GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 30, 2024

Robert Norcross
Medilodge of Grand Rapids
2000 Leonard Street
Grand Rapids, MI 49505

RE: License #: AH410413805
Investigation #: 2024A1021086
Medilodge of Grand Rapids

Dear Mr. Norcross:

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 #:	AH410413805
Investigation #:	2024A1021086
Complaint Receipt Date:	09/11/2024
Investigation Initiation Date:	09/16/2024
Report Due Date:	11/11/2024
Licensee Name:	Grand Rapids Opco, LLC
Licensee Address:	2000 Leonard St. NE Grand Rapids, MI 49505
Licensee Telephone #:	(618) 458-1133
Administrator:	Jill Damveld
Authorized Representative:	Robert Norcross
Name of Facility:	Medilodge of Grand Rapids
Facility Address:	2000 Leonard Street Grand Rapids, MI 49505
Facility Telephone #:	(616) 458-1133
Original Issuance Date:	09/01/2022
License Status:	REGULAR
Effective Date:	02/28/2024
Expiration Date:	07/31/2024
Capacity:	103
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A neglected.	No
Resident B neglected.	No
Soiled linen and trash are kept in shower room.	Yes
Shower leaks and floor is wet.	No
Additional Findings	Yes

III. METHODOLOGY

09/11/2024	Special Investigation Intake 2024A1021086
09/16/2024	Special Investigation Initiated - On Site
09/18/2024	Contact-Telephone call made Interviewed Interim Hospice
09/30/2024	Exit Conference

ALLEGATION:

Resident A neglected.

INVESTIGATION:

On 09/11/2024, the licensing department received an anonymous complaint with allegations on 09/10/2024, Resident A was left covered in urine for over an hour. The complainant alleged staff would turn off the residents call light but not change Resident A's brief.

Due to the anonymous complaint, I was unable to contact the complainant for additional information.

On 09/16/2024, I interviewed staff person 1 (SP1) at the facility. SP1 reported she was aware of this complaint. SP1 reported on 09/10/2024, a first shift worker responded to Resident A's pendent request and told Resident A she was with

another resident but would be back very soon. SP1 reported before the employee could return to assist Resident A, another staff member provided assistance to Resident A. SP1 reported later in the shift, there were allegations made staff members were turning off Resident A's call light. SP1 reported while this did occur, Resident A was made aware staff would be in to assist her very soon, and a care staff did provide assistance within 10 or 15 minutes. SP1 reported Resident A is very vocal and will make her needs known. SP1 reported she followed up with Resident A and Resident A has no concerns about the care she receives.

On 09/16/2024, I interviewed SP2 at the facility. SP2 reported care staff respond very quickly to Resident A as Resident A prefers to stick to her schedule. SP2 reported she has never observed staff members not responding to Resident A's call light or for Resident A to be covered in urine.

On 09/16/2024, I interviewed Resident A at the facility. Resident A reported in the past she has had to wait an extended time for employees to help her, however, this has not occurred recently. Resident A reported care staff treat her well and she is happy with the care received.

I observed Resident A to be sitting in her wheelchair. Resident A was in clean clothes, her hair was washed, and I did not smell any urine on Resident A.

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.**
	(p) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.

ANALYSIS:	Interviews conducted and observations made revealed lack of evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident B neglected.

INVESTIGATION:

The complainant alleged Resident B does not eat because staff do not assist Resident B. The complainant alleged Resident B is left in soiled briefs.

On 09/16/2024, I interviewed SP2 at the facility. SP2 reported Resident B's health has declined and Resident B is at his end stage of life. SP2 reported care staff assist with meal service in the dining room, then deliver food trays, and then assist Resident B with eating. SP2 reported Resident B does not have the energy to feed himself. SP2 reported Resident B has decreased amount of food he is eating. SP2 reported Resident B has a catheter and staff are responsible for providing catheter care every shift. SP2 reported Resident B is rotated and changed every hour. SP2 reported Resident B is a two person assist. SP2 reported Resident B has an open wound on his back that is being managed by Interim Hospice. SP2 reported Resident B does not like to get rotated or pressure off the wound which is making it difficult for the wound to heal. SP2 reported no knowledge of Resident B not receiving care from staff.

SP1 reported Resident B is on comfort measures due to Resident B is at end of life. SP1 reported Resident B is checked on hourly to be rotated and is changed every two hours. SP1 reported education was provided to the staff on rotating procedures as Resident B does not like to be rotated. SP1 reported Resident B receives all care in bed and is a two person assist. SP1 reported Resident B receives good care at the facility.

SP3 reported Resident B's health has declined over the past month. SP3 reported care staff pass room trays and assist Resident B with eating. SP3 reported Resident B has a small pressure sore that is being monitored by Interim hospice. SP3 reported Resident B does not have many bowel movements and she has not observed Resident B to have been left with a soiled brief.

On 09/18/2024, I interviewed Interim Hospice registered nurse Amber Slachter by telephone. Ms. Slachter reported Resident B passed away two days ago. Ms. Slachter reported six months ago she had concerns with soiled briefs left on Resident B, however, the facility addressed the concerns and there have been no more issues since then. Ms. Slachter reported when she has observed Resident B,

he always had a clean brief on. Ms. Slachter reported Resident B was not eating much because he was at his end of life. Ms. Slachter reported no concerns with the care Resident B received at the facility.

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.**
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ANALYSIS:	Interviews conducted revealed lack of evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Soiled linen and trash are kept in shower room.

INVESTIGATION:

The complainant alleged soiled linen and trash are kept in the shower room.

SP2 reported due to the renovations one of the shower rooms is not used but should be open to residents soon. SP2 reported the other shower room, has three individual rooms. SP2 reported one room staff uses the restroom, the other room has clean linen in the room, and the third room has a shower the resident’s use.

While onsite, I observed the shower room. The shower room had one separate bathroom unit with a toilet, sink, and walk in shower. In this room, there was a trash

bin. The other separate bathroom unit had a toilet, sink, and shower unit. In this unit, there was a clean linen cart that blocked the usage of the shower.

APPLICABLE RULE	
R 325.1968	**Toilet and bathing facilities.**
	(4) A resident toilet room or bathroom shall not be used for storage or housekeeping functions.
ANALYSIS:	Interviews conducted and observations made revealed the shower room is used for storage and housekeeping functions.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Shower leaks and floor is wet.

INVESTIGATION:

The complainant alleged the shower leaks, and the floor is always wet.

SP2 reported no concerns with the shower leaking. SP2 reported at times the floor is wet, due to the number of residents taking a shower. SP2 reported when a resident goes into the shower room, there is always an employee with the resident to ensure the resident's safety. SP2 reported there have been no falls in the shower room.

SP3 reported the shower must be completely turned off or it will continue to run. SP3 reported caregivers are trained on how to turn off the shower. SP3 reported employees always prep the shower by ensuring the floor is dry prior to showering a resident.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	Interviews conducted revealed lack of evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

SP1, SP2, and SP3 reported Resident B required assistance with eating and staff would provide this 1:1 assistance. SP1, SP2, and SP3 reported Resident B had a pressure sore, was a two person assist, and was to be rotated every hour.

Resident B's service plan read,

"*Bed mobility: 1 person for repositioning and offloading.*
Eating: The resident is able to: feed self independently"

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	Review of Resident B's service plan revealed the service plan was not updated to correctly reflect the care needs of Resident B.
CONCLUSION:	**VIOLATION ESTABLISHED.**

IV. RECOMMENDATION

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

Kimberly Horst 09/18/2024

Kimberly Horst Date
Licensing Staff

Approved By:

Andrea L. Moore 09/30/2024

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