RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

May 29, 2018

Marcia Curtiss
Lifehouse Crystal Manor Operations LLC
Suite 115
21800 Haggerty Rd.
Northville, MI 48167

RE: License #: AL410302931
Investigation #: 2018A0355037
Addington Place of Grand Rapids Seaside

Dear Mrs. Curtiss:

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,

Grant Sutton, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4437

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410302931
Investigation #:	2018A0355037
Complaint Receipt Date:	04/02/2018
Investigation Initiation Date:	04/03/2018
Report Due Date:	06/01/2018
Licensee Name:	Lifehouse Crystal Manor Operations LLC
Licensee Address:	Suite 115 21800 Haggerty Rd. Northville, MI 48167
Licensee Telephone #:	(616) 262-1792
Administrator:	Kathy Higgins
Licensee Designee:	Marcia Curtiss
Name of Facility:	Addington Place of Grand Rapids Seaside
Facility Address:	1175 68th Street S.E. Grand Rapids, MI 49508
Facility Telephone #:	(616) 281-8054
Original Issuance Date:	03/25/2010
Status:	REGULAR
Effective Date:	09/26/2016
Expiration Date:	09/25/2018
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED, AGED, MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
The facility was short staffed on 04/01/2018.	No
Resident A was left in a wet brief for approximately 4 hours.	Yes

III. METHODOLOGY

04/02/2018	Special Investigation Intake 2018A0355037
04/02/2018	APS Referral Received from APS
04/03/2018	Special Investigation Initiated - On Site Interviewed staff, reviewed resident files
04/27/2018	Contact - Telephone call made Review with APS staff investigating allegations
05/14/2018	Contact - Telephone call received Interviewed staff
05/23/2018	Exit Conference Licensee designee

ALLEGATION: The facility was short staffed on 04/01/2018.

INVESTIGATION: On 04/02/2018, I received a complaint filed on behalf of Resident A from the Adult Protective Services Centralized Intake Unit (APS). The complaint alleged that on 04/01/2018, the facility was short staffed in that only 1 person was observed “working on the floor.”

On 04/03/2018, I conducted an unannounced investigation on-site and interviewed the lead nursing staff person for the licensee, Janene Hayes. While on-site, I reviewed the staff schedule and the Assessment Plans for each of the 18 current residents.

Ms. Hayes stated that there was in fact 2 staff working on 04/01/2018; 1 medication technician (med tech) and 1 aide. Ms. Hayes stated that the problem on the date in question is that the med tech was filling in from another program and for unknown reasons, was not assisting the aide with resident care. Ms. Hayes stated that once APS made contact with the facility and made the licensee aware of the situation, the issue with the med tech was dealt with and she no longer works for the licensee.

The schedule indicated that there were two staff working on the date in question and previous schedules indicated that there have been a minimum of two staff working on the 1st, 2nd, and 3rd shifts for the past three weeks.

My review of the resident Assessment Plans indicates that 7 of the current 18 residents require 2-person transfers from their wheelchairs necessitating the minimum staffing level currently utilized to meet assessed needs.

On 05/14/2018, I interviewed by telephone staff Rachael Pisacreta, the staff who was identified as working 'alone' on 04/01/2018. Ms. Pisacreta confirmed that there was a med tech on duty on the date in question but the med tech was not assisting with resident care during the course of the shift.

On 05/23/2018, I conducted by telephone an exit conference with the licensee designee, Marcia Curtiss. Mrs. Curtiss concurred with the findings of my investigation and did not have any further comment for my report.

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.
ANALYSIS:	There were 2 staff working each of the 3 shifts on 04/01/2018. There was a minimum of 2 staff working, per the schedule, on each of the 3 shifts for the past 3 weeks.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A was left in a wet brief for approximately 4 hours.

INVESTIGATION: On 04/02/2018, I received a complaint filed on behalf of Resident A by her family via the Adult Protective Services Centralized Intake Unit (APS). The complaint indicated that Resident A was left unchecked in her adult brief for approximately 4 hours on 04/01/2018.

On 04/03/2018, I conducted an unannounced investigation at the facility and interviewed the lead nursing staff person for the licensee, Janene Hayes. While on-site, I reviewed the Assessment Plan for Resident A.

Ms. Hayes acknowledged that on the date in question, the medication technician present for the 1st shift was not assisting the aide working that shift with resident care so it is possible that Resident A was not checked for 4 hours. Ms. Hayes stated that once APS staff contacted her with the allegation, she did a preliminary investigation and could not determine whether Resident A's family was in fact present for 4 hours during the 1st shift on 04/01/2018.

Resident A's Assessment Plan indicated that she requires help with personal care and is unable to request assistance due to her dementia.

Through previous Special Investigations, I have observed and been told that the policy for this facility is that all residents are to be checked every 2 hours to see if they need assistance with the bathroom or if they need to have their brief changed.

On 04/27/2018, I contacted the APS staff assigned to this complaint, Zach Blevins. Mr. Blevins stated that per his conversations with Resident A's daughter, Resident A was not checked for 4 hours and the daughter could smell urine on Resident A. Mr. Blevins stated that the daughter did acknowledge that she did not request or seek assistance for her mother during the 4 hour time period.

On 05/14/2018, I interviewed by telephone staff Rachael Pisacreta, the aide working on 04/01/2018. Ms. Pisacreta could not recall checking Resident A and/or changing her that date when Resident A's family was present.

On 05/23/2018, I conducted by telephone an exit conference with the licensee designee, Marcia Curtiss. Mrs. Curtiss accepted the findings of my investigation and will produce a corrective action plan to address the issue.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	On 04/01/2018, Resident A's family reported that Resident A was not checked and/or changed for a 4 hour period and Resident A smelled of urine. The licensee's policy of checking all residents every two hours to see if assistance to the bathroom or a change of their brief is needed was not followed on 04/01/2018.

CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend that the status of the license remain unchanged.

05/24/20218

Grant Sutton Date
Licensing Consultant

Approved By:

05/24/2018

Jerry Hendrick Date
Area Manager