GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 24, 2024

William and Stephanie Hansma
338 Cleveland West
Coopersville, MI 49404

RE: License #: AF700086098
Investigation #: 2024A0350012
Hansma Home

Dear William and Stephanie Hansma:

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) 356-0100.

Sincerely,

Ian Tschirhart, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 644-9526

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF700086098
Investigation #:	2024A0350012
Complaint Receipt Date:	01/04/2024
Investigation Initiation Date:	01/04/2024
Report Due Date:	02/03/2024
Licensee Name:	William and Stephanie Hansma
Licensee Address:	338 Cleveland West Coopersville, MI 49404
Licensee Telephone #:	(616) 837-7015
Name of Facility:	Hansma Home
Facility Address:	338 Cleveland West Coopersville, MI 49404
Facility Telephone #:	(616) 837-7015
Original Issuance Date:	06/28/1999
License Status:	REGULAR
Effective Date:	11/21/2023
Expiration Date:	11/20/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The regular medication log as well as the narcotic medication log were initialed in advance, before medications were administered, for several days in December 2023.	Yes

III. METHODOLOGY

01/04/2024	Special Investigation Intake 2024A0350012
01/04/2024	Special Investigation Initiated - Telephone I received a call from Detective Dave Dewitt, discussed allegations
01/04/2024	Contact - Telephone call received I participated in a TEAMS meeting with Detective Dewitt, and Attorneys General (AG) Lewandowski and Macon
01/05/2024	Contact - Face to Face I met Detective Dewitt at the Hansma Home and we spoke with William and Stephanie Hansma, Co-Licensees
01/08/2024	Contact - Document Received I received an email from Leah Osterhaven, Residential Ombudsman with Community Mental Health of Ottawa County
01/22/2024	Contact - Document Sent I sent an email to Detective Dewitt
01/23/2024	Contact - Document Received I received an email from Detective Dewitt
01/24/2024	Exit conference – Held with William Hansma, Co-Licensee

ALLEGATION: The regular medication log as well as the narcotic medication log were initialed in advance, before medications were administered, for several days in December 2023.

INVESTIGATION: On 01/04/2024, I received an email from Detective David Dewitt of the Ottawa County Sheriff's Department with several documents attached. One of the documents was a police investigation report regarding a death at this home on 12/20/2023. The report states that the cause of Resident A’s death will be investigated. It further states that the medication logs for Resident A were “prefilled”

with initials for each day of the week for the whole month of December (2023), but Resident A died on 12/20/2023. Copies of the Medication Logs were attached to the email. Detective Dewitt informed me in this email that he was going to take part in a virtual TEAMS meeting today at 10:30 a.m. with Mark Lewandowski and Drew Macon of the Attorney General's office and invited me to the meeting.

On 01/04/2024, I participated in a virtual TEAMS meeting with Detective Dewitt, and Attorneys General (AG) Lewandowski and Macon. Detective Dewitt provided a summary of what he found out so far, which was that the Medication Log for Resident A was prefilled, as described above. In addition, the Controlled Drug log for Resident A appeared to be "filled out in a rush," as it showed that Resident A was given Clobazam on 12/21, 12/22, and 12/23; however, as previously noted, Resident A passed away on 12/20. Detective Dewitt informed us that the autopsy did not show any signs of trauma and that a toxicology evaluation was being performed but is not yet complete. Detective Dewitt further stated that he confiscated all of Resident A's medications and is in the process of assessing the pill count and liquid medication supply. He said that his initial impression was that not enough medications had been given to Resident A. AG Lewandowski informed Detective Dewitt and me that Mr. Macon is his supervisor, and his title is Chief Investigator. AG Lewandowski reported that the AG's office investigates Medicaid fraud in addition to other matters and also has a "nurse investigator" who audits medication supplies and drug orders. There was discussion among the other three as to what arrangement would be made for their coordinated investigation and I sought clarification on how they would prefer me to proceed with my investigation so as not to interfere with theirs. I was informed that it would be acceptable for me to go ahead with my investigation. Detective Dewitt requested that he be present during my interviews of Stephanie and William (Bill) Hansma, and Resident B if she has the cognitive ability to answer questions. Detective Dewitt mentioned that he spoke briefly with Carrie Monterra, Supports Coordinator from Network 180 and said that Ms. Monterra told him she believed the Hansmas provide very good care to their residents.

On 01/04/2024, I received a phone call from Detective Dewitt and we arranged to meet at Hansma Home on 01/05 at 9:30 a.m.

On 01/04/2024, I reviewed Deputy Daniel Lewkowski's report. This report includes the following: *'On 12/20/23 I was dispatched to 338 West Cleveland Street for obvious death with extended down time. Contact with Stephanie Hansma: Stephanie, the owner of Hansma House, stated that went to check on (Resident A) this morning and realized she had passed away over night. Stephanie has cared for (Resident A) for approximately five years. Stephanie stated she last seen (Resident A) when she went to sleep at approximately 8pm. Stephanie advised (Resident A) had the covers pulled up to her neck and the sheet was over her face. (Resident A) sleeps in this manner every night. Stephanie supplied a copy of (Resident A)'s file. I noted the medications given had been initialed by Stephanie for the entire month. Stephanie advised (Resident A) gets her medications everyday, and she just fills out*

the form for the month. (Resident A) was in her bed with the covers pulled up over her head. (Resident B) was sleeping in the same room. (Resident B) is non-ambulatory and needs assistance to get out of bed. Everything appeared to be in order in the room. (Resident A) suffers from Cerebral Palsy, seizures, and bi-polar disorder. (Resident A) was last seen by a doctor on 12/11/23 to have her feeding tube replaced. (Resident A) had minimal verbal skill and had a very short memory. (Resident A) showed minor cold symptoms, running nose sneezing and a cough, the night before. (Resident A's) physician is Maxwell MacDonald of Corewell Heath. The following medications were taken off of (Resident A's) medication sheets: Trazadone, Oxcarbazepin, Melatonin, Clobazam, Nystatin, Levetiraceta, Lacosamide, Clotrimazole, Zippasidone, Gabapentin, Thera-M, Omeppazole, and Nitrofuramantoin. Stephanie turned over (Resident A's) medications to Detective Dewitt. Sergeant Wildfong made contact with (Resident A's) sister, (Relative 1), at her residence for notification. I took photographs of the scene. Claletta Duckett-Freeman of LIFE ambulance provided a time of death of 6:24 am. I made contact with Bob Tovey (Medical Examiner) via the phone and he responded to the scene. (Resident A) was turned over to Adam Cowley of Phoenix for transport to Holland Community Hospital [sic].'

On 01/04/2024, I reviewed Detective Dewitt's report. This report includes the following: *'On 12/20/23, I was called to assist with the investigation into the death of (Resident A) (37) at the Hansma Home in Coopersville, 338 W. Cleveland St, Coopersville. I responded to the scene and collaborated with Dep. Dan Lewkowski who was first to arrive. I collaborated with MEI Bob Tovey on scene. I interviewed Stephanie and William Hansma, who provide long term care for disabled residents in the facility. I spoke to Keri Laporte-Montero, a support coordinator for (Resident A) and liaison for (Resident A's) sister/guardian, (Relative 1). Stephanie is a 54 y/o resident of Coopersville. Stephanie and her husband, Bill, own a single story ranch style home in a residential neighborhood, that has been modified to a long term, Assisted Living facility. Stephanie and Bill have been involved in assisted living for decades. Stephanie said that (Resident A) has been a resident of Hansma Home for 5 years. (Resident A) was described as having Cerebral palsy and seizures. (Resident A) has an abdominal feeding tube that was replaced last week, without complications. Stephanie reports that (Resident A) has been experiencing cold symptoms, specifically: runny nose, coughing and sneezing. Stephanie quoted (Resident A) as saying, "I'm giving my cold away." Stephanie said that (Resident A) and roommate (Resident B) both go to bed at 8am, and that was (Resident A's) last known alive time. Stephanie reports that (Resident A) is "up to speed" on her seizure medication, and offered a "routine medications" form as evidence of that. The form bears the initials SH on every day of December from the 1st to the 31st and each medication is documented as having been administered. It should be noted that the date she provided this to me was 12/20/23, making the forms inappropriately prefilled. Stephanie said that she gave (Resident A) morning meds on 12/19/23 via feeding tube and that Bill gave her medications in the evening. Stephanie said that Bill does it normally, but that Stephanie "backed him up" last night. She then corrected herself and said that she backed him up in the morning, but that Bill*

provided the meds on the night of the 19th. Stephanie went on to say that she gave (Resident A) medication in the morning, via feeding tube, then got (Resident A) dressed for the day. Stephanie reports that there were no issues with the replacement of the abdominal port used as a feeding tube. It was also reported that (Resident A) was the first of the residents in the home to develop a cough and runny nose. Stephanie explained that (Resident A) had "pressure ulcers" on both of her heels and had an appointment with the Spectrum Wound Clinic in Grand Rapids. Stephanie said that (Resident A) is typically treated at the Butterworth campus but has been to Spectrum in Zeeland in the past. I double checked with Stephanie as to the administration of medication, and she confirmed that it was through the abdominal port.

*Bill is a 56 y/o resident of Coopersville. Bill is husband and co-worker of Stephanie and provides personal care to the residents of his home as a profession. When I asked who "normally" gives (Resident A) her medications, Bill said that it "could be either of us" that administer medications to (Resident A). Bill believes that Stephanie gave (Resident A) medication on the morning and evening of the 19th. Bill said that when he gives (Resident A) medication she, "takes it with applesauce." Bill went on to say that (Resident A) takes "all" her medication with applesauce. Bill wanted to explain that for the past year (Resident A) has been "not right" and details that she has been experiencing hallucinations, and yelling "F-bombs" at the ceiling. (Resident A) has been going to Psychiatric therapy but does not have any diagnosis. Bill assisted me with gathering all of (Resident A's) medications, and provided "Health Care Appraisal" form, "Current Meds & Allergies Report" (2 pages), "Controlled drug receipt/record/disposition" form (7 pages), "Routine Medications" form (3 pages) (which) was filled out in a rush, and all at the same time. The dates show that the medications were administered on 12/21, 22, 23/2023. (Resident A) was found deceased on 12/20/23. **It should be noted that the 7 pages of "Controlled drug receipt/record/disposition" document the administration of Clobazam (a.m. and p.m.), Gabapentin (a.m., Noon, p.m.) and Lacosamide (a.m. and p.m.) These forms only document 3 days of medication distribution. The writing pattern, ink color, shape and size, as well as the consistency of the errors indicate that the, I noted that she was shirtless and wearing an adult diaper.*

I observed (Resident A) lying in her bed, under covers. When the covers were removed I noted (Resident A's) feeding port had some redness around it, consistent with irritation that comes from the installation of the device. (Resident A's) head was contorted up and to her left with some mucus on the face and fluid bubbling in the mouth. Her arms were flexed and the hands were in clenched near the sternum. (Resident A) had no external injuries that appeared fatal. There were wrappings on her feet that appeared consistent with Stephanies report of pressure ulcers on the feet. There was no evidence of physical assault or abuse, no ligature markings on the neck or petechiae to suggest suffocation. There were no hematoma or laceration to the head suggesting a fall or blunt force trauma. There were no signs of struggle in the room or defensive wounds that indicate an attack of any sort. When (Resident A) was rolled to her side to reveal her back, some fluid was expelled from the mouth.

There were no visible injuries to the back. (Resident A's) roommate, (Resident B) is non-ambulatory and is not suspected to have any involvement in (Resident A's) death. I have concerns that the death is related to (Resident A's) seizures, and may have been preventable if proper medications were administered. It is not clear if medications were administered properly, because the documentation of that has been falsified. There are contradicting statements by Bill and Stephanie as to who administered the meds, and how that is done i.e. applesauce or feeding tube. I have counted medications and have ordered beakers to assist in measuring the liquid medication to determine if the counts are consistent with the proper distribution of the medications. I have requested an autopsy and toxicology to determine the presence of the proper medications in (Resident A's) blood. I have notified LARA of the concerns with the documentation, and began to collaborate with the AG's office to determine possible criminal charges. STATUS: Open pending further investigation [sic].'

On 01/05/2023, I met Detective Dewitt at the Hansma Home and we spoke with William Hansma, Co-Licensee. I informed Mr. Hansma that I was investigating an allegation of falsified medication logs and whether that was associated with Resident A's death in any way. I showed Mr. Hansma copies of Resident A's controlled drug logs that had his signature on them after the dates of 12/21, 12/22, and 12/23 for each of the eight controlled medications Resident A took. I asked him why the logs were filled out for the three days following Resident A's death, and he replied, "Just to get ahead." He stated that he knew it was wrong to prefill the logs this way. I inquired as to how Mr. Hansma administered medications to Resident A, and he stated that he would put the pills in applesauce and she would take them orally and the liquid medications she would also take orally. He reported that he had been administering Resident A's medications as prescribed following the correct dosage at the correct times. I asked to see Resident A's Assessment Plan and Individual Plan of Service (IPOS) and Mr. Hansma produced them. There was no mention in either document of Resident A requiring a certain amount of supervision or visual checks. Under the Personal Safety Risks section of Resident A's IPOS it states, *'At home, (Resident A) is not left by herself. She can spend time by herself in her room during waking hours, but someone should always be within hearing distance.'* At this point in the interview, Stephanie Hansma, William's wife and Co-Licensee, arrived and joined the conversation. I asked Mrs. Hansma why she initialed the Medication Administration Record (MAR) for the whole month of December (2023) for Resident A's medications, even though she died on 12/20. Mrs. Hansma said that Resident A always took her medications every day, so she just prefilled the MAR, knowing she was going to give her the medications anyway. She reported that she had been administering Resident A's medications as prescribed, including the correct dosage at the correct times. I asked Mr. and Mrs. Hansma if it was part of their routine to check on the residents during the night, and if so, what these checks involved; (open the door and look; listen through the door; etc), and Mrs. Hansma explained that on evenings when she is doing paperwork after the residents have gone to bed, she will sometimes do quick visual checks on them. Mrs. Hansma reported that on the night of 12/19/2023, she opened the door and checked on Resident A and her roommate,

Resident B, and around 8 p.m. She stated that they both appeared to be alright, and remembers that Resident A said to her, “Hi, honey.”

Mrs. Hansma informed Detective Dewitt and me that Resident A had a runny nose and a cough. Mr. and Mrs. Hansma told us that Resident A would pull the sheet and blanket over head when she went to sleep every night. I asked them what they did when Resident A had a seizure, and Mrs. Hansma said that if she had the seizure while she was in her wheelchair, they just monitored her, but if she had one outside of her wheelchair, they would clear a space around her so that she would not get injured. Mrs. Hansma added that Resident A always had Grand Mal seizures but none lasted longer than five minutes, so she was never taken to the hospital for having a seizure. She stated that Resident A’s last seizure was in June of 2023. I requested a medical document that listed Resident A’s diagnoses, and Mrs. Hansma provided Detective Dewitt and me with a copy. It showed that she had been diagnosed with: ADHD (attention deficit hyperactivity disorder); Anemia; Autism; Bipolar disorder; Decubitis ulcer of foot, stage 2; Decubitis ulcer of right buttock; Depression; Mass of left thigh; Pressure injury of deep tissue of right foot; Pressure injury of toe of right foot, stage 3; Right medial tibial plateau fracture; Seizures; and Temporal lobe epilepsy, intractable.

With Mr. Hansmas permission, I went to Resident A’s bedroom and spoke a little louder than normal tone, while he and Detective Dewitt were in Mrs. and Mr. Hansma’s bedroom, which is in the basement, to see if I could be heard. Detective Dewitt said that he could hear me from that distance. Detective Dewitt asked the Hansmas if the MARs and Controlled Drug logs were prefilled for the other residents as well and for different months, and they both acknowledged that they were. Detective Dewitt asked if he could take several months’ worth of MARs, and Mr. Hansma gave him permission to do so. I informed the Hansmas that there was definitely a rule violation for having prefilled the medication logs, but that I needed to wait for the toxicology and autopsy results to determine if there was a relationship between the medication levels in Resident A’s system and her death in order to make my recommendation. Mr. and Mrs. Hansma understood this and were very cooperative during this interview. Detective Dewitt and I attempted to interview Resident A’s roommate, Resident B, but she lacked the cognitive ability to follow our questions.

On 01/08/2024, I received an email from Leah Osterhaven, Residential Ombudsman with Community Mental Health of Ottawa County. She wrote: *‘I wanted to let you know that Briana (Fowler, Recipient Rights Officer) and I went out to Hansma’s this morning and everything looked good with our Ottawa consumers living there. The current medication logs were filled out correctly and matched the medication count. I did ask Stephanie (Hansma) why she didn’t notify licensing sooner about the death and she said that she emailed and faxed a copy of the IR (Incident Report) when the death occurred. I encouraged her to reach out to you to make sure she has your correct information. Please let me know if you find any other concerns with this provider.’*

On 01/22/2024, I sent an email to Detective Dewitt inquiring as to when the autopsy and toxicology reports would be completed. The following day (01/23/2024) I received an email from Detective Dewitt. In it he wrote, *'Autopsy reports are 8-10 weeks recently. With this special request to check for additional toxicology it may be longer.'*

On 01/24/2024, I called and held an exit conference with William Hansma. I informed Mr. Hansma that I was citing a violation of this rule and that a Corrective Action Plan is due within 15 days. Mr. Hansma said he would get that to me, and inquired as to when he would hear from the Detective. I told him that I could not answer for another agency, but told him that I was informed it could take up to two months before the toxicology and autopsy reports were completed.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(2) Medication shall be given pursuant to label instructions. **(4) When a licensee or responsible person supervises the taking of medication by a resident, the licensee or responsible person shall comply with the following provisions:** **(a) Maintain a record as to the time and amount of any prescription medication given or applied. Records of prescription medication shall be maintained on file in the home for a period of not less than 2 years.**
ANALYSIS:	Willaim and Stephanie Hansma, Co-Licensees, admitted to initialing the medication logs for every resident several months in advance and the Controlled Drug Log for Resident A several days in advance. William said he did this, "Just to get ahead" and Stephanie said she prefilled the medication log knowing she was going to give the medications anyway. My findings support that this rule had been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend that the status of this home's license remain unchanged, and that this special investigation be closed.

January 24, 2024

Ian Tschirhart | Date
Licensing Consultant

Approved By:

January 24, 2024

Jerry Hendrick | Date
Area Manager