GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 2nd, 2024

Lauren Gowman
Appledorn Assisted Living Center
727 Apple Avenue
Holland, MI 49423

RE: License #: AH700236753
Investigation #: 2024A1021017
Appledorn 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 authorized representative 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) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH700236753
Investigation #:	2024A1021017
Complaint Receipt Date:	11/29/2023
Investigation Initiation Date:	11/30/2023
Report Due Date:	1/29/2024
Licensee Name:	Appledorn Living Center LLC
Licensee Address:	950 Taylor Ave. Grand Haven, MI 49417
Licensee Telephone #:	(616) 842-2425
Administrator:	Gregory Hooson
Authorized Representative:	Lauren Gowman
Name of Facility:	Appledorn Assisted Living Center
Facility Address:	727 Apple Avenue Holland, MI 49423
Facility Telephone #:	(616) 392-4650
Original Issuance Date:	03/01/2000
License Status:	REGULAR
Effective Date:	05/12/2023
Expiration Date:	05/11/2024
Capacity:	174
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Insufficient staff on second and third shift.	Yes
Additional Findings	No

III. METHODOLOGY

11/29/2023	Special Investigation Intake 2024A1021017
11/30/2023	Special Investigation Initiated - Letter referral sent to APS
12/12/2023	Inspection Completed On-site
12/18/2023	Contact-Telephone call made Interviewed SP1
12/18/2023	Contact-Telephone call made Interviewed SP2
12/18/2023	Contact-Telephone call made Interviewed SP3
12/21/2023	Contact-document received Received additional staff schedule
01/02/2024	Exit Conference

ALLEGATION:

Insufficient staff on second and third shift.

INVESTIGATION:

On 11/29/2023, the licensing department received an anonymous complaint with allegations the facility has insufficient staff for most of second and all of third shift.

On 11/30/2023, the allegation in this report was sent to centralized intake at Adult Protective Services (APS).

On 12/12/2023, I interviewed licensee regional nurse Beth Pavlak at the facility. Ms. Pavlak reported she is filling in for vacant clinical roles within the facility. Ms. Pavlak reported the facility is currently using agency to fill in staff shortages, however, the use of agency has decreased. Ms. Pavlak reported for the past pay period agency workers were in the facility for 100 hours. Ms. Pavlak reported the facility had stopped taking admissions to decrease agency usage but has since started taking admissions again. Ms. Pavlak reported second and third shifts are the hardest shifts to hire. Ms. Pavlak reported the facility has 84 residents with 14 in the Terrace memory care unit, six in the Courtyard memory care unit, and 64 in general assisted living. Ms. Pavlak reported the employees that are scheduled to work in the secure memory care units typically do not leave the unit to work other assignments. Ms. Pavlak reported management recently re-arranged medication carts to lighten the load of medication technicians. Ms. Pavlak reported medication technicians are primary responsible for administering medications and resident service associates (RSA) are responsible for providing care. Ms. Pavlak reported the employees utilized walkie-talkies to communicate between each other. Ms. Pavlak reported the facility is currently hiring for all shifts and has orientation for new employees every week. Ms. Pavlak reported the facility has been creative in finding staff for unexpected calls in by having a third shift supervisor come from a different facility to work.

On 12/12/2023, I interviewed records specialist Bethany Potthoff at the facility. Ms. Potthoff reported she is responsible for developing the schedule. Ms. Potthoff reported when the schedule is developed one month in advance there are open shifts. Ms. Potthoff reported these open shifts are then sent to the employees for them to pick up. Ms. Potthoff reported if employees do not pick up the shifts, she will request agency to fill in staff vacancies. Ms. Potthoff reported when there is an unexpected staff shortage due to a call in, she will request for an employee that is currently working to stay over, a caregiver to come in early, or for an employee to pick up the shift. Ms. Potthoff reported the facility offers incentives of bonuses and points to earn gift cards. Ms. Potthoff reported there is no mandation policy for an unexpected staff shortages. Ms. Potthoff reported typically staff do pick up extra shifts and work together to ensure vacancies are filled. Ms. Potthoff reported the facility has a shift supervisor that oversees the entire facility. Ms. Potthoff reported at times the shift supervisor does take an assignment. Ms. Potthoff reported employees work 12 hours shifts and eight-hour shifts. Ms. Potthoff reported the eight shifts are scheduled during the busy times, such as morning and evening times.

On 12/12/2023, I interviewed Resident A at the facility. Resident A reported caregivers at the facility treat her well but sometimes she must wait an extended period for assistance. Resident A reported it appears there are often not enough caregivers to care for the residents.

While onsite I observed the facility. The facility was very large and spread out with the two memory care units located at each end of the facility. The general assisted living is split into Neighborhood 1 and Neighborhood 2. There were ABCDEFGH hallways for general assisted living. Resident rooms were spread out within each

general assisted living hallway. The layout of the facility resulted in increased time to walk from one area to another.

On 12/18/2023, I interviewed staff person 1 (SP1) by telephone. SP1 reported staffing is very low on second and third shifts. SP1 reported the secure memory care units are typically appropriately staffed but the general assisted living units have low staffing levels. SP1 reported the shift supervisor typically is assigned an assignment which makes it difficult if there is an emergency or care issue.

On 12/18/2023, I interviewed SP2 and SP3 by telephone. SP2 and SP3 statements were consistent with those made by SP1.

I reviewed the staff schedule for 11/26-12/09. The staff schedule revealed the following staff shortage:

12/8: 7:30p-6:00a- only one RSA in general assisted living (64 residents)
10:00p-6:00am- only employee in Terrace memory care unit (14 residents)

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:	The facility has insufficient staffing as evidenced by: Interviews conducted revealed the facility has had to bring in an employee from a different facility to fill in shift shortages. Review of employee schedule revealed the facility operated below their desired staffing levels. Interviews conducted with residents and staff persons revealed concerns with staffing levels.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

12/21/2023

Kimberly Horst — Date
Licensing Staff

Approved By:

01/02/2024

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