STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

January 26th, 2022

Anna Sullivan
Christian Haven Home
704 Pennoyer
Grand Haven, MI 49417

RE: License #: Investigation #:	AH700236766 2022A1021021 Christian Haven Home

Dear Ms. Sullivan:

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) 284-9730.

Sincerely,

Kimberly Horst

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH700236766
Investigation #:	2022A1021021
Complaint Receipt Date:	01/04/2022
Investigation Initiation Date:	01/05/2022
Report Due Date:	03/03/2022
Licensee Name:	Christian Haven Inc.
Licensee Address:	704 Pennoyer Ave. Grand Haven, MI 49417
Licensee Telephone #:	(616) 842-0170
Administrator/ Authorized representative:	Anna Sullivan
Name of Facility:	Christian Haven Home
Facility Address:	704 Pennoyer Grand Haven, MI 49417
Facility Telephone #:	(616) 842-0170
Original Issuance Date:	06/01/1999
License Status:	REGULAR
Effective Date:	04/28/2021
Expiration Date:	04/27/2022
Capacity:	60
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive emergency medical care.	Yes
Additional Findings	No

III. METHODOLOGY

01/04/2022	Special Investigation Intake 2022A1021021
01/05/2022	Special Investigation Initiated - Letter referral sent to APS
01/05/2022	Contact - Telephone call made interviewed administrator
01/06/2022	Contact-Document Received received Resident A chart notes, service plan, and incident reports
01/06/2022	Contact-Telephone call made Interviewed caregiver Julia Barrow
01/07/2022	Contact-Telephone call made Interviewed caregiver Amanda Krusinsky
01/07/2022	Contact-Telephone call made Interviewed caregiver Sabrina Johnson
01/26/2022	Exit Conference Exit Conference with authorized representative Anna Sullivan

ALLEGATION:

Resident A did not receive emergency medical care.

INVESTIGATION:

On 1/4/22, the licensing department received a complaint with allegations Resident A did not receive required medical care. The complainant alleged Resident A had low oxygen saturation for over 12 hours which was not addressed by staff. The

complainant alleged Resident A was sent to the emergency room by morning staff after she became unresponsive.

On 1/5/22, the allegations in this report were sent to Adult Protective Services (APS).

On 1/5/22, I interviewed the administrator Anna Sullivan by telephone. Ms. Sullivan reported Resident A had Covid-19 a few months ago and since that has required supplemental oxygen due to difficulty breathing. Ms. Sullivan reported Resident A is mostly independent and able to vocalize her needs. Ms. Sullivan reported on 12/20/21, Resident A complained of shortness of breath and difficulty with urination. Ms. Sullivan reported Resident A was then sent to North Ottawa Hospital for evaluation. Ms. Sullivan reported Resident A was in the hospital until 12/21/21. Ms. Sullivan reported while in the hospital Resident A required a catheter and her oxygen levels were not stable. Ms. Sullivan reported on 12/21/21 the hospital reported Resident A's oxygen levels were stable and she no longer required a catheter. Ms. Sullivan reported Resident A was transferred back to the facility on 12/21/21. Ms. Sullivan reported Resident A was put-on two-hour checks and had continuous oxygen. Ms. Sullivan reported in the evening hours of 12/21/21, caregivers observed Resident A grey in color and complaining of shortness of breath. Ms. Sullivan reported caregivers called emergency medical services and Resident A was transferred to Mercy Hospital where she was diagnosed with atypical pneumonia. Ms. Sullivan reported Resident A has returned to the facility and is doing well. Ms. Sullivan reported when a caregiver observes a change in condition, they are to contact the supervisor on call for direction. Ms. Sullivan reported the supervisor will then put orders in the ECP for the caregivers to follow. Ms. Sullivan reported Resident A's oxygen levels are taken at the beginning of each month and if the physician requests it.

On 1/5/22, I interviewed facility nurse Theresa Coleman by telephone. Ms. Coleman's statements were consistent with those made by Ms. Sullivan.

On 1/6/22, I interviewed caregiver Julia Barrow by telephone. Ms. Barrow reported she was working 12/19-12/20. Ms. Barrow reported she received shift report from second shift reporting that Resident A's oxygen was low. Ms. Barrow reported the second shift contacted the shift supervisor who advised to check on Resident A throughout the night and the shift supervisor would evaluate Resident A the following morning. Ms. Barrow reported she checked on Resident A at 10:00pm, 12:00am, 5:00am, and 6:00am. Ms. Barrow reported Resident A was sleeping in her bed and did move into her chair. Ms. Barrow reported when she checked on Resident A at 6:00am, Resident A was not at her baseline. Ms. Barrow reported she was having a difficult time breathing. Ms. Barrow reported she contacted the medication technician, and it was determined to send Resident A to the hospital.

On 1/7/22, I interviewed medication technician Sabrina Johnson by telephone. Ms. Johnson reported she worked second shift on 12/19/21. Ms. Johnson reported

Resident A was at baseline throughout her shift, ate dinner in the dining room, and took her medications. Ms. Johnson reported as she assisted Resident A to bed, Resident A's oxygen was between 86-89%. Ms. Johnson reported she contacted the shift supervisor who advised caregivers to monitor Resident A and the shift supervisor would evaluate Resident A in the morning. Ms. Johnson reported low oxygen levels was not normal for Resident A. Ms. Johnson reported she made third shift aware to monitor Resident A throughout the night.

On 1/7/22, I interviewed caregiver Amanda Krusinsky by telephone. Ms. Krusinsky reported she worked the first shift on 12/20/21 when Resident A was sent to the hospital. Ms. Krusinsky reported third shift reported Resident A was having a difficult time breathing and she slept in her chair. Ms. Krusinsky reported Resident A's oxygen was taken and it was at 84-86%. Ms. Krusinsky reported Resident A was visibility having a difficult time breathing and agreed to have her family transport her to the emergency room. Ms. Krusinsky reported caregivers assisted Resident A to the bathroom and then Resident A became unresponsive. Ms. Krusinsky reported emergency medical services was then contacted and transported Resident A to the hospital.

I reviewed oxygen levels for Resident A. The records revealed at the beginning of November Resident A's oxygen level was at 94%. There was no documentation of Resident A's oxygen levels for 12/19-12/20/21.

I reviewed observation notes for Resident A. The notes read,

"12/19: Resident has a low O2 84-85 on the left finger. T-97.4 BP 148-66 p-56. Theresa is aware and will follow her on 12-20-21. Please monitor throughout the night.
12/20: Writer went in to check on resident and she was sleeping in her chair. When in her room she was wheezing with every breath. I asked her why she was sleeping in her chair and she said "because I have a hard time breathing when laying down." Took her O2 for two minutes each hand and it was at 85, 84. She also complained that she could not control when she urinated and writer noticed some underwear on the ground with a good amount of blood on the side of them. Please follow up with resident.
12/20: Resident stated that she was having a difficult time breathing this AM. O2 was 83-85%, resident agreed to go to the hospital. Daughter was contacted and was going to transport. While returning to residents room she was in the bathroom sitting on the toilet, this writer observed resident breathing heavily and gasping for air. Within seconds resident became unresponsive. 911 called immediately while this writer stayed with resident. Resident became unresponsive on and off. Sent to NOCH (North Ottawa Community Hospital)."

I reviewed incident report for Resident A. The incident report was dated 12/19/21 8:50pm. The narrative read,

"East med tech (Sabrina) contacted writer about residents O2 levels. Med tech stated residents O2 levels were between 84-85 on left finger. Writer advised med tech to check O2 levels on right side. Residents O2 levels on right side were between 89-90. Writer advised med tech to ask resident if she was having any signs/symptoms of difficult breathing. Med tech stated that resident had no visible signs/symptoms of difficulty breathing. Writer advised 2nd shift med tech to monitor resident and 3rd shift med tech to monitor resident during the night. Writer knowing resident Hx of low O2 levels from side effect of Covid."

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(1) A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization, which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.
For Reference: MCL 333.20201	**(2) (e) A patient or resident is entitled to receive adequate and appropriate care, and to receive from the appropriate individual within the health facility or agency, information about his or her medical condition, proposed course of treatment, and prospects for recovery, in terms that the patient or resident can understand, unless medically contraindicated as documented by the attending physician in the medical record.**
ANALYSIS:	Resident A did not receive adequate and appropriate care as she experienced low oxygen levels on 12/19. There was no continued monitoring of oxygen levels nor communication with appropriate medical personnel on medical intervention Resident A required.

CONCLUSION:	VIOLATION ESTABLISHED

On 1/26/22, I conducted an exit conference with authorized representative Anna Sullivan by telephone. Ms. Sullivan had no questions regarding the findings in this report.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

1/14/22

Kimberly Horst — Date
Licensing Staff

Approved By:

01/26/2022

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