GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 27, 2023

Jennifer Brown
Hope Network Rehabilitation Serv
1490 E Beltline SE
Grand Rapids, MI 49506

RE: License #: AL410083023
Investigation #: 2023A0583027
Sojourners Transitional Living

Dear Ms. Brown:

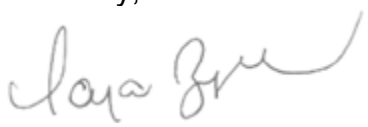
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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 (616) 356-0183.

Sincerely,



Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AL410083023 |
| | |
| **Investigation #:** | 2023A0583027 |
| | |
| **Complaint Receipt Date:** | 04/13/2023 |
| | |
| **Investigation Initiation Date:** | 04/17/2023 |
| | |
| **Report Due Date:** | 05/13/2023 |
| | |
| **Licensee Name:** | Hope Network Rehabilitation Serv |
| | |
| **Licensee Address:** | 1490 E Beltline SE<br>Grand Rapids, MI 49506 |
| | |
| **Licensee Telephone #:** | (616) 643-3977 |
| | |
| **Administrator:** | Jennifer Brown |
| | |
| **Licensee Designee:** | Jennifer Brown |
| | |
| **Name of Facility:** | Sojourners Transitional Living |
| | |
| **Facility Address:** | 1490 E Beltline Avenue SE<br>Grand Rapids, MI 49506-4336 |
| | |
| **Facility Telephone #:** | (616) 940-0040 |
| | |
| **Original Issuance Date:** | 02/19/1999 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 08/22/2021 |
| | |
| **Expiration Date:** | 08/21/2023 |
| | |
| **Capacity:** | 20 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED, DEVELOPMENTALLY DISABLED, MENTALLY ILL, TRAUMATICALLY BRAIN INJURED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Facility staff do not provide Resident A with adequate personal care. | No |
| Resident A missed medical appointments. | No |
| Additional Findings. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 04/13/2023 | Special Investigation Intake<br>2023A0583027 |
| 04/14/2023 | APS Referral |
| 04/14/2023 | Contact - Telephone call made<br>Relative 1 |
| 04/17/2023 | Special Investigation Initiated - Letter<br>APS complaint emailed |
| 04/17/2023 | Contact - Telephone call made<br>Relative 1 |
| 04/17/2023 | Contact - Telephone call made<br>Public Guardian Heidi Swieringa |
| 04/18/2023 | Inspection Completed On-site<br>Residential Coordinator Lindsey McBride, Staff Morgan Glasscoe, Resident A |
| 04/21/2023 | Contact - Telephone call made<br>Spectrum Wound Clinic Kenyatta Curry, RN |
| 04/25/2023 | Contact – Email<br>Residential Coordinator Lindsey McBride |
| 04/26/2023 | Exit Conference<br>Licensee Designee Jennifer Brown |

**ALLEGATION: Facility staff do not provide Resident A with adequate personal care.**

**INVESTIGATION:** On 04/13/2023 complaint allegations were received from the BCAL online reporting system. The complaint stated Resident A is diagnosed with a traumatic brain injury and is confined to a wheelchair. The complaint stated Resident A currently resides at the Hope Network Sojourners Transitional Living facility and his appointed public guardian is Heidi Swierenga. The complaint alleged that Resident A was not being provided adequate personal care by facility staff and "ended up in the hospital the first week of January with 3 major wounds to his legs". The complaint elaborated that "the first wound from spring of 2021 had opened back up completely, there was also a wound on his right leg about 6? long, 1-2? wide and not sure how deep in the same area as the one on his left", and "a third wound on his ankle that Nathan said was due to the aides tying his shoes too tight due to his swollen ankles causing a pressure wound". The complaint alleged that Hope Network staff are not trained well enough to care for paralyzed patients putting them into their chairs, not paying close enough attention to skin prior to getting them up/putting them back into bed and not paying attention to proper pad placement/ equipment on their chairs. The complaint alleged that Resident A's wounds are not provided enough care because all they are doing is having the Spectrum Health Visiting Nurse who only comes three days a week change the pads, which should be changed twice a day, every day, seven days a week not three times a week.

On 04/14/2023 I emailed the complaint allegations to Adult Protective Services Centralized intake.

On 04/14/2023 I telephoned Relative 1 however there was no answer. The voicemail box was full and therefore a message could not be left.

On 04/17/2023 I telephoned Relative 1 however there was no answer, voicemail box was full, and therefore a message could not be left.

On 04/17/2023 I interviewed Heidi Swieringa via telephone. Ms. Swieringa stated she has been Resident A's public guardian since 2011. Ms. Swieringa stated Resident A "can converse" and "is pleasant". Ms. Swieringa stated Resident A suffers memory deficits associated with his traumatic brain injury which "waxes and wanes". Ms. Swieringa stated Resident A was admitted to the facility in 2021. Ms. Swieringa stated Resident A has a history of skin care break down prior to his admittance to the facility which has necessitated Resident A to utilize the Spectrum Health Wound Clinic for care. Ms. Swieringa stated she is happy with the level of care provided at the facility and feels staff are adequately trained to provide for Resident A's personal care needs. Ms. Swieringa stated Resident A is "less than compliant" with facility staff's attempts to assist Resident A with personal care such as allowing facility staff to turn Resident A in the middle of the night. Ms. Swieringa stated Resident A's wounds are currently addressed by Spectrum Health's Wound Care Clinic. Ms. Swieringa explained that Resident A receives three times per week in-home wound care by Spectrum Health Visiting Nurses as well as monthly wound care appointments completed in the office by a physician or nurse practitioner. Ms. Swieringa stated Resident A is receiving adequate wound care services provided by

Spectrum Wound Care Clinic and adequate personal care provided by the facility staff. Ms. Swieringa denied facility staff caused Resident A's ankle wound due to tying his shoes too tight and stated staff are trained to address his personal care needs.

On 04/18/2023 I completed an unannounced onsite investigation at the facility and privately interviewed Residential Coordinator Lindsey McBride, Staff Morgan Glasscoe, and Resident A.

Residential Coordinator Lindsey McBride stated Resident A receives adequate personal care from staff and adequate wound care from the Spectrum Health Wound Clinic. Ms. McBride stated Resident A has a history of skin breakdown prior to being admitted to the facility on 12/16/2021 and since admission Resident A has refused to allow facility staff to care for his wounds because he prefers his wound care be provided by Spectrum Health. Ms. McBride stated Resident A receives three times per week in facility wound care and dressing changes from Spectrum Health in-home nursing staff and once per month in office wound care checks from the Spectrum Health Wound Clinic physicians and nurse practitioners. Ms. McBride stated Resident A has one open wound in the process of healing on his ankle which is classified as stable. Ms. McBride stated that in January of 2023 Resident A was admitted to the hospital due to an infected wound necessitating IV antibiotics but prior to the admission Resident A was receiving in-home nursing wound care via Spectrum Health. Ms. McBride stated facility staff provide Resident A with showering assistance and cover Resident A's wound during showering and bathing. Ms. McBride denied facility staff tied Resident A's shoes "too tight" causing a pressure wound. Ms. McBride stated facility staff are diligent in monitoring residents for skin break down and address such wounds with appropriate care.

While onsite I reviewed Resident A's Assessment for AFC Residents, signed 12/27/2021. The Assessment Plan stated Resident A requires staff assistance with toileting, bathing, grooming, and dressing.

Staff Morgan Glasscoe stated she has worked at the facility for approximately "three years" and is familiar with Resident A's personal care needs. Ms. Glasscoe stated Resident A has one current wound which is classified as "stable" on his ankle. Ms. Glasscoe stated Spectrum Health in-home nursing provides adequate care of the wound and facility staff are diligent in keeping the wound dry during showers. Ms. Glasscoe stated facility staff visually assess the wound and report changes to the Spectrum Health Wound Clinic. Ms. Glasscoe stated Resident A is provided adequate personal care.

Resident A stated he has a history of wounds requiring the services of the Spectrum Health wound clinic. Resident A stated he has a history of wounds on his right ankle, left calf, and right calf. Resident A stated he currently has one wound identified as stable on his ankle. Resident A stated Spectrum Health in-home nursing provides three times weekly in home dressing changes for his ankle wound

and he is happy with their services. Resident A stated he attends monthly in-clinic appointments at the Spectrum Health Wound clinic with a physician or nurse practitioner. Resident A stated he was hospitalized January of 2023 due to an infected right calf wound necessitating the administration of IV antibiotics. Resident A denied facility staff have tied his shoes too tight and stated he is happy with the level of care provided by facility staff.

On 04/21/2023 I interviewed Spectrum Health Wound Clinic RN, Kenyatta Currey, via telephone. Ms. Curry stated Resident A is a patient of the clinic and attends monthly in-clinic visits with a physician or nurse practitioner. Ms. Curry stated Resident A also receives three times weekly in-facility wound care from Spectrum Health visiting nurses. Ms. Curry stated Resident A currently has one wound located on his ankle that is classified as “stable”. Ms. Curry stated Resident A was hospitalized 01/06/2023 due to an infected wound on his right calf which necessitated IV antibiotics and was discharged back to the facility. Ms. Curry stated Resident A was receiving in-home nursing care for his wound prior to the hospitalization.

On 04/26/2023 I completed an Exit Conference with Licensee Designee Jennifer Brown via telephone. Ms. Brown stated she agreed with the findings.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.15303** | **Resident care; licensee responsibilities.** |
| | **(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.** |
| **ANALYSIS:** | Resident A receives three times weekly in-facility wound care from the Spectrum Health Visiting Nurses and monthly in-clinic appointments with Spectrum Health Wound Clinic physicians and nurse practitioners.<br><br>Resident A and Public Guardian Heidi Swieringa both reported they are happy with level of care provided by facility staff and Resident A’s current wound is classified as stable.<br><br>A preponderance of evidence was not discovered during the Special Investigation to substantiate violation of the applicable rule. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

**ALLEGATION: Resident A missed medical appointments.**

**INVESTIGATION:** On 04/13/2023 complaint allegations were received from the BCAL online reporting system. The complaint stated, “on March 15, 2023 (Resident A) stated that he has missed three appointments one being the wound clinic, which is very important due to the fact that HELP was not able to take him”.

On 04/17/2023 I interviewed Heidi Swieringa via telephone. Ms. Swieringa stated Resident A’s medical appointments are scheduled by both Resident A and facility staff. Ms. Swieringa stated Resident A has memory deficits but does request to make his own medical appointments and Ms. Swieringa permits this arrangement. Ms. Swieringa stated she was recently aware of facility staff forgetting to pick up Resident A’s “sleep study” materials and that was rescheduled and ultimately completed. Ms. Swieringa stated she was unaware of missed medical appointments for wound care. Ms. Swieringa stated it is ultimately the responsibility of the facility to make sure Resident A completes medical appointments.

On 04/18/2023 I completed an unannounced onsite investigation at the facility and privately interviewed Residential Coordinator Lindsey McBride, Staff Morgan Glasscoe, and Resident A.

Residential Coordinator Lindsey McBride stated Resident A suffers memory deficits yet is permitted by his legal guardian to schedule his own medical appointments. Ms. McBride stated Resident A has sporadically forgotten to communicate the dates and times of medical appointments to staff which have resulted in missed and/or rescheduled medical appointments. Ms. McBride stated Resident A completed a medical appointment with the Spectrum Health Wound Clinic on 03/03/2023 and a Mary Free Bed medical appointment on 03/13/2023. Ms. McBride stated she was aware that on 03/07/2023 Resident A was scheduled to complete a catheter change but that appointment was rescheduled because Resident A did not communicate the appointment date and time to staff in a timely manner and subsequently there was not adequate staffing to transport Resident A to the appointment. Ms. McBride stated the catheter change appointment was rescheduled and completed on 03/09/2023. Ms. McBride stated that to her knowledge, Resident A completed all required medical appointments on or around 03/15/2023.

Staff Morgan Glasscoe stated Resident A schedules his own medical appointments and “tells staff of the appointments”. Ms. Glasscoe stated Resident A “sometimes doesn’t communicate well enough” when the medical appointments are scheduled to afford staff adequate time to arrange staff transportation.

Resident A stated he prefers to schedule his own medical appointments. Resident A stated he schedules his own medical appointments and subsequently communicates the dates and times to facility because facility staff provide transportation for the medical appointments. Resident A stated he missed an appointment with the Spectrum Health Wound Clinic in late March because he forgot to inform facility staff of the appointment in a timely manner. Resident A stated facility staff forgot to pick

up his sleep study material recently, but the device was ultimately picked up a week later.

On 04/21/2023 I interviewed Spectrum Health Wound Clinic RN, Kenyatta Currey, via telephone. Ms. Curry stated Resident A was seen at the clinic by Dr. Witty on 03/03/2023. Ms. Curry stated Resident A was scheduled in clinic on 03/14/2023 and that appointment was cancelled with no reason identified in their computer system. Ms. Curry stated the 03/14/2023 appointment was rescheduled on 04/07/2023 and completed.

On 04/26/2023 I completed an Exit Conference with Licensee Designee Jennifer Brown via telephone. Ms. Brown stated she agreed with the findings.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.15310** | **Resident health care.** |
| | **(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following:**<br>**(a) Medications.**<br>**(b) Special diets.**<br>**(c) Susceptibility to hyperthermia and hypothermia and related limitations for physical activity, as appropriate.**<br>**(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.** |
| **ANALYSIS:** | Resident A has been diagnosed with a traumatic brian injury which impairs his memory. Resident A has been permitted to schedule his own medical appointments despite a history of forgetting to inform facility staff in a timely manner resulting in missed and/or rescheduled appointments.<br><br>A preponderance of evidence was not discovered during the Special Investigation to substantiate violation of the applicable rule. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

**Additional Finding: Resident A's Resident Assessment Plan was not completed annually.**

**INVESTIGATION:** On 04/18/2023 I completed an unannounced onsite investigation.

While onsite I reviewed Resident A's Assessment for AFC Residents and noted it was signed on 12/27/2021.

On 04/24/2023 I received and reviewed an email from Residential Coordinator Lindsey McBride which stated that 12/27/22021 is the most recently updated Resident Assessment Plan.

On 04/26/2023 I completed an Exit Conference with Licensee Designee Jennifer Brown via telephone. Ms. Brown stated she agreed with the findings and would submit an acceptable Corrective Action Plan.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.15301** | **Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.** |
| | **(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.** |
| **ANALYSIS:** | Resident A's most recent Assessment for AFC Residents was signed 12/27/2021.<br><br>A preponderance of evidence was discovered during the Special Investigation to substantiate violation of the applicable rule. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

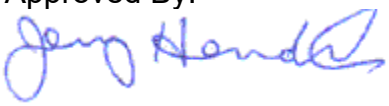
## IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend the license remain unchanged.

04/26/2023

Toya Zylstra Date
Licensing Consultant

Approved By:



04/27/2023

_____

Jerry Hendrick Date
Area Manager