GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 10, 2025

Toni LaRose
AH Spring Lake Subtenant LLC
Ste 1600
1 Towne Sq
Southfield, MI 48076

RE: License #: AL700397744
Investigation #: 2025A0579014
AHSL Spring Lake Pebblebrook

Dear Toni LaRose:

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) 356-0183.

Sincerely,

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(269) 615-5050

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL700397744
Investigation #:	2025A0579014
Complaint Receipt Date:	01/15/2025
Investigation Initiation Date:	01/17/2025
Report Due Date:	03/16/2025
Licensee Name:	AH Spring Lake Subtenant LLC
Licensee Address:	Ste 1600, 1 Towne Sq, Southfield, MI 48076
Licensee Telephone #:	(248) 203-1800
Administrator:	Toni LaRose
Licensee Designee:	Toni LaRose
Name of Facility:	AHSL Spring Lake Pebblebrook
Facility Address:	17387 Oak Crest Parkway, Spring Lake, MI 49456
Facility Telephone #:	(616) 844-2880
Original Issuance Date:	03/18/2019
License Status:	REGULAR
Effective Date:	09/18/2023
Expiration Date:	09/17/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED/ AGED

II. ALLEGATION(S)

	Violation Established?
Residents do not receive adequate care due to insufficient staffing.	No
Additional Findings	Yes

III. METHODOLOGY

01/15/2025	Special Investigation Intake 2025A0579014
01/17/2025	Special Investigation Initiated - Face to Face Shelby Vanderstelt, Direct Care Worker, Deanna Pullum, Direct Care Worker, Toni LaRose, Licensee Designee
01/17/2025	APS Referral
01/27/2025	Contact- Document Received Toni LaRose, Licensee Designee
03/03/2025	Contact- Document Sent Toni LaRose, Licensee Designee
03/05/2025	Contact- Document Received Toni LaRose, Licensee Designee
03/06/2025	Contact- Document Received Toni LaRose, Licensee Designee
03/10/2025	Exit Conference Toni LaRose, Licensee Designee

ALLEGATION: Residents do not receive adequate care due to insufficient staffing.

INVESTIGATION: On 1/15/25, I received this referral which alleged 10 residents live at the Pebblebrook home. The home has not had adequate staffing in three weeks and as a result, residents are not receiving sufficient care due to direct care workers (DCWs) working by themselves. Residents must wait to be toileted.

On 1/17/25, I completed an unannounced on-site investigation. Interviews were completed with DCWs Shelby Vanderstelt and Deanna Pullum as well as licensee Toni LaRose.

Ms. Vanderstelt reported she is responsible for scheduling. She stated within the last few weeks, she has struggled to maintain adequate staffing in the home. She stated due to conflicts with a new manager on-site, DCWs have been ending their employment. She stated if this person's leadership style is not addressed soon, additional current DCWs have threatened to end their employment as well. She stated Ms. LaRose is aware of this and they are attempting to hire more staff.

Ms. Vanderstelt stated she always schedules two DCWS in the home, although it would be "safer" to have three DCWs. She stated Resident A is not ambulatory, uses a Hoyer lift, and is over 300 lbs. so two DCWs struggle to transfer her, even when using the Hoyer. She stated DCWs are regularly toileting and providing care for residents, they are not neglected, but care may be delayed, and residents must wait when only two people are working in the home. She stated her primary concern regarding staffing is the safety of transferring Resident A with only two DCWs.

Ms. Vanderstelt stated she knows of one occasion when a former DCW worked alone from 11:00 p.m.-3:00 a.m. due to the on-site manager refusing to come in to relieve this person who could not stay. She stated the manager told the DCW to "walk off" even though she knew that would leave only one DCW in the home. Ms. Vanderstelt showed me a text message exchange which she reported included the former DCW and the manager and confirmed what Ms. Vanderstelt reported.

Ms. Pullum reported she was reluctant to speak to me due to a fear of retaliation by the new on-site manager. She stated she has not worked alone and typically works with one other DCW. She stated two DCWs are not sufficient to adequately care for residents in this home due to their transfer needs. She stated Resident A requires three DCWs and her Hoyer lift to safely transfer. She stated DCWs are regularly toileting and providing care for residents, they are not neglected, but residents must wait for care when only two people are working in the home.

While leaving the home, I met Ms. LaRose outside of the home. She denied having and concern regarding staffing and reported the home has been adequately staffed. She stated there will also be a hiring event occurring soon, so she does not feel staffing is a concern.

On 3/5/25, I received the Resident Register for the home which confirmed there were 11 residents in the home on the date of the on-site investigation. I received the assessment plans for each resident. Three residents were listed as independently transferring. One resident was listed as needing minimal assistance, such as verbal cues. One resident was listed as needing moderate assistance and may require a DCW on standby. Two residents require extensive assistance requiring DCW assistance and an assistive device. Four residents were listed as needing total assistance and were completely dependent on DCWs for transferring, including Resident A. No resident assessment plan specified the number of DCWs needed to safely transfer the resident.

On 3/6/25, I received and the reviewed the staff schedule and sign-in sheets for the home from 12/22/24 to 1/18/25. The staff sign-in sheets noted at least two DCWs in the home at all times.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours. **(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.**
ANALYSIS:	DCW Ms. Pullum denied working alone. She reported she typically works with one other person. The DCW sign-in sheets confirmed there were two DCWs in the home at all times. DCW Ms. Vanderstelt reported she does the scheduling for this home and always schedules two people. She reported there was one occasion when from 11:00 p.m.-3:00 a.m. there was one DCW in the home, but this was not confirmed by the DCW sign-in sheets. Ms. LaRose denied having any concern regarding adequate staffing. Ms. Pullum and Ms. Vanderstelt expressed concern that two DCWs are not sufficient to meet resident transfer and safety needs. Resident assessment plans were reviewed and did not specify the number of staff needed for transferring. Based on the interviews completed and documentation reviewed, there is not sufficient evidence to indicate the home is inadequately staffed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING:
On 1/17/25, Ms. Vanderstelt stated she does not feel resident assessment plans accurately note resident’s transfer needs. She stated she believes there are four residents who need “extensive” assistance which she stated requires two DCWs and

an assistive device such as a gait belt. She stated there are three residents who require “total” assistance who also require the assistance of two DCWs or in the case of Resident A, three DCWs and a Hoyer lift. She stated Resident B is also listed as “independent” but due to a recent fall and decline, she feels this is incorrect. She stated resident assessment plans do not specify how many DCWs are needed to safely transfer a resident, it is just implied by their transfer needs.

Ms. Pullum reported Resident A requires three DCWs and her Hoyer lift to safely transfer.

On 3/5/25, I reviewed the resident assessment plans and found three residents were listed as independently transferring, including Resident B. One resident was listed as needing minimal assistance such as verbal cues. One resident was listed as needing moderate assistance and may require a DCW on standby. Two residents require extensive assistance requiring staff assistance and an assistive device. Four residents were listed as needing total assistance and were completely dependent on DCWs for transferring, including Resident A. No resident assessment plan specified the number of DCWs required to safely transfer the resident.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.**
ANALYSIS:	Ms. Vanderstelt expressed concern that assessment plans do not accurately reflect resident transfer needs. She reported the number of DCWs was not specified. She and Ms. Pullum reported Resident A requires three DCWs and a Hoyer lift to safely transfer. I reviewed resident assessment plans and found the number of DCWs needed to transfer was not specified. Based on the interviews completed and documentation reviewed, there is sufficient evidence to indicate that residents were admitted without completing a written assessment that ensured they were suitable based on the amount of personal care, supervision, and protection required for the resident being

	available in the home in regard to specifying the number of DCWs needed to safely transfer residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 1/17/25, I observed Ms. Pullum in the home. I observed Ms. Pullum leave this home to go to another home and another DCW arrive to assist Ms. Vanderstelt.

On 3/6/25, I reviewed the staff schedule and staff sign-in sheets for the home. I found the staff schedule listed DCWs as working but not specify which home they were working in. At times, it was noted that no DCW or one DCW was in the home, which was not consistent with the staff sign-in sheet. On 1/17/25, Ms. Pullum was not listed on the staff schedule but she signed-in on the sign-in sheet as working from 7:00 a.m. to 7:00 p.m. Ms. Pullum leaving the home to assist in another home was not noted on the sign-in sheet.

On 3/7/25, while reviewing the schedule for the neighboring AFC home, I noticed on 12/24/24, direct care worker Cherise Copeland was signed-in to both this home and the neighboring home from 7:00 a.m. to 7:00 p.m. Ms. Copeland's name on the sign-in sheet for this home was not consistent with her signature which was repeated on the other sign-in sheet I reviewed.

APPLICABLE RULE	
R 400.15208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.** **(b) Job titles.** **(c) Hours or shifts worked.** **(d) Date of schedule.** **(e) Any scheduling changes.**

ANALYSIS:	I reviewed the staff schedule and sign-in sheet for the home. I found the schedule was not complete or consistent with the sign-in sheet completed by DCWs in the home. I also found a DCW signed-in at this home and a neighboring home at the same time. I observed Ms. Pullum in the home although she was not on the schedule. I observed she was signed-in at the home from 7:00 a.m. to 7:00 p.m. although I observed her leaving the home while I was present. Based on the documentation reviewed and observations made, there is sufficient evidence that a daily schedule including the necessary information specified in the rule is not accurately maintained in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 3/10/25, I completed an exit conference with Ms. LaRose who did not dispute my findings or recommendations.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of corrective action, I recommend the status of the license remain the same.

Cassandra Duursma 03/10/2025

Cassandra Duursma Date
Licensing Consultant

Approved By:

Jerry Hendrick 03/10/2025

Jerry Hendrick Date
Area Manager