GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 7, 2022

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

RE: License #: AL700397742
Investigation #: 2022A0467035
AHSL Spring Lake Timberbrook

Dear Ms. LaRose:

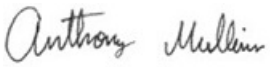
Attached is the Special Investigation Report for the above referenced facility. Due to the violation identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violations.
- Specific time frames for the violations 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,



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 #:	2022A0467035
Complaint Receipt Date:	04/26/2022
Investigation Initiation Date:	04/26/2022
Report Due Date:	06/25/2022
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 ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A and B both require a two-person assist and the facility had only one employee working 3rd shift on 4/20/22 and 4/21/22.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/26/2022	Special Investigation Intake 2022A0467035
04/26/2022	Special Investigation Initiated - Telephone
05/02/2022	Inspection Completed On-site
06/07/2022	Exit conference completed with licensee designee, Toni LaRose

ALLEGATION: Resident A and B both require a two-person assist and the facility had only one employee working 3rd shift on 4/20/22 and 4/21/22.

INVESTIGATION: On 4/26/22, I spoke to the complainant via phone and she confirmed the allegations.

On 5/2/22, I made an unannounced onsite investigation to the facility. Upon arrival, I spoke to Kayla Strasser (wellness director), Nancy Bullock (assistant wellness director), and Toni LaRose (executive director/licensee). Ms. Strasser stated that the facility does not have any residents that require a two-person assist.

Ms. Strasser stated that on 4/20/22, staff members Sequoia Wallace, Rose Nyabindi (agency staff) and Jameaniq Moore worked 3rd shift. Ms. Wallace worked from 11:00 pm to 7:30 am. Ms. Nyabindi and Ms. Moore worked a split shift, with Ms. Nyabindi working the first half (11:00 pm to 3:00 am) and Ms. Moore working the second half (3:30 am to 7:30 am). Records were reviewed and confirmed that all three staff members worked their scheduled shift. Based on these schedules, there was a 30-minute window between 3:00 am and 3:30 am where Ms. Wallace worked by herself. Ms. Strasser reviewed Resident A and B's assessment plan, which indicated that Resident A does in fact require a two-person assist. Although Resident A's assessment plan states that she requires "up to 2-person" assistance with transfer, Ms. Strasser stated that her care plan does not specify that she needs two people for transfers. I explained to Ms. Strasser that if a resident's assessment plans states that they may need a two-person assist, the facility needs to be appropriately staffed with at least two staff on duty at all times. Ms. Strasser agreed to send me a copy of

Resident A and B's assessment plan and care plan via email. Ms. Strasser stated that on 4/21/22, Anetra Singleton and Leslie Wade-Roberson worked 3rd shift at the facility. Staff schedules were reviewed and confirmed that Ms. Singleton and Ms. Wade-Roberson both worked at the facility from 12:30 am until 3:15 pm.

On 5/10/22, I reviewed Resident A and B's care plan that was sent from Ms. Strasser on 5/2/22. During this time, I realized that the email did not include Resident A and B's assessment plan. On the same day, I sent Ms. Strasser an email requesting both assessment plans. Ms. Strasser sent me a copy of Resident B's assessment plan. Resident B's assessment plan was reviewed and did not state that she requires a two-person assist. Ms. Strasser stated she was unable to send Resident A's assessment plan due to technical difficulties. I explained to Ms. Strasser that if she could take a picture of Resident A's assessment plan that mentions she requires up to two people for transfers, sending it to me via email or text would be sufficient.

After not hearing back from Ms. Strasser for more than three weeks, I sent her an email on 6/2/22 requesting Resident A's assessment plan. Ms. Strasser sent me an email with the requested assessment plan and stated that their system issue was just fixed.

On 6/6/22, I reviewed Resident A's assessment plan, which states, "Resident requires hands on assistance with all transfers and/or changes in position including two-person assistance and assisted transfers with mechanical lifts." On the same day, I reviewed the staff's schedule from 4/21/22. The schedule did not indicate who worked at the facility from 7:00 pm until 12:30 am. I called Nancy Bullock, assistant wellness director for clarification of the staff schedule. Ms. Bullock confirmed that on 4/21/22, agency staff member Jamia was scheduled to work from 7:00 pm until 11:30 pm. However, staff are not allowed to end their shift until their release arrives. Therefore, Ms. Bullock believes that Ms. Jamia worked from 7:00 pm until 12:30 am. Ms. Bullock reviewed the schedule and did not see other staff members scheduled to work from 7:00 pm until 12:30 am on 4/21/22. Based on the information provided, the facility had one staff member working on 4/20/22 between 3:00 am and 3:30 am and one staff member working on 4/21/22 from 7:15 pm to 12:30 am. Per Resident A's assessment plan, two staff members should be working on every shift.

On 06/07/2022, I conducted an exit conference with licensee designee, Toni LaRose. She was informed of the investigative findings and agreed to complete a CAP.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services

	specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Resident A's assessment plan indicates she requires a two-person transfer. The facility staff schedule indicates that the facility had only one staff member working on 4/20/22 from 3:00 am to 3:30 am, as well as one staff member working on 4/21/20 from 7:15 pm to 12:30 am. Therefore, a preponderance of evidence exists to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 6/1/22, I received an email from Ms. Strasser with an incident report explaining Resident A's passing on 5/26/22. The incident report stated staff entered Resident A's room during rounds and observed that she was "absent respirations, no pulse present. Resident was actively passing and was expected to pass. Hospice and family notified." Per licensing rule 311(1)(a), licensing should be notified within 48 hours of the death of a resident. I was not notified until 6 days later.

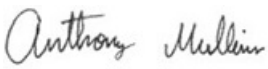
On 06/07/2022, I conducted an exit conference with licensee designee, Toni LaRose. She was informed of the investigative findings and agreed to complete a CAP.

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: (a) The death of a resident. (b) Any accident or illness that requires hospitalization. (c) Incidents that involve any of the following: (i) Displays of serious hostility. (ii) Hospitalization. (iii) Attempts at self-inflicted harm or harm to others. (iv) Instances of destruction to property.

	(d) Incidents that involve the arrest or conviction of a resident as required pursuant to the provisions of section 1403 of Act No. 322 of the Public Acts of 1988.
ANALYSIS:	Resident A passed away on 5/26/22. I was not notified until 6 days later on 6/1/22. Therefore, a preponderance of evidence exists to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

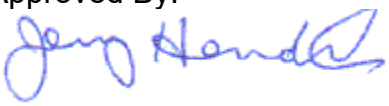
Upon receipt of an acceptable corrective action plan, I recommend no change to the current license status.



06/07/2022

Anthony Mullins Date
Licensing Consultant

Approved By:



06/07/2022

Jerry Hendrick Date
Area Manager