GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 7, 2023

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

RE: License #: AH700299440
Investigation #: 2023A1021062
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 authorized representative 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

I. IDENTIFYING INFORMATION

License #:	AH700299440
Investigation #:	2023A1021062
Complaint Receipt Date:	05/23/2023
Investigation Initiation Date:	05/24/2023
Report Due Date:	07/22/2023
Licensee Name:	Grand Pines Assisted Living LLC
Licensee Address:	950 Taylor Ave. Grand Haven, MI 49417
Licensee Telephone #:	(616) 846-4700
Administrator:	Amanda Moore
Authorized Representative:	Lauren Gowman
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:	05/12/2023
Expiration Date:	05/11/2024
Capacity:	177
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Facility failed to provide medical attention to Resident A.	No
Resident A's Guardian unaware of service plan.	Yes
Facility has insufficient staff.	No
Additional Findings	No

III. METHODOLOGY

05/23/2023	Special Investigation Intake 2023A1021062
05/24/2023	Special Investigation Initiated - Telephone interviewed complainant
05/24/2023	APS Referral referral sent to centralized intake at APS
05/25/2023	Inspection Completed On-site
06/07/2023	Exit Conference

The complainant identified some concerns that were not related to home for the aged licensing rules and statutes. Therefore, only specific items pertaining to homes for the aged provisions of care were considered for investigation. The following items were those that could be considered under the scope of licensing.

ALLEGATION:

Facility failed to provide medical attention to Resident A.

INVESTIGATION:

On 05/23/2023, the licensing department received a complaint with allegations the facility failed to provide medical attention to Resident A. The complainant alleged on 02/16/2023, Resident A fell at the facility. The complainant alleged that Resident A was sent to the emergency room after the fall but that it took multiple days to get a

mobile x-ray completed at the facility and for the family to be updated on Resident A's condition.

On 05/25/2023, I interviewed administrator Amanda Moore at the facility. Ms. Moore reported Resident A had an unwitnessed fall at the facility on 02/16/2023. Ms. Moore reported Resident A was immediately sent to the local emergency room for an evaluation. Ms. Moore reported caregivers told the paramedics that Resident A was complaining of wrist pain. Ms. Moore reported the facility does not send facility caregivers to the emergency room with the residents as the caregivers cannot leave the facility. Ms. Moore reported Resident A returned to the facility with no new orders. Ms. Moore reported the emergency room did CT of head and neck but imaging on the wrist was not completed. Ms. Moore reported Resident A's physician ordered a mobile X-Ray on 02/17/2023 and it was completed on 02/18/2023. Ms. Moore reported there was some miscommunication on the results of the X-Ray but that on 02/18/2023 Resident A was sent back to the emergency room to get a cast on the wrist. Ms. Moore reported the facility ensured Resident A received timely medical attention and informed Resident A's DPOA of Resident A's medical updates.

On 05/25/2023, I interviewed staff person 1 (SP1) at the facility. SP1 reported she was the shift supervisor on duty when Resident A fell. SP1 reported she was alerted that Resident A fell and she observed Resident A on the floor. SP1 reported Resident A had face injuries and was complaining of wrist pain. SP1 reported Resident A was sent to the emergency room for an evaluation and returned later that day. SP1 reported caregivers told the paramedics to evaluate the wrist. SP1 reported the hospital did not complete an X-Ray on the wrist but that Resident A received an X-Ray at the facility. SP1 reported the facility ensured Resident A had a splint on her arm after the fracture was identified and that Resident A received timely medical attention.

On 05/25/2023, I interviewed SP2 at the facility. SP2 reported she was the caregiver in the unit when Resident A fell. SP2 reported Resident A was sitting in the chair and she told Resident A that it was almost lunch time and she walked away to get another resident ready for lunch. SP2 reported she was gone approximately two minutes and when she came back Resident A was on the floor. SP2 reported she believes Resident A tripped on her purse. SP2 reported Resident A was sent out to the emergency room and returned later that day. SP2 reported the facility ensured Resident A had appropriate and timely medical attention.

I reviewed facility observation notes for Resident A. The notes read,

> *"02/16/2023: Around 11:40am RSA called a code white to the I hall in the Courtyard community. Resident (A) resides in I2 apartment in the Courtyard community. (SP2) observed the resident sitting on the floor in the I hall common area in front of the couch. There was blood to the right of the resident on the carpet. Resident had a bloody nose, and mouth, and a swollen, bruising right*

arm/wrist with a red mark on the right side of her face. Resident stated her right arm hurt. Resident stated she doesn't know what happened. Resident walks independently. Intervention for this incident is new shoes, current shoes have worn out soles. Resident's family was contacted to get resident a new pair of shoes. Resident was wearing her shoes. Resident's family was notified. Resident was transferred to NOCH ER.
02/16/2023: Resident retuned from ER around 3:20pm. She returned with no hospital discharge paperwork. Trinity Grand Haven was called at approximately 3:45pm and requested discharge information to be sent to Grand Pines.
02/16/2023: Shelli Endline, (Resident A's PCP) was notified the resident was sent to the ED. She has ordered an X-Ray for the R arm and other orders are coming.
02/17/2023: Resident has increased bruising and swelling on the right side of her face relating to her fall on 2/16/23. She has no complaints of pain and says "I feel fine."
02/17/2023: We received a new order for Afrin 0.005% nasal spray: spray 2 sprays into affected nostril q12 hours PRN for nasal bleeding. The order was faxed from hometown and a message was left for her DPOA.
02/17/2023: The resident is very bruised from her recent fall. She is moving quite slowly and is having difficulty with her R arm. We currently waiting for an X-Ray of this arm. While the resident is not able to clearly articulate her pain level verbally, nonverbal cues indicate that she is in some discomfort.
02/17/2023: The Resident was unable to clearly verbalize pain level so nonverbal cues were used to determine that she would benefit from PRN Tylenol. Upon follow up, the resident seems to be less tense and more comfortable.
02/17/2023: Called Lynn with Trident Care and scheduled X-rays of resident's right wrist and forearm due to a fall with pain and swelling.
02/17/2023: The resident has had some relief from taking the Tylenol but still shows some facial expressions when she touches her arm.
02/17/2023: Mobile X was here and was able to complete an x-ray of the right arm and right forearm. Results conclusion with fractured wrist. Faxed to PCP.
02/18/2023: Pain and swelling to RT wrist due to fall, Pain and swelling of right forearm from fall Wrist AO and LAT, Right Results: No comparison study is available. Acute comminuted, impacted distal radius fracture and mildly displaced ulnar styloid process fracture area seen. The bones appear diffusely demineralized. Soft tissue swelling noted. Conclusion: fractured wrist.
02/18/2023: Resident's (DPOA) notified of resident's right wrist fracture.
02/18/2023: Spoke with Bailey at the careline group, Shelli Endline (Resident A's PCP) this morning regarding resident's right wrist fracture. Bailey stated her apologies for the discrepancies between the 2 X-rays obtained yesterday for the resident. Bailey ordered to keep resident's arm stable with a pillow. Around 1:00pm Bailey called back and stated Dr wants resident sent back out to ER today to get her right arm in a cast.
02/18/2023: Resident's (DPOA) was notified of resident going out to NOCH ER to get her Right wrist in cast. (DPOA) would like a phone call when resident returns.

02/19/2023: Discharge Instructions: wear the splint and sling as directed. Elevate the wrist to help with swelling. You can also use ice on the wrist to help with swelling. You will need to contact Dr. Palmer's office on Monday to follow up for the facial bone and nasal nose fractures. You will also need to follow up with Dr. Baszler, contact their office on Monday to make an appointment for wrist fracture. Return with new or worsening symptoms.
02/2/2023: The resident is doing well since her recent fall. She took off her splint, but staff put it back on her as best as we could. Her bruises look to be progressing and she has less edema in her wrist and face. The resident's pain level also seems to be less."

I reviewed incident report completed for Resident A's fall. The narrative of the report read,

"Around 11:40am RSA called a code white to the I hall Courtyard community. Resident (A) resides in I2 apartment in the Courtyard community. (SP2) observed the resident sitting on the floor in the I hall common area in front of the couch. There was blood to the right of the resident on the carpet. Resident had a bloody nose, and mouth, and a swollen, bruising right/arm wrist with a red mark on the right side of her face. Resident stated her right arm hurt. Resident stated she doesn't know what happened. Resident walks independently. Intervention for this incident is new shoes, current shoes have worn-out soles. Resident's family was contacted to get resident a new pair of shoes. Resident was wearing her shoes. Resident's family was notified. Resident was transferred to NOCH ER."

I reviewed emergency room paperwork for Resident A. The paperwork stated,

"Physical she will this was a mechanical fall versus a syncopial episode as the patient was found down and this was unwitnessed and she cannot provide history she is an unreliable historian. In speaking with Grand Pines it does sound like she has baseline mentation. I do not appreciate any gross focal neurological deficits on exam. Although patient denies any pain with cervical spine palpation given her mental states a CT of the C-spine was obtained. Additionally CT of facial bones and head were obtained. I did obtain baseline labs and EKG. I did order a tetanus for her. Patient's workup here is as normal labs and EKG. Her CT findings are discussed in detail, most notable for maxillary sinus and nasal bone fractures bilaterally, right greater than left. Patient has no evidence of entrapment on exam. She will be referred to ENT for follow-up. I did write the discharge paperwork to contact Dr. Palmer's office tomorrow for follow up appointment in regards to the facial bones and nasal bones fractures. She will be placed on Augmentin and encouraged not to blow her nose. Also use ice to help with swelling. Patient was ambulated here with no difficulty. She will be discharged back to Grand Pines. If worsening symptoms to return here."

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.**
For Reference: R 325.1901	**Definitions.**
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	Interviews conducted and review of documentation revealed Resident A had an unwitnessed fall on 02/16/2023 and was sent to the emergency room for an evaluation. The emergency room failed to evaluate Resident A's wrist for injury, the facility coordinated with Resident A's PCP for mobile X-Ray which was completed on 02/17/2023, and results were obtained on 02/18/2023. Resident A was taken to emergency room on 02/18/2023 for wrist splint. Resident A's DPOA was notified of changes and updates to Resident A's condition. There is lack of evidence to support the allegation that Resident A was not provided medical attention.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's Guardian unaware of service plan.

INVESTIGATION:

The complainant alleged that the facility did not update Resident A's guardian on the service plan.

Ms. Moore reported at minimum the facility updates the service plan yearly. Ms. Moore reported Resident A's first annual assessment was completed on 01/29/2022 and another one was completed on 02/24/2023. Ms. Moore reported the *Care/Service Plan Participated* was signed by Resident A's DPOA on 01/29/2022. Ms. Moore reported no documentation of DPOA's participated in the service plan changes for the year 2023.

I reviewed *Care/Service Plan Participation* for Resident A. The document read,

> *"AT MOVE IN participation in plan development is a legal requirement of our licensing rules. Licensing Rules for Homes for the Aged R 325.1922 (2) (c) "That the individual seeking admission and his or her authorized representative, if any, shall participate in the development of the individual's service plan.*
> *Verbal Consent by: (Resident A's DPOA) 01/29/2022."*

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:	The facility could not demonstrate that Resident A's DPOA participated in the annual review of Resident A's service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Facility has insufficient staff.

INVESTIGATION:

The complainant alleged that the facility is understaffed and overworked. The complainant alleged that visitors must request access to the unit and must request access to leave the unit.

Ms. Moore reported staffing has improved at the facility. Ms. Moore reported as of 04/15/2023, the facility is no longer using agency staff for staff shortages. Ms. Moore reported for the Courtyard memory care unit, for first and second shift the facility always has two staff people in the unit but will try to schedule three. Ms. Moore reported for third shift there is always one staff member in the unit but usually there are two. Ms. Moore reported if there is only one staff member scheduled, the shift

supervisor and the float worker assist in the unit. Ms. Moore reported the staff communicate between each other using walkie-talkies. Ms. Moore reported typically the staff members do not leave the unit to work in the assisted living. Ms. Moore reported the facility is a locked unit to keep the residents safe due to the cognitive impairments of the residents and that visitors must request access to enter and to exit the building. Ms. Moore reported the facility does not have a mandation policy, but the facility asks employees to fill in during staff shortages. Ms. Moore reported if there a shift shortage, the shift supervisor is required to find replacement worker such as utilizing the on-call workers. Ms. Moore reported if the shift supervisor is unable to find coverage, the supervisor will work the floor. Ms. Moore reported management can always work, if needed. Ms. Moore reported the facility is not hiring for the memory care units. Ms. Moore reported the caregivers in the memory care unit can be responsible for serving food, light housekeeping, and some laundry. Ms. Moore reported there are 14 residents in the Courtyard unit. Ms. Moore reported there is one resident that uses a Hoyer lift, one resident that is a two person assist, one resident on oxygen, one resident with a catheter, and one resident that requires 1:1 feed. Ms. Moore reported there is significant staff to meet the needs of the residents.

On 05/25/2023, I interviewed SP4 at the facility. SP4 reported the facility is usually fully staffed. SP4 reported she always works with two other people. SP4 reported residents receive good care and their needs are met. SP4 reported she has no concerns with staffing levels.

SP3 reported the employees work together to ensure the needs of the residents are met. SP3 reported there is always three workers in the unit. SP3 reported residents need are met. SP3 reported no concerns with staffing levels at the facility.

On 05/25/2023, I interviewed SP4 at the facility. SP4 reported sometimes the unit has culinary staff assigned to serve and assist with meal service. SP4 reported when there is no culinary staff assigned, it can be difficult to meet the needs of the residents during meal service.

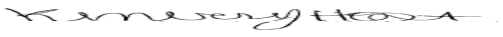
I reviewed the staff schedule for 05/16/2023-05/25/2023. There were employees that called off for their shift in the Courtyard unit. However, the facility found replacement staff to work the shift. Review of the staff schedules revealed the facility is operating at their desired staffing levels as described by Ms. Moore.

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:	Review of schedules and attestations from staff revealed the facility is operating at their desired staffing level. Employees reported they are fully meeting the needs of the residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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



06/06/2023

_____

Kimberly Horst Date
Licensing Staff

Approved By:

06/06/2023

_____

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