GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 31, 2023

AH Holland Subtenant LLC
6755 Telegraph Rd Ste 330
Bloomfield Hills, MI 48301

RE: License #: AL700397726
Investigation #: 2023A0350028
AHSL Holland Bay Pointe

Dear Mechelle Genigeski:

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 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 (616) 356-0100.

Sincerely,

Ian Tschirhart, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 644-9526

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL700397726
Investigation #:	2023A0350028
Complaint Receipt Date:	07/17/2023
Investigation Initiation Date:	07/18/2023
Report Due Date:	08/16/2023
Licensee Name:	AH Holland Subtenant LLC
Licensee Address:	One SeaGate, Suite 1500 Toledo, OH 43604
Licensee Telephone #:	(616) 283-9221
Administrator:	Mechelle Genigeski
Licensee Designee:	Mechelle Genigeski
Name of Facility:	AHSL Holland Bay Pointe
Facility Address:	11899 James Street Holland, MI 49423
Facility Telephone #:	(616) 393-2174
Original Issuance Date:	04/08/2019
License Status:	REGULAR
Effective Date:	10/08/2021
Expiration Date:	10/07/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Some staff members have not been fully trained.	No
There are not always enough staff members working to meet the needs of the residents.	Yes
Resident A has unexplained bruises on her hands and wrists.	No

III. METHODOLOGY

07/17/2023	Special Investigation Intake 2023A0350028
07/18/2023	Special Investigation Initiated - On Site I met with Shawn Scott, Wellness Direcrtor, and Mechelle Genigeski, Executive Director, and interviewed staff
07/19/2023	Contact - Telephone call made spoke with Jabria Warren, Resident Assistant
07/19/2023	Contact - Telephone call made spoke with Rosenda Garcia, Resident Assistant
07/19/2023	Contact - Telephone call made spoke with Raul Robles, Resident Assistant
07/19/2023	Contact - Document Sent I sent an email to Ms. Genigeski requesting documents
07/19/2023	Contact – Document received I received an email from Ms. Genigeski with the requested documents
07/20/2023	Contact – Document sent I sent another email to Ms. Genigeski requesting further information
07/21/2023	Contact – Document received I received an email from Ms. Genigeski
07/21/2023	Contact – Document sent I sent another email to Ms. Genigeski requesting documentation of staff trainings

07/21/2023	Contact – Document received I received an email from Ms. Genigeski with documents attached
07/21/2023	Contact – Telephone call made I spoke with Julie Marks, Resident Assistant
07/26/2023	Contact – Document received I received an email from Ms. Genigeski with training documents attached
07/27/2023	APS referral made
07/28/2023	Exit conference – Held with Mechelle Genigeski, Licensee Designee

ALLEGATION: Some staff members have not been fully trained.

INVESTIGATION: On 07/18/2023, I made an onsite inspection and met with Shawn Scott, Wellness Director, and Mechelle Genigeski, Executive Director. I spoke with Ms. Scott and Ms. Genigeski regarding the allegation that there are some staff members providing care for residents who have not been fully trained. Ms. Genigeski informed me that there is a list of trainings each new employee must complete, which are checked off as they complete them. Some of the trainings are on-the-job and some on done through computer programs. I requested copies of this list for each employee who currently works at Bay Pointe. Ms. Genigeski provided me with one staff member's file, Amy Beyer, but requested time to get the lists for the other employees. I agreed, and requested that she scan and email me the lists, but if that was not possible, I told her that if she printed them off I would come pick them up.

On 07/21/2023, I received an email from Ms. Genigeski stating that they just hired a new Business Office Manager who started last week, and that they were in the midst of reorganizing. Ms. Genisgeski said that she was going through all the unfiled paperwork to pull the training documents I requested.

On 07/21/2023, I sent Ms. Genigeski another email, informing her that I needed documents showing that each employee who works at Bay Pointe had completed all the required trainings for Adult Foster Care.

On 07/21/2023, Ms. Genigeski sent me another email with the training documents for the four newest employees. I reviewed the documents, which show that Jameaniq Moore, Jabria Warren, Ebonnie Billings, and Lori Rhoda completed all the required trainings for Adult Foster Care.

On 07/26/2023, I received an email from Ms. Genigeski with documents attached showing that the rest of the staff at Bay Pointe have completed all the required training for Adult Foster Care. There are a total of eight care staff members who work at Bay Pointe. I compared the training documents with the staff schedule and there was documentation for each person shown on the schedule. There were four employees who had completed all the required trainings but were not shown on the schedule as yet.

On 07/28/2023, I called and held an exit conference with Mechelle Genigeski, Licensee Designee. I informed Ms. Genigeski that I was not citing a violation of this rule. She thanked me and had no further comment.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**
ANALYSIS:	Documentation was provided that verified each staff member who works at Bay Pointe has completed all the required training for Adult Foster Care. My findings do not support that this rule had been violated.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: There is not always enough staff members working to meet the needs of the residents.

INVESTIGATION: On 07/18/2023, I made an onsite inspection and met with Shawn Scott, Wellness Director, and Mechelle Genigeski, Executive Director. I informed them of the allegations and then went over each allegation with them providing me information and documentation as requested.

On 07/18/2023, Ms. Scott stated that there were six licensed facilities on this campus, and that there are two Resident Assistants (same as Direct Care Workers) assigned to Bay Pointe on each of the two shifts (1st and 2nd). She added that there are usually four or five Medication Technicians (Med Tech) on campus at any given time, and that if the Resident Assistants in any of the facilities need additional help for any reason, a Med Tech will provide it. Ms. Scott showed me the staff schedule on the computer program they use for this purpose, and Ms. Genigeski also printed it out for me. The schedule verifies what Ms. Scott told me. I also asked for a list of staff names and their phone numbers, and this was provided to me as well. Per my request, Ms. Scott went through the residents' care need levels on her computer as I observed. There are only 13 residents at this facility at the present time, although it is licensed for 20. Out of the 13 residents, only one requires two-person assistance; the others only need one-staff assistance for some of their Activities of Daily Living (ADLs) and most of the residents just need verbal prompting to remind them to do their ADLs. Ms. Scott informed me that Bay Pointe is a Memory Care facility and that each resident has some level of dementia.

On 07/19/2023, I called and spoke with Rosenda Garcia, Resident Assistant. Ms. Garcia informed me that she works 2nd shift (6:30 p.m. to 7:00 a.m.). She stated that there have been a couple of times when she worked by herself, and that when she needed assistance, she called a Med Tech, who came over from another building, but went back to that building after helping her.

On 07/19/2023, I called and spoke with Raul Robles, Resident Assistant. Mr. Robles stated that he works 1st shift (6:30 a.m. to 7:00 p.m.) and that there have been occasions when he was working alone. He reported, like Ms. Garcia, that there have been times when he was working alone when he needed assistance, so he used the phone at the nurse's station to call a Med Tech from another building.

On 07/21/2023, I spoke with Julie Marks, Resident Assistant. Ms. Marks informed me that she is a "floater," a staff member who works where needed among the six facilities on campus. Ms. Marks stated that there have been times when she was the only one working in a building, including Bay Pointe. She told me that sometimes someone from the Temp Agency who works as a Resident Assistant does not show up for his or her shift, making it so the staff-to-resident ratio is not what it's supposed to be.

On 07/28/2023, I called and held an exit conference with Mechelle Genigeski, Licensee Designee. I informed Ms. Genigeski that I was citing a violation of this rule. Ms. Genigeski was not aware that this -not enough staff on shift- had occurred.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and

	protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Resident Assistant Raul Robles reported that there have been times when he was the only one working and when he needed assistance with a resident, he had to call a Med Tech from another building. After the Med Tech was done helping him, the Med Tech went back to the building he or she was working in. Resident Assistant Rosenda Garcia reported the exact same thing has happened to her on more than one occasion. There have been more than one occasion within the past few month in which there was only one staff member working in Bay Pointe, which is a memory care facility. There is at least one resident there who requires two-person assistance for various reasons. My findings support that this rule has been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A has unexplained bruises on her hands and wrists.

INVESTIGATION: On 07/18/2023, I spoke with Ms. Scott and Ms. Genigeski regarding Resident A allegedly having bruises on her hands. Ms. Scott reported that this past Saturday (07/15), Resident A became combative towards two Resident Assistants, Jameaniq Moore and Jabria Warrant, as they were trying to toilet her. Ms. Scott said that these two staff members had difficulty assisting Resident A and two other staff members were called to come help them. Ms. Scott told me that Resident A's hands and wrists were likely bruised as a result of this incident but didn't know how they were injured. I asked for the names of the staff who were involved and was provided them. Three of the four staff members were working at the time of my onsite inspection, so I interviewed them while I was there.

On 07/18/2023, I spoke with Amy Beyer, Med Tech. Ms. Beyer explained that she was working in another building when she received a call from Ms. Scott stating that Ms. Moore and Ms. Warren needed assistance with toileting Resident A. Ms. Beyer told me that she and another Resident Assistant, Lori Rhoda, went to assist. Ms. Beyer said that when she and Ms. Rhoda arrived, she observed that Resident A was crying, holding her wrist, was combative, and was spitting towards the staff members. Ms. Beyer reported that she could see "red spots" on Resident A's wrists that she knew from experience would turn into bruises. Ms. Beyer stated that she and Ms. Rhoda took over and were able to clean Resident A up and transfer her as

Resident A then settled down once they took over. Ms. Beyer informed me that she did not see what may have caused the injuries to Resident A's hands.

On 07/18/2023, I spoke with Ms. Moore, who reported that on 07/15, she and Ms. Warren were working at Bay Pointe and that she took Resident A to be toileted. When they got to the toilet, Ms. Moore said that she tried to take off Resident A's diaper, which "had a lot of poop in it", but Resident A became combative with her and wouldn't let her. She stated that Resident A bit her lip causing it to bleed. Ms. Moore told me that she sat Resident A on the toilet with her diaper still on so she could call for help. Ms. Moore pulled the pull cord and Ms. Warren arrived to help her, but Resident A was too combative, scratching at and spitting on them. She said that both Ms. Moore and Ms. Warren were holding Resident A's hands to keep her from scratching them. Ms. Moore did not see Resident A's hands hit a wall, handrail, a staff member, or anything else that may have caused bruising to them.

On 07/18/2023, I spoke with Lori Rhoda, Resident Assistant, who stated that she and Ms. Beyer were called to go to Bay Pointe to help with Resident A because Ms. Moore and Ms. Warren were having difficulty with her. Ms. Rhoda informed me that when she and Ms. Beyer got there, Resident A was crying and appeared "distraught." She said that Resident A was spitting on staff and was holding her wrist. Ms. Rhoda observed that Resident A's wrists were bruised and that her lip was bleeding. Ms. Rhoda told me that she did not witness Ms. Moore or Ms. Warren holding Resident A's hands or wrists. She reported that when she and Ms. Beyer arrived, Resident A settled down and she and Ms. Beyer were able to clean and transfer her and change her. I asked Ms. Rhoda if she was trained in how to handle a resident who is being physically combative, and if so, what she would have done regarding how Resident A was behaving during this incident. Ms. Rhoda stated that she was trained in how to deal with combative residents but couldn't remember what she was taught because it was several years ago.

On 07/19/2023, I called and spoke with Jabria Warren, Resident Assistant. I asked her to describe what happened on 07/15 with Resident A. Ms. Warren stated that she was in another resident's room near Resident A's, assisting another resident with a shower. Ms. Warren told me that during this time, she heard yelling and screaming, and went to see what was going on. Ms. Warren reported that she saw Resident A sitting on the toilet in her room yelling and screaming. Ms. Warren said that Resident A then slid off the toilet and she and Ms. Moore helped her back up by putting their arms under Resident A's arms and lifting her back on the toilet. Ms. Warren stated that she asked Resident A if she could help her change her briefs, but she wouldn't let her. Ms. Warren informed me that she saw that Resident A's hands were reddish and her lip was bleeding, but she didn't see how these injuries occurred. Ms. Warren denied that she or Ms. Moore held Resident A by her hands. Ms. Warren said that she then went to get help from Ms. Beyer, who was in another building, and Ms. Beyer and another Resident Assistant, Ms. Rhoda, came over and were able to clean and change Resident A, who had calmed down once they came.

Ms. Warren did not see Resident A's hands hit a wall, handrail, a staff member, or anything else that may have caused bruising to them.

On 07/19/2023, I sent an email to Ms. Genigeski requesting any written material pertaining to how employees are to handle a resident who is being combative.

On 07/19/2023, Ms. Genigeski sent me an email with two PowerPoint presentations attached, one called Managing Disruptive Behaviors and the other called Dementia Training.

On 07/19/2023, I reviewed the presentations mentioned above. Although there were many suggestions on how to handle a combative resident, none of them stated whether it was positive or negative to physically restrain a resident's hands while he or she is being combative, to prevent him or her from hurting his- or herself or someone else.

On 07/28/2023, I called and held an exit conference with Mechelle Genigeski, Licensee Designee. I informed Ms. Genigeski that I was not citing a violation of this rule. She thanked me and had no further comment.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.** **R 400.15102 Definitions.** **(s) "Physical restraint" means the bodily holding of a resident with no more force than is necessary to limit the resident's movement.**
ANALYSIS:	On 07/15/2023, Resident Assistant Jameaniq Moore attempted to assist Resident A with toileting and cleaning her after she had a bowel movement. Resident A was combative, scratching at and spitting on Ms. Moore and other staff members. During this incident, Resident A slid off the toilet onto the floor. Ms. Moore held Resident A's hands for part of this incident to try to protect her from harming herself or staff members. None of the staff members involved in this incident observed Resident A hit her hands against anything that may have caused them to bruise.

	The bruising to Resident A's hands and wrists were most likely caused because she was fighting staff members while they were holding her hands, trying to assist her and keep her from hurting herself or others. My findings do not support that this rule had been violated.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend that the status of this home's license remain unchanged, and that this special investigation be closed.

July 31, 2023

Ian Tschirhart — Date
Licensing Consultant

Approved By:

July 31, 2023

Jerry Hendrick — Date
Area Manager