GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 27, 2023

Gina Dillon
Chandler Pines, LLC
1435 Coit Ave NE
Grand Rapids, MI 49505

RE: License #: AM410390297
Investigation #: 2023A0583028
Chandler Pines

Dear Mrs. Dillon:

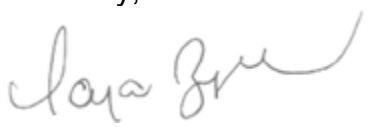
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AM410390297
Investigation #:	2023A0583028
Complaint Receipt Date:	04/19/2023
Investigation Initiation Date:	04/19/2023
Report Due Date:	05/19/2023
Licensee Name:	Chandler Pines, LLC
Licensee Address:	1435 Coit Ave NE Grand Rapids, MI 49505
Licensee Telephone #:	(616) 745-4675
Administrator:	Gina Dillon
Licensee Designee:	Gina Dillon
Name of Facility:	Chandler Pines
Facility Address:	Unit A 7555 Chandler Dr. NE Belmont, MI 49306
Facility Telephone #:	(616) 745-4675
Original Issuance Date:	04/22/2019
License Status:	REGULAR
Effective Date:	10/22/2021
Expiration Date:	10/21/2023
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED, AGED, DEVELOPMENTALLY DISABLED, ALZHEIMERS,

II. ALLEGATION(S)

	Violation Established?
Facility staff do not provide adequate personal care.	No
Facility staff smoke marijuana with residents.	No
Staff Elizabeth Guernsey restrains Resident C into her chair with a gait belt.	Yes
Staff do not adequately document the administration of Resident B's medication.	Yes
Staff Grace Boyd and Mikayla Krawczyk wear residents' clothing.	No

III. METHODOLOGY

04/19/2023	Special Investigation Intake 2023A0583028
04/19/2023	APS Referral
04/19/2023	Special Investigation Initiated - Telephone Staff Ashley Eisen
04/20/2023	Inspection Completed On-site
04/21/2023	Contact - Telephone call made Licensee Designee Gina Dillon
04/21/2023	Contact - Telephone call made Staff Grace Boyd
04/22/2023	Contact - Document Sent License Designee Gina Dillon
04/24/2023	Contact - Telephone call made Staff Mikayla Krawczyk
04/25/2023	Contact - Telephone call made Staff Rose Robinson
04/27/2023	Exit Conference Licensee Designee Gina Dillon

ALLEGATION: Facility staff do not provide adequate personal care.

INVESTIGATION: On 04/19/2023 complaint allegations were received from Adult Protective Services Centralized Intake. The complaint allegations stated that Resident A is 83 years and is diagnosed with dementia. Resident A "can walk to the bathroom on her own and needs assistance sitting" however on "4/17/23, it was

observed that Resident A's vaginal area is red and slightly peeling from her briefs". It was alleged that some of the staff do not always take residents for toileting and will wait until they have soiled their brief before it is changed.

On 04/19/2023 I interviewed staff Ashley Eisen via telephone. Ms. Eisen stated that on 04/17/2023 she observed Resident A presented with "red" and "raw areas of skin" in her vaginal area that Ms. Eisen stated were the result of facility staff not changing Resident A's adult brief often enough. Ms. Eisen stated Resident A is able to walk to the bathroom on her own but requires reminders from facility staff to do so. Ms. Eisen stated facility staff prefer to allow Resident A to urinate in her adult briefs rather than escort Resident A to the toilet. Ms. Eisen stated facility staff do not change residents' adult briefs every two hours which is the facility's protocol.

On 04/20/2023 I completed an unannounced onsite investigation at the facility and privately interviewed staff Stacie Crider, Elizabeth Guernsey, Relative 1, and Resident B. While onsite I visually observed the wellbeing of Resident A and Resident C.

Staff Stacie Crider stated Resident A suffers from anxiety associated with using the toilet. Ms. Crider stated that if Resident A is exhibiting anxiety associated with using the toilet, staff will allow Resident A to use her adult brief. Ms. Crider stated staff attempt to take Resident A to the toilet "three to four times" per eight hour shift and if Resident A refuses to use the toilet staff are completing adult brief check and changes every two hours. Ms. Crider stated Resident A has historically suffered from rashes in her vaginal area however Resident A's vaginal area is currently in a better state than previous. Ms. Crider stated staff check all residents' adult briefs "every two hours" and are diligent in providing adequate personal care.

Staff Elizabeth Guernsey stated that Resident A often exhibits anxiety when staff attempt to toilet Resident A. Ms. Guernsey stated facility staff attempt to toilet Resident A every two hours however if Resident A refuses, staff check Resident A's adult briefs. Ms. Guernsey stated staff attempt to toilet and/or change Resident A's adult briefs every two hours. Ms. Guernsey stated Resident A has a history of vaginal skin irritation which waxes and wanes but is currently minimal.

Relative 1 stated she visits the facility at least three times per week and is happy with the level of care provided by staff. Relative 1 stated Resident A "won't use toilets very much" because it causes her anxiety. Relative 1 stated staff will ask Resident A to use the toilet but if refuses staff will allow Resident A to use her adult brief. Relative 1 stated she observed Resident A's vaginal area today and it "doesn't look that bad". Relative 1 stated Resident A's vaginal area has a history of "maxing and waning" irritation and currently it appears to exhibit minimal redness.

Resident A visually appeared clean and free of odor. Resident A was not formally interviewed as a result of her memory deficits associated with diagnosed Dementia.

Resident B stated she is happy with the level of care provided by staff. Resident B stated staff are diligent in toileting residents and providing regular adult brief check and changes. Resident B presented as clean and adequately dressed.

Resident C appeared clean and adequately dressed. Resident C was not formally interviewed as a result of her memory deficits associated with diagnosed Dementia.

On 04/21/2023 I interviewed Licensee Designee Gina Dillon via telephone. Ms. Dillon stated Resident A is diagnosed with dementia and often refuses to use the toilet therefore staff do allow Resident A to relieve herself in her adult briefs. Ms. Dillon stated staff offer to escort Resident A to the toilet every two hours and if she refuses staff will check and change her adult briefs every two hours. Ms. Dillon stated Resident A has a history of redness in her vaginal area which has waxed and waned, and staff apply a cream as needed. Ms. Dillon stated Resident A's vaginal area is stable and there is no skin breakdown. Ms. Dillon stated staff provide the same level of care to all residents and their personal care needs are met.

On 04/22/2023 I received an email from Licensee Designee Gina Dillon which contained Resident A's Resident Assessment Plan signed 07/25/2022. The document states Resident A is continent but requires staff assistance with toileting and "pericare".

On 04/27/2023 I completed an Exit Conference with Licensee Designee Gina Dillon via telephone. Ms. Dillon stated she agreed with the Special Investigation Findings.

APPLICABLE RULE	
R 400.14303	**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 B stated she is happy with the level of care provided by staff. Resident B stated staff are diligent in toileting residents and providing regular adult brief check and changes. Relative 1 stated Resident A won't use toilets very much because it causes her anxiety. Relative 1 stated staff ask Resident A to use the toilet but if she refuses staff will allow Resident A to use her adult brief. Relative 1 stated she observed Resident A's vaginal area today and it "doesn't look that bad". Relative 1 stated Resident A's vaginal area has a history of maxing and waning irritation and currently it appears to exhibit minimal redness.

	A preponderance of evidence was not discovered during the course of the Special Investigation to substantiate violation of the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Facility staff smoke marijuana with residents.

INVESTIGATION: On 04/19/2023 complaint allegations were received from Adult Protective Services Centralized Intake. I reviewed that complaint allegations stated "Resident C is 81 years old and has dementia". The complaint alleged that on an unknown date, Resident C was taken out of the facility by two staff members, names unknown and provided her with marijuana. The complaint further alleged that it is believed they were also smoking in Resident C's room while the staff was on shift.

On 04/19/2023 I interviewed staff Ashley Eisen via telephone. Ms. Eisen stated she has observed staff Stacie Crider, Mikayla Krawczyk, and Grace Boyd smoke marijuana outside of the facility on their break while working on first shift. Ms. Eisen stated she did not inform administration of the incident. Ms. Eisen stated she heard from staff Rose Robinson that staff Stacie Crider, Mikayla Krawczyk, and Grace Boyd took Resident C outside of the facility and allowed Resident C to smoke their marijuana. Ms. Eisen stated she heard a rumor circulating amongst staff that staff Stacie Crider, Mikayla Krawczyk, and Grace Boyd smoked marijuana in Resident C's bedroom.

On 04/20/2023 I completed an unannounced onsite investigation at the facility and privately interviewed staff Stacie Crider, Elizabeth Guernsey, Relative 1, and Resident B.

Staff Stacie Crider stated she has never smoked marijuana while working at the facility and has never smoked marijuana with any residents. Staff Elizabeth Guernsey stated she has never observed staff to smoke marijuana while working at the facility and has never observed staff to smoke marijuana with any residents.

Relative 1 and Resident B stated they have not observed staff smoke marijuana at the facility.

On 04/21/2023 I interviewed Licensee Designee Gina Dillon via telephone. Ms. Dillon stated she has never observed staff smoke marijuana while working at the facility and has never observed staff to smoke marijuana with any resident.

On 04/21/2023 I interviewed staff Grace Boyd via telephone. Ms. Boyd stated she has never smoked marijuana while working at the facility and has never smoked marijuana with any residents.

On 04/24/2023 I interviewed staff Mikayla Krawczyk via telephone. Ms. Krawczyk stated she has never smoked marijuana while working at the facility and has never smoked marijuana with any residents.

On 04/25/2023 I interviewed staff Rose Robinson via telephone. Ms. Robinson stated she has never observed staff smoke marijuana while working at the facility and has never observed staff to smoke marijuana with any resident.

On 04/27/2023 I completed an Exit Conference with Licensee Designee Gina Dillon via telephone. Ms. Dillon stated she agreed with the Special Investigation findings.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Staff Ashley Eisen stated she has observed staff Stacie Crider, Mikayla Krawczyk, and Grace Boyd smoke marijuana outside of the facility on their break while working on first shift. Staff Stacie Crider, Mikayla Krawczyk, and Grace Boyd each denied smoking marijuana while working at the facility and denied supplying Resident C with marijuana. Licensee Designee Gina Dillon, staff Elizabeth Guernsey, and staff Rose Robinson each stated they have never observed staff smoke marijuana while working at the facility and have never observed staff to smoke marijuana with any resident. A preponderance of evidence was not discovered during the course of the Special Investigation to substantiate violation of the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Staff Elizabeth Guernsey restrains Resident C into her chair with a gait belt.

INVESTIGATION: On 04/19/2023 an additional allegation was received after completing a 04/19/2023 telephone interview with Staff Ashley Eisen. Ms. Eisen stated staff Elizabeth Guernsey stated Ms. Guernsey restrains Resident C into her chair utilizing Resident C's gait belt. Ms. Eisen stated she never observed Ms. Guernsey restrain Resident C in her chair with Resident C's gait belt, but Ms. Guernsey admitted having done it herself. Ms. Eisen stated Ms. Guernsey told Ms. Eisen that Licensee Designee Gina Dillon had approved of staff using Resident C's gait belt to restrain Resident C in her chair.

While onsite on 04/20/2023, I privately interviewed staff Elizabeth Guernsey. Ms. Guernsey denied restraining Resident C into her chair utilizing Resident C's gait belt.

On 04/21/2023 I interviewed Licensee Designee Gina Dillon via telephone. Ms. Dillon stated she was aware that on approximately two occasions staff Elizabeth Guernsey utilized Resident C's gait belt to restrain Resident C in her chair. Ms. Dillon stated she did not directly observe the practice but was informed of the practice from Ms. Guernsey. Ms. Dillon stated Resident C has a history of falling out of her chair and the gait belt was used for a short time to keep her from falling out of the chair.

On 04/27/2023 I completed an Exit Conference with Licensee Designee Gina Dillon via telephone. Ms. Dillon stated she agreed with the Special Investigation findings and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14308	**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: **(c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.**
ANALYSIS:	Licensee Designee Gina Dillon stated that she was aware that on two occasions staff Elizabeth Guernsey utilized Resident C's gait belt to restrain Resident C in her chair. Ms. Dillon stated she did not directly observe the practice but was informed of the practice from Ms. Guernsey. Staff Ashley Eisen stated Elizabeth Guernsey stated she (Ms. Guernsey) restrains Resident C in her chair utilizing Resident C's gait belt. Ms. Eisen stated she never observed Ms.

	Guernsey restrain Resident C in her chair with Resident C's gait belt, but Ms. Guernsey admitted having done it herself. A preponderance of evidence was discovered during the course of the Special Investigation to substantiate violation of the applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff do not adequately document the administration of Resident B's medication.

INVESTIGATION: On 04/19/2023 an additional allegation was received after completing a 04/19/2023 telephone interview with Staff Ashley Eisen. Ms. Eisen stated staff have been documenting the administration of Resident B's Nystatin powder however staff were not actually administering the medication.

While onsite on 04/20/2023, I privately interviewed staff Stacie Crider. Ms. Crider stated staff have been documenting the administration of Resident B's Nystatin powder however staff were not actually administering the medication.

On 04/21/2023 I interviewed Licensee Designee Gina Dillon via telephone. Ms. Dillon stated Resident B is prescribed Nystatin powder and staff have been documenting the administration of Resident B's Nystatin powder however staff were not actually administering the medication.

On 04/22/2023 I received an email from Licensee Designee Gina Dillon which contained Resident B's Medication Administration Record. I observed that Resident B is prescribed Nystatin powder three times per day. I observed that during the month of April 2023 Resident B's Medication Administration record indicates she has been receiving the medication three times per day.

On 04/27/2023 I completed an Exit Conference with Licensee Designee Gina Dillon via telephone. Ms. Dillon stated she agreed with the Special Investigation findings and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the

	requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Licensee Designee Gina Dillon stated Resident B is prescribed Nystatin powder and staff have been documenting the administration of Resident B's Nystatin powder however staff were not actually administering the medication. A preponderance of evidence was discovered during the course of the Special Investigation to substantiate violation of the applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff Grace Boyd and Mikayla Krawczyk wear residents' clothing.

INVESTIGATION: On 04/19/2023 an additional allegation was received after completing a 04/19/2023 telephone interview with staff Ashley Eisen. Ms. Eisen stated she had heard a report from a staff whose name she could not recall; that staff Grace Boyd and Mikayla Krawczyk have worn residents' clothing. Ms. Eisen stated she has never observed this behavior herself and had no other details to offer.

While onsite on 04/20/2023 I privately interviewed staff Stacie Crider, Elizabeth Guernsey, and Resident B. Staff Stacie Crider, Elizabeth Guernsey, and Resident B each stated that they have never observed staff Grace Boyd or Mikayla wear residents' clothing.

On 04/21/2023 I interviewed Licensee Designee Gina Dillon via telephone. Ms. Dillon stated she has never observed any staff wear residents' clothing.

On 04/21/2023 I interviewed staff Grace Boyd via telephone. Ms. Boyd stated she has never worn residents' clothing.

On 04/24/2023 I interviewed staff Mikayla Krawczyk via telephone. Ms. Krawczyk stated she has never worn residents' clothing.

On 04/27/2023 I completed an Exit Conference with Licensee Designee Gina Dillon via telephone. Ms. Dillon stated she agreed with the Special Investigation findings.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(10) A licensee, administrator, direct care staff, other employees, volunteers under the direction of the licensee, and members of their families shall not accept, take, or borrow money or valuables from a resident, even with the consent of the resident.
ANALYSIS:	Staff Grace Boyd and Mikayla Krawczyk both stated that they have never worn residents' clothing. Licensee Designee Gina Dillon, staff Stacie Crider, Elizabeth Guernsey, and Resident B each reported that they have not witnessed staff Grace Boyd or Mikayla Krawczyk wear residents' clothing. A preponderance of evidence was not discovered during the course of the Special Investigation to substantiate violation of the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

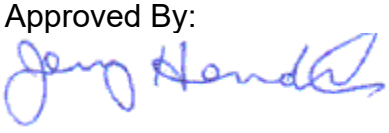
IV. RECOMMENDATION

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

04/27/2023

Toya Zylstra — Date
Licensing Consultant

Approved By:



04/27/2023

Jerry Hendrick — Date
Area Manager