STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

December 22, 2022

Jamie Lopez
Grand Brook Memory Care
5281 Wilson Avenue
Wyoming, MI 49418

RE: License #: AH410398724
Investigation #: 2023A1010012
Grand Brook Memory Care

Dear Mrs. Lopez:

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) 241-1970.

Sincerely,

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa NW Unit 13, 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410398724
Investigation #:	2023A1010012
Complaint Receipt Date:	12/02/2022
Investigation Initiation Date:	12/02/2022
Report Due Date:	02/01/2023
Licensee Name:	Grand Brook Memory Care of Grand Rapids, LLC
Licensee Address:	5281 Wilson Avenue Wyoming, MI 49418
Licensee Telephone #:	(469) 331-8200
Administrator:	Charity Songer
Authorized Representative:	Jamie Lopez
Name of Facility:	Grand Brook Memory Care
Facility Address:	5281 Wilson Avenue Wyoming, MI 49418
Facility Telephone #:	(317) 914-2357
Original Issuance Date:	10/01/2020
License Status:	REGULAR
Effective Date:	04/01/2022
Expiration Date:	03/31/2023
Capacity:	44
Program Type:	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A eloped on 10/29/22 and residents are not supervised. Residents are ingesting toxic materials such as liquid cleaning chemicals.	Yes
There are not enough staff to meet resident care needs consistent with their service plans.	No

III. METHODOLOGY

12/02/2022	Special Investigation Intake 2023A1010012
12/02/2022	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
12/02/2022	APS Referral APS referral emailed to Centralized Intake
12/13/2022	Inspection Completed On-site
12/13/2022	Contact - Document Received Received resident service plan and staff schedule
12/22/2022	Exit Conference

ALLEGATION:

Resident A eloped on 10/29/22 and residents are not supervised. Residents are ingesting toxic materials such as liquid cleaning chemicals.

INVESTIGATION:

On 12/2/22, the Bureau received the allegations from the online complaint system. The complaint read, “Some residents are ingesting inedible materials such as foam and plastic and liquid chemicals. One resident, [Resident A], escaped the facility on 10/29/22 and upon his return Kyle Root screwed his window completely shut to where it will not even open at all. There are several other issues from sexual conduct between residents. The complainant was anonymous; therefore I was unable to gather additional information.

The facility's program type is designated for residents with memory loss and Alzheimer's. The entire facility is secured to accommodate memory loss programming and care for its residents.

On 12/2/22, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 12/2/22, I reviewed the facility file and re-reviewed Resident A's incident report that was dated 10/29/22. The *Narrative description of facts of incident* section of the report read, "ED received phone call at 1715 that the staff had went into [Resident A's] room to serve him dinner, and he was not in there. A butterknife was found and the double-locked and bracketed windows were tampered with. One bracket was removed and the other bracket was dislodged. The screen was bent and kicked out and the window was opened and dislodged past normal boundary. The premises was searched by all staff, and when he was not located, the police were called. The police arrived, took the report and picture of [Resident A] with his emergency contact information. [Resident A] was located down the road at a church party with three bags of clothes/belongings packed. He was brought back to the residence and told the ED that he just got 'pissed off and wanted to leave to see his girlfriend, that he loves.'"

The *Corrective measures taken to prevent recurrence of this incident* section of the report read, "1:1 supervision throughout the rest of this weekend provided by GB staff this evening, then family provided agency 1:1 as needed. Window secured again and bolted shut with hex screws bolted to the 2x6's. Baby monitor with screen purchased and put in [Resident A's] room. Monitor kept with staff at all times when [Resident A] in in [sic] room. All courtyard doors locked at night time. Guardian-Brother [relatives] notified. Asked family to stay with resident tonight, but they were unable to do so. Local daughters stated they were too "intoxicated to do so." Guardian-[Relative A1] to call home care companies tomorrow am to set up private-pay one-on-one sitting services. Reviewing GPS cell phone obtainment with pre-programmed numbers, and Smart Soles to put in his shoes to track his location at all times. PCP contacted to provide medication review this week, and requested additional lorazepam dosing for prn use (increased anxiety of [Resident A]).

The facility's administrator, Charity Songer, reported Resident A did not have a history of exit seeking and this was his first attempt to elope.

On 12/13/22, I interviewed Ms. Songer at the facility. Ms. Songer's statements regarding Resident A's elopement from the facility on 10/29/22 were consistent with the incident report she submitted in accordance with the licensing incident reporting administrative rules. Ms. Songer explained prior to Resident A's elopement, his window opened approximately six inches. Ms. Songer reported after the incident on 10/29/22, maintenance staff secured the window to open approximately two inches. Ms. Songer stated Resident A was also provided with a cell phone he can use to call

his family. Ms. Songer said Resident A has not exhibited exit seeking behavior since the incident.

Ms. Songer reported there was an incident several months ago when a care staff person brought a cleaning chemical to the facility in a pop bottle. Ms. Songer said the staff person brought the pop bottle into the facility in her purse and was going to use the liquid cleaner to clean. Ms. Songer stated the staff person placed her purse in a common area under a blanket in attempt to hide it. Ms. Songer reported Resident B found the purse and the pop bottle as it was not secured.

Ms. Songer explained staff found Resident B with the pop bottle. Ms. Songer reported staff were uncertain whether Resident B had ingested any of the cleaner, so she was sent out to the hospital to be evaluated. Ms. Songer said Resident B returned the same day and there was no evidence to conclude she ingested the cleaner. Ms. Songer reported the staff person who brought the cleaner in and left it unsecured received a written reprimand.

Ms. Songer explained Resident B wanders the facility and often uses the bathroom in other resident rooms. Ms. Songer stated there was an incident several months ago in which Resident B entered a male resident's room. Ms. Songer reported staff found Resident B in front of the male resident in the common area of his room with her pants down. Ms. Songer stated the male resident was fully dressed and neither were in distress. Ms. Songer reported it could not be confirmed whether anything happened as the male resident was fully dressed and not touching Resident B. Ms. Songer said there have been no incidents since as the male resident no longer resides in the facility. Ms. Songer reported all residents in the facility are checked on every two hours.

Ms. Songer provided me with a copy of Resident B's service plan for my review. The *Behavior Assistance* section of the plan read, "Per husband she gets side tracked. She is stubborn at times frequent cueing and reminding which frustrates her-does better with one task at a time. Easily redirected from frustration. She is a walker and is busy with task and needs to always be doing something. She fidgets but is cooperative. [Resident B] walks around the community frequently. She spends time on both lake and cabin. She will go into rooms that are not locked. She will take objects and carry them around. If she thinks it is edible she will try to eat it. Staff to watch what she has in her hands. She is busy and quick-likes to have purpose-cleans and likes to pick up and tidy up house also likes to be helpful with other residents."

On 12/13/22, I interviewed wellness director Peg Makowski at the facility. Ms. Makowsi's statements were consistent with Ms. Songer.

On 12/13/22, I interviewed Staff Person 1 (SP1) at the facility. SP1's statements were consistent with Ms. Songer and Ms. Makowski.

On 12/13/22, I interviewed Staff Person 2 (SP2) at the facility. SP2's statements were consistent with Ms. Songer, Ms. Makowski, and SP1.

On 12/13/22, I inspected the entire facility, including unsecured cabinets in common areas. I found one mechanical room was unlocked and had bottles of Clorox bleach and other cleaning chemicals unsecured. These items were accessible to the residents who suffer memory loss and have poor safety awareness.

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: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	The interviews with staff revealed there was an incident in which resident B was found with a liquid cleaner in her possession that was unsecured. My inspection of the facility revealed a mechanical room door was unlocked and bottles of toxic liquid cleaning items were unsecured and accessible to the residents who have poor safety awareness. This is not consistent with an organized program of protection. The interviews with staff, along with review of Resident A's incident report revealed he eloped on 10/29/22. This was Resident A's first and only elopement from the facility. The facility took adequate corrective measures after Resident A's elopement.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

There are not enough staff to meet resident care needs consistent with their service plans.

INVESTIGATION:

On 12/2/22, the complaint read, "The facility is severely understaffed with residents falling down and hurting themselves and being left unattended for long periods of time leaving them in soiled garments."

On 12/13/22, Ms. Songer reported there are enough staff on first, second and third shift to ensure resident care needs are met consistent with their service plans. Ms. Songer reported there are three direct care staff persons and two medication technicians (med techs) scheduled on first and second shifts. Ms. Songer stated there are two direct care staff persons and one med tech scheduled on third shift. Ms. Songer said there are 43 residents in the facility at this time and three require the assistance from two staff persons to transfer.

Ms. Songer stated resident care needs can still be met if there is one shift vacancy. Ms. Songer reported management staff are available during first shift to assist care staff as needed. Ms. Songer said the facility uses an “oncall” or “mandate” schedule to fill shift vacancies if no staff volunteer to work the vacant shift. Ms. Songer stated this system is effective in covering shift vacancies. Ms. Songer reported staff utilize two-way radios to communicate with each other during their shifts.

Ms. Songer said there have been resident falls, however the incidents have not been reportable. Ms. Songer reported incident reports are submitted in accordance with the administrative licensing rules. Ms. Songer stated residents are checked on every two hours at the facility as they are in various stages of memory loss and have poor safety awareness. Ms. Songer explained residents are not intentionally left soiled for long periods of time. Ms. Songer said staff are trained to change a resident immediately if they are found to be incontinent. Ms. Songer reported some residents may require needing to be re-approached to get them to comply with being changed.

Ms. Songer provided me with a copy of the staff schedule for 11/21/22 through 12/4/22 for my review. I observed the schedule was consistent with Ms. Songer’s statements regarding the number of staff on first, second, and third shifts.

On 12/13/22, Ms. Makowski’s statements were consistent with Ms. Songer.

On 12/13/22, SP1’s statements were consistent with Ms. Songer and Ms. Makowski. SP1 reported some staff work harder than others, however resident care needs are met with the amount of staff scheduled.

On 12/13/22, SP2 reported resident care needs are met by the number of staff scheduled, however there is a concern first and second shift are transitioning to having four total care staff persons (including med techs) scheduled rather than five total care staff persons scheduled. SP2 stated this transition just occurred, therefore it is unknown if resident care needs will still be met consistent with their service plans.

On 12/13/22, I attempted to interview Resident A at the facility. I was unable to engage Resident A or any other residents I observed in meaningful conversation as they are all in various stages of memory loss.

I interviewed Relative A1 at the facility. Relative A1 reported there are enough staff at the facility to meet Resident A's care needs. Relative A1 stated the only issue observed is that it takes staff some time to let visitors in the main entrance on the weekends. Relative A1 denied concerns regarding Resident A's care.

On 12/13/22, I observed several residents in the facility's two dining rooms during the lunch meal. I observed the residents were all well-groomed, in clean clothing, and I did not detect any foul odors.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	The interviews with staff, review of the staff schedule, and the interview with Relative A1 revealed there is an adequate and sufficient amount of staff at the facility to meet resident care needs consistent with their service plans.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

I shared the findings of this report with licensee authorized representative Jamie Lopez by telephone on 12/22/22.

IV. RECOMMENDATION

I recommend the status of the license remain unchanged.

Lauren Wohlfert 12/19/2022

Lauren Wohlfert Date
Licensing Staff

Approved By:

Andrea Moore 12/20/2022

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