GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 03, 2022

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

RE: License #: AL700397744
Investigation #: 2022A0467032
AHSL Spring Lake Pebblebrook

Dear Ms. LaRose:

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 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

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

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

I. IDENTIFYING INFORMATION

License #:	AL700397744
Investigation #:	2022A0467032
Complaint Receipt Date:	04/05/2022
Investigation Initiation Date:	04/05/2022
Report Due Date:	06/04/2022
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 Pebblebrook
Facility Address:	17387 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

II. ALLEGATION(S)

	Violation Established?
On 3/31/22, Resident A had a black eye, swelling and bruising on her right ankle and a gouge on the top of her hand. No one knows how these injuries occurred.	No
Additional Findings	Yes

III. METHODOLOGY

04/05/2022	Special Investigation Intake 2022A0467032
04/05/2022	Special Investigation Initiated - Telephone
04/07/2022	Inspection Completed On-site
04/25/2022	APS Referral Complaint received from APS
05/02/2022	Exit conference completed with Licensee designee, Toni LaRose.

ALLEGATION: On 3/31/22, Resident A had a black eye, swelling and bruising on her right ankle and a gouge on the top of her hand. No one knows how these injuries occurred.

INVESTIGATION: On 4/5/22, I received an Adult Protective Services (APS) complaint stating that on 3/31/22, Resident A had a black eye, swelling and bruising on her right ankle and a gouge on top of her hand and no one knows how the injuries occurred. The allegations also stated that Resident A requires assistance to transfer. Resident A was asked if she fell and she said no. Resident A was also asked if someone dropped her and she said no. Resident A denied her ankle hurting but when the area was examined, she screamed and almost came out of her chair. Resident A was again asked what happened and stated; “I don’t know,” which was followed by her stating “no lawsuits.” No incident reports were written up for her injuries.

On 4/5/22, I spoke to the complainant via phone and she confirmed the allegations.

On 4/7/22, APS worker Melissa Dyke and I made an unannounced onsite investigation to the facility. Upon arrival, entry was made and staff directed us to Resident A’s room. Upon entry into Resident A’s room, Resident A and her family were meeting with Spectrum Health Visiting Nursing staff. Spectrum Health staff left

and introductions were made with Resident A and her daughter and son in-law. Resident A agreed to discuss case allegations.

I observed that Resident A had a faint bruise near her right eye. Resident A was asked how the injury occurred and she was adamant that the bruise had been there. Resident A stated that the bruise was from “sometime long ago” when she hit her head hard. Resident A stated that she used to have quite a few falls in the past and she has learned something new from each of them in an attempt to prevent further injury. Resident A mentioned that she had a brain tumor in 1990 and related her fall history to this. Resident A’s daughter interjected and stated that her mother can’t remember things from a couple of days ago, which Resident A disagreed with as she stated her memory is good. Resident A remained adamant that the injury near her eye happened a long time ago. Resident A stated that the bruising “comes and goes.” Resident A’s daughter stated that she feels her mother’s eye injury could have been caused from her bedrail.

I then asked Resident A about the bruising and swelling around both of her ankles. Resident A stated that her ankles swell when she has salt in her meals. Resident A was unable to provide a specific time frame as to when her ankles began to swell. The allegations mentioned that Resident A initially stated that she did not have pain in her ankle. However, Resident A’s daughter stated that she screamed when it was assessed by Spectrum Health visiting nursing. Resident A denied that she screamed when her ankles were assessed. Resident A’s daughter stated that an X-Ray was completed on her mother’s right ankle, which she believes to be fractured. However, she has yet to receive the results. Resident A was adamant that her ankle isn’t broken. Instead, she feels it’s just swollen. Resident A’s daughter stated that she made the wellness director, Sherry Shatney-Meidema aware of the injury and she did nothing. I explained to Resident A’s daughter that Ms. Shatney-Meidema is no longer employed at the facility. The allegations also noted that Resident A mentioned “no lawsuits” when she was initially asked what happened to her ankle. Resident A was asked about her reported statement and she acknowledged that she said it as a joke as she feels that there are people that are “always doing that,” referring to filing lawsuits.

I observed Resident A had a bandage on her right hand. When asked what happened, Resident A was unable to recall. She did state that a nurse turned back her sheet and noticed blood in the bed. Resident A acknowledged that she requires transfer assistance when moving from her bed or chair to another place and staff help her with this. It should be noted that Resident A has been sleeping in her chair by choice as she feels it’s more comfortable for her. Resident A stated, “they’ve (staff) been very nice to me. No one hurts me. They’ve been awfully nice.” Resident A’s daughter interjected and stated that the facility’s transfer techniques aren’t the best. Resident A’s daughter stated that the staff could do a better job in assisting her mother with transfers. This prompted Resident A to state that she has never had a fall from her bed or chair during her 3 to 4 weeks in the facility. Resident A also shared that she has never been dropped or pushed by staff and again, insisted that

she is being treated “very nice” at the facility. Resident A’s daughter stated that four days ago she witnessed staff at the facility tell her mother to get up from her chair and get into her wheelchair. The staff that was assisting at the time reportedly did not lock Resident A’s wheelchair and she did not have her gait belt on, causing her to almost fall. Despite this, Resident A continued to speak highly of the care and treatment she receives from staff at the facility.

After speaking to Resident A and her family, Melissa Dyke and I spoke to Kayla Strasser, who is now the wellness director at the facility. Ms. Strasser stated that she didn’t work this past Wednesday through Tuesday, and she spoke to Resident A’s daughter on the phone Friday night. Ms. Strasser stated that she’s aware that an X-Ray was ordered for Resident A’s ankle this past Thursday to be completed by mobile services. There appeared to be a delay in this taking place due to receiving a note from the physician as opposed to an order for the X-Ray. On Friday, 4/1/22, Ms. Strasser stated that she assessed Resident A and noticed that she had swelling on the right side of her ankle/foot but there was no pain. She also denied noticing any bruises near Resident A’s face or eye. Monday morning, 4/4/22, Ms. Strasser stated that she received the order for the ankle X-Ray and believes mobile services completed it the same day. Ms. Strasser provided me with a copy of the radiology report, which indicated that Resident A had soft tissue swelling but no fracture. Ms. Strasser stated she has no idea what occurred that caused Resident A’s ankle to swell. Ms. Strasser stated that Resident A’s son has stated that she would have falls and not tell people. Ms. Strasser stated that she wonders if Resident A had an unsupervised fall and didn’t tell anyone. Ms. Strasser did not see any notes or incident reports indicating that Resident A sustained an injury at the facility.

On 4/19/22, I spoke to Resident A’s second daughter via phone. She stated that her mother told her “this morning they treated me nice. Last night (4/18/22) they threw me in a chair” and left her although she wasn’t in her chair correctly. This incident reportedly occurred after dinner when a staff member assisted Resident A back to her room. Resident A reportedly told her daughter “I’m going to die in this place.” The second daughter stated that her mom is a kind person and would never complain about anyone.

On 4/20/22, Ms. Strasser sent me the staff schedule for 4/18/22 and phone numbers of the staff members. Per the schedule, staff members Kamaia Barnes and Jabria Warren were both scheduled to work 2nd shift on the day in question.

On 4/21/22, I spoke to staff member Jabria Warren via phone. Ms. Warren recalled working this past Saturday, 4/18/22 from 3-7pm. Ms. Warren acknowledged that she assisted Resident A with using the bathroom and assisted her to the dining area to have dinner. Ms. Warren denied that she brought Resident A back to her room after dinner. Ms. Warren denied that she has ever heard anything about Resident A being throw**n** into her chair. She also denied that Resident A has mentioned any concerns to her. Ms. Warren was working with a colleague on 4/18/22 but was unable to recall who the staff member was.

On 4/21/22, I spoke to staff member Kamaia Barnes via phone. I explained to her that per the staff schedule, she was scheduled to work at Pebblebrook on 4/18/22 during second shift. I asked Ms. Barnes if she recalled assisting Resident A to her room after dinner on this day. Ms. Barnes is a medication tech and stated that she does not do any aide work and therefore, it was not her that assisted Resident A to her bedroom after dinner. In fact, Ms. Barnes is unaware as to who Resident A is as she does not work in Pebblebrook often. Ms. Barnes recalled working with Ms. Warren on the day in question and she denied that she ever witnessed her pushing or throwing anyone in a chair.

On 05/02/22, I conducted an exit conference with licensee designee, Toni LaRose. She was informed of the investigative findings and denied having any questions.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Resident A was observed with a faint bruise near her right eye and stated it was from “sometime long ago.” She was also observed with swelling to her ankles and a bandage on her right hand. Resident A stated that her ankles swell when she eats salt. An x-ray was completed and confirmed soft tissue swelling without a fracture. She was unsure as to what happened to her hand that was bandaged but remained adamant that she is well cared for in the facility. Resident A reportedly told her second daughter that she was thrown into her chair on 4/18/22 by staff. However, during my interview with Resident A 11 days earlier, she denied that she has ever been pushed or dropped by staff in the facility. She remained adamant that staff treat her well and that no one hurts her. If Resident A was being abused or neglected by staff, her second daughter does not believe she would tell me as the licensing consultant. Staff members Ms. Warren and Ms. Barnes both denied throwing Resident A into her chair on 4/18/22. Therefore, there is not a preponderance of evidence to support the allegation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION: While investigating the allegations listed above, Resident A's daughter expressed concern for her mother calling her to inform her that she pulled her call light to use the bathroom and no one came to help her. As a result of this, Resident A's daughter had to call the facility and tell them that her mother needed assistance. Resident A acknowledged that this incident occurred one time approximately 2-3 weeks ago. Resident A stated that it was midnight and she needed to use the bathroom. Resident A used her call light for assistance but staff never came. Therefore, she called her daughter, who then called staff at the facility to come assist her. Resident A stated that after her daughter called the facility, staff arrived at her room quickly. Although Resident A stated that this incident happened 2-3 weeks ago, her daughter stated that the incident occurred within the past week.

On 4/19/22, I spoke to Resident A's daughter to see if she can provide specific dates regarding her listed concerns. In particular, the date Resident A had to call her because staff didn't answer her call light. Resident A's daughter stated that her mother called her sister with this concern, not her. Resident A's daughter provided me with her sister's contact information.

On 4/19/22, I spoke to Resident A's second daughter regarding receiving calls from her mother about staff not attending to her needs after she pulls the call light. The second daughter confirmed that this has occurred with her mother more than once. The second daughter stated that her mother is unable to pull the call light again after she pulls it once as it doesn't reset by itself. The second daughter stated that the same situation occurred this past Saturday, 4/16/22. The second daughter stated that there was one time that her mom pulled her call light and had to wait more than 3 hours. The second daughter stated that her mom told her 'they're going to treat me bad now that you had those people come in," referring to myself and APS. The second daughter was asked if she could review her call log to provide me with a specific date and time the incidents listed above occurred.

On 4/20/22, the second daughter called me and stated that 3/28/22 at 11:42pm is when she received a call from her mother stating that she pulled the call light an hour-and-a-half ago and no one answered. The second daughter stated that she called the facility and staff told her that they forgot to reset the call light. The second daughter was unable to recall the name of the staff member she spoke to but she did acknowledge that staff finally made it to her mother's room just after midnight.

The most recent incident of Resident A pulling her call light and not receiving assistance occurred on 4/16/122. The second daughter stated that her mother called her at 10:47 am stating that she pulled her call light a half an hour ago and had not received help. The second daughter stated that she was 15 minutes away from the facility when she received that call from her mother. The second daughter went to the facility. When she arrived, her mother's call light was still on. The second daughter stated that her mother was in distress due to needing to use the bathroom

so she helped her. The second daughter was curious as to how long it would take staff to assist her mother. The second daughter stated that staff arrived in her mother's room after an hour and 10 minutes of the call light being on, which she feels is unacceptable. The second daughter stated that the staff member that arrived apologized and stated that it took her so long to get to Resident A due to being "short staffed". The second daughter stated that her mother is constantly overlooked.

On 4/20/22, Ms. Strasser sent me staff schedules and phone numbers for 3/28/22 and 4/16/22 as requested. Per the schedules, staff member Sequoia Wallace was scheduled to work 3rd shift on 3/28/22 and staff member Dametria Holt was scheduled to work 1st on 4/16/22.

On 4/21/22, I spoke to staff member Sequoia Wallace regarding her scheduled shift on 3/28/22. Although Ms. Wallace was scheduled to work by herself on the day in question, she is unsure if she worked alongside a colleague. Ms. Wallace was asked if she received a call from Resident A's daughter informing her that her mother pulled her call light an hour and a half ago and needs assistance. Ms. Wallace stated that this never happened to her knowledge. Ms. Wallace stated that she has not had any issues with Resident A and that she doesn't work in Pebblebrook often. Ms. Wallace denied any knowledge of other staff member having concerns regarding Resident A. However, Ms. Wallace stated that she knows they (staff at the facility) gets complaints because resident's call lights ring to all the facilities on campus. Ms. Wallace did not provide specific names of other residents. Ms. Wallace stated that if she is working by herself and attending to a resident, she can't stop helping one resident to check on another, even if they have pulled their call light. I asked Ms. Wallace how long it typically takes to response to a call light. She stated that it depends on how long it takes to finish addressing other resident's needs. If Ms. Wallace is working by herself, it will take her longer to get to other residents.

On 4/21/22, I spoke to staff member Dametria Holt regarding Resident A not being attended to for an hour and 10 minutes after pulling her call light on 4/16/22. Ms. Holt recalls working first shift on 4/16/22. She stated that she was working by herself in Pebblebrook. Ms. Holt stated that an agency staff member was scheduled to work first shift with her but she was not in the facility when she arrived. This led to Ms. Holt calling the agency to inquire about the staff member's whereabouts. The agency told Ms. Holt that they would call her back and never did. This led to Ms. Holt calling the agency again at 10:00 am for an update. The agency informed Ms. Holt that their staff had been on campus since 6:50 am. Ms. Holt found out that the agency staff member was at Stoneybrook instead of Pebblebrook due to the manor coordinator, Anetra Singleton keeping her there although she was needed in Pebblebrook where she was scheduled.

As a result of the agency staff member working at Stoneybrook, Ms. Holt stated, "my people really suffered," referring to the residents at Pebblebrook. Ms. Holt stated that some of the residents had to wait longer to be attended to due to being the only staff member working. Ms. Holt stated that this has happened in the past as well,

approximately one month ago. While working by herself on 4/16/22, Ms. Holt stated that she was responsible for caring for 19 residents.

I explained to Ms. Holt that it was brought to my attention that Resident A's daughter explained that her mother had to wait an hour and 10 minutes after pulling her call light for assistance. Ms. Holt confirmed that it took a while before she could answer Resident A's call light. Ms. Holt stated that she recalled hearing Resident A's call light go off on 4/16/22. After hearing the call light go off, Ms. Holt stated that she silenced it in the hallway because she was attending to Resident B. Ms. Holt stated that Resident B had a bowel movement, which took quite some time clean. Not only did she have to clean Resident B, she also had to clean his wheelchair too as there was feces in it. After cleaning Resident B, Ms. Holt stated that she was heading to Resident A's room. While doing so, another call light went off and she stopped and attended to that resident as it was on her way to Resident A. Ms. Holt then made her way to Resident A's room. When Ms. Holt arrived in Resident A's room, she stated that she didn't realize that so much time had passed. Ms. Holt stated that she apologized to Resident A and her daughter for how long it took to answer the call look. Ms. Holt stated that there were 2 people that did a no-call/no-show on 4/16/22. However, this shouldn't have impacted Pebblebrook the building was scheduled to have 2 staff members.

On 05/02/22, I conducted an exit conference with licensee designee, Toni LaRose. She was informed of the investigative findings and agreed to complete a corrective action plan.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours.
ANALYSIS:	Ms. Holt stated that she worked by herself at the facility on 4/16/22 from the time her shift started until after the lunch hour, which was approximately 4 to 5 hours. Ms. Holt confirmed that it took a long time for her to answer Resident A's call light due to attending to other residents' needs. Ms. Holt stated that she was responsible for providing care to 19 residents, which means the facility was not in compliance with the staffing ratio during waking hours. Therefore, a preponderance of evidence exists to support the allegations.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 4/7/22, Resident A's son in-law stated that he is concerned about a lack of baths that she has received since being admitted to the facility. Resident A's son in-law stated that she's had a total of three baths since she was admitted on March 10th. After concluding my interview with Resident A and her family on 4/7/22, APS worker Melissa Dyke and I spoke to Kayla Strasser, wellness director at the facility. I informed Ms. Strasser that the family listed some concerns about the lack of baths that Resident A has received since being admitted to the facility. Ms. Strasser was unaware of any concerns related to Resident A bathing. She acknowledged that Resident A is scheduled to bath twice a week, once on Monday and once on Thursday. Ms. Strasser agreed to email me Resident A's assessment plan and shower sheets since her admission as she has not been at the facility for a long time.

On 4/14/22, I received an email from Ms. Strasser that included Resident A's shower sheets. There was a shower sheet dated 3/18/22 and 3/21/22. Ms. Strasser has been a resident of the facility since approximately 3/10/22.

On 4/19/22, I spoke to Resident A's second daughter via phone. Resident A's second daughter stated that she is concerned that staff at the facility are not giving her baths as she stated she's had to fight with the facility to give her two baths. During Resident A's first bath, staff at the facility reportedly left the door open in the bathroom and the water was only halfway up her calf.

On 4/20/22, I received an email from Ms. Strasser with Resident A's assessment plan and care plan. I reviewed both documents, which indicated that Resident A is scheduled to shower 1-2 times per week, with Tuesday and Friday being her scheduled days. Per the shower sheets reviewed on 4/14/22, Resident A has not received 2 baths per week as she is scheduled.

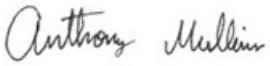
On 05/02/22, I conducted an exit conference with licensee designee, Toni LaRose. She was informed of the investigative findings and agreed to complete a corrective action plan.

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:	Resident A's assessment plan and care plan indicates that she is to receive two baths per week. Ms. Strasser acknowledged that Resident A is scheduled to have two baths per week.

	Resident A has been at the facility since 3/10/22 and per the shower sheets, she has only received two showers in the month of March. Therefore, there is a preponderance of evidence to support the allegation of Resident A not receiving personal care as identified in her assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

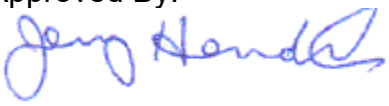
After receipt of an acceptable corrective action plan, I recommend no change to the current license status.



05/02/2022

Anthony Mullins Date
Licensing Consultant

Approved By:



05/03/2022

Jerry Hendrick Date
Area Manager