GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 24, 2023

Theresa Bursley
AH Jenison Subtenant LLC
6755 Telegraph Rd Ste 330
Bloomfield Hills, MI 48301

RE: License #: AL700397747
Investigation #: 2023A0467051
AHSL Jenison Cottonwood

Dear Mrs. Bursley:

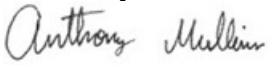
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 356-0183.

Sincerely,



Anthony Mullins, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL700397747
Investigation #:	2023A0467051
Complaint Receipt Date:	06/30/2023
Investigation Initiation Date:	07/03/2023
Report Due Date:	08/29/2023
Licensee Name:	AH Jenison Subtenant LLC
Licensee Address:	One SeaGate, Suite 1500 Toledo, OH 43604
Licensee Telephone #:	(248) 203-1800
Administrator:	Theresa Bursley
Licensee Designee:	Theresa Bursley
Name of Facility:	AHSL Jenison Cottonwood
Facility Address:	834 Oak Crest Lane Jenison, MI 49428
Facility Telephone #:	(616) 457-3576
Original Issuance Date:	03/11/2019
License Status:	REGULAR
Effective Date:	09/11/2021
Expiration Date:	09/10/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
The facility is insufficiently staffed to meet residents' needs.	Yes
Residents are not receiving their medications as scheduled.	Yes
Resident F did not receive dinner on 07/02/23.	No
Additional Finding	Yes

III. METHODOLOGY

06/30/2023	Special Investigation Intake 2023A0467051
07/03/2023	Special Investigation Initiated - Telephone Spoke to complainant via phone.
07/05/2023	Inspection Completed On-site
08/24/2023	APS referral – sent via email
08/24/2023	Exit conference completed with Licensee designee, Theresa Bursley

ALLEGATION: The facility is insufficiently staffed to meet residents' needs.

INVESTIGATION: On 7/3/23, I received a BCAL online complaint stating that during 3rd shift, the facility only has one staff member providing care to 17 residents, despite the facility having residents who require a two-person assist. Specifically, the resident in room 20 (Resident A) reportedly requires a two-person assist and is not receiving the care he needs, including rehab on his hip and wound care. The complainant stated that there are other residents who require a lot of care and assistance to keep them safe and the facility lacks the staffing to provide adequate care.

On 7/3/23, I spoke to the complainant via phone, and she confirmed that the lack of staffing is her concern. The complainant stated that Resident A requires a two-person assist. Despite this, the facility often has only one staff member working.

On 7/6/23, I made an unannounced onsite investigation at the facility. Upon arrival, introductions were made with Resident A and he agreed to discuss the allegations. Resident A stated that he has been a resident at the facility for approximately four days. Resident A stated that approximately one week ago, he was in Wisconsin with his son when he fell and broke his leg. Resident A stated that he will remain at AHSL Jenison for 1-2 weeks prior to returning home to Wisconsin. Resident A was asked if he needs assistance with any of his activities of daily living (ADL's) and stated that

he should have someone in the room with him when using the bathroom, “but I use the urinal.” Despite this, Resident A stated that things are going well for him at the facility. Resident A stated that the staff have never had to treat someone with a broken leg and, “they’re doing a good job.” Resident A stated that he can transfer to his chair and bed by himself, but he likes to have a staff present with him. Resident A stated, “if I have to wait too long, I do it myself.” Resident A stated that the average wait time to receive assistance from staff has been 10 minutes. Resident A stated, “the girls (staff) couldn’t be better to me. I’m not receiving the care that the people in Wisconsin provided but the girls are very helpful.” Resident A’s assessment plan was reviewed and indicated that he is independent with his mobility/ambulation and does not require assistance with transfers, toileting, or bathing. Resident A was thanked for his time as this interview concluded.

After speaking to Resident A, introductions were made with Resident B and she agreed to discuss the allegations. Resident B stated that she has been a resident at the facility for approximately five months. Resident B stated that things are going “okay” within the facility. Resident B stated that she receives the care she is supposed to receive from “some staff.” However, other staff members don’t always follow the instructions provided by PT/OT. Resident B continued as she stated, “I feel like I’m in danger because I can’t walk” due to currently having a broken hip. Resident B’s stated concern with some of the staff is not being aware of her broken hip and that the information from PT doesn’t always make it to the direct care staff. Resident B stated that staff have transferred her without a gait belt although one is supposed to be used. Resident B’s assessment plan confirms this. Resident B stated that the facility has so many new people that, “they don’t know what my needs are. They don’t know that I have a broken hip and can’t walk.” Resident B also stated that she felt her life is in danger due to staff transferring her without a gait belt. Resident B stated that she has not talked to anyone about her concerns. Resident B was asked about pulling her call light for assistance. She stated that the longest she has ever had to wait for assistance was 30 minutes, which she states was an outlier. Resident B stated that since the facility has more staff, “they’ve been pretty good” answering her call light. Resident B denied any other concerns.

After speaking to Resident B, introductions were made with Resident C and he agreed to discuss the allegations. Resident C stated that things are going “okay” for him at the facility. Resident C was asked about his needs being met. He stated that sometimes at night, it takes staff, “a couple of hours” to assist him after pulling his call light. Resident C was unable to list any staff members, but he did state it depends on who’s working. Resident C stated, “I guess so” when asked if he feels that his needs are addressed promptly during business hours. Resident C stated that for the most part, he feels that his care needs are being met. He did add that staff have walked out of the room to assist other residents when he has asked them for help putting his blanket over him. Again, Resident C was unable to provide names of staff members. Resident C added that prior to staff member Ruth Baribeau changing his adult briefs this morning, that he wore the same brief all night. Resident C spoke highly of staff members Ms. Baribeau, Carol, and Ms. Cole. Resident C confirmed

that he requires a one-person assist when transferring to the toilet.
After speaking to Resident C, introductions were made with Resident D and he agreed to discuss the allegations. Resident D stated that he has been at the facility for approximately one week. When asked how things are going, Resident D stated, “the food is good and staff attitudes are good.” Without being prompted, Resident D stated, “I failed at my effort to get better. My blood pressure took over. I have low blood pressure and it keeps me from exercising.” Resident D spoke highly of the management team within the facility and denied having any complaints or concerns with the care he is receiving.

After speaking to Resident D, introductions were made with Resident E and she agreed to discuss the allegations. Resident E stated that she has lived at the facility for four years and things are going “okay” for her. Resident E stated staff always help her lift her legs into bed at night. She denied any other need for assistance from staff. Resident E stated that when she pulls her call light, staff respond and assist her within a couple of minutes. Resident E’s only concern is that she does not like seeing new faces all the time. Resident E was thanked for her time as this interview was concluded.

An interview was completed with staff member, April Cole. Ms. Cole stated that she has worked at the facility for one year as an “agency staff” and 2.5 months as facility staff. Ms. Cole stated that she works first shift, which is 7:00 am to 3:30 pm. Ms. Cole stated that the facility currently has 16 to 17 residents and is receiving a new one this week. Ms. Cole confirmed that during her shift, there are always two people working. However, during second shift there are times that the facility has only one staff member to address the residents’ needs.

Regarding resident needs, Ms. Cole stated that sometimes, Resident B and Resident C will pull their call light at the same time and the response time will depend on the resident’s needs. Ms. Cole was adamant that while working, a resident has never had to wait more than 20 minutes for a response. Ms. Cole stated that she typically responds to resident’s call lights within 5-7 minutes. Ms. Cole stated that during 3rd shift, staff does checks/rounds on residents every two hours and there is only one med tech on 3rd shift. When there is only one tech available and constant call lights, it can be hard to get to the residents and address their needs immediately. Ms. Cole stated that on second shift, if staff doesn’t have aids, they have holes in the schedule, leaving one person to do all care needs. Ms. Cole stated that none of the residents in the facility requires a two-person assist at this time.

After speaking to Ms. Cole, I spoke to staff member, Ruth Baribeau. Ms. Baribeau stated that she has worked at the facility for two years and she is currently a nursing student that comes back to work at the facility during school breaks. Ms. Cole denied knowledge of any resident requiring a two-person assist in the facility. Although Resident F doesn’t require a two-persons assist, Ms. Baribeau stated that there are moments that she has needed two-person assist when she gets confused. Ms.

Baribeau stated that she typically works first shift but does pick up other shifts as needed. She stated that currently, the facility has a total of 17 residents. Ms. Baribeau stated that she has never worked at the facility by herself. Ms. Baribeau stated that she is not trained to pass medications so there is always someone working with her to do this.

Executive Director, Theresa Bursley stated that none of the residents in Cottonwood require a two-person assist. Wellness Director Jennifer Hicks provided me with a copy of Resident A's assessment plan and the staff schedule from 06/01/23 through 07/01/23. The assessment plan was reviewed and indicated that Resident A is independent with all care needs, including transfers, toileting, and bathing. The schedule confirmed that there was only one staff member scheduled to work on 3rd shift from 11:15 pm to 7:00 am daily between 06/01/23 and 07/01/23.

On 8/1/23, I received an email from Ms. Cole. The email stated that the staffing issues continue to remain the same at the facility. Ms. Cole stated that she works until 3:30 pm and the aids leave at 3:00 pm, leaving her alone in the building that she knows has 2-3 residents that require a two-person assist. Ms. Cole stated that there are days that she is left alone to provide care for 19 residents for an hour or more. Ms. Cole indicated that one of the resident's family members have asked her not to go in his room as the two of them do not get alone. Ms. Cole stated that she is okay with this due to the resident being verbally abusive to staff. However, Ms. Cole asked for clarification on addressing the resident's needs when she is the only person working. Ms. Cole added that she comes to work at least 30 minutes prior to her shift starting and when she arrives, residents call lights are going off. Ms. Cole stated that a staff member can't leave a resident unattended in a shower to address a call light. Ms. Cole is concerned that with only one staff member working with several call lights going off, it is hard to determine the needs/urgency of the other residents due to the lack of additional staffing.

Due to ongoing reports from staff regarding staffing concerns and residents requiring a two-person assist, I requested a copy of all the resident's assessment plans. On 8/15/23, Mrs. Hicks sent me copies of all 16 residents' assessment plans. Each assessment plan was reviewed and 15 of the 16 residents require one-person assist at most. However, Resident C's assessment plan was reviewed and his level of assistance with transferring stated, "resident requires extensive assistance including two-person assistance to safely transfer." The assessment plan indicated that Resident C may need two-person assistance with transferring up to three times per day, every day. On 8/24/23, I made an unannounced onsite visit to the facility. I

On 08/24/23, I conducted an exit conference with licensee designee, Theresa Bursley. She was informed of the investigative findings and aware that a corrective action plan is due within 15 days of receipt of this report.

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 A stated that all his needs are being met and denied having any concerns regarding the care he is receiving at the facility. AFC staff Ms. Cole and Ms. Baribeau were interviewed and initially denied that any of the residents require a two-person assist. Ms. Cole subsequently sent me an email on 8/1/23 stating that residents do require a two-person assist but didn't specify who. Ms. Cole also stated that she often works alone with residents when she should have another staff assisting her. A review of each resident's assessment plan indicated that Resident C requires a two-person assist with transfers. In addition to this, Resident B stated that her life is in danger due to staff transferring her without a gait belt as indicated in her assessment plan. Resident C stated that he has waited hours to have his needs addressed after pulling his call light at night. Due to the facility having a resident who requires a two-person assist (per their assessment plan), residents expressing that their needs are not being met, and staff members expressing that residents needs are not being met, there is a preponderance of evidence to support that the facility is inadequately staffed to address the resident's needs.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Residents are not receiving their medications as scheduled.

INVESTIGATION: On 07/03/23, I received a BCAL online complaint stating that residents are not receiving their medications as scheduled.

On 7/3/23, I spoke to the complainant via phone. The complainant stated that Resident E received her 6:00 am medication on 07/01/23 and 07/02/23 at 7:30 am. The complainant stated that Resident E's MAR should accurately reflect the medication being given later than the scheduled time.

On 07/05/23, I made an unannounced onsite investigation at the facility. Upon arrival, I spoke to Resident E in her room. Resident E stated that she has lived at the

facility for four years and things are going “okay.” Resident E confirmed that she receives her medications as scheduled and denied any concerns related to this. Resident E stated that she needs assistance lifting her legs in bed at night and staff always assist her. She denied any other needs for assistance from staff. The only concern that Resident E expressed is that she doesn’t like seeing new staff members all the time. Resident E stated that staff “come and go” and she would prefer to have consistent staff daily. She was also understanding that in this field of work, with facilities of this size, seeing new staff members is not uncommon. Resident E was thanked for her time and denied having any questions.

AFC staff member, April Cole was interviewed regarding residents receiving their medication as scheduled. Ms. Cole stated that sometimes there are no medications to pass to residents. For example, Ms. Cole stated that yesterday (07/05/23), Resident C didn’t have his “patch medication for his dementia.” Per Ms. Cole, no one ordered medications for the 4th of July holiday and Resident C’s wife had to take him home and give him the medication, in addition to a couple extra until the script comes in. Ms. Cole stated that sometimes, residents do not receive their medications due to their prescription not being filed.

I then spoke to AFC staff member, Ruth Baribeau. Ms. Baribeau stated that she is not trained to pass medications but there is always a staff working with her that is trained to do this. Ms. Baribeau stated that staff do their best to get medications to residents on time. Ms. Barbeau stated that occasionally, she’ll find a pill on a bed, but she assumes it must have missed a resident’s mouth when being passed. Ms. Baribeau was adamant that this has not happened often.

Prior to concluding this onsite investigation, Wellness Director Mrs. Hicks provided me with a copy of Resident A, Resident B, Resident C, and Resident D’s Medication Administration Record (MAR) from 07/01/23 through 07/05/23.

The MARs provided by Mrs. Hicks indicated the following: Resident A: Acetaminophen 325 MG Tablet on 7/1/23 states that he is to receive 2 tablets (650MG) by mouth every 6 hours for 7 days total. On 7/1/23, staff member Lavonda Martinez-Thompson added a note stating that the prescription card is for 500MG, although the MAR states 650MG. Therefore, Resident A did not receive the medication as scheduled. Resident B: No concerns noted. Resident C: Eliquis 5MG Tablet, Metoprolol Succ ER 25MG TA, and Desenex 2% PWD (Mixonazor) on 7/4/23 was not given to the resident due to “resident out of facility with wife.” Staff are responsible for accommodating residents and/or their family by providing them with their medications to take while in the community. Also, Resident C did not receive his Rivastigmine 13.3MG/24HR P medication on 7/4/23 due to not being available at the facility. The explanation provided by staff member April Cole stated, “called to get a refill this AM.” Resident D: No concerns noted.

On 08/24/2023, I conducted an exit conference with licensee designee, Theresa Bursley. She was informed of the investigative findings and agreed to complete a

CAP within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	AFC staff member Ms. Cole also stated that there have been times that staff did not have medications to pass to residents due to the medications not being filled in time. The MARs for Resident A indicated he did not receive his medication as scheduled on 07/01/23 and Resident C did not receive his medication as scheduled on 7/4/23. Therefore, a preponderance of evidence exists to support this allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident F did not receive dinner on 07/02/23.

INVESTIGATION: On 07/03/23, I received a BCAL online complaint stating that Resident F did not receive dinner on the evening of 07/02/2023.

On 07/03/23, I spoke to the complainant via phone, and she confirmed the allegation. The complainant stated that instead of dinner, staff gave Resident F a protein shake. Per the complainant, this was after staff gave Resident F, “many opportunities” to eat dinner. The complainant stated that Resident F does need assistance/prompts with dinner, but she does not feel that staff were being patient with her.

On 7/3/23, I made an unannounced onsite investigation at the facility. Upon arrival, I attempted to speak to Resident F regarding the allegation. Resident F declined to be interviewed and did not make any additional statements.

I spoke to AFC staff member, April Cole. Ms. Cole was asked about Resident F reportedly not receiving dinner on 7/2/23. Ms. Cole stated that she has heard from

2nd shift staff that Resident A doesn't always receive meals and that staff have said, "I'm just not going to deal with her." However, she has not observed this herself. Ms. Cole stated that Resident F can be difficult as she has a history of being verbally abusive towards staff.

I then spoke to AFC staff member, Ruth Baribeau. Ms. Baribeau was asked about Resident F not receiving meals. Ms. Baribeau stated that sometimes, Resident F refuses meals and there is a rule to make sure she eats at least twice a day since she often refuses to eat. Ms. Baribeau stated that Resident F typically refuses to eat when she is tired. Ms. Baribeau denied any knowledge of staff intentionally not providing Resident F with a meal. Ms. Baribeau did share that one time, the lead staff stated that if Resident F doesn't come down to the dining table to eat, she won't get her meal. Resident F did make her way down to the dining room table and was able to eat, despite the statement from staff.

AFC wellness director, Jennifer Hicks denied any knowledge of Resident F not receiving dinner on 07/02/23. Ms. Hicks stated that residents are given the option to eat in their room if they're unable to make it to the dining room table. Therefore, there should be no reason for Resident F to miss a meal other than the resident refusing.

On 08/24/23, I conducted an exit conference with licensee designee, Theresa Bursley. She was informed of the investigative findings and denied having any questions.

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	The complainant stated that AFC staff gave Resident F "many opportunities" to eat prior to giving her a protein shake. Resident F declined to be interviewed. AFC staff member Ms. Cole stated that she has heard from 2nd shift staff that Resident F doesn't always receive dinner, but she has not witnessed this herself. AFC Staff member Ms. Baribeau stated that Resident F often refuses meals. However, she denied knowledge of any staff intentionally not providing Resident F with dinner.

	Due to no disclosure from Resident F and no supporting evidence, there is not a preponderance of evidence to support this allegation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING:

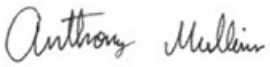
INVESTIGATION: On 8/24/23, I made an unannounced visit to the facility. Upon arrival, I spoke to licensee designee, Theresa Bursley and wellness director, Jennifer Hicks. We discussed and reviewed the facility's census and staff schedule from 6/1/23 through 7/31/23. Mrs. Bursley confirmed that as of 6/30/23, the facility has 16+ residents. Due to this, the facility is required to have at least two staff members working during waking hours. While reviewing the 7/2/23 staff schedule and punch report, it indicated that staff member Lawanda Martinez Thompson worked from 7:00 am to 3:39 pm. Mrs. Hicks stated that agency staff member Paula Casler also worked the morning of 7/2/23 with Ms. Martinez Thompson. Mrs. Hicks showed me the hours and location that Ms. Casler worked at on 7/2/23 per their career staff system. This indicated that Ms. Casler worked at AHSL Jenison Sandalwood from 6:30 am 1:00 pm and 11:30 pm to 7:00 am. Mrs. Hicks was on-call during this weekend and was adamant that Ms. Casler was pulled from AHSL Jenison Sandalwood to work at AHSL Jenison Cottonwood. Despite this, the documentation needs to accurately reflect where residents are working as opposed to there initial assigned facility. Without proper documentation, it is difficult confirm that staff are not working alone with 16+ residents. An exit conference was completed with Mrs. Bursley and Mrs. Hicks onsite. They were understanding of this and aware that a CAP is due within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours.
ANALYSIS:	Documentation provided by Mrs. Bursley and Mrs. Hicks regarding the staff schedule on 7/2/23 indicates that only one staff member worked at the facility during first shift. Mrs. Hicks was adamant that agency staff member Paula Casler was pulled from another facility to work at this one. However, the documentation did not support this. The facility has 16+ residents and therefore, documentation needs to reflect that two

	staff members are working at the facility during waking hours. A preponderance of evidence exists to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change to the current license status.



08/24/2023

Anthony Mullins Date
Licensing Consultant

Approved By:

08/24/2023

Jerry Hendrick Date
Area Manager