GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 30, 2023

Lauren Gowman
Grand Pines Assisted Living Center
1410 S. Ferry St.
Grand Haven, MI 49417

RE: License #: AH700299440
Investigation #: 2023A1028018
Grand Pines Assisted Living Center

Dear Mrs. Gowman:

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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
Cell (616) 204-4300

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

I. IDENTIFYING INFORMATION

License #:	AH700299440
Investigation #:	2023A1028018
Complaint Receipt Date:	01/05/2023
Investigation Initiation Date:	01/05/2023
Report Due Date:	03/04/2023
Licensee Name:	Grand Pines Assisted Living LLC
Licensee Address:	950 Taylor Ave. Grand Haven, MI 49417
Licensee Telephone #:	(616) 846-4700
Administrator:	Lauren Gowman
Authorized Representative:	Mandy Moore
Name of Facility:	Grand Pines Assisted Living Center
Facility Address:	1410 S. Ferry St. Grand Haven, MI 49417
Facility Telephone #:	(616) 850-2150
Original Issuance Date:	07/08/2009
License **Status:**	REGULAR
Effective Date:	05/12/2022
Expiration Date:	05/11/2023
Capacity:	177
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A's hospitalization and death were not reported to the department.	Yes
Residents are not receiving adequate care in accordance with service plans.	Yes
The facility continues to be understaffed.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/05/2023	Special Investigation Intake 2023A1028018
01/05/2023	Special Investigation Initiated - Letter
01/05/2023	APS Referral APS referral sent to Centralized Intake.
01/11/2023	Contact - Face to Face Interviewed Admin/Mandy Moore at the facility.
01/11/2023	Contact - Face to Face Interviewed Employee A at the facility.
01/11/2023	Contact - Face to Face Interviewed Employee B at the facility.
01/11/2023	Contact - Face to Face Interviewed Employee C at the facility.
01/11/2023	Contact - Face to Face Interviewed Employee D at the facility.
01/11/2023	Contact - Document Received Received Resident A and Resident B's service plans and records; and staff schedules from Admin/Mandy Moore.

This special investigation will only address violations pertaining to rules and regulations for Homes for the Aged (HFA).

ALLEGATION:

Resident A's hospitalization and death were not reported to the department.

INVESTIGATION:

On 1/5/2022, the Bureau received the allegations anonymously from the online complaint system.

On 1/5/2022, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 1/11/2023, I interviewed the facility administrator, Mandy Moore at the facility who reported she was unaware that Resident A's hospitalization and death was not reported to the department. Ms. Moore reported corrective action was taken with the staff involved to include termination and demotion with corrective action write-ups due to the incidents. Ms. Moore provided me Resident A's record for my review.

On 1/11/2023, I interviewed Employee A who reported the facility failed to report Resident A's recent hospitalization and death to the department. Employee A reported the family was also not notified of Resident A's hospitalization and death until afterwards. Employee A reported corrective action was taken with staff due to the error.

On 1/11/2023, I interviewed Employee B who reported knowledge that the facility should have submitted the report of Resident A's hospitalization and death but did not. Employee B reported corrective action was taken against staff for the error.

On 1/11/2023, I interviewed Employee C and Employee D at the facility whose statements are consistent with Ms. Moore's statements, Employee A's statements, and Employee B's statements.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(1) The home shall complete a report of all reportable incidents, accidents, and elopements. The incident/accident report shall contain all of the following information: **(a) The name of the person or persons involved in the incident/accident.**

	(b) The date, hour, location, and a narrative description of the facts about the incident/accident which indicates its cause, if known. **(c) The effect of the incident/accident on the person who was involved, the extent of the injuries, if known, and if medical treatment was sought from a qualified health care professional.** **(d) Written documentation of the individuals notified of the incident/accident, along with the time and date.** **(e) The corrective measures taken to prevent future incidents/accidents from occurring.**
ANALYSIS:	Interviews and review of departmental facility file reveal no incident report was submitted by the facility to the department concerning Resident A's hospitalization on 10/19/2022 and subsequent death on 10/19/2022. The facility also failed to notify Resident A's family about Resident A's hospitalization until after Resident A passed in the hospital.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents are not receiving adequate care in accordance with service plans.

INVESTIGATION:

On 1/11/2023, Ms. Moore reported she has received reports from staff that other staff are not completing care routines in accordance with resident service plans. Ms. Moore reported those staff were provided re-education and extra training to ensure care. Ms. Moore reported there is continual training ongoing due to the recent staff turnover and because a lot of the staff are new.

On 1/11/2023, Employee A reported knowledge of a staff member not performing care routines in accordance with the service plans and this staff member was recently terminated. Employee A reported no knowledge of any staff member not completing a care routine but marking it as completed. Employee A reported that would not be tolerated at the facility. Employee A reported there is a lot of new staff with continual training ongoing.

On 1/11/2023, Employee B reported knowledge of "an agency staff member marking cares complete when they were not completed at all". Employee B reported that agency staff member was not allowed to return to the facility. Employee B reported a lot of new staff are being trained and still learning and some of the new staff are still

not completing care routines as trained. Employee B reported it is happening on all shifts.

On 1/11/2023, Employee C reported knowledge of current staff not completing care routines in accordance with service plans, despite training. Employee C reported there have been times recently when new staff member(s) marked a care routine as completed in the computer system, but it was not. Employee C reported it has been brought to management's attention, but this behavior is still continuing. Employee C reported it is happening on all shifts.

On 1/11/2023, Employee D's statements were consistent with Employee B's statements and Employee C's statements.

On 1/11/2023, I completed an on-site inspection of the facility and observed a care staff member assisting/re-training another care staff member to re-do and complete a care routine because the care routine was initially completed incorrectly for the resident.

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 and on-site inspection with observation reveal there is evidence that staff are not completing care in accordance with resident service plans; and that there is a lack of appropriate carry over of training and skill with the newly trained staff resulting in resident routines being completed inappropriately or incorrectly.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility continues to be understaffed.

INVESTIGATION:

On 1/11/2023, Ms. Moore reported the facility was struggling with staffing when she came on-board in mid-December 2022, but it is improving. Ms. Moore reported there are three shifts with seven to eight care staff scheduled on first and second shifts;

and at least six care staff scheduled for third shift. Ms. Moore reported the facility was short staffed at Christmas from call-ins due to the blizzard, but current staffing ratios is “comfortable”. Ms. Moore reported agency, on-call staff, and supervisors assist to fill in any shift vacancies. Ms. Moore reported the facility is consistently hiring as well. Ms. Moore provided me a copy of the working staff schedules for my review.

On 1/11/2023, Employee A reported the facility staffing has improved recently, but the facility was short staffed on Christmas due to the blizzard. Employee A reported call-ins are still occurring, but agency staff and on-call staff is utilized. Supervisors assist as well to help prevent short shifts.

On 1/11/2023, Employee B reported the facility is short staffed at times still even though it is improving. Employee B reported there are seven to eight care staff scheduled on first and second shifts; and at least six care staff scheduled for third shift. Employee B reported agency is being used again to help prevent short shifts and on-call staff is used as well. Employee B reported certain supervisors will stay assist to fill in to prevent a short shift, but not all stay.

On 1/11/2023, Employee C reported the facility continues to be short staffed despite showing signs of improving. Employee C reported agency staff and on-call staff are utilized when there is a call-in, but call-ins are ongoing. Employee C reported some supervisors do stay and help to prevent short shifts, but “sometimes that is still not enough help because the on-call staff or agency staff don’t show up.”

On 1/11/2023, Employee D’s statements were consistent with Employee B’s statements and Employee C’s statements.

On 1/11/2023, I completed an on-site inspection due to this special investigation.

On 1/19/2023, I reviewed the working staff schedules from November 1, 2022 to January 11, 2023 which revealed:

- There were 81 call-ins in November 2022 across all shifts and all facility departments; with 13 of the call-ins being tardy or left early; and 4 of the call-ins were FMLA leave.
- There were 253 total call-ins in December 2022 across all shifts and all facility departments; with 19 of the call-ins being tardy or left early; and 8 of the call-ins were bereavement and/or FMLA leave.
- No call-ins list was provided for January 2023, so it is undetermined if any call-ins occurred and/or how many call-in may have occurred up until January 11, 2023.
- Review of the staffing schedules provided do not reflect which staff were on-call staff and which staff are agency staff. The staffing schedules reflect the days and times the staff are scheduled to work.
- The staffing schedules demonstrate some supervisors splitting shifts to assist with supervisor shift coverage and med tech shift coverage on 115/2022,

11/18/2022, 11/19/2022, 11/22/2022, 11/23/2022, 12/2/2022, 12/4/2022, 12/5/2022, and 12/24/2022.

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:	Interviews, on-site inspection, and review of staff schedules reveal the facility was significantly short staffed in December 2022 due to 253 call-ins. There were not enough adequate staff coverage to provide appropriate and timely resident care in accordance with service plans.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 1/11/2023, I received Resident A's record notes from Ms. Moore. Upon review of the record notes, the following was noted:

- Resident A complained of anxiety to facility staff on 10/18/2022 at 9:45pm. Resident A requested and received *PRN anxiety medication after supper and then called staff later saying it did not help and [they] feel worse.*
- Resident A called staff again later and asked to be sent to the hospital. Staff took vitals instead and did not send Resident A to hospital, despite Resident A's request. Vitals documented at 9:45pm were BP: 143/80; Temperature - 99; 115 Heart rate. No documentation recorded for O2 level.
- At 1:30am on 10/19/2022, Resident A reports shortness of breath to staff.
- At 5:15am on 10/19/2022 Resident A called a friend to have the friend call emergency services due to continued shortness of breath and staff not sending Resident A despite [their] request. It is documented that prior to emergency services being called and arriving, staff responded Resident A's call light with Resident A complaining of shortness of breath. Staff took Resident A's O2 level and it was 90%. Staff again administered another PRN anxiety medication with emergency services arriving shortly after.
- Staff documented the following: *No assessment for injuries, or ROM was performed due to EMS being on scene. No vitals were obtained due to EMS*

on scene. No intervention is needed at this time due to no fall, no injury, no decline in cognitive status.

- At 5:30pm on 10/19/2022, Resident A's family arrived at the facility and reported *[Resident A] passed away at 10am due to acute respiratory failure related to heart disease.*

On 1/11/2023, I received Resident B's record notes from Ms. Moore and upon review the following was noted:

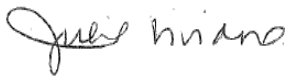
- Resident B incurred a fall on 11/19/2022 at 9:30pm when a staff member was transferring Resident B to the toilet using the sit to stand. The shift supervisor was called to assess for injuries observed no injuries and reported Resident B denied any increased pain. Resident was assisted off floor and vitals were taken and within normal limits.
- On 11/20/2022 at 10:15am, staff were assisted Resident B in getting up for the day and observed skin tears to left wrist and forearm and Resident B complained of pain. The shift supervisor was called to assess injuries and Resident B explained [they] fell the night before. The shift supervisor called Resident B's physician and Resident B was sent to the hospital for further evaluation.
- Resident B returned to the facility later on 11/20/2022 with a diagnosis of fracture to the left arm/wrist and treatment for skin tears.
- The facility terminated the staff member who transferred Resident B using only one person assist and provided re-education to the second shift supervisor for completing a proper assessment.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(1) A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization, which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff.

	Patients or residents shall be treated in accordance with the policy.
For Reference: MCL 333.20201	**(2) (e) A patient or resident is entitled to receive adequate and appropriate care, and to receive from the appropriate individual within the health facility or agency, information about his or her medical condition, proposed course of treatment, and prospects for recovery, in terms that the patient or resident can understand, unless medically contraindicated as documented by the attending physician in the medical record.**
ANALYSIS:	Resident A complained of shortness of breath multiple times to staff and requested to go to the hospital. Staff did not send Resident A to the hospital as requested resulting in Resident A calling a friend to call emergency services to the facility for help. Staff took Resident A's vitals, but the vitals were incomplete because it cannot be determined if Resident A's O2 level was ever obtained on 10/18/2023, as it was not documented. Resident A passed away the next morning at the hospital due acute respiratory failure related to heart disease. Resident B was transferred inappropriately and fell on 11/19/2022 but was not sent to the hospital for further evaluation due to the second shift supervisor's failure to assess Resident B appropriately. Resident B sustained a left arm/wrist fracture, increased pain, and multiple skin tears from the fall. While the facility took corrective action and terminated the staff member who completed the transfer inappropriately and provided re-education to second shift supervisor for assessing inappropriately, staff did not provide adequate and appropriate care for Resident B in timely manner. In both incidents, the facility did not comply with ensuring Resident A and Resident B were provided with adequate, timely, and appropriate care which resulted in significant injuries for both residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, I recommend that the license remain unchanged.



1/20/2023

Julie Viviano Date
Licensing Staff

Approved By:

01/27/2023

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