GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 26, 2023

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

RE: License #: AH700299440
Investigation #: 2023A1010073
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 that I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,
Lauren Wohlfert

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa NW Unit 13, 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH700299440
Investigation #:	2023A1010073
Complaint Receipt Date:	07/07/2023
Investigation Initiation Date:	07/11/2023
Report Due Date:	09/06/2023
Licensee Name:	Grand Pines Assisted Living LLC
Licensee Address:	950 Taylor Ave. Grand Haven, MI 49417
Licensee Telephone #:	(616) 846-4700
Administrator:	Ami Moy
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:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident B was not included in a recent care conference scheduled to discuss her service plan.	Yes
Staff did not provide Resident B with her pendant and check on her through out the night as outlined in her service plan.	No

III. METHODOLOGY

07/07/2023	Special Investigation Intake 2023A1010073
07/11/2023	Special Investigation Initiated - Telephone Interviewed the APS complainant by telephone
07/26/2023	Inspection Completed On-site
07/26/2023	Contact - Document Received Received resident service plan and staff notes
10/26/2023	Exit Conference

ALLEGATION:

Resident B was not included in a recent care conference scheduled to discuss her service plan.

INVESTIGATION:

On 7/7/23, the Bureau received the allegations from Adult Protective Services (APS). The complaint was not assigned for APS investigation. The complaint read, “Kelly Bush [sic] is the quality assurance LPN at the facility. [Relative B1] is [Resident B’s] daughter who resides out of the home. Today, there was a care conference between [Relative B1] and Kelly that [Resident B] was supposed to be involved in because [Resident B] makes all of her own decisions. [Relative B1] and [Resident B] told Kelly that [Resident B] wanted to be a part of the meeting. Kelly was supposed to get [Resident B] for the meeting and make sure that she was present. Kelly met with [Relative B1], via telephone, without [Resident B] and then spoke with [Resident B] after the meeting. [Resident B] was upset that [Relative B1] was spoken to without [Resident B] present.”

On 7/11/23, I interviewed the APS complainant by telephone. The APS complainant reported she was present when Resident B was upset about not being included in a care conference between Relative B1 and Ms. Busch on 7/26/23 at 1:30 pm. The APS complainant stated Resident B informed her she did not know where the meeting was taking place, so she wheeled Resident B to Ms. Busch's office. The APS complainant said she and Resident B observed Ms. Busch's office door was closed. The APS complainant reported she opened the door and Ms. Busch "waived her hand" towards the door motioning for her to close it while she was on the telephone with Relative B1.

The APS complainant stated she then "wheeled" Resident B back to her room. The APS complainant said Resident B was very upset that she was not a part of the meeting to discuss her service plan. The APS complainant reported Relative B1 informed Ms. Busch that Resident B wanted to be a part of the meeting, however Resident B was still not included. The APS complainant said Resident B is her own person and decision maker. The APS complainant reported Ms. Busch did speak with Resident B later that day.

On 7/26/23, I interviewed Ms. Busch at the facility. Ms. Busch acknowledged Resident B should have been present when she and Relative B1 had a telephone conversation on 7/6/23 to discuss Resident B's service plan. Ms. Busch reported she went to Resident B's room after her conversation with Relative B1 to apologize to Resident B for not including her in the discussion. Ms. Busch said Resident B is her own person. Ms. Busch stated Resident B's service plan was updated after her discussions with Relative B1 and Resident B.

Ms. Busch provided me with a copy of Resident B's staff observation notes for my review. A note dated 7/6/23 read, This resident told this MT early in the morning that she had a care conference to discuss her care plan scheduled for 1:30pm today that she would like to attend with [Relative B1] and the interim RSC. Around 1:30pm, this resident went into the hallway and asked this MT if someone was coming to pick her up for the meeting. No one came to pick her up. This MT went to the RSC office, but the door was closed. By this point, resident was crying and said, 'I hate liars. I was told I would be part of this meeting.' This MT called [Relative B1], who stated that she was currently in the meeting (phone conference) with the RSC. [Relative B1] stated that she was aware of [Resident B's] request to be involved in the meeting and did voice that concern during the phone conference. Resident told this MT that she would like to wait outside the RSC office door. This MT told her to please ring if she needs anything."

On 7/26/23, I interviewed Resident B at the facility. Resident B stated she was upset the day that she was not included in the discussion with Relative B1 to discuss her service plan. Resident B reported Ms. Busch did enter her room that day and apologized for not including her in the meeting with Relative B1. Relative B1 said her service plan changed to include an increase in her care needs and Relative B1

wanted an explanation regarding the increase “in her bill.” Resident B reported she wanted to be a part of that discussion.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(2) The admission policy shall specify all of the following: **(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.**
ANALYSIS:	The interviews with Ms. Busch, Resident B, along with review of Resident B’s staff observation note dated 7/6/23, revealed Resident B did not participate in a meeting to discuss her service plan. Resident B is her own person and decision maker and was upset she did not participate in the discussion Ms. Busch had with Relative B1 by telephone.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff did not provide Resident B with her pendant and check on her throughout the night as outlined in her service plan.

INVESTIGATION:

On 7/7/23, the complaint read, “All the residents at the facility have a pendant in the bathroom. Due to [Resident B] being in a wheelchair and unable to get out of bed on her own, [Resident B] could not get the pendant herself. [Resident B] is supposed to be checked on and therefore was not able to go to the bathroom when she needed to. [Resident B] has been unable to go to the bathroom during the night on other occasions as well.”

On 7/11/23, the APS complainant reported Resident B informed her there was an incident when a staff person left her pendant in Resident B’s bathroom and forgot to place it back around her neck. The APS complainant stated Resident B does have a pull cord by her bed, however it is unknown whether Resident B was able to reach it.

The APS complainant said Resident B is also supposed to be checked on by staff three times during third shift. The APS complainant reported Resident B informed her there were incidents in which staff only opened Resident B’s door and did not ask her if she needed to use the bathroom.

On 7/26/23, Ms. Busch reported she maintains regular contact with Resident B to ensure her needs are being met by staff. Ms. Busch stated she did speak to Resident B regarding the incident in which a staff person accidentally forgot to place Resident B's pendant around her neck after assisting Resident B in her bathroom. Ms. Busch said the incident was not intentional.

Ms. Busch stated it is outlined in Resident B's service plan for staff to check on her during the night. Ms. Busch reported Resident B complained staff were waking her up during the night when they entered to check on her. Ms. Busch said staff were instructed to enter Resident B's room quietly and not disturb her if she is asleep. Ms. Busch stated Resident B is to use her pendant to summon staff for assistance at night when she needs to use the bathroom.

Ms. Busch said Resident B's service plan was updated on 7/24/23 to reflect her change to a two person assist with transfers. Ms. Busch reported Resident B has a toileting schedule for every two hours while she is awake. Ms. Busch stated Resident B does have a pull cord by her bed that she can also use to summon staff for assistance. Ms. Busch reported Resident B also wears a brief in case she is incontinent.

Ms. Busch provided me with a copy of Resident B's service plan for my review. The *INCONTINENCE BRIEFS* section of the plan read, "Briefs or other incontinence products are provided by: family." The *TOILETING – 2 PERSON FULL ASSIST* section of the plan read, "I need assistance from 2 staff members to aid me in meeting my toileting needs. At night, please make sure you are assisting me to the bathroom to prevent me from being incontinent. Put my leg brace on at night before getting me up to go to the bathroom. I do not want to use my shower chair to go to the bathroom. Schedule: Daily @ 6:00 AM, 8:00 AM, 10:00 AM, 12:00 PM, 2:00 PM, 4:00 PM, 6:00 PM, 8:00 PM, 10:00 PM, As needed."

The *NIGHTLY VISUAL CEHCKS 2 TIMES NIGHTLY* section of the plan read, "I require or request a visual check 2 times during the night. PLEASE DO NOT WAKE ME UP WHILE CHECKING ON ME. Schedule: Daily @ 1:00 AM, 5:00 AM."

On 7/26/23, Resident B reported there was an incident when a staff person forgot to place her pendant back around her neck after assisting her in the bathroom one evening. Resident B was unable to recall the date or the staff person's name. Resident B said she does have a pull cord by her bed. I observed Resident B's pull cord.

Resident B reported she did not like being transferred to her commode by staff at night when she had to use the bathroom. Resident B stated she informed staff and Ms. Busch that she did not like using the commode, therefore two staff persons now transfer her to the toilet at night and put her leg brace on when they transfer her. I observed Resident B was wearing her pendant around her neck.

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:	The interview with Ms. Busch and Resident B revealed there was an incident in which a staff person forgot to place Resident B's pendant back around her neck after assisting Resident B in her bathroom. This incident was addressed by Ms. Busch. I observed Resident B has a pull cord near the pillow by her bed that she can utilize to summon staff for assistance. Resident B's service plan was updated to reflect her nightly toileting schedule and that staff are not to wake her while checking on her at night.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

I shared the results of this report with licensee authorized representative Lauren Gowman on 10/26/23.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

08/17/2023

Lauren Wohlfert — Date
Licensing Staff

Approved By:

10/25/2023

Andrea Moore — Date
Area Manager