhaven Living Center 4 (Cottage)
Facility Address:	3165 W. Mount Hope Avenue Lansing, MI 48911
Facility Telephone #:	(517) 485-5966
Original Issuance Date:	03/17/2005
License Status:	REGULAR
Effective Date:	12/23/2021
Expiration Date:	12/22/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
On 03/09/23 Resident A was observed with bruising over his right eye, on his left shoulder, and on his right buttock.	No
On 03/07/2023 Resident A was observed covered in feces and direct care staff did not assist him timely.	Yes

III. METHODOLOGY

03/09/2023	Special Investigation Intake 2023A0790033
03/10/2023	APS Referral is not necessary as APS is investigating the allegations in this complaint.
03/10/2023	Special Investigation Initiated - On Site
03/10/2023	Inspection Completed On-site- Interviewed direct care staff member (DCSM) Rasheen Henry, operations specialist Bobbie Huizen, and Resident A.
03/13/2023	Contact - Telephone call made to interview Sparrow Hospice nurse practitioner Stacey Sutton.
03/16/2023	Contact - Telephone call made to interview Sparrow Hospice nurse Beth Ward. Voicemail message left requesting a return call.
03/16/2023	Inspection Completed-BCAL Sub. Compliance
03/16/2023	Corrective Action Plan Requested and Due on 04/03/2023.
03/21/2023	Contact – Telephone call made to interview operations specialist Bobbie Huizen a second time.
03/22/2023	Contact – Telephone call made to follow up with Ms. Sutton. Voicemail message left requesting a return call.
03/22/2023	Contact – Telephone call received from Ms. Sutton. Follow up interview.
03/22/2023	Contact – Telephone call made to interview DCSM Takeria Taylor.
03/23/2023	Contact – Telephone call made to Ms. Huizen. Follow up call.
03/23/2023	Contact – Telephone call made to DCSM Mr. Henry.

03/23/2023	Contact – Telephone call made to interview DCSM Ms. Taylor.
03/23/2023	Exit Conference with licensee designee Rochelle Lyons.

ALLEGATION:

On 03/09/23 Resident A was observed with bruising over his right eye, on his left shoulder, and on his right buttock.

INVESTIGATION:

I reviewed an open APS investigation on 03/09/2023. The allegations were as follows: Resident A lives at Grandhaven Living Center 4 (Cottage). Resident A receives hospice services due to a subdural hemorrhage. Resident A is incontinent for the most part and uses a wheelchair for mobility. On 03/09/23, Resident A was observed with bruising over his right eye, on his left shoulder, and on his right buttock. Resident A could not recall if he had fallen, and the facility had not documented of having any falls. There are concerns Resident A has bruising with no known explanation. Resident A did not allege any abuse. Resident A was not observed with these injuries on 03/07/23 when he was discovered covered in feces.

I conducted an unannounced onsite investigation on 03/10/2023. I interviewed direct care staff member (DCSM) Rasheen Henry. Mr. Henry said he has no knowledge of Resident A recently falling. He stated Resident A did fall several months ago but was not injured. Mr. Henry stated he has not noticed any bruising on Resident A.

Mr. Henry said Resident A will often walk around his room without his walker. He stated he has checked on Resident A and found him in the bathroom, closet, or other side of the room without his walker.

I interviewed operations specialist Bobbie Huizen and Ms. Huizen stated Adult Protective Services Worker Shonna Simms-Rosa is also investigating these allegations and was at the facility earlier this morning (03/10/2023). Ms. Huizen stated she was told Ms. Simms-Rosa took pictures of Resident A, received pictures Ms. Sutton took of Resident A on 03/07/2023, interviewed Resident A, and interviewed DCSMs.

Ms. Huizen said nurse practitioner Stacey Sutton examined Resident A on 03/07/2023 and registered nurse Beth Ward from Sparrow Hospice examined Resident A on 03/09/2023. She said neither Ms. Sutton nor Ms. Ward found any bruises of concern when examining Resident A. Ms. Huizen stated Ms. Ward informed her she found a bruise on the top of Resident A's left wrist consistent with bumping it while using his wheelchair. She said Resident A self-propels his wheelchair in his room and around the facility.

Ms. Huizen stated she has no record of Resident A falling recently. She said Resident A fell four or five months ago but was not injured.

I requested Ms. Ward's nurse's notes. Ms. Huizen stated Sparrow Hospice does not provide their nurse's notes to the facility.

I interviewed Resident A and noticed no bruising over his right eye. Resident A denied having bruising over his right eye, on his left shoulder, or on his right buttock. He said he does not believe he has bruising on any other part of his body other than his wrist. Resident A showed me the bruise on the top of his left wrist. The bruise was red and purple in color and approximately the size of a fifty-cent piece. Resident A could not recall how he received the bruise. He said the bruise does not hurt and he feels no pain. He said no one has grabbed him by the wrist or harmed him in any way.

Resident A said he has not fallen in months. He stated he did fall several months ago, but it was a minor fall, and he had no bruises or injuries as a result.

I interviewed Sparrow Hospice nurse practitioner Stacey Sutton via phone on 03/13/2023. Ms. Sutton said she examined Resident A on 3/07/2023 and did not observe any bruising on Resident A. She stated she specifically did not observe bruising over Resident A's left eye, on his left shoulder, or on his right buttock.

Ms. Sutton said Sparrow Hospice home health aide Michelle Smith had reported on 03/09/2023 observing bruising over Resident A's right eye, on his left shoulder, and on his right buttock. Ms. Sutton said upon hearing this, Sparrow Hospice registered nurse Beth Ward went to the facility on 03/09/2023, examined Resident A, and observed no bruising. Ms. Ward specifically reported she did not observe bruising over Resident A's left eye, on his left shoulder, or on his right buttock.

Ms. Sutton said she and Ms. Ward have never observed Resident A with any bruises of concern. She said Ms. Ward informed her Resident A had a small superficial bruise on the top of his left wrist on 03/09/2023 thought to be caused by Resident A using his wheelchair. Ms. Sutton stated Resident A self-propels his wheelchair in his room and throughout the facility and believed to have bumped his wrist while doing so.

I attempted to interview Ms. Ward via phone on 03/16/2023. Ms. Ward did not answer so I left a voicemail message requesting a return call. I did not hear from Ms. Ward.

I reviewed Resident A's *Assessment Plan for AFC Residents* and found under Community Movement, Resident A has good safety awareness and may be outside on campus grounds unsupervised but needs supervision to leave campus. Resident A requires baseline monitoring at change of each shift, mid-day meal and once per mid third shift.

I interviewed DCSM Takeria Taylor on 03/23/2023 via phone and Ms. Taylor did not disclose witnessing any bruises on Resident A.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	Based on information gathered during this special investigation through review of documentation and interviews with DCSM Rasheen Henry, Resident A, operations specialist Bobbie Huizen, Sparrow Hospice nurse practitioner Stacey Sutton, and DCSM Takeria Taylor there was no evidence found indicating Resident A had been physically harmed. Ms. Sutton said she examined Resident A on 3/07/2023 and did not observe any bruising on Resident A. According to Ms. Sutton, Sparrow Hospice registered nurse Beth Ward went to the facility on 03/09/2023, examined Resident A, and observed no bruising. Ms. Sutton said she and Ms. Ward have never observed Resident A with any bruises of concern.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

On 03/07/2023 Resident A was observed covered in feces and direct care staff did not assist him timely.

INVESTIGATION:

Mr. Henry stated he was not aware of Resident A being covered in feces on 03/07/2023. He said a certified nursing assistant from Sparrow Hospice comes to the facility to assist Resident A with his activities of daily living (ADL) including toileting and showering.

Resident A stated he feels he receives good care at the facility. He said DCSMs help him quickly when he has a soiled adult brief. Resident A could not provide a specific timeframe when asked how long on average it takes DCSMs to respond when he requires assistance changing his adult brief.

Sparrow Hospice nurse practitioner Stacey Sutton said when she arrived at the facility on 03/07/2023 to examine Resident A, he was completely covered in feces from head to toe. She said Resident A had dried feces covering the back of his legs.

Ms. Sutton emailed pictures she had taken, and upon reviewing the pictures I observed feces covering the front right tire of Resident A's wheelchair as well as a blue cushion laying on the floor under the wheelchair. I also observed feces on Resident A's hands, running down the inside of both of his legs, and the top and bottom of his feet. There was feces all over his fitted bed sheet and carpet in his room.

Ms. Sutton said she asked DCSM Rasheen Henry if he would help change Resident A's adult brief and get him and his room cleaned up. Ms. Sutton stated Mr. Henry said he would help Resident A as soon as possible. She said she cleaned Resident A's extremities and left to examine other residents. Ms. Sutton stated approximately 30 minutes later she went back to check on Resident A. She said Mr. Henry never came to assist Resident A and he was still lying in his bed covered in feces. She said she went and found Mr. Henry and a housekeeper, name unknown, sitting at the dining room table reading the newspaper. Ms. Sutton stated when she asked Mr. Henry if he was going to help Resident A change his adult brief and get cleaned up, Mr. Henry asked when the Sparrow Hospice home health aide would be arriving to assist Resident A with his ADLs. Ms. Sutton said she was at the facility from approximately 10:30 a.m. until 11:40 a.m. and Mr. Henry had yet to assist Resident A.

Resident A's *Assessment Plan for AFC Residents* indicates under Toileting Assistance, Resident A is incontinent of bowel and/or bladder and manages protective and/or assistive devices independently. Resident A wears pull up protective underwear according to his plan. Resident A's *Assessment Plan for AFC Residents* under Bathing indicated requires stand by assist for shower, requires continuous supervision and cueing, and requires assistance with both Upper and Lower body dressing.

I interviewed operations specialist Bobbie Huizen on 03/21/2023 via phone. Ms. Huizen said Resident A is now on two-hour checks and two-hour toileting assistance is being offered since speaking with his nurse practitioner Ms. Sutton and finding out what occurred on 03/07/2023.

Ms. Huizen stated she interviewed Mr. Henry who denied the allegations. She said she then interviewed the other DCSM working on 03/07/2023 named Takeria Taylor and Ms. Taylor informed her it was closer to lunch time when Ms. Taylor witnessed Resident A covered in feces and needing to be cleaned up. Ms. Huizen stated Ms. Taylor disclosed she informed Mr. Henry Resident A needed assistance getting cleaned up and assumed Mr. Henry helped Resident A clean up. Ms. Huizen said Ms. Taylor indicated the bath aide from Sparrow Hospice who assists Resident A with bathing and other ADL arrived shortly after.

I interviewed Ms. Sutton a second time on 03/22/2023 via phone. Ms. Sutton stated the home health aide Michelle Smith informed her she arrived at the facility to assist

Resident A with his ADL at approximately 12:30 p.m. on 03/07/2023. Ms. Smith told Ms. Sutton Resident A had gotten himself to the bathroom and was sitting on the toilet yelling for assistance when she arrived. Ms. Sutton said Ms. Smith disclosed Resident A was still covered in feces and his room had not yet been cleaned up. Ms. Smith assisted Resident A with showering, dressing, and cleaning his room. Ms. Sutton said she would have Ms. Smith contact me via phone but never heard from her.

I attempted to interview DCSM Takeria Taylor on 03/22/2023 via phone. Ms. Taylor said she was working, could not talk, and would call back later this afternoon/evening. I never heard from Ms. Taylor.

I contacted Ms. Huizen on 03/22/2023 via phone. I asked if DCSMs Rasheen Henry and Takeria Taylor were working today and available to speak. Ms. Huizen said Mr. Henry called in and appears to know there are concerns regarding his work performance which require appropriate disciplinary action. Ms. Huizen said Ms. Taylor worked today and will be off shift shortly.

I attempted to contacted Mr. Henry on 03/23/2023 via phone. I received a communication indicating the phone was not receiving messages at this time.

I interviewed Ms. Taylor on 03/23/2023 via phone. Ms. Taylor said she was scheduled to pass medication on 03/07/2023. She stated she did witness Resident A covered in feces while passing medication around lunch time. Ms. Taylor said she tried to get Resident A up and attempt to clean him, but he is a big guy and when he does not want to do something it is impossible to force him to do so.

Ms. Taylor stated she was unable to get Resident A up on her own so went and told Mr. Henry Resident A was covered in feces and needed help cleaning up. She said Mr. Henry was busy doing something at this time but she could not recall up he was doing. Ms. Taylor said she went by Resident A's room a second time and notice he was still covered in feces. She again attempted to get him up on her own but was unable to do so. Ms. Taylor stated she went and found Mr. Henry and again informed him Resident A still needed help cleaning up. She said Mr. Henry indicated Resident A's home health aide from Sparrow Hospice should be arriving soon to help Resident A shower. Ms. Taylor stated the home health aide from Sparrow Hospice arrived shortly after her conversation with Mr. Henry and helped Resident A clean up.

Ms. Taylor said she did not know for sure how long Resident A remained covered in feces. She stated she could not provide a timeframe regarding how long he remained in this condition.

I conducted an exit conference with licensee designee Rochelle Lyons on 03/23/2023 informing her a rule violation was established because of this special investigation and requesting a Corrective Action Plan (CAP) be written, implemented, and emailed as soon as administratively possible.

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:	Based on information gathered during this special investigation through review of documentation and interviews with DCSM Rasheen Henry, Resident A, operations specialist Bobbie Huizen, Sparrow Hospice nurse practitioner Stacey Sutton, and DCSM Takeria Taylor there was evidence found indicating Resident A was not treated with dignity and his personal needs were not attended to on 03/07/2023. Sparrow Hospice nurse practitioner Stacey Sutton said when she arrived at the facility on 03/07/2023 to examine Resident A, he was completely covered in feces from head to toe. She said Resident A had dried feces covering the back of his legs. Ms. Sutton stated she was at the facility over an hour and DCSMs had not yet helped Resident A change his soiled adult brief or clean up.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, it is recommended that the status of the license remains unchanged.

03/17/2023

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Rodney Gill Date
Licensing Consultant

Approved By:

03/28/2023

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Dawn N. Timm Date
Area Manager