GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 15, 2024

Marie Wieland
The Ridge at Lansing
1634 Lake Lansing Road
Lansing, MI 48912

RE: License #: AH330386131
Investigation #: 2024A1010076
The Ridge at Lansing

Dear Licensee:

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) 241-1970.

Sincerely,

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa NW Unit 13, 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH330386131
Investigation #:	2024A1010076
Complaint Receipt Date:	08/07/2024
Investigation Initiation Date:	08/08/2024
Report Due Date:	10/06/2024
Licensee Name:	Ridgeline Lansing, LLC
Licensee Address:	Ste 207 2095 Summer Lee Dr Rockwall, TX 75032
Licensee Telephone #:	Unknown
Authorized Representative/ Administrator:	Marie Wieland
Name of Facility:	The Ridge at Lansing
Facility Address:	1634 Lake Lansing Road Lansing, MI 48912
Facility Telephone #:	(517) 507-3303
Original Issuance Date:	11/30/2018
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	66
Program Type:	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident C was observed with bruises and marks on his right forearms and bicep area.	No
An incident report was not completed, and Resident C's responsible person was not notified after bruising was observed on Resident C on 8/5/24.	Yes

III. METHODOLOGY

08/07/2024	Special Investigation Intake 2024A1010076
08/08/2024	Special Investigation Initiated - Letter Emailed assigned Ingham Co APS worker Emily Presendieu
08/13/2024	Inspection Completed On-site
08/13/2024	Contact - Document Received Received resident report dated 8/5/24, resident service plan, and staff training documents
09/30/2024	Contact – Telephone call made Interviewed Relative C1 by telephone
09/30/2024	Contact – Telephone call made Interviewed Ms. Presendieu by telephone
10/02/2024	Contact – Document sent Lansing Twp. Police Report request sent via email
10/02/2024	Contact – Telephone call made Interviewed SP2 by telephone
10/02/2024	Contact – Telephone call made Interviewed SP3 by telephone
10/15/2024	Exit Conference

ALLEGATION:

Resident C was observed with bruises and marks on his right forearms and bicep area.

INVESTIGATION:

On 8/7/24, the Bureau received the complaint from Adult Protective Service (APS). The complaint read on 8/4/24, "[Resident C] was observed to have grab marks on his right forearm and bruising on bicep area. It is unclear how [Resident C] obtained these bruises and there is concern that staff may be cover for what has happened to [Resident C]. Management reported a small note this morning, that [Resident C] had a bruise but no explanation and no context, such as color and shape and area of the bruise."

On 8/8/24, I emailed assigned Ingham County APS worker Emily Presendieu. Ms. Presendieu reported she observed a large bruise on Resident C's right inner forearm and several other small marks/bruises on the other areas of his arm and also on his left arm and hand as well." Ms. Presendieu reported she is in the process of interviewing care staff at the facility.

On 8/13/24, I interviewed interim administrator Dale Woytek at the facility. Ms. Woytek reported Resident C requires the assistance from staff to reposition him while he is in his bed. Ms. Woytek stated as a result, staff often "handle" or touch Resident C to reposition him. Ms. Woytek said Resident C also requires the use of a sit to stand assistive device to transfer.

Ms. Woytek reported a bruise was observed on Resident C's upper arm that appeared to be in the shape of a handprint. Ms. Woytek stated Staff Person 1 was the first staff person to observe and document the bruise. Ms. Woytek explained SP1 noticed the bruise on Resident C's arm when she arrived for first shift on 8/5/24. Ms. Woytek provided me with a copy of the day shift *24 Hour Resident Report* dated 8/5/24 for my review. The document completed by SP1 read, "#44 bruise (L) middle finger (R) arm."

Ms. Woytek stated there is insufficient evidence to suggest Resident C's bruises were intentionally caused by staff physically harming or assaulting Resident C. Ms. Woytek reported allegations regarding staff being physically aggressive towards residents are out of character for them. Ms. Woytek said she has not received any complaints from staff, family, or visitors regarding staff being physically or verbally aggressive towards residents in the facility. Ms. Woytek reported all staff receive resident rights training upon hire at the facility.

Ms. Woytek reported the bruising observed on Resident C may have been unintentionally caused by staff while repositioning or transferring Resident C. Ms. Woytek stated after the bruising was observed on Resident C, all staff completed transfer and repositioning a resident re-education and re-training. Ms. Woytek provided me with a copy of the *Training Attendance Sheet* document dated 8/9/24

for my review. The *Course Name* section of the document read, “Rolling, Lifting, Transfers” and had the signatures of all the staff persons who attended. Ms. Woytek also provided me with the PowerPoint presentation of the information that was presented to staff for my review. I observed education and training regarding “Proper Lifting and Patient Moving Techniques” and “How to Safely Position Patients” were some of training topics presented.

Ms. Woytek stated she received a written statement from SP2 who worked during third shift starting on 8/4/24 into the early morning hours of 8/5/24. Ms. Woytek provided me with a copy of SP2’s written statement for my review. The statement read, “I [SP2] was the caregiver scheduled for residents in Hoyer hall on Sunday overnight 8/4/24. Room 44 was one of my assigned rooms. When caring for [Resident C] I noticed a few bruises/abrasions on him in various stages of healing. This is not abnormal given the integrity of his skin.”

Ms. Woytek provided me with a copy of Resident C’s service plan for my review. The *Ambulation: 1 Person assist* section of the plan read, “[Resident C] will need SBA/cueing when ambulating in his wheelchair. Staff will ensure that [Resident C] is safe when in wheelchair and ensure other residents [sic] safety when [Resident C] is in wheelchair. Staff will provide stand by assistance with cues/prompting as needed for safety. Staff will monitor resident for safety and will provide hands on assistance as needed for unsteady or unsafe ambulation and/or to assist resident with proper use of an assistive device.

The *Transfer: Assist of 2* section of the plan read, “[Resident C] requires a sit to stand for transfers r/t inability to stand safely. There will be 2 staff members at all times when [Resident C] is in sit to stand to maintain safety. Staff will explain transfer to resident prior to beginning transfer. Staff will use gait belt for safety during transfer. Staff will move slowly, make eye contact, count together, and encourage the resident to participate in transfer. Staff will provide two person transfer. Staff will notify nurse of any changes or problems.”

On 8/13/24, I interviewed SP1 at the facility. SP1’s statements were consistent with the day shift *24 Hour Resident Report* dated 8/5/24 that she completed. SP1 reported she entered Resident C’s room when she arrived for her shift in the morning on 8/5/24 because Resident C had a nosebleed. SP1 explained she observed Resident C had a bruise on his right upper arm and on his finger when she was tending to his nosebleed.

SP1 said she did not know how Resident C obtained the bruising. SP1 reported she did not observe the bruise on Resident C’s upper arm to be in the shape of a handprint. SP1 stated Resident C is unable to communicate how he got the bruises due to his cognitive status. SP1 said she received resident rights training upon hire at the facility. SP1’s statements regarding staff at the facility were consistent with Ms. Woytek. SP1 explained she also received abuse and neglect reporting when she started at the facility.

SP1's statements regarding Resident C's care needs were consistent with Ms. Woytek and Resident C's service plan.

On 8/13/24, I interviewed SP3 at the facility. SP3's statements were consistent with Ms. Woytek, SP1, and Resident C's service plan.

On 8/13/24, I attempted to interview Resident C at the facility. The facility is secured and only admits residents who require memory care services. I was unable to engage Resident C in meaningful conversation due to his memory loss. I was unable to observe Resident C's right arm because he was wearing a sleeved shirt that he was unable to pull up. Staff reported Resident C's bruise has healed.

On 9/30/24, I interviewed Relative C1 by telephone. Relative C1 reported Resident C had to have gotten the bruise on his right forearm between second and third shift the evening of 8/4/24 going into 8/5/24. Relative C1 explained she was at the facility visiting Resident C in the evening on 8/4/24 until approximately 9:00 pm. Resident C reported she observed Resident C and he did not have any bruising during her visit the evening of 8/4/24. Relative C1 reported staff observed and insufficiently documented the bruising on Resident C during first shift on 8/5/24.

Relative C1 reported that when she went to visit Resident C the evening of 8/5/24, she observed the bruise on Resident C's right forearm was in the shape of a handprint. Relative C1 expressed concern regarding how Resident C obtained the handprint bruise. Relative C1 said she suspects one staff person who worked 8/4/24 into 8/5/24 caused the bruise on Resident C's right forearm. Relative C1 was not willing to provide the name of the staff person she suspected of causing the bruising on Resident C. Relative C1 reported she previously "observed panic" in Resident C's eyes when this staff person was near him. Again, Relative C1 would not provide the name of the staff person she suspects caused Resident C's bruise. Relative C1 reported Resident C moved out of the facility at the end of August.

On 9/30/24, I Interviewed Ms. Presendieu by telephone. Ms. Presendieu reported she notified the Lansing Township Police Department regarding the bruising on Resident C. Ms. Presendieu stated she did not know whether law enforcement investigated the cause of Resident C's bruises. Ms. Presendieu stated she did substantiate her APS investigation due to the bruise appearing to be in the shape of a handprint, however she was unable to identify a staff person who was the perpetrator of physical abuse against Resident C.

Ms. Presendieu provided me with the pictures she took of the bruise on Resident C's right forearm and on his left middle finger. I observed the bruise on Resident C's right forearm did appear to be in the shape of a handprint with distinguishable fingertip marks.

On 10/2/24, I requested the Lansing Township Police report regarding Resident C.

On 10/2/24, I interviewed SP4 by telephone. SP4 said she first learned of the bruise on Resident C's right forearm when it was brought to her attention by Relative C1 who was visiting Resident C in the evening. SP4 was unable to recall the exact date she spoke with Relative C1 and observed the bruise on Resident C. SP4 reported she worked second shift the prior evening and did not observe bruising on Resident C. SP4 said after she spoke with Relative C1 and observed Resident C's bruising, she called the facility's health service director and verbally reported it to him. SP4 reported she learned first shift staff documented Resident C's bruises. SP4 said she could not determine that the bruise on Resident C's right forearm appeared to be a handprint. SP4 reported she did not know how Resident C received the bruises on his right forearm and middle finger.

SP4's statements regarding staff's treatment of Resident C and other residents in the facility were consistent with Ms. Woytek, SP1, and SP3. SP4 reported she received resident rights training and abuse and neglect reporting when she started at the facility. SP4 denied ever seeing staff be physically or verbally aggressive towards Resident C or any other residents in the facility. SP4 stated although Resident C has memory loss, he is capable of verbalizing if someone intentionally harmed him. SP4 said Resident C made no statements to her that any staff intentionally injured him.

On 10/2/24, I interviewed SP5 by telephone. SP5's statements were consistent with SP4. SP5 said Relative C1 brought Resident C's bruises to her attention. SP5 reported she did not see the bruises when she assisted in getting Resident C ready for bed the same evening she spoke to Relative C1. SP5 was unable to recall the exact date this occurred. SP5 reported she did not know how Resident C obtained the bruises on his right fore are and middle finger.

SP5's statements regarding resident rights and abuse and neglect reporting were consistent with SP4.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(l) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services for a specified and limited time or as are**

	necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician or physician's assistant. In case of a chemical restraint, a physician shall be consulted within 24 hours after the commencement of the chemical restraint.
ANALYSIS:	The interviews with Ms. Woytek, along with care staff who worked second and third shift on 8/4/24 going into the early morning hours of 8/5/24, revealed Resident C did have a bruise on his right forearm and left middle finger, however it is unknown how Resident C obtained the bruises. There is insufficient evidence to suggest staff at the facility intentionally caused the bruising observed on Resident C on 8/5/24.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

An incident report was not completed, and Resident C's responsible person was not notified after bruising was observed on Resident C on 8/5/24.

INVESTIGATION:

On 8/7/24, the complaint read, "The staff did not notify [Resident C's] family about the bruises. The bruise timeline may have taken place the night of 8-4-24 or morning of 8-5-24, after [Resident C's] family left and before they arrived today for visits."

On 8/13/24, Ms. Woytek reported an incident report was not completed after staff observed the bruising on Resident C. Ms. Woytek denied knowledge that SP1 contacted Resident C's responsible person and physician after she observed Resident C's bruises. Ms. Woytek said an incident report and contact with Resident C's responsible person and physician should have been made by SP1, however SP1 did not follow the facility's incident reporting policy and procedure.

On 8/13/24, SP1 confirmed she did not complete a formal incident report or notify Resident C's responsible person or physician that Resident C had unexplained bruises that she observed on 8/5/24. SP1 stated on 8/5/24, she did verbally report Resident C's bruises to the second shift medication technician (med tech) when the second shift change over occurred.

On 9/30/24, Relative C1 reported she was not notified by staff that Resident C had hand and fingerprint shaped bruising on his right forearm or left middle finger. Relative C1 was upset and stated staff are “trying to cover up” what happened to Resident C.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, quality review program.**
	(7) The facility must have a policy and procedure to ensure that an incident, once known by facility staff, is reported as soon as possible, but not later than 48 hours after the incident, to a resident’s authorized representative or designated health care professional, as appropriate. Verbal or written notification must be documented in the resident’s record to reflect the date, time, name of staff who made the notification, and name of the representative or professional who was notified.
ANALYSIS:	The interviews with Ms. Woytek and SP1 revealed an incident report regarding the handprint bruise on Resident C’s right forearm and the bruise on his left middle finger was not completed. Notifications of the injuries to Resident C’s responsible person and physician were also not made. The facility was not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Marie Lynn Wieland on 10/15/24.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

10/07/2024

Lauren Wohlfert Date
Licensing Staff

Approved By:

10/15/2024

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