GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 6, 2023

Carol Del Raso
Grandhaven Living Center LLC
Suite 200
3196 Kraft Avenue SE
Grand Rapids, MI 49512

RE: License #: AL330267336
Investigation #: 2023A1033050
Grandhaven Living Center 1 (Lighthouse)

Dear Ms. Del Raso:

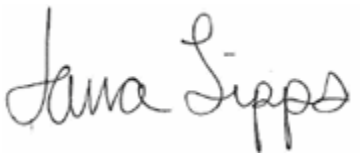
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Jana Lipps, 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 #:	AL330267336
Investigation #:	2023A1033050
Complaint Receipt Date:	06/12/2023
Investigation Initiation Date:	06/13/2023
Report Due Date:	08/11/2023
Licensee Name:	Grandhaven Living Center LLC
Licensee Address:	Suite 200 3196 Kraft Avenue SE Grand Rapids, MI 49512
Licensee Telephone #:	(517) 420-3898
Administrator:	Carol Del Raso
Licensee Designee:	Carol Del Raso
Name of Facility:	Grandhaven Living Center 1 (Lighthouse)
Facility Address:	3135 W. Mount Hope Avenue Lansing, MI 48911
Facility Telephone #:	(517) 485-5966
Original Issuance Date:	07/15/2004
License Status:	REGULAR
Effective Date:	05/14/2023
Expiration Date:	05/13/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
On 6/8/23 around 10pm, Resident A fell in her bedroom. She was not found by direct care staff until 6/9/23 around 7am, despite efforts to use her call button and verbally call out for assistance.	Yes

III. METHODOLOGY

06/12/2023	Special Investigation Intake 2023A1033050
06/13/2023	Special Investigation Initiated – Telephone call made. Interview with Complainant, via telephone.
06/13/2023	Contact - Telephone call made. Interview with Citizen 1, via telephone.
06/21/2023	Inspection Completed On-site- Interview with Executive Director, Marie Jonzun, direct care staff, Susan Kuzmanov, and Resident A. Review of Resident A's resident record initiated.
06/21/2023	Contact - Telephone call made. Interview with direct care staff, Jasmine Ward, via telephone.
06/21/2023	Inspection Completed-BCAL Sub. Compliance
06/21/2023	APS Referral made per protocol.
07/10/2023	Exit Conference Conducted via telephone. Voicemail message left for licensee designee, Carol Del Raso.

ALLEGATION:

On 6/8/23 around 10pm, Resident A fell in her bedroom. She was not found by direct care staff until 6/9/23 around 7am, despite efforts to use her call button and verbally call out for assistance.

INVESTIGATION:

On 6/13/23 I received an online complaint regarding the Grandhaven Living Center 1 (Lighthouse) adult foster care facility (the facility). The complaint alleged that on 6/8/23 around 10pm, Resident A fell in her bedroom. She was not found by direct

care staff until 6/9/23 around 7am, despite efforts to use her call button and verbally call out for assistance. On 6/13/23 I interviewed Complainant via telephone. Complainant reported Citizen 1, had more detailed information regarding the incident.

On 6/13/23 I interviewed Citizen 1, via telephone. She reported that she received a phone call the morning of 6/09/23 that Resident A had a fall at the facility and was being sent to Sparrow Hospital for evaluation. Citizen 1 reported that when she arrived at the hospital, Resident A was wearing her call button which uses at the facility. Citizen 1 stated Resident A reported the evening of 6/8/23 she had been coming back into her bedroom with her electric scooter when Resident A tried to transfer herself to her chair and was unsure what transpired, but the next thing she knew she was on the floor. Citizen 1 reported Resident A claimed she pushed her call button over 100 times and there was not a response to these calls. Citizen 1 also reported Resident A stated that she had verbally called out for help for hours and no one came to her assistance. Citizen 1 reported that she went to the facility the morning of 6/10/23 and observed Resident A's bedroom. She reported that there was a stain on the carpet, where Resident A had laid, when she fell, and must have been incontinent. Citizen 1 reported Resident A's phone was found in her bathroom by the sink and that her bed did not appear to have been slept in as it was still made. She reported that she had a conversation with the facility Wellness Director, Buffy Torok, and the Executive Director, Marie Jonzun, regarding Resident A's fall. Citizen 1 reported that neither Ms. Torok nor Ms. Jonzun appeared to be aware of the length of time Resident A had been on the floor after the fall occurred. Citizen 1 reported Resident A stated she had fallen between 9:30pm and 10pm on 6/8/23 and was not found until around 7am on 6/9/23. Citizen 1 reported that Ms. Jonzun and Ms. Torok noted they would check the call system for the resident call buttons to see if Resident A had tried to call for help with this device. Citizen 1 reported that it was discovered on 6/11/23 that Resident A's call button was not working properly, and she was issued a new call button.

On 6/21/23 I completed an on-site investigation at the facility. I interviewed Resident A. Resident A reported she did recall the recent fall she had in her bedroom but could not recall the exact date of the fall. She reported she fell in the evening around 9:30pm and was not found until the next morning around 7am. She reported she had to lay on the ground the entire night and no direct care staff members came into her bedroom to check on her status this entire time. She reported she had been wearing her call button and she had pushed the button "150 times" with no response. She reported she was unaware if direct care staff ever come into her bedroom, at night, to check on her needs. She reported it was discovered that her call button was broken, and she was issued a new call button. Resident A reported that having a new call button does not make her feel safer at the facility since the direct care staff take so long to respond to call buttons on a regular basis.

During on-site investigation on 6/21/23 I interviewed Ms. Jonzun. Ms. Jonzun reported that she was not in the facility the date and time that Resident A

experienced the fall in her bedroom. She reported that this information was reported to her from direct care staff, Susan Kuzmanov, and Ms. Torok. Ms. Jonzun provided a copy of the direct care staff schedule for the dates 6/8/23 and 6/9/23 for review. She reported that direct care staff, Jasmine Ward, worked from 1045pm – 6:45am (6/8/23-6/9/23), and Ms. Kuzmanov relieved Ms. Ward on 6/9/23 to work the 6:30am to 3pm shift. Ms. Jonzun reported that Ms. Kuzmanov found Resident A lying on the floor of her bedroom around 6:55am on 6/9/23. She further reported that Resident A was sent to Sparrow Hospital for evaluation. Ms. Jonzun reported when Resident A returned from the hospital, Ms. Jonzun had a conversation with Resident A and Citizen 1 regarding the incident. Ms. Jonzun reported that at this time she was informed Resident A had reported she had been on the floor of her bedroom the entire evening from around 9:30pm to 7am the next morning. Ms. Jonzun reported that the expectation of third shift (10:45pm to 6:45am) direct care staff is that they check on residents and walk the halls listening for residents who may need assistance. She reported they have a call button system, called *Inform*, which connects the call buttons to the facility Smart Phones. She reported she checked the *Inform* system to see if Resident A had pushed her call button to receive assistance and noted that the *Inform* system had no logged attempts from Resident A's device during the time period from 6/8/23 around 9:30p to 6/9/23 around 7am. Ms. Jonzun reported she did replace Resident A's call button as they felt it could be damaged and this was why the device was not registering any attempts made by Resident A to receive assistance. Ms. Jonzun reported she spoke with Ms. Ward about the incident and Ms. Ward reported she walked the halls of the facility throughout her shift and did not hear any verbal cries for help from Resident A and did not receive any call light notifications. Ms. Jonzun reported Ms. Ward did not directly open Resident A's bedroom door to make a visual check on her status during this time. Ms. Jonzun reported that unless a resident has "hourly checks" identified in their *Service Plan* document then the direct care staff rely on the resident to use their call button to reach out for assistance. Ms. Jonzun reported she reviewed Resident A's daily chart notes from 6/8/23 to 6/9/23 and found one notation, from Ms. Kuzmanov, reporting finding Resident A on the floor of her bedroom.

During on-site investigation on 6/21/23 I interviewed Ms. Kuzmanov. Ms. Kuzmanov reported that she arrived for her scheduled shift on 6/9/23 and began conducting her morning rounds to resident bedrooms. She reported that she first stopped at Resident A's bedroom and found her on the floor by her chair at 6:55am. She reported Resident A appeared to be sleeping on the floor and was easily roused. She reported Resident A stated, "Where have you been?" "I've been on the floor all night!" "I was yelling for help!" She further reported Resident A had been able to pull a cushion from her wheelchair to use as a pillow and a blanket from her chair to cover herself. Ms. Kuzmanov reported Resident A been incontinent of urine during the time she had been on the floor. She reported Resident A was found laying on her right side and the right side of her face was swollen, and red. Ms. Kuzmanov further reported that Resident A's call button, which she wears around her neck, had been stuck underneath her body. She reported that it appeared to have been like this for a long period of time and was not accessible to Resident A. Ms. Kuzmanov

reported that it made sense to her that there were no call lights going off from Resident A pushing her call button as she was not able to reach her call button in the position she was laying. Ms. Kuzmanov reported Resident A was scheduled to have at least two supervision checks throughout the night to monitor her needs. She reported that these checks are documented on the *Medication Administration Record* (MAR). Ms. Kuzmanov reported that from the best of her knowledge it appeared Resident A had been on the floor for a prolonged period due to the position she was found in and her physical condition of having been incontinent and having redness and swelling in her face due to how she was laying.

On 6/21/23 I interviewed Ms. Ward via telephone. Ms. Ward reported that she had been working 10:45pm to 6:45am the evening of 6/8/23 to 6/9/23. She reported that she went to check on Resident A for her morning rounds, around 7am, and Resident A was laying on the floor of her bedroom. She further reported that it appeared Resident A had been trying to go to the bathroom and had fallen. Ms. Ward reported that she did not receive any call light notifications for Resident A during this shift. Ms. Ward reported that she had done two checks on Resident A during her shift, the last check being at 5am on 6/9/23 and Resident A was in bed sleeping.

During on-site investigation on 6/21/23 I reviewed the June 2023 MAR for Resident A. On page 5 of this printed MAR is a section titled, “Supervision Monitoring – Baseline”, which states, “Observe location of resident. Document location in note.” The following times are listed below this notation for direct care staff to initial that they have checked on Resident A’s status:

- 2:00 AM
- 6:30 AM
- 12:00 PM
- 3:00 PM
- 5:00 PM
- 10:45 PM

On 6/9/23 Ms. Ward’s initials for checking on Resident A were entered for 2:00 AM and 6:30 AM. On 6/10/23 Ms. Ward’s initials for checking on Resident A were entered for 2:00 AM and 6:30 AM. Resident A was reported to have been taken to Sparrow Hospital on 6/9/23 and did not return to the facility until 6/10/23 in the evening hours. When observing this MAR there were no documentations of resident location as indicated on the MAR to document this information.

During on-site investigation on 6/21/23 I reviewed the document, *AFC Licensing Division – Incident/Accident Report* (IR), for Resident A, dated 6/9/23. This IR was signed by Licensee Designee, Carol Del Raso, and Ms. Jonzun. The IR was completed by Ms. Kuzmanov. Under section, *Explain What Happened/Describe Injury*, it notes, “Resident was observed on the floor of her apartment at 6:55am, lying on her right side.” Under section, *Action Taken by Staff/Treatment Given*, it reads, “Staff contacted Molly Baliley (resident’s NP), Buffy Torok (Grandhaven Wellness Director), called 911.” Under section, *Corrective Measures Taken to*

Remedy and/or Prevent Recurrence, “Resident went to Sparrow hospital via Molly Vaily, NP. Will follow up upon return.”

During on-site investigation on 6/21/23 I reviewed the document, *Resident Negotiated Service Plan Without Schedule (*Service Plan*)*, for Resident A, dated 9/20/22. On page 2 of this document, under section, Supervision Monitoring Frequency, it reads, “Requires hourly supervision monitoring. Knock before entering apartment.” I discussed this document with Ms. Jonzun. Ms. Jonzun was not aware that this directive was written in Resident A's Service Plan. Ms. Jonzun reviewed Resident A’s record and did not find any modifications/updates to this document that would make this Service Plan obsolete.

During on-site investigation on 6/21/23 I reviewed the document, *Resident Evaluation for [Resident A], Grandhaven Living Center*, dated 9/20/22. On page 2 of this document, under section, *Supervision Monitoring Frequency*, it states, “Requires hourly supervision monitoring. Knock before entering apartment.”

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based upon interviews with Citizen 1, Resident A, Ms. Jonzun, Ms. Kuzmanov, & Ms. Ward, as well as review of Resident A’s resident record, it can be determined that the direct care staff have not been providing supervision and protection to Resident A as defined in her assessment plan/Resident Evaluation/Service Plan. Upon review of these documents, it was highlighted that Resident A is to receive hourly supervision monitoring, which has not been documented and direct care staff have reported has not been initiated. Ms. Jonzun reported not being aware of this written directive in Resident A’s Service Plan. If Resident A had received hourly supervision monitoring from direct care staff, it would have been identified in a timelier manner that she had fallen and required the assistance of direct care staff members.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the status of the license recommended at this time.

06/22/23

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Jana Lipps Date
Licensing Consultant

Approved By:

07/06/2023

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Dawn N. Timm Date
Area Manager