GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 20, 2024

Lauren Gowman
Grand Pines Assisted Living Center
1410 S. Ferry St.
Grand Haven, MI 49417

RE: License #: AH700299440
Investigation #: 2024A1021030
Grand Pines Assisted Living Center

Dear Lauren 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

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 #:	AH700299440
Investigation #:	2024A1021030
Complaint Receipt Date:	01/24/2024
Investigation Initiation Date:	01/24/2024
Report Due Date:	03/23/2024
Licensee Name:	Grand Pines Assisted Living LLC
Licensee Address:	950 Taylor Ave. Grand Haven, MI 49417
Licensee Telephone #:	(616) 846-4700
Administrator:	Lauren Gowman
Authorized Representative:	Ami Moy
Name of Facility:	Grand Pines Assisted Living Center
Facility Address:	1410 S. Ferry St. Grand Haven, MI 49417
Facility Telephone #:	(616) 850-2150
Original Issuance Date:	07/08/2009
License Status:	REGULAR
Effective Date:	05/12/2023
Expiration Date:	05/11/2024
Capacity:	177
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A has increased call light response times.	Yes
Resident A does not receive showers.	Yes
Resident A received incorrect medication.	No
Additional Findings	No

III. METHODOLOGY

01/24/2024	Special Investigation Intake 2024A1021030
01/24/2024	Special Investigation Initiated - Letter referral sent to APS
01/30/2024	Inspection Completed On-site
02/02/2024	Contact-Telephone call made Interviewed SP5
02/20/2024	Exit Conference

ALLEGATION:

Resident A has increased call light response times.

INVESTIGATION:

The complainant alleged Resident A has had excessive wait times for a call light to be answered by staff for her to be assisted to the restroom. The complainant alleged as a result; Resident A has had multiple urinary tract infections (UTI).

On 01/30/2024, I interviewed staff person 1 (SP1) at the facility. SP1 reported Resident A has chronic UTI's due to kidney stones. SP1 reported Resident A has been followed by urology to have the kidney stones removed. SP1 reported once these kidney stones were removed, the amount of UTI's has decreased. SP1 reported the expectation is for call lights to be answered within five minutes or less.

On 01/30/2024, I interviewed SP4 at the facility. SP4 reported Resident A has frequent UTI's due to decreased kidney function. SP4 reported care staff encourage Resident A to drink fluids. SP4 reported it does take some time for call lights to be answered but call light response times have gotten better.

On 01/30/2024, I interviewed administrator Ami Moy at the facility. Ms. Moy reported call light response times are to be five minutes or less. Ms. Moy reported she has not received call light response concerns.

I reviewed the call light response times for Resident A for 01/15-01/29. There were 40 call light requests and the average response times was 10 minutes.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
For Reference: R 325.1901	**Definitions.**
	(4) "Assistance" means help provided by a home or an agent or employee of a home to a resident who requires help with activities of daily living.
ANALYSIS:	Review of documentation revealed on average Resident A must wait for 10 minutes for staff assistance. This practice results in Resident A not receiving the assistance, such as assistance in toileting and dressing.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A does not receive showers.

INVESTIGATION:

The complainant alleged Resident A has not received showers and the facility incorrectly reports that Resident A refuses showers. The complainant alleged caregivers changed Resident A and did not provide peri-care. The complainant alleged Resident A does not receive proper hygiene which resulted in skin and vaginal infections.

SP1 reported Resident A typically does not refuse showers and receives two showers a week. SP1 reported Resident A has no history of skin or vaginal infections. SP1 reported no knowledge of improper peri-care.

SP4 reported Resident A receives excellent care. SP4 reported last week Resident A did refuse a shower which was not typical of her, but she complained of a headache. SP4 reported when she provided care to her last weekend, Resident A was incontinent of urine, and she provided a shower to Resident A. SP4 reported Resident A typically has the same caregiver and the caregiver and Resident A have a good relationship. SP4 reported no knowledge of any infections due to improper care.

On 01/30/2024, I interviewed Resident A at the facility. Resident A was dressed and appeared well kept. Resident A reported caregivers assist with showers, and she does not miss showers. Resident A reported caregivers treat her well. Resident A reported no concerns with the care at the facility.

02/02/20024, I interviewed SP5 by telephone. SP5 reported if asked about a shower, Resident A will refuse a shower. SP5 reported the facility updated Resident A's service plan to reflect that caregivers are to tell Resident A that it is time for a shower and not to ask Resident A if she wishes to shower.

I reviewed Resident A's care plan. The care plan read,

> *"I need one person to assist me with peri care twice daily as part of my daily hygiene. It is imperative that you clean her peri area thoroughly as she has a history of UTI's. I need one staff person to assist me with all of my showering and or bathing. Please assist with washing my hair. Please do not ask if I want to take a shower, per my family because I will always say no. Just tell me that it is time and lead me into the bathroom and assist me. If you are unable to give her a shower for any reason, please notify the shift supervisor. Shower weekly Wednesday and Sunday."*

I reviewed observation notes for Resident A. The observation notes read,

> *"10/03: Resident states that she has concerns that her catheter is coming out and she also has concerns about increased vaginal discharge and a pungent smell coming from her pubic area. Upon examination, resident noted to have thick white discharge in her brief with a strong odor. Resident's catheter noted to look like it is in place and also seems to be functioning correctly. SS notified and will inform next SS to contact the resident's PCP during normal business hours. Resident was asked if she would like to be cleaned now. Resident refused and states that she will wait to be cleaned in the morning as long as she is cleaned by a female.*

10/05: New order obtained from PCP. Vagisil cream topical twice a day for 10 days for candidiasis.
10/05: Another order obtained to cleanses peri area twice a day. CP updated."

I reviewed care history for Resident A. The documentation revealed Resident A received a shower on 01/03, 01/07, 01/10, 01/14, and 01/17. The documentation revealed on 01/21/2024, Resident A was not offered a shower due to "*no time can be done in the morning? Was all of south.*" On 01/24/2024 Resident A refused a shower, SP6 was notified, and caregiver answered "*N/A*" if resident was re-approached and told it was time to shower.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	Interviews conducted and review of documentation revealed Resident A was to be offered a shower on Wednesdays and Sundays. If Resident A refused a shower, caregivers were to re-approach Resident A by telling Resident A it was time for a shower. Review of documentation revealed Resident A was not offered a shower on 01/21 due to staffing and on 01/24 caregivers did not re-approach Resident A after Resident A refused the shower. The facility did not appropriately follow Resident A's service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A received incorrect medication.

INVESTIGATION:

The complainant alleged on 01/19/2024, Resident A received incorrect medications.

SP1 reported SP2 had prepared Resident C's medications when SP3 came to her and requested for SP2 to administer Resident B's medications as Resident B did not want SP3 to administer his medications. SP1 reported SP2 took Resident B's medications and SP3 took Resident C's medications. SP1 reported SP3 took Resident C's medications to Resident A and administered several medications. SP1 reported Resident A reported to SP2 that the medications looked different, and she stopped taking the medications. SP1 reported SP2 then realized she administered

the incorrect medications. SP1 reported SP2 and SP3 came to her and reported the medication error. SP1 reported Resident A's physician was notified and it was advised to send Resident A to the emergency department for evaluation. SP1 reported Resident A returned to the facility a few hours later with new orders to monitor blood glucose levels for 12 hours as Resident A had received diabetic medication. SP1 reported the facility monitored blood glucose levels and Resident A did not have any adverse effects from the medication error. SP1 reported SP2 and SP3 re-completed the medication training course and will not be in the role of medication technician for six months. SP1 reported SP2 and SP3 had no previous history of medication errors.

Ms. Moy reported Resident B had recently moved into the facility and Resident B was adjusting to the move. Ms. Moy reported Resident B had requested multiple caregivers not to provide care or medications. Ms. Moy reported the facility was working to ensure Resident B was satisfied with the care. Ms. Moy reported no management was made aware that Resident B was refusing to accept medications from SP3. Ms. Moy reported after the medication error occurred, SP2 and SP3 were retrained on medication administration, will not be in the role of medication technician for 6 months, and will complete the medication administration course again. Ms. Moy reported a medication error like this had never occurred and both staff members understood the severity of the error.

I reviewed SP2 and SP3 training record. The training record revealed SP2 had successfully completed the medication administration training on 07/22/2019 and SP3 completed the medication administration training on 12/12/2023.

I reviewed observation notes for Resident A. The notes read,

"01/19/24 10:00am: Resident was given the wrong medications. She was given Metoprolol 25mg, Losartan 25mg, Januvia 50mg, Sertaline 150mg, Multivitamin, GA Pentin 100mg, and Pepcid 20mg. PCP notified, RSC notified, and family notified. Resident sent to Mercy ER for evaluation per PCP.
01/19/24 10:45am: AM Medication was not given due to resident being given the wrong medication and being sent to ER for eval.
01/19/24 2:45: Resident returned from ER with blood sugar will need to be checked every 2-3 hours for the next 12 hours. There is no evidence of adverse effect of these medications right now. Return for any worsening symptoms."

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.

ANALYSIS:	Interviews conducted and review of documentation revealed Resident A was administered incorrect medications. When the error occurred, the facility acted timely and appropriate to ensure medical attention was provided, appropriate parties were contacted, and discipline action was taken. While the error did occur, it was an isolated occurrence and not a systemic issue at the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

02/12/2024

Kimberly Horst Date
Licensing Staff

Approved By:

02/20/2024

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