GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 26, 2022

Rochelle Lyons
Grandhaven Living Center LLC
Suite 200
3196 Kraft Avenue SE
Grand Rapids, MI 49512

RE: License #: AL330237775
Investigation #: 2022A0466045
Grandhaven Living Center 1 (Pier)

Dear Ms. Lyons:

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 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) 284-9727.

Sincerely,

Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL330237775
Investigation #:	2022A0466045
Complaint Receipt Date:	06/03/2022
Investigation Initiation Date:	06/03/2022
Report Due Date:	08/02/2022
Licensee Name:	Grandhaven Living Center LLC
Licensee Address:	Suite 200 3196 Kraft Avenue SE Grand Rapids, MI 49512
Licensee Telephone #:	(810) 334-8809
Administrator:	Brandy Shumaker
Licensee Designee:	Rochelle Lyons
Name of Facility:	Grandhaven Living Center 1 (Pier)
Facility Address:	3145 W Mt Hope Avenue Lansing, MI 48911
Facility Telephone #:	(517) 485-5966
Original Issuance Date:	02/12/2002
License Status:	REGULAR
Effective Date:	01/26/2021
Expiration Date:	01/25/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION:

	Violation Established?
Resident A has sores on her body and she is not being administered the medication that has been prescribed to heal those sores.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/03/2022	Special Investigation Intake- 2022A0466045.
06/03/2022	Special Investigation Initiated – Telephone from Complainant interviewed.
06/07/2022	Inspection Completed On-site.
07/19/2022	Contact- email sent/received to administrator Brandy Shumaker.
07/25/2022	Contact- email sent to administrator Brandy Shumaker.
07/26/2022	Exit Conference with licensee designee Rochelle Lyons, message left.

ALLEGATION: Resident A has sores on her body and she is not being administered the medication that has been prescribed to heal those sores.

INVESTIGATION:
On 06/03/2022, Complainant reported Resident A is diagnosed with Alzheimer's disease and is currently in her 7-8th year of progression. Complainant reported Resident A is independent and ambulatory but that she does require help with showering and medication administration. Complainant reported Resident A is a heavy-set woman and prone to sores in the folds of her skin and/or on her bottom. Complainant reported Resident A has cream she uses to help keep sores at bay. Complainant reported that 10 days ago, Resident A called Complainant to report she was developing a sore in the folds of her stomach. Complainant reported she contacted the staff at the facility and that she was assured they checked on Resident A and helped her put cream on it/dry it out. Complainant reported direct care staff assured Complainant it was not serious. Complainant reported that over the course of the next 10 days, direct care staff assured Complainant things were progressing well. Compliant reported that on the evening of 05/31/2022, Resident A called Complainant and she was sobbing, in pain, and reported she was bleeding. Complainant reported Resident A reported that her sores were much worse and had split open/were bleeding and very painful. Complaint reported she

called staff and they went to check on Resident A. Complainant reported direct care staff described Resident A's sores as really bad and she needed to be taken to Urgent Care or the hospital emergency room for evaluation. Complainant reported that she and Relative A1 took Resident A to the emergency room and she was assessed by a physician assistant (PA). Complainant reported Resident A's sores (now plural) were the size of a half dollar and per Complainant's count, there were five on Resident A's belly area and four on her rectum/anus area. Complainant reported the sores were bleeding/oozing and had pus present, although the PA did not think they were not infected just yet. Complainant reported Resident A was prescribed two prescriptions and released Resident A back to the facility around midnight. Complainant reported she took the unfilled prescriptions and paperwork on Resident A's care back to the facility and helped make Resident A comfortable. Complainant knew the prescriptions would not be filled until the next morning by the pharmacy connected with the facility. Complainant reported she spoke with direct care staff about the situation (they also had the paperwork from the hospital) and they assured Complainant they would take care of Resident A as soon as the meds arrived.

Complainant reported that today, 06/03/2022 at 10:30 am, Resident A called me crying and in pain. Complainant reported one of the medications Resident A was prescribed was to help with pain. Complainant reported she called the facility about the lack of care and was informed Resident A's prescribed medications were administered at 8:00 am this morning. However, Complainant reported that in fact, they were not. Complainant reported that this is not the first time the facility has falsified medication sheets. Complainant reported Care Coordinator (Cassie last name unknown) informed Complainant they were not responsible/able to administer salve/powder to Resident A or assess in any way. Complainant reported that the facility suggested Complainant get a physician to order Home Health Nurses to help Resident A. Complainant reported Resident A's sores were not a problem 10 days ago. Complainant reported facility direct care staff members let it get out of hand, did not use the physician on staff and did not help Resident A with her care.

On 06/07/2022, I conducted an unannounced investigation and I reviewed Resident A's record which contained a *After Visit Summary* from Sparrow Hospital dated 5/31/2022 for Resident A. The *After Visit Summary* documented that Resident A was prescribed nystatin powder with the instructions to apply to skin folds topically twice a day and to continue treatment for three days after symptoms have subsided. Additional instructions were:

- "Wash skin twice daily on buttocks and pannus, pat dry and allow to air before applying powder or cream.
- Apply nystatin powder to dry skin BID until rash is gone.
- Apply nystatin/triamcinolone cream to area of open wounds on pannus BID until skin is healed, then transition to nystatin powder until rash is gone.
- Wounds should be assessed weekly by facility.
- Return to ER if wounds get larger with increased drainage, or worsening erythema."

Resident A's record contained a *Michigan Family Medicine and Urgent Care Progress Note* dated 06/02/2022 which documented in the "chief complaint" section of the report "sores under abdominal apron, difficulty walking." In the "history of present illness" section of the report it stated "[Resident A] was seen in the ER for wounds under her abdominal apron. She has wounds bilaterally. She was sent back to the facility with nystatin power and cream. These were filled inadvertently at the wrong pharmacy. Resident states that the sores have been present for a few days and she thinks it is caused by being hot and sweaty. She said she showers two times per week but finds it hard to stay cool during the day, especially in the areas of the skin-to-skin contact like under her of abdominal folds and under her breasts. Resident also states she has not been able to do her usual walking exercises due to the sores on her skin and how they hurt more when they get hot and sweaty." In the "physical exam" section of the report under "skin" it stated "warm and dry without rash or lesions. 3cm wounds bilateral under abdominal fold. They are red and moist. No pus, no heat." On the *Physician Order Form* it stated, "PT/OT eval and treat muscle weakness. Skilled nursing to assess wounds."

I reviewed a *Health Care Appraisal* dated 03/30/2022 which documented that Resident A weighs 230 pounds. In the "physical exam" portion of the report 'abnormal' was checked for skin. Under breasts, genitalia and rectal, it was checked deferred.

I reviewed Resident A's written *Assessment Plan for Adult Foster Care Residents* which was dated 5/11/2021 and signed by Relative A1. In the "bathing" section "needs help, standby for bathing." In the "taking medication" section, it stated "staff will administer all medications." In the "bathing" section of the report it stated that Resident A does not require any assistance.

I reviewed Resident A's medication administration records (MAR)s for 05/2022 and June 2022. Resident A's 06/2022 MAR documented nystat/triam cream, "apply topically twice a day to areas of open skin, continue treatment for days after symptoms have subsided for cutaneous canduduasus." Resident A's 06/2022 MAR documented that this was prescribed on 05/31/2022. Resident A's 06/2022 MAR documented that nystat/triam cream was administered beginning on 06/02/2022 at 8pm, 06/03/2022 at 8am and on 06/03/2022 at 8pm. Resident A's 06/2022 MAR documented the following in the "exceptions"

- "06/04/2022,10:33 am, nystat/triam cream not in cart.
- 06/05/2022,10:50 am, nystat/triam cream not in cart.
- 06/05/2022. 3:15 pm wound care bhakti admin."

Resident A's 06/2022 MAR documented nyamyc powder 100000, "apply topically twice a day to folds. Continue treatment for days after symptoms has subsided for cutaneous canduduasus" was prescribed on 05/31/2022. Resident A's 06/2022 MAR documented that nyamyc powder 100000 was administered beginning on 06/02/2022

at 8pm, 06/03/2022 at 8am and on 06/03/2022 at 8pm.Resident A's 06/2022 MAR documented the following in the "exceptions"

- "06/04/2022, 8:08 am, nyamyc powder 100000 not in cart.
- 06/05/2022,10:50 am, nyamyc powder 100000 not in cart."

On 06/07/2022, I interviewed care coordinator Cassie Myers who reported that on 05/31/2022, Relative A2 took Resident A to the hospital due to pain in the sores on her body and she was discharged back to the facility the same day. Care coordinator Myers reported Resident A was seen the next day by house Dr. Al-Sheikh. Care coordinator Myers reported Resident A was uncomfortable and offered Tylenol for pain. Care coordinator Myers reported the hospital diagnosed Resident A with a yeast infection and Dr. Al-Sheikh diagnosed Resident A with chafing. Care coordinator Myers reported there was a delay in receiving the orders from Dr. Al-Sheikh. Care coordinator Myers reported she was unaware why there was a delay.

On 06/07/2022, I interviewed Resident A who reported that she does have a rash on her bottom and that the sore on her stomach did split open. Resident A reported that she has had the sore for a long time. Resident A says she does have a prescription for ointment to be put on the sores but reported direct care staff members are not applying it twice a day as prescribed, so the sores were not getting better. Resident A reported direct care staff members at the facility help her get in and out of the shower but that she does have privacy during the shower as she does not require assistance while showering, just assistance getting in and out of the shower.

On 07/19/2022, administrator Brandy Shumaker reported that when the MAR documents that there is an "exception" or a "pass notes" documented in a MAR that says medication is not in cart, that means that the facility is waiting on medication to be delivered when it was re-ordered, or it could be a new prescribed medication. Administrator Shumaker did not provide an explanation for Resident A's June 2022 MAR which documented both the cream and powder medications were administered on 06/02/2022 and 06/03/2022 (three times prior) and then had exceptions and pass notes for the next two days saying the medication is not in the cart.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	Care coordinator Myers reported that the hospital diagnosed Resident A with a yeast infection and Dr. Al-Sheikh diagnosed Resident A with chafing. Care coordinator Myers reported that there was a delay in receiving the prescription orders from house Dr. Al-Sheikh. Care coordinator Myers reported she was unaware what caused the delay. Resident A's medication administration records (MAR)s for June 2022, documented Resident A was prescribed "nystat/triam cream, on May 31, 2022, apply topically twice a day to areas of open skin, continue treatment for days after symptoms have subsided for cutaneous canduduasus." Resident A's June 2022 MAR documented Resident A was prescribed nyamyc powder 100000, on May 31, 2022 "apply topically twice a day to folds. Continue treatment for days after symptoms has subsided for cutaneous canduduasus." Resident A's MAR documented that neither of these medications were administered to Resident A on June 04, 2022 and June 05, 2022, therefore a violation has been established as Resident A's medication was not being administered as prescribed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 06/07/2022, I interviewed Resident A in her bedroom which contained several different over the counter pain gels and antifungal powders. Additionally, Resident A's room contained two prescription medications:

- a prescription eye drop written for Resident A on 03/01/2021 for Prednisolone, "instill 1 drop in each eye four times a day for 1 week, twice daily for 1 week, then shake bottle well before each."
- Fluticasone Propionate 50 mg, written for Resident A on 10/30/2020, "inhale 1 spray in each nostril one time a day."

Both of these medications were located in Resident A's room by her nightstand. Resident A reported she could not remember if she uses these medications or not.

On 06/07/2022, I reviewed Resident A's resident record and I did not see any written documentation from a physician documenting that Resident A was able to self-administer any over the counter or physician prescribed medications.

On 06/07/2022, I reviewed Resident A's written *Assessment Plan for Adult Foster Care Residents* which was dated 5/11/2021 and signed by Relative A1. In the "taking medication" section, it stated "staff will administer all medications."

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	On 06/07/2022, Resident A's bedroom contained two prescribed medications and several over the counter medications that were not locked up therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 06/07/2022, I conducted an unannounced investigation and I reviewed Resident A's written *Assessment Plan for Adult Foster Care Residents* (assessment plan) which was dated 5/11/2021 and signed by Relative A1. The facility provided an updated written assessment plan that was dated 05/03/2022, however the document did not contain any signatures including the resident's designated representative and the licensee. There was also no other documentation, such as a letter or written statement, documenting Relative A1's participation in the assessment plan dated 05/03/2022.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.

ANALYSIS:	On 06/07/2022, Resident A's record did not contain a written *Assessment Plan for Adult Foster Care Residents* that had been updated annually and had been completed with the resident's designated representative and the licensee.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

07/25/2022

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Julie Elkins — Date
Licensing Consultant

Approved By:

07/26/2022

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Dawn N. Timm — Date
Area Manager