GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 6, 2024

Anita Anderson
2189 S. 86th. Ave
Shelby, MI 49455

RE: License #: AS700402240
Investigation #: 2024A0357012
Woodland Gardens Spring Lake

Dear Ms. Anderson:

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,

Arlene B. Smith

Arlene B. Smith, MSW, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor,
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4213

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS700402240
Investigation #:	2024A0357012
Complaint Receipt Date:	01/09/2024
Investigation Initiation Date:	01/09/2024
Report Due Date:	03/09/2024
Licensee Name:	Anita Anderson
Licensee Address:	2189 S 86th Ave Shelby, MI 49455
Licensee Telephone #:	(231) 760-3023
Administrator:	Anita Anderson
Name of Facility:	Woodland Gardens Spring Lake
Facility Address:	18157 174th Ave Spring Lake, MI 49456
Facility Telephone #:	(616) 633-5733
Original Issuance Date:	07/01/2020
License Status:	REGULAR
Effective Date:	01/01/2023
Expiration Date:	12/31/2024
Capacity:	6
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
There is concern that Resident A could harm other residents in the home.	No
Additional Findings	Yes

III. METHODOLOGY

01/09/2024	Special Investigation Intake 2024A0357012
01/09/2024	Special Investigation Initiated - Telephone Telephoned License, Anita Anderson, to discuss the complaint.
01/09/2024	Contact - Telephone call received. Received a telephone from Licensee and Ron Lankford, Manager.
01/09/2024	Contact - Telephone call received, From Licensee about Resident A.
03/02/2024	Inspection Completed On-site Unannounced inspection for the AFC home. Interviewed staff Jennette Bowers, Resident D and Resident E.
03/04/2024	Contact - Telephone call made, To Katie Sterling, Chief Operating Officer, and I left a message,
03/05/2024	Contact - Telephone call made, Telephone interview with Stephan Bullerman.
03/05/2024	Contact - Document Received Received Resident A's Health Care Appraisal.
03/05/2024	Contact - Telephone call made. To Resident A's daughter. I left a message to return my call.
03/05/2024	Telephone call received. Telephone interview with Katie Sterling.
03/06/2024	Exit telephone conference with the Licensee, Anita Anderson.

ALLEGATION: There is concern that Resident A could harm other residents in the home.

INVESTIGATION: This complaint came from Department of Health and Human Services, Ottawa County, Adult Protective Services (APS). APS denied the complaint. The complaint read that Resident A is paralyzed on this left side and has dementia. There are four residents in the home that have various needs. On 01/03/2024 Resident A was screaming, yelling and threatening to kill other residents and staff. Residents reportedly felt their lives were in danger and made attempts to leave the home but had nowhere to go. Law enforcement was called, and they refused to remove Resident A unless they had a court order. Resident A has two daughters that have not answered their telephones.

On 01/03/2024, the licensee, Anita Anderson and Ron Langford, Manager, called me to ask if they could issue a 24-hour discharge notice to Resident A. Mr. Lankford (Manger) reported that when the staff called him, he could hear Resident A yelling, swearing and threatening to kill others. They both explained that in their other licensed homes in other counties, when they have called 911 because a resident is threatening to harm others, the police have taken the resident to the hospital. This time the police said they cannot take Resident A from the home without a court order. They reported that the staff of the home called them when Resident A was making his threats. The staff had called Resident A's two daughters, but they had not answered or returned the telephone calls. Mr. Langford reported that when the police had arrived Resident A was calm and not threating or yelling. Eventually, later on in the evening Resident A's daughters showed up and took Resident A with them. The staff assumed they were taking him to the local hospital.

On 03/02/2024, I made an unannounced inspection of the AFC home. I conducted a face-to-face interview with direct care staff, Jeannet Bowers. She reported she has worked in the home a couple of months. I asked her about what had happened on 01/03/2024. She explained that Resident A was knocking on the walls and hollering "nurse, nurse." She said she went to Resident A's room and helped him into his wheelchair. Later he yelled that he had to go to the bathroom, and he was yelling "nurse, nurse." Ms. Bower's asked him if he could wait a few minutes because she was making breakfast for the residents and she reported that he responded with, "What the hell am I paying you for?" She reported that she helped Resident A get cleaned up and washed his hands and asked him where he wanted to go. He planted his feet into the floor and told her, "This ain't my room." He was yelling and he pinched Ms. Bowers in her side, and he swore at her. She said she told him that was not being polite and not to pinch her. She reported that Resident A is blind, and he wanted her attention all the time. She also reported that he had hit other female staff who worked in the home. She reported that Katie Sterling, the Chief Operating Officer called, and Ms. Sterling told her to call the police. She said the police came to the home and Resident A came out of his room into the living room in his wheelchair and kept saying he was going to kill somebody. He would not stop hollering, "nurse, nurse." The Officer asked her to call Mr. Landford, Manager and

the officer told him that they can't take Resident A unless there is a court order. She reported that she talked to the police and then they left. She reported that later, Resident A went to sleep. She reported that his daughters showed up and they took him in their vehicle. She said she learned latter that that he was taken to a Psychiatric hospital in Indiana. I asked how the other residents were doing when Resident A was yelling that he was going to kill them. She said Resident B said he was afraid and asked if he could leave and go the Fruitport home. I asked if I could speak to Resident B and Ms. Bowers informed me that he has passed away. She reported that Resident C has also passed away since this incident occurred. She reported that Resident D and Resident E are both available to speak with me. They were both in the dining room and I introduced myself and I asked them about Resident A. They both reported that he kept yelling "nurse, nurse." They said Resident A had "temper tantrums". I asked if Resident A had threatened to kill anyone, and they did not seem to remember that.

On 03/05/2024, I conducted a telephone interview with Katie Sterling, Chief Operating Officer. She reported that she did type up a 24-hour discharge for Resident A but because his daughters came and picked him up, she did not issue the 24-hour notice. She said she understood that the daughters took him to the hospital emergency room and then he was sent to a Psychiatric hospital in Indiana. She reported that Resident A is a veteran, and he had suffered a stroke and was paralyzed on one side. She reported that Resident A could be very verbally threating, and she had been called many times to come and work with him to calm down. I told her I had asked Resident D and Resident E if Resident A had threatened to kill people and they informed me they did not remember. She reported that both Resident D and Resident E have problems with their memory. She expressed hope that Resident A had received the care he needed. She reported that he was discharged from the home.

On 03/06/2024, I conducted a telephone exit conference with the Licensee, Anita Anderson. She agreed with my findings.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	There is concern that Resident A could harm another resident of the home. Ms. Jeannet Bowers, direct care staff reported that Resident A was yelling and threating to kill others. She stated Resident B wanted to leave the home because he was scared.

	The Manager, Mr. Ron Lankford reported that Ms. Bowers had called him, and he heard Resident A threating to kill others and he used swear words. Resident A's daughters came and picked up Resident A and he had not hurt any of the residents. Chief Operating Officer, Katie Sterling, reported that she instructed Ms. Bowers to call the police when Resident A was yelling and threating to kill others. The police would not take Resident A because they said they did have a court order. She confirmed that Resident A's daughters picked Resident A up from the AFC home, so they did not issue a 24-hour discharge order. During this investigation none of the residents were hurt physical and their needs including protection and safety were attended to. Therefore, there is not a violation to the rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION: On 03/02/2024, Ms. Bowers reported that Resident B and Resident C had died in the AFC home. I asked to see the Incident/Accident Reports because I had not received one for either of their deaths. She said she had not been trained on how to complete the Incident/Accident Report so therefore she had not completed the documents.

On 03/05/2024, I conducted a telephone interview with Katie Sterling, Chief Operating Officer. She explained that after the previously described incident involving Resident A, she learned that Resident A's daughters had taken Resident A to the hospital emergency room and then he was taken to a Psychiatric hospital in Indiana. She reported that Ms. Bowers had been trained on how to complete an Incident/Accident Report (IR) and was not aware that Ms. Bowers had not completed the IR concerning Resident A being taken to the hospital. I asked her about Resident B and Resident C's deaths, and she stated that she had reminded Ms. Bowers to complete the IR's for the deaths. She acknowledged that she did not follow-up to see if the IR's had been completed and sent to licensing.

On 03/06/2024, I conducted a telephone exit conference with the License, Anita Anderson and she agreed with my findings.

APPLICABLE RULE	
R 400. 14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	Rule 11 (1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: (a) The death of a resident. (c) Incidents that involve any of the following: (ii) Hospitalization.
ANALYSIS:	Direct care staff, Ms. Jannett Bowers acknowledged that she failed to complete an Incident/Accident Report on Resident A's hospitalization. Direct care staff, Ms. Jannett Bowers acknowledged that Resident B and Resident C had died in the AFC home, and she failed to complete an Incident/Accident Report. During this investigation it was learned that the direct care staff Ms. Bowers failed to complete the required Incident/Accident Reports and to send the two deaths of residents to licensing. Therefore, there is a violation to the rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend that the License provide an acceptable plan of correction to our department and then the complaint will be closed.

Arlene B. Smith 03/06/2024

Arlene Smith Date
Licensing Consultant

Approved By:

Jerry Hendrick 03/06/2024

Jerry Hendrick Date
Area Manager