GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 13, 2022

Rochelle Lyons
Grace Haven Assisted Living, LLC
Suite 200
3196 Kraft Ave SE
Grand Rapids, MI 49512

RE: License #: AL190294037
Investigation #: 2022A1029028
Grace Haven Assisted Living-Specialized Care

Dear Ms. Lyons:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 (231) 922-5309.

Sincerely,

Jennifer Browning

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
Browningj1@michigan.gov - (989) 444-9614

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL190294037
Investigation #:	2022A1029028
Complaint Receipt Date:	02/11/2022
Investigation Initiation Date:	02/11/2022
Report Due Date:	04/12/2022
Licensee Name:	Grace Haven Assisted Living, LLC
Licensee Address:	Suite 200 3196 Kraft Ave SE Grand Rapids, MI 49512
Licensee Telephone #:	(989) 224-1650
Administrator:	Rochelle Lyons
Licensee Designee:	Rochelle Lyons
Name of Facility:	Grace Haven Assisted Living-Specialized Care
Facility Address:	1507 Glastonbury Dr. St. Johns, MI 48879
Facility Telephone #:	(989) 224-1650
Original Issuance Date:	08/26/2008
License Status:	REGULAR
Effective Date:	06/23/2021
Expiration Date:	06/22/2023
Capacity:	20
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive timely medical attention after falling at Grace Haven Assisted Living which led to her decline in health.	No
There was not adequate supervision to prevent Resident A from falling.	No

III. METHODOLOGY

02/11/2022	Special Investigation Intake 2022A1029028
02/11/2022	Special Investigation Initiated – Telephone to Relative A1
03/02/2022	Contact - Telephone call made to Relative A2
03/02/2022	Contact - Telephone call made to Leslie Herrguth; licensing consultant assigned to this facility
03/02/2022	Contact - Telephone call made to Amy Langford at Advanced Medical House calls
03/02/2022	Contact - Face to Face with Jennifer Herald, Lindsey McKee Nicole Castello
03/17/2022	Contact - Telephone call made to Relative A2
04/12/2022	Contact - Telephone call made to direct care staff member, Emberleigh Perry
04/12/2022	Contact - Telephone call made direct care staff member, Tamika Upshaw
04/12/2022	Contact - Telephone call made contacted nurse practitioner, Christina from The Care Team. Left a message.
4/12/2022	Contact – Received call from Sandra Rosenick, RN from The Care Team Home Health and Hospice
4/12/2022	Contact – Voice mail from Penny, Quality Care and Compliance The Care Team Home Health and Hospice. Returned call to her and left a message.

4/13/2022	Contact – telephone call from Penny Neff, RN from The Care Team
04/13/2022	Exit conference with Licensee designee Rochelle Lyons

ALLEGATION:

Resident A did not receive timely medical attention after falling at Grace Haven Assisted Living which led to her decline in health.

INVESTIGATION:

On February 11, 2022, a complaint was received from the BCHS online complaint system alleging Resident A not receiving timely medical attention at Grace Haven Assisted Living. There were additional concerns the family was notified on April 11, 2020 stating Resident A was unresponsive for a week and they were calling Hospice. She passed away shortly after and her cause of death was cardiopulmonary arrest.

On February 11, 2022, a call was made to the complainant who stated Resident A was in the memory care unit at Grace Haven Assisted Living for four months. He stated the old administrator was not there any longer but while Resident A resident at the facility Advanced Medical House Calls provided medical care to Resident A. The complainant was concerned Resident A did not receive timely medical attention from her falls which led to her death.

On March 2, 2022, I interviewed Amy Langford at Advanced Medical House Calls. Ms. Langford confirmed they saw her at the facility from November 2019- March 2020. March 25, 2020 was their last visit with Resident A because she was admitted to Hospice on April 11, 2022.

On March 2, 2022 I interviewed administrator, Jennifer Herald at Grace Haven Assisted Living. Ms. Herald stated she was not working at the facility when Resident A resided there, however the policy at Grace Haven is to document all falls. Ms. Herald stated Hospice services and physical therapy were provided through The Care Team for Resident A. Ms. Herald was able to print off a log from her Medication Administration Record (MAR) regarding falls and progress notes were documented. In her resident record, there was an after visit summary from a head injury on March 9, 2020 when she was examined by Jane Sbalchiero, MD and Richard McCoy, NP. There is no documentation she was hemorrhaging after this fall. During this fall, she fell in the common area and hit her side and head. There were communication entries in her resident record recording each fall and this form included documentation of when the family and her primary doctor was contacted. Her resident record also included physician contacts from visits related to falls.

During the onsite investigation on March 2, 2022, Resident A's resident record was reviewed. According to Resident A's *Assessment Plan for AFC Residents* signed on November 20, 2019, under mobility, there was documentation she self-ambulated with the assistance of a four wheeled walker. Bathing, grooming, dressing, personal hygiene was all "stand by assistance with cuing" and there was no indication that additional supervision was needed to prevent falls. According to Resident A's *Health Appraisal*, she used a walker for mobility assistance.

On March 2, 2022, I interviewed direct care staff member, Lindsey McKee. Ms. McKee has worked there for over three years. She stated Resident A did not want to use her walker at times leading her to have more falls. She stated when Resident A was in memory care, sometimes she would not look down and would trip on her feet. When Resident A first moved in, she did pretty well with mobility but this declined over time. Resident A was very social and would do the activities however shortly before she passed, she had a sudden decline. Ms. McKee remembered Resident A spent the whole day sleeping prior to her leaving the facility. The week before, she was still participating in activities with other residents. Ms. McKee found documentation on April 6, 2020; Resident A was sitting in the memory care unity with other residents watching television. Resident A had many family members had a lot of contact with the facility. Ms. McKee stated in the beginning of COVID-19 pandemic she helped call the families to inform them they could not visit. She stated they did not keep a log of these calls but they were following through with the health department guidelines. Shortly before Resident A moved out of the facility, Hospice was called in to provide services on April 11, 2020. She stated Resident A's family took her home because she wanted her to be there when she passed. Ms. McKee stated she did not hear of any falls right before Resident A moved home. To her knowledge, Resident A was not hemorrhaging blood and did not have bruising when she left the facility. She stated that Hospice would have visited her briefly. Resident A was always tended to promptly when she fell and she was assessed to ensure she had no injuries.

On March 2, 2022 I interviewed direct care staff member, Nicole Castello. Ms. Castello stated Resident A's family moved her out of the facility because they wanted her to pass away at home. Ms. Costello stated although she did not provide care to her often, she knew she declined toward the end of her stay at Grace Haven Assisted Living. Resident A was diagnosed with Parkinson's and dementia. Ms. Costello stated Resident A was only home for a short time before she passed away. Ms. Castello stated she did not remember if she was nonresponsive before she was taken home. She stated she had quite a bit of falls because she did not want to consistently use the walker. She stated they would cue / remind her and then she still would not use it. She does not remember any of her falls causing major bruising or injuries. Sometimes she would have small bruising due to her falls and age. Ms. Costello stated all falls were documented and medical care was obtained quickly and family was notified.

On March 17, 2022, I contacted Relative A2 who acted as the medical power of attorney for Resident A who stated she spend a lot of time at the facility. Overall, she felt the facility had good communication with her so she was concerned when she was not

notified about a fall before she left the facility. She stated Resident A had Parkinson's and would often have falls. She stated she was at work around Mid-March and she fell and hit her head. After that, she brought her to her home for dinner. On April 3rd, 2020, She talked to her via video call and Resident A seemed unkempt. On April 11, 2020, the director of nursing (she could not recall her name) left her a message asking if she would consent to Hospice care because Resident A was having a hard time getting out of bed. She was surprised she did not get a call before this and she was upset she would not be allowed in the building due to Covid-19. However, when she was unresponsive, she knew it was time for Hospice care. The next day an ambulance was called and they took Resident A to Relative A2's house. On April 14th, 2020, she passed away at her home two hours later. According to the progress notes reviewed at Grace Haven Assisted Living, there is documentation the staff called Relative A2 on April 10th, 2020 and left a voicemail. Relative A2 stated she did not receive the voicemail. However, she wouldn't have been surprised if it was actually on April 11. 2020.

On April 12, 2022 I called former direct care staff member, Tamika Upshaw. She has not worked there in almost a year. She was familiar with Resident A but did not remember the details of how Resident A passed away and only cared for her a few times. She did not remember specific falls that Resident A had but knew that she would not use her walker consistently leading to some falls. Ms. Upshaw stated if a resident had a fall, they were supposed to leave them on the ground, take their vitals, and make sure they were not injured. If they hit their head or bleeding, they would call 911 to evaluate them. They would call the on call nurse to inform of the fall. They were also required to fill out the incident report and call the family.

On April 12, 2022, I received a call from Sandra Rosenick, RN from The Care Team Home Health and Hospice who worked with her through their home health program who stated they provided physical and occupational therapy for Resident A at Grace Haven February 13, 2020-March 12, 2020. She said there was a document from Christina Danko, NP from January 16, 2020 because she was complaint for finger pain because she fell and fractured her left middle finger. Documentation she called the daughter and she was suggested to wear a finger brace. Staff was encouraged to redirect her during the times of agitation. She had a cognitive and physical impairment at that time. During that visit it was recommended she continue Ativan for her agitation and Resident A continue to use walker to reduce the risk for falls.

Resident A had four physical therapy visits during this time and eight occupational therapy visits and then she was discharged. RN Rosenick stated there was no documentation of the facility not documenting falls or failing to get medical treatment for Resident A. RN Rosenick stated she reviews the incident reports for the patients and she does not recall any concerns regarding Resident A or the facility not following through with necessary treatment. The original referral was from Dr. Mark Wilkerson from OT and PT because of her frequent falls and because Resident A was refusing to keep the splint on the finger. She believes that the services stopped when the facility was locked down due to COVID-19 starting. According to her documentation, Resident

A required stand by assistance for mobility due to decreased cognition. The Care Team also started providing services for Hospice on April 11, 2022. RN Rosenick stated that it is very possible that she had a sharp decline.

On April 13, 2022, I received a call from Penny Neff from The Care Team Hospice – She stated there was a lot of documentation in the MAR regarding her status. She was on a significant decline when they were involved. She was admitted to the Hospice program on April 11, 2020 and there were no concerns she did not receive timely medical care. She stated they updated Relative A2 regarding her status and the current plan of care. According to the documentation she agreed with the plan of care. There was no indication that she was unresponsive a week before she left. Relative A2 took Resident A home on April 14, 2020 and according to documentation, Resident A passed during visit with Hospice at Relative A2's home.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Resident A had various falls while residing at Grace Haven Assisted Living. There is no indication that she did not receive needed care immediately for any of these incidents. The direct care staff members responded appropriately to these concerns and the facility had detailed documentation from each of her falls. According to Resident A's *Assessment Plan for AFC Residents* signed on November 20, 2019, under mobility, there was documentation that she self-ambulated with the assistance of a four wheeled walker. Bathing, grooming, dressing, personal hygiene were all "stand by assistance with cuing" and there was no indication that additional supervision was needed to prevent falls. There were also outside services provided through The Care Team Home Health and Hospice that were involved in Resident A's care the month prior to her death. RN Rosenick and RN Neff were interviewed and neither of them had concerns regarding Resident A not receiving timely medical attention.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

There was not adequate supervision to prevent Resident A from falling.

INVESTIGATION:

On February 11, 2022, a complaint was received from the BCHS online complaint system alleging that Resident A fell several times while residing at Grace Haven Assisted Living and should have been supervised closer.

During the onsite investigation on March 2, 2022, Resident A's resident record was reviewed. According to Resident A's *Assessment Plan for AFC Residents* signed on November 20, 2019, under mobility, there was documentation that she self-ambulated with the assistance of a four wheeled walker. Bathing, Grooming, Dressing, personal hygiene were all "stand by assistance with cuing" and there was no indication that additional supervision was needed to prevent falls. According to Resident A's *Health Appraisal*, she used a walker for mobility assistance.

On April 13, 2022, I received a call from Penny Neff, RN from The Care Team Hospice. RN stated that there were a lot of falls from her but she did not have concerns that they were not providing adequate supervision related to her falls.

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:	There is no indication that the direct care staff members at Grace Haven Assisted Living did not follow the *Assessment Plan for AFC Residents* for Resident A. Direct care staff members, Ms. McKee, and Ms. Castello both indicated that she had to be reminded regularly to use her walker for mobility assistance. According to her *Assessment Plan for AFC Residents*, she requires stand by assistance and queuing for her ADL's. There is no indication that Resident A needed hands on assistance for mobility that would have prevented her from falling at Grace Haven Assisted Living.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

I recommend no change in the license status.

Jennifer Browning _____4/13/2022_____

Jennifer Browning Date

Licensing Consultant

Approved By:

_____

Dawn N. Timm Date
Area Manager