GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 14, 2021

Toni LaRose
AH Spring Lake Subtenant LLC
6755 Telegraph Rd Ste 330
Bloomfield Hills, MI 48301

RE: License #: AL700397742
Investigation #: 2021A0467019
AHSL Spring Lake Timberbrook

Dear Ms. LaRose:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation identified in the report, a written corrective action plan was required. On 9/14/21, you submitted an acceptable written corrective action plan. It is expected that the corrective action plan be implemented within the specified time frames

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,

Anthony Mullins

Anthony Mullins, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL700397742
Investigation #:	2021A0467019
Complaint Receipt Date:	09/09/2021
Investigation Initiation Date:	09/09/2021
Report Due Date:	11/08/2021
Licensee Name:	AH Spring Lake Subtenant LLC
Licensee Address:	One SeaGate, Suite 1500 Toledo, OH 43604
Licensee Telephone #:	(248) 203-1800
Administrator:	Toni LaRose
Licensee Designee:	Toni LaRose
Name of Facility:	AHSL Spring Lake Timberbrook
Facility Address:	17383 Oak Crest Parkway Spring Lake, MI 49456
Facility Telephone #:	(616) 844-2880
Original Issuance Date:	03/18/2019
License Status:	REGULAR
Effective Date:	09/18/2021
Expiration Date:	09/17/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 9/3/21, Resident A was restrained to his wheelchair with a gait belt.	Yes

III. METHODOLOGY

09/09/2021	Special Investigation Intake 2021A0467019
09/09/2021	Special Investigation Initiated - Telephone
09/09/2021	Inspection Completed On-site
09/10/2021	Contact - Telephone call received Telephone call received from Ms. Shatney and Ms. LaRose.
09/14/2021	Exit Conference Completed with licensee designee, Toni LaRose

ALLEGATION: On 9/3/21, Resident A was restrained to his wheelchair with a gait belt.

INVESTIGATION: On 9/9/21, I received a complaint from Adult Protective Services (APS). The complaint stated that on 9/3/21, Resident A was restrained to his wheelchair by a gait belt while his arm was bleeding. When made aware that Resident A was bleeding, assistant wellness director Sherry Shatney dismissed his needs and yelled at him for picking at his arm. Ms. Shatney then advised staff members to put Resident A in his room and shut the door, to which they reportedly did while he was still restrained to his wheelchair.

On 9/9/21, I commenced the investigation by speaking with Ottawa County APS worker, Melissa Dyke. Mrs. Dyke informed me that she spoke with an outside agency staff member who witnessed this occur. The agency staff member was unable to recall Resident A's full name, nor did she know the name of the other staff member that was involved in this incident with Ms. Shatney. Resident A's cognitive ability is unknown at this time. Mrs. Dyke and I agreed to meet at the facility today at 1:30 pm to address the complaint jointly.

On 9/9/21, Mrs. Dyke and I arrived at AHSL Spring Lake Timberbrook at 1:30 pm as planned. Upon arrival, we made entry into the building. Staff confirmed Resident A's demographic information to us. Resident A was observed sleeping on the couch in the living area of the facility while his wife was sitting in his wheelchair beside him. Mrs. Dyke and I approached Resident A and his wife and introductions were made. Resident A slept for the duration of the interview. However, his wife was able to

answer questions on his behalf. Mrs. Dyke and I immediately noticed Resident A had a bruise near his right eyebrow and asked his wife how the injury occurred. Resident A's wife stated that her husband has had "quite a few falls" as he struggles to maintain his balance. Resident A's wife stated that the injury to his right eyebrow area is the result of a fall approximately two weeks ago. Resident A received stitches near his eye as a result of the fall. She also lifted Resident A's arm sleeve to show that he had a bandage on his right forearm from a previous fall. Resident A's wife stated that staff do a great job of attending to his bandages. Resident A's wife stated, "you can't tie him in, it's not that people (staff members) aren't watching him." Resident A's wife stated that when staff members turn their backs, "it happens," referring to her husband falling out of his wheelchair. As mentioned above, Resident A's wife was sitting in his wheelchair and demonstrated to Mrs. Dyke and I that her husband often leans forward in his wheelchair, causing him to fall. Resident A's wife was adamant that it is not the staff members fault that her husband is falling. She added that staff members at the facility "are really good to him."

Resident A's wife stated that she is usually at the facility every day for approximately 1 to 3 hours with her husband. She recalled being at the facility on 9/3/21 from 1:00 pm until sometime after 3:30 pm. During her time at the facility on 9/3/21, she denied witnessing her husband being restrained to his wheelchair by a gait belt. She denied ever witnessing her husband being restrained to his chair by staff at the facility. Resident A's wife stated, "they're (staff) not doing anything they're not supposed to" to her husband. Resident A's wife stated that her husband is on Hospice and she was unable to recall which agency is involved. Resident A's wife stated that he is unable to communicate well and when he does, it doesn't make sense. She denied any concerns about her husband's care and treatment in the facility.

After speaking to Resident A's wife, Mrs. Dyke and I spoke to the assistant wellness director, Sherry Shatney. Ms. Shatney confirmed that on Friday, 9/3/21, she did in fact observe Resident A with a gait belt tied around him and his wheelchair as she and Marquetta Jones (Aide) went to stand him up to fix his pants. Ms. Shatney stated that she immediately removed the gait belt as she and staff members are aware that you can't do that. Ms. Shatney stated that she has since spoken to staff members about this incident, and she has been told that staff member Demetria Holt tied Resident A to his wheelchair with a gait belt. Ms. Shatney is planning to speak with Ms. Holt tomorrow morning to receive her statement. Ms. Shatney confirmed that Resident A was bleeding from his finger on 9/3/21 and she had Ms. Jones take him to his room due to blood being everywhere. Ms. Jones also took Resident A to his room to clean him up and for safety purposes. Resident A has a history of picking at his skin and Ms. Shatney was adamant that she did not yell at him but she may have been louder when addressing this with him. I explained to Ms. Shatney that I would be citing the facility due to Resident A being restrained to his wheelchair. Mrs. Dyke explained that she would substantiating the facility for neglect for the same reason.

Mrs. Dyke and I interviewed staff member Tameka Ball after speaking to Ms. Shatney. Ms. Ball stated that she did work on 9/3/21 from 7:00 am until 3:00 pm. However, she denied witnessing Resident A being tied to his wheelchair with a gait belt. Ms. Ball stated that she knows those actions are not permitted. She also denied witnessing Resident A bleeding but acknowledged that he often picks at his scabs and she and other staff members stop him before it gets worse.

After speaking to Ms. Ball, I was able to speak with staff member Kaylyn Merriweather at the facility next door. Ms. Merriweather stated that she did work at AHSL Spring Lake Timberbrook on Friday, 9/3/21 from 7:00 am until approximately 3:30 pm. Around 3:00 pm, Ms. Merriweather stated that she did see the gait belt tied around Resident A and his wheelchair. In fact, Ms. Merriweather stated that she witnessed staff member Demetria Holt tie the gait belt around Resident A. Ms. Merriweather stated that Ms. Holt was working in another building and when she happened to come over, Resident A fell from his wheelchair. Ms. Merriweather and Ms. Holt helped Resident A back into his wheelchair and Ms. Holt put the gait belt on him. Resident A has a seatbelt on his wheelchair and Ms. Merriweather stated that she explained to Ms. Holt that they can't use the seat belt unless Resident A is able to take it off himself. However, Ms. Holt used a gait belt in an attempt to secure Resident A to chair and prevent him from falling. Ms. Merriweather denied witnessing Resident A bleeding and denied him being put in his room while the gait belt was attached.

On 9/10/21, I received a call from the assistant wellness director, Ms. Shatney and the licensee designee, Ms. Toni LaRose. Ms. Shatney stated that she spoke with Ms. Holt and she did in fact admit to tying the gait belt around Resident A in an attempt to prevent him from falling. Resident A's wheelchair has a seat belt mounted to it, which was factory built and provided by his wife. Ms. Holt reportedly thought that the seat belt was broken on the wheelchair, so she thought it was okay to use the gait belt to keep him in his chair. Ms. Shatney stated that the incident was a misunderstanding and Resident A has since received a new wheelchair from North Ottawa Community Hospice that fits appropriately and does not have a seat belt attached. Ms. LaRose stated that she had hospice observe the previous wheelchair and confirmed that Resident A's wife brought the wheelchair in with the seat belt attached by the manufacturer. Ms. LaRose stated that once the staff member realized Resident A's seat belt was broken, she tried to "makeshift" it. Ms. LaRose stated that Ms. Holt was honest about the incident and her intentions were to keep Resident A safe. I explained to Ms. LaRose and Ms. Shatney that I would be citing due to this incident and both were understanding. Ms. LaRose stated that she plans to submit a summary of what occurred, in addition to a corrective action plan.

On 9/14/21, Ms. LaRose submitted an investigation summary of what occurred, as well as a corrective action plan via email that I approved.

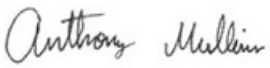
On 9/14/21, I conducted an exit conference with licensee designee, Ms. LaRose. I explained the investigative findings and Ms. LaRose was accepting of the outcome.

Ms. LaRose already submitted a corrective action plan and agreed for the plan to be implemented within the specified time frames.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.**
ANALYSIS:	Ms. Shatney stated that she observed Resident A restrained to his wheelchair with a gait belt on 9/3/21 and immediately removed it. Ms. Shatney and Ms. LaRose completed an internal investigation and confirmed that Ms. Holt put the gait belt on Resident A in an attempt to prevent him from falling. Ms. Holt was reportedly unaware that the gait belt could not be used. Although it is apparent that Ms. Holt did not act with malicious intent, there is a preponderance of evidence to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Licensee designee, Toni LaRose submitted an acceptable corrective action plan on 9/14/21. Therefore, I recommend the status of the license remain unchanged.



09/14/2021

Anthony Mullins Date
Licensing Consultant

Approved By:

09/14/2021

Jerry Hendrick Date
Area Manager