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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 12, 2022

Beth Covault
Samaritas Senior Living Grand Rapids Woods
1900-32nd Street, SE
Grand Rapids, MI 49508-1583

RE: License #: AH410236832
Investigation #: 2022A1021051
Samaritas Senior Living Grand Rapids Woods

Dear Ms. Covault:

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) 284-9730.

Sincerely,

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
REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AH410236832
Investigation #:	2022A1021051
Complaint Receipt Date:	08/12/2022
Investigation Initiation Date:	08/17/2022
Report Due Date:	10/11/2022
Licensee Name:	Samaritas
Licensee Address:	Suite A 2080 Union Ave. SE Grand Rapids, MI 49507
Licensee Telephone #:	(313) 823-7700
Administrator/Authorized Representative:	Beth Covault
Name of Facility:	Samaritas Senior Living Grand Rapids Woods
Facility Address:	1900-32nd Street, SE Grand Rapids, MI 49508-1583
Facility Telephone #:	(616) 452-4470
Original Issuance Date:	02/15/1994
License Status:	REGULAR
Effective Date:	02/28/2022
Expiration Date:	02/27/2023
Capacity:	61

II. ALLEGATION(S)

	Violation Established?
Residents do not receive medical attention.	No
Resident A is not changed.	No
Residents are called names.	No
Facility is not clean.	No
Additional Findings	Yes

III. METHODOLOGY

08/12/2022	Special Investigation Intake 2022A1021051
08/17/2022	Contact - Telephone call made interviewed complainant
08/17/2022	APS Referral intake was sent by APS. APS denied complaint
08/17/2022	Special Investigation Initiated - On Site
08/19/2022	Contact-Telephone call made Interviewed Care Resources-PACE social worker Ashley Paxson
09/12/2022	Exit Conference Exit conference with authorized representative Beth Covault

ALLEGATION:

Residents do not receive medical attention.

INVESTIGATION:

On 8/12/22, the licensing department received a complaint from Adult Protective Services (APS) with allegations residents do not receive appropriate medical attention. The complainant alleged residents will have a change in status, and the facility will not provide medical attention.

On 8/17/22, I interviewed the complainant by telephone. The complainant alleged Resident B had a stroke but was not sent to the hospital for an evaluation for one or two days. The complainant alleged Resident C has a urinary tract infection that is not being treated.

On 8/17/22, I interviewed the administrator Michelle DuBridge at the facility. Ms. DuBridge reported in July 2022, care staff observed Resident B to be more lethargic and withdrawn. Ms. DuBridge reported Resident B was sent to the hospital and was diagnosed with electrolyte imbalance and meningitis. Ms. DuBridge reported Resident B was discharged to a sub-acute facility from the hospital. Ms. DuBridge reported the facility is working closely with physicians and family of Resident C to address her medical and psychological needs. Ms. DuBridge reported in July 2022, Resident C had a maniac episode in which the family was providing 1:1 care to ensure the safety of Resident C. Ms. DuBridge reported the facility worked with Resident C's physician and family on ways to manage the behaviors of Resident C but eventually Resident C was sent to the hospital for evaluation and behaviors have decreased. Ms. DuBridge reported at that time, Resident C was checked for a urinary tract infection, and it was found that she did not have one. Ms. DuBridge reported if a resident has a change in status, they are to report the change to the medication technician or the nurse manager. Ms. DuBridge reported it was found this did not occur with Resident B. Ms. DuBridge reported since then the facility has implemented "*Stop and Watch."* Ms. DuBridge reported this is a tool for care staff to communicate resident's change of status. Ms. DuBridge reported care staff are to complete the document and provide it to the medication technician if a resident has a change in status. Ms. DuBridge reported this was implemented last month and has been well received.

On 8/17/22, I interviewed staff person 1 (SP1) at the facility. SP1 reported she was trained on "*Stop and Watch."* SP1 reported if a resident has a change in status, they are to complete the document and provide it to the medication technician. SP1 reported care staff are good at communicating change in status to medication technicians and that residents do receive appropriate medical attention.

On 8/17/22, I interviewed SP2 at the facility. SP2 reported if a resident has a change in status, it must be communicated to the medication technician. SP2 reported the facility has implemented "*Stop and Watch."*

I reviewed the "*Stop and Watch*" documentation. The documentation read,

> *"If you have identified an important change while caring for a resident today, please circle the change and discuss it with the nurse/supervisor before the end of your shift.*
>
> *Seems different than usual*
> *Talks or communicates less than usual*
> *Overall needs more help than usual*

Participated in activities less than usual

Ate less then usual
N
Drank less than usual

Weight change
Agitated or nervous more than usual
Tired, weak, confused or drowsy
Change in skin color or condition
Help with walking, transferring, toileting more than usual

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(c) Assure the availability of emergency medical care required by a resident.**
ANALYSIS:	Interviews with management revealed caregivers are to report any change in status to medication technician and/or shift supervisor. When this did not occur with Resident B, the facility implemented a new policy, Stop and Watch, to ensure residents receive the appropriate medical attention. While there was a deficit found in delay of care for Resident B, this is not a systematic issue within the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A is not changed.

INVESTIGATION:

The complainant alleged employees leave Resident A in soaked briefs for extended period, including overnight, because nobody wants to change him due to his size.

Ms. DuBridge reported Resident A has autism, dementia, and is a larger sized resident. Ms. DuBridge reported Resident A has behaviors and can be resistant to care. Ms. DuBridge reported Resident A is incontinent of bowel and wears a depend. Ms. DuBridge reported Resident A is on a 2-hour check for incontinence. Ms. DuBridge reported Resident A does have some skin breakdown on his bottom due to incontinence. Ms. DuBridge reported over the weekend the facility had a caregiver

walk off the job because they were told Resident A is “violent.” Ms. DuBridge reported Resident A is not violent and if approached correctly, he is receptive to care. Ms. DuBridge reported it can be difficult to change Resident A but that she has not received complaints that Resident A is not changed appropriately.

SP1 reported Resident A can be a “handful” and can be aggressive with care staff during changes. SP1 reported Resident A is changed appropriately.

SP2 reported Resident A is incontinent and can be difficult to change. SP2 reported if care staff talk to Resident A and re-direct him, he will be agreeable to be changed. SP2 reported at times Resident A is not changed because he is not receptive to it, but with change of face, Resident A is able to be changed.

I observed Resident A at the facility. Resident A was in clean clothes and did not smell of urine. I observed Resident A’s room. Resident A’s room was clean as observed by dirty clothes were picked up and the room did not smell of urine.

On 8/19/22, I interviewed Care Resources-PACE social worker Ashley Paxson by telephone. Ms. Paxson reported Resident A does not use the bathroom and will urinate throughout the facility. Ms. Paxson reported Resident A was on a toileting schedule. Ms. Paxson reported the facility has worked with Resident A to be successful with changing him and managing his incontinence. Ms. Paxson reported she has observed Resident A at the facility and has never observed him to have a soiled depend on or smell of urine. Ms. Paxson reported no concerns with Resident A residing at the facility.

I reviewed Resident A’s service plan. The service plan read,

“*Resident will urinate and defecate anywhere when he needs to go. Two hour toileting schedule to promote continence. Two hour toileting schedule.”*

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(1) Personal care and services that are provided to a resident by the home shall be designed to encourage residents to function physically and intellectually with independence at the highest practical level.
ANALYSIS:	Interviews with care staff and observations made revealed Resident A can be difficult to change but caregivers can manage Resident A’s incontinence. There is lack of evidence to support the allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents are called names.

INVESTIGATION:

The complainant alleged that residents are called “dumb” and “retarded” to their faces and that employees tell residents to “shut the fuck up.”

Ms. DuBridge reported upon hire employees complete resident rights and dementia training. Ms. DuBridge reported she has not heard any employee call residents’ names or use foul language. Ms. DuBridge reported at times residents will use foul language towards care staff. Ms. DuBridge reported she has not disciplined any employee for not treating a resident with respect. Ms. DuBridge reported there has not been any complaints of employee conduct.

SP1, SP2, and SP3 reported no knowledge of employees using foul language or calling residents names. They reported upon hire they received resident rights and dementia training.

Ms. Paxson reported she has never observed any caregivers call residents names. Ms. Paxson reported caregivers have appropriate interactions with residents at the facility.

I observed appropriate employee interactions with multiple residents. I observed employees calling residents by name, assisting them with care, engaging residents in activities, and re-directing residents.

I reviewed SP1, SP2, and SP3 employee record. The record revealed that the employees received training on resident rights and resident abuse.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	Interviews with caregivers and outside providers, observations made at the facility, and review of employee files revealed lack of evidence to support the allegation residents are treated disrespectfully at the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Facility is not clean.

INVESTIGATION:

The complainant alleged the facility is dirty and employees do not sweep or clean regularly. The complainant alleged there are ants and bugs in the rooms of residents and the toilets do not get cleaned regularly so there is feces all over the toilets.

Ms. DuBridge reported there are two full time housekeepers that are responsible for cleaning resident rooms and common areas. Ms. DuBridge reported resident rooms are cleaned weekly and more often, if necessary. Ms. DuBridge reported if an employee observes a resident room or common area that is dirty, the expectation is for the employee to clean the area. Ms. DuBridge reported there was a complaint about a resident's bathroom and this complaint was brought to the housekeeper's attention. Ms. DuBridge reported since then there has been no complaints about the cleanliness of the facility. Ms. DuBridge reported the facility is clean and tidy.

On 8/17/22, I interviewed SP5 at the facility. SP5 reported it is her responsibility to clean the facility. SP5 reported she cleans resident rooms, resident bathrooms, and common areas. SP5 reported she vacuums the floor, dusts, cleans toilets, and cleans the vanity in the bathroom. SP5 reported the facility is kept clean.

SP1 reported the facility is kept clean. SP1 reported the housekeepers are responsible for cleaning residents' rooms and the common area. SP1 reported the employees will also clean, if needed.

I observed the common areas of the facility including the living area, dining area, hallways, and bathrooms. The common areas of the facility were clean as observed by the floors were vacuumed, there was no litter on the floor, and the facility smelt clean.

I observed multiple resident rooms and bathrooms. The rooms were tidy and clean. The bathrooms were also clean.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.

ANALYSIS:	Interviews with employees and observations made at the facility revealed the facility is kept clean. There is lack of evidence to support the allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

SP2 reported Resident A can be difficult to change and can refuse care. SP2 reported if a caregiver can talk to Resident A, he will sometimes be more agreeable to care.

SP3 reported it can be difficult to provide care to Resident A. SP3 reported if you offer food to Resident A, he will be more agreeable to care.

SP4 reported if Resident A refuses care, if the caregiver leaves and comes back, Resident A will be more agreeable to care. SP4 reported it sometimes helps if a different caregiver tries to provide care.

Review of Resident A's service plan read,

"*Resist care, Socially inappropriate behavior. Resident may resist care during ADLs such as dressing, showering, toileting, and grooming."*

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	Resident A's service plan identifies behaviors of Resident A. However, it does not provide enough detail on how staff are to manage the behaviors and interventions to utilize when Resident A is exhibiting behaviors. Interviews with staff members revealed each staff member has a different technique for providing care to Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/12/22, I conducted an exit conference with authorized representative Beth Covault by telephone. Ms. Covault had questions on this report.

IV. RECOMMENDATION

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

8/26/22

Kimberly Horst — Date
Licensing Staff

Approved By:

09/07/2022

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