GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 5, 2019

Shannon VanHouten
Grand Village Assisted Living LLC
3939 44th Street SW
Grandville, MI 49418

RE: License #: AH410384010
Investigation #: 2019A1010048
Grand Village Assisted Living LLC

Dear Ms. VanHouten:

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.

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,

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor

350 Ottawa, N.W.
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 #:	AH410384010
Investigation #:	2019A1010048
Complaint Receipt Date:	08/16/2019
Investigation Initiation Date:	08/19/2019
Report Due Date:	10/15/2019
Licensee Name:	Grand Village Assisted Living, LLC
Licensee Address:	3939 44th Street Grandville, MI 49418
Licensee Telephone #:	(616) 719-5895
Administrator:	Beth Terborg
Authorized Representative:	Shannon VanHouten
Name of Facility:	Grand Village Assisted Living LLC
Facility Address:	3939 44th Street SW Grandville, MI 49418
Facility Telephone #:	(616) 719-5895
Original Issuance Date:	01/30/2018
License Status:	REGULAR
Effective Date:	07/30/2019
Expiration Date:	07/29/2020
Capacity:	72
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A had a skin tear that occurred in mid-July. His bandage was not changed until 8/2.	No
ADDITIONAL FINDINGS	Yes

III. METHODOLOGY

08/16/2019	Special Investigation Intake 2019A1010048
08/19/2019	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
08/19/2019	APS Referral APS referral emailed to Centralized Intake
08/22/2019	Contact - Telephone call made Interviewed the complainant by telephone
08/22/2019	Inspection Completed On-site
08/22/2019	Contact - Document Received Received Resident A's service plan, skilled nursing referral, flow sheet, and physician notes
08/23/2019	Contact – Telephone call made Message left for Atrio Home Care nurse Emily Nolan
08/27/2019	Contact – Telephone call made Interviewed Ms. Nolan with Atrio Home Care
09/05/2019	Exit Conference Completed with AR Shannon VanHouten

ALLEGATION:

Resident A had a skin tear that occurred in mid-July. His bandage was not changed until 8/2.

INVESTIGATION:

On 8/16/19, the Bureau received the allegations from the online complaint system. The complaint read, “Resident had a bandage arm from a skin tear that occurred around the middle of July. (Exact dates are in doc flow binders). On August 2nd 2019 I unwrapped the gauze to clean and rebandage the skin if necessary to find that the bandage had not been changed. The bandage was stuck to the wounds where in the photo you can see it was healing around the bandage. It took me 20 min to remove the badage [sic] without causing more injury. Once badage [sic] was removed I assessed and found no evidence of infection. I calmed [sic] my supervisor in to give further instruction to see that the bandage had been on so long. Thre [sic] on instructions received was to let the wound air dry because the skin was so white that it [sic] you touched it you could rip it.”

On 8/19/19, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 8/22/19, I interviewed the complainant by telephone. The complainant reported Resident A got a skin tear after he fell in the activity room in the facility in mid-July. The complainant stated she did not witness the incident and an incident report was completed. The complainant explained she changed Resident A’s bandage for the first time three or four days after he fell. The complainant reported the next time Resident A’s bandage was changed was when she changed it on 8/2.

The complainant stated when she changed Resident A’s bandage on 8/2, it was stuck to his skin and she had to saturate it with water to remove it. The complainant said Resident A’s skin was “very white” underneath. The complainant reported she contacted her supervisor, Josh Shirk, regarding what she observed. The complainant stated Mr. Shirk instructed her to let the wound “air dry.” The complainant explained Resident A’s skin tear was not infected.

The complainant reported staff were supposed to document when Resident A’s bandage was changed on the “doc flow” sheet for residents. The complainant stated she documented both times that she changed Resident A’s bandage. The complainant said the “doc flow” sheets are kept in a binder at the facility. The complainant stated staff read the “doc flow” sheets at shift change.

On 8/22/19, I interviewed administrator Beth Terborg at the facility. Ms. Terborg denied knowledge regarding Resident A’s bandage not being changed. Ms. Terborg reported Mr. Shirk is the facility’s director of resident care. Ms. Terborg stated Mr. Shirk would be able to provide additional information.

On 8/22/19, I interviewed Mr. Shirk at the facility. Mr. Shirk reported Resident A’s bandage was changed regularly. Mr. Shirk denied knowledge regarding Resident A’s bandage only being changed once since he got the skin tear in July. Mr. Shirk explained a referral for skilled nursing wound care was made shortly after Resident A got his skin tear. Mr. Shirk stated Atrio Home Care staff are in the facility once a

week to treat and dress Resident A's wound. Mr. Shirk reported he observed Atrio staff in the facility a couple of days ago to treat Resident A's wound.

Mr. Shirk stated care staff person Bailee Yax informed him she had to change Resident A's bandage because it looked "crusty." Mr. Shirk was unable to recall when Ms. Yax informed him of this. Mr. Shirk said Ms. Yax told him she had to wet the bandage so it would not hurt when she removed it. Mr. Shirk said this occurred before the referral to Atrio was made. Mr. Shirk reported he received no other staff comments regarding Resident A's bandage.

Mr. Shirk provided me with a copy of Resident A's physician referral for skilled nursing for wound care. The *Order* section of the document read, "Refer to skilled nursing to evaluate and treat for COPD exacerbation. Refer to skilled nursing to evaluate and treat for wound care." The document was dated 8/15/19.

Mr. Shirk provided me with a copy of Resident A's physician notes dated 8/14. The *Subjective* section of the document read, "Skin avulsion Facility staff report a skin tear from a previous fall. The wound has been getting worse and is not healing. On exam, near the left elbow there is layers of torn skin with an area where a flap of skin remains. The wound is bleeding. Bruising is noted to the left forearm. Skilled nursing to evaluate and treat for wound care." Mr. Shirk provided me with Resident A's *Resident Documentation/Notification Flow Sheet* for my review. A note dated 7/22 read, "Cleaned and rebandaged left forearm." There was no additional documentation regarding Resident A's bandage.

Mr. Shirk provided me with a copy of Resident A's service plan for my review. The *Ambulation/Mobility* section of the plan read, "Ambulates or propels self with or without use of an assistive device. The *Transferring* section of the plan read, "Transfers independently with or without the use of an assistive device."

On 8/22/19, I interviewed resident care staff person Bailee Yax at the facility. Ms. Yax reported prior to Resident A's Atrio Home Care referral, staff at the facility changed Resident A's bandage once a day. Ms. Yax stated staff wrote the date they changed Resident A's bandage on the bandage itself, rather than in his "doc flow" sheet. Ms. Yax said a referral to Atrio was made because Resident A's wound was not healing.

Ms. Yax reported the longest Resident A went without a bandage change prior to the Atrio referral was a couple of days. Ms. Yax stated Resident A never went "weeks" without his bandaged changed prior to the Atrio referral. Ms. Yax said staff properly treated and bandaged Resident A's wound prior to the Atrio referral. Ms. Yax reported staff did the correct thing when they contacted Resident A's physician when the wound didn't heal. Ms. Yax stated Atrio staff instructed care staff at the facility not to change Resident A's bandage while they provide his wound care treatment.

On 8/22/19, I interviewed resident care staff person Julissa Zamora at the facility. Ms. Zamora's statements were consistent with Ms. Yax.

On 8/22/19, I attempted to interview Resident A at the facility. Resident A resides in the secured memory care unit in the facility. I was unable to engage Resident A in meaningful conversation. I observed the bandage and wrapping on Resident A's left forearm was clean and appropriate. I did not have any concerns regarding the bandage.

On 8/27/2019, I interviewed Atrio Home Care nurse Emily Nolan by telephone. Ms. Nolan reported Atrio Home Care received a referral to treat Resident A's wound on 8/16. Ms. Nolan stated she was at the facility last Monday, Wednesday, and Friday to treat Resident A's wound and change the dressing. Ms. Nolan said she will be at the facility twice this week to treat Resident A's wound and change the dressing.

Ms. Nolan reported she had no concerns regarding the care Resident A receives at the facility by the staff. Ms. Nolan stated the only issue she had was when staff changed the dressing themselves recently and the gauze stuck to Resident A's wound. Ms. Nolan explained she left a note for staff not to change the dressing themselves. Ms. Nolan reported Resident A's dressing did not need to be changed every day due to the amount of drainage it had. Ms. Nolan stated she wrote in the note that staff at the facility can replace the dressing if it falls off or if Resident A pulled it off.

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.**
ANALYSIS:	The interviews with Mr. Shirk, Ms. Yax, and Ms. Zamora revealed staff changed Resident A's bandage prior to his referral for in home skilled nursing to treat and dress his wound. A referral for Atrio Home Care was made on 8/15. Ms. Nolan confirmed Resident A is currently receiving wound care treatment through Atrio Home Care. The facility was in compliance with this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

Investigation:

On 8/22/19, Mr. Shirk provided me with a copy of Resident A's incident report. The report was dated 7/21. The *Describe Incident Based on Brief Facts* section of the report read, "resident was brought back to mc." The *Corrective Measure(s) taken at time of incident to reduce risk of occurrence* section of the report was blank.

On 8/28/19, I reviewed the facility file. I did not receive an incident report regarding Resident A's fall that resulted in his skin tear.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(1) The home shall complete a report of all reportable incident, accidents, and elopements. The incident/accident report shall contain all of the following information: **(b) The date, hour, location, and a narrative description of the facts about the incident/accident which indicates its cause, if known.** **(c) The effect of the incident/accident on the person who was involved, the extent of the injuries, if known, and if medical treatment was sought from a qualified health care professional.** **(e) The corrective measures taken to prevent future incident/accidents from occurring.**
ANALYSIS:	Review of Resident A's incident report that the facility completed on 7/21 revealed inadequate detail regarding Resident A's fall that resulted in a skin tear that was not documented. The effect of the incident on Resident A and the extent of his injuries were not properly documented, nor were the corrective measures taken to prevent future incidents from occurring. The incident report was incomplete and lacked the required information as outlined in this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.
ANALYSIS:	Review of the facility file revealed licensing did not receive an incident report regarding Resident A's fall that resulted in his skin tear.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Shannon VanHouten by telephone on 9/5.

IV. RECOMMENDATION

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

8/29/19

Lauren Wohlfert — Date
Licensing Staff

Approved By:

8/29/19

Russell B. Misiak — Date
Area Manager