GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 11, 2023

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

RE: License #: AL700397750
Investigation #: 2023A0467056
AHSL Jenison Cherrywood

Dear Mrs. Bursley:

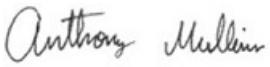
Attached is the Special Investigation Report for the above referenced facility. Due to the violation identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- Specific time frames for the 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 #:	AL700397750
Investigation #:	2023A0467056
Complaint Receipt Date:	08/21/2023
Investigation Initiation Date:	08/21/2023
Report Due Date:	10/20/2023
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 Cherrywood
Facility Address:	798 Oak Crest Lane Jenison, MI 49428
Facility Telephone #:	(616) 457-3576
Original Issuance Date:	03/12/2019
License Status:	REGULAR
Effective Date:	09/12/2023
Expiration Date:	09/11/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED, AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A's shoulder was injured as a result of an improper transfer by staff.	Yes

III. METHODOLOGY

08/21/2023	Special Investigation Intake 2023A0467056
08/21/2023	Special Investigation Initiated - Telephone
08/21/2023	APS Referral Complaint received from Ottawa County APS worker, Tyler Mihalatos
08/22/2023	Inspection Completed On-site
08/23/2023	Contact - Telephone call made Spoke to Detective Jake Mucha with Ottawa County Sheriff's Department
08/31/2023	Contact – Telephone call made Spoke to staff member Shayla Stegehuis
08/31/2023	Contact – Telephone call made Spoke to staff member Yusuf Mberwa
08/31/2023	Contact – Telephone call made Spoke to staff member Felipa "Monique" Barrientos-Hinkle
09/05/2023	Contact – Telephone call made Spoke to staff member Laura Baca
09/11/2023	Exit conference completed with licensee designee, Theresa Bursley

ALLEGATION: Resident A's shoulder was injured as a result of an improper transfer by staff.

INVESTIGATION: On 8/21/23, I received a BCAL online complaint from Ottawa County Adult Protective Services (APS) worker, Peter Tyler Mihalatos. The complaint stated that Resident A is 80 years old and is diagnosed with COPD and

severe arthritis. Resident A is also wheelchair bound. The complaint alleged that approximately 10 days ago, Resident A was in bed and requested assistance to go to the bathroom. Resident A reportedly received assistance from two staff members, Shayla Stegehuis and Yusuf Mberwa. While assisting Resident A with standing, Ms. Stegehuis reportedly grabbed her arm. Resident A reportedly told Ms. Stegehuis not to grab or pull her arm but she did it anyways. Mr. Mberwa reportedly corrected Ms. Stegehuis behavior by also telling her not to grab or pull Resident A's arm.

Resident A reportedly had some pain in her shoulder/arm area that she did not disclose to her family. On 8/9/23, Resident A was examined by a doctor due to her inability to move her arm. Resident A's X-ray that was received on 8/10/23 was concerning and she was told to go to the ER. Resident A went to the ER on the morning of 8/11/23 and it was discovered that her shoulder was displaced, likely from Ms. Stegehuis grabbing and pulling her during an improper transfer. Resident A was given a sling and Tylenol for pain and returned to the AFC facility on 8/11/23. It was also reported that Ms. Stegehuis has gotten in trouble for this type of behavior with other residents in the past.

On 8/21/23, I spoke to Ottawa County APS worker, Mr. Mihalatos via phone. Mr. Mihalatos stated that he interviewed Resident A and she disclosed how her injury occurred, which was from Ms. Stegehuis pulling and grabbing her during a transfer. Mr. Mihalatos stated that he took pictures of the injury and agreed to email me the pictures. Mr. Mihalatos stated that Detective Jake Mucha from the Ottawa County Sheriff's Department is involved as well. Mr. Mihalatos was thanked for his time as this call concluded.

On 8/22/23, I made an unannounced onsite investigation at the facility. Upon arrival, staff assisted me to Resident A's room where introductions were made. Present in the room with Resident A was her husband (Resident B), who also resides at the facility. Resident A has resided at the facility for less than a year. Resident A was aware that I was at the facility to discuss the incident related to her shoulder/arm. Resident A stated that the incident occurred during 3rd shift on or around 8/8/23. Resident A stated that she was sitting on the commode and needed to get up. Resident A stated that Ms. Stegehuis was the staff member working with her on this night. Resident A stated that Ms. Stegehuis had her right hand on her left arm/shoulder when grabbing/pulling her. Resident A stated that she told Ms. Stegehuis not to lift her but she did anyways. Resident A stated that she is supposed to be transferred with a gait belt instead of her arm. Resident A was adamant that Ms. Stegehuis did not use a gait belt while transferring her off the commode. Resident A denied anyone assisting Ms. Stegehuis during the incident.

Resident A stated the following day that, "I could hardly move my arm." Resident A acknowledged that she had issues with her shoulder prior to this improper transfer but not to this extent. On or around 8/10/23, Resident A stated that she had an appointment with her Rheumatologist. While there, Resident A discussed the pain she had in her shoulder and an X-ray was completed. After the results of the x-ray

became available, Resident A's doctor called her daughter and told her to get Resident A to the emergency room (ER) right away to have her shoulder examined. Resident A stated that she went to Spectrum Health Blodgett ER on 8/11/23. While at the ER, she was told by medical professionals that she had a dislocated shoulder, and she was given a sling to wear. During my onsite visit with Resident A, she was not wearing her sling, but she still has it and uses it. Resident A stated that Occupational Therapy (OT) met with her this morning, and they stated that bruises have healed up from being grabbed and pulled by Ms. Stegehuis. Resident A stated that Ms. Stegehuis has said several times that she doesn't like to be told what to do, referring to Ms. Stegehuis not listening to her when she told her not to grab/pull her arm. Resident A confirmed that last week, she spoke with a Detective from the Ottawa County Sheriff's Department. She also confirmed that she spoke with an APS worker as well. Resident A provided me with contact information for her daughters to contact if needed. Resident A was thanked for her time as this interview concluded.

After speaking to Resident A, I spoke to licensee designee, Theresa Bursley and wellness director, Jennifer Hicks. They provided me with a copy of Resident A's medical records from Spectrum Health Butterworth on 8/11/23 and records from Elder Care of West Michigan visit at the facility with Resident A on 8/10/23. Mrs. Bursley and Mrs. Hicks stated that Resident A's medical records initially stated that her left shoulder looks like it was dislocated. Mrs. Bursley and Mrs. Hicks then stated that Resident A had a "tear or deformity" as opposed to a dislocated shoulder.

I reviewed the medical records from 8/11/23 and the findings state: *'Superior dislocation of the prosthetic humeral head from the postsurgical glenoid has occurred in the interval. The glenoid prosthesis is again displaced anterior to the humeral neck. Sclerosis and articular irregularity of the residual glenoid redemonstrated.'* Dr. Daniel Mercier at Spectrum Health then indicated that he reviewed Resident A's x-ray from two days ago and there was reported concern about a rotator cuff injury, *'but some displacement maybe of the shoulder in the glenoid'* so a repeat x-ray was completed. Dr. Mercier reviewed Resident A's x-ray from 8/9/23 and did not observe any acute fracture. Dr. Mercier's *'interpretation of the shoulder x-ray on the left is the humeral head is seated high similar to the past x-ray consistent with a rotator cuff tear. It is sort of subluxed but it is not dislocated.'* Dr. Mercier planned to discuss his findings with orthopedic surgery after radiology reading indicated superior glenoid dislocation. Resident A's After Visit Summary (AVS) confirmed that she had a left rotator cuff injury. Specifically, a rotator cuff tear as opposed to a dislocated shoulder. Resident A was instructed to use a sling as needed and she was given Tylenol. It should be noted that medical records also indicated that Resident A has, *'age-related osteoporosis without current pathological fracture.'*

On 8/23/23, I spoke to Detective Jake Mucha with Ottawa County Sheriff's Department. He confirmed that he has already interviewed Ms. Stegehuis regarding the allegations, and she denied yanking or pulling Resident A's arm or intentionally

hurting her. Detective Mucha also stated that Ms. Stegehuis told him she didn't remember specific things when questioning her and stated that hurting or pulling a resident's arm doesn't sound like something she would do. Detective Mucha plans to continue gathering information prior to submitting his case to the prosecuting attorney.

On 8/24/23, I received a copy of Resident A's assessment plan from Mrs. Hicks. The assessment plan was reviewed and stated the following: *'Level of Assistance – Transferring: Extensive. Resident requires extensive assistance including at times a two-person assistance to safely transfer.'* The plan also requires the use of a gait belt when transferring Resident A.

On 8/31/23, I spoke to AFC staff member, Shayla Stegehuis via phone. Ms. Stegehuis was asked to share what occurred during a 3rd shift in early August when she attempted to transfer Resident A. Ms. Stegehuis did not know the exact date but confirmed it was early August when she transferred Resident A from the commode to her bed. Ms. Stegehuis was adamant that she used a gait belt and lifted her from the center of her back. Ms. Stegehuis stated that Resident A did not complain of pain during the transfer and never told her to stop or not to transfer her. Ms. Stegehuis stated that she did notice a "red spot" on the upper left inside of Resident A's arm near her armpit. Ms. Stegehuis stated that she transferred Resident A to her bed and reported this information to her mother, Rochelle Stegehuis when she picked her up to take her home. Ms. Stegehuis stated that her mother is her supervisor at the facility. Ms. Stegehuis stated that she also reported this information to the lead staff member in the morning but was unable to recall who.

Ms. Stegehuis confirmed that she works 3rd shift, which is from 11:30 pm to 7:00 am. She also confirmed that she was the only staff member who transferred Resident A on the day in question. Ms. Stegehuis denied any knowledge of Resident A requiring the assistance of two staff. Ms. Stegehuis was adamant that she did not transfer Resident A inappropriately or cause any harm to her, despite the allegations against her. Ms. Stegehuis stated that her colleagues, Felipa "Monique" Barrientos-Hinkle and Laura Baca told her that Resident A disclosed to them that she injured her left shoulder from working with Physical Therapy (PT). Ms. Stegehuis stated that this is the first time she's been accused of doing something like this. Ms. Stegehuis stated that she spoke with a Detective from Ottawa County Sheriff's Department, and she told him the same thing. Ms. Stegehuis stated that she is unable to return to work "until this B.S. is cleared."

On 8/31/23, I spoke to AFC staff member, Yusuf Mberwa via phone. Mr. Mberwa is aware that Ms. Stegehuis is suspended pending the current investigation. Mr. Mberwa clarified that he did not work with Ms. Stegehuis on the day in question and did not witness her transfer Resident A. Mr. Mberwa stated that he works first shift and when he arrives at 6:30 am, he does rounds with Ms. Stegehuis and then she sits in the facility until her mother picks her up. Mr. Mberwa stated that rounds

include checking residents, providing verbal cues, and changing their diapers if needed.

Mr. Mberwa stated that he is aware of the injury that Resident A sustained as she told him that her shoulder hurt and not to pull her arm on the same day Ms. Stegehuis transferred her. Mr. Mberwa stated that he always asks Resident A if she's in any pain prior to transferring her. Mr. Mberwa stated that staff have to be careful with Resident A and must always use a gait belt. When he transferred Resident A on the same day that Ms. Stegehuis transferred her, she did not complain of any additional pain. Mr. Mberwa transferred Resident A himself. Mr. Mberwa stated, "they've been telling (Ms. Stegehuis) to be careful with Resident A's arm. She didn't listen and that's what happened," referring to her left shoulder injury. Mr. Mberwa stated that 3rd shift med tech, Laura Baca is the staff member that told Ms. Stegehuis to be careful with Resident A's arm when transferring her.

On 8/31/23, I spoke to AFC staff member, Felipa "Monique" Barrientos-Hinkle via phone. She did not know an exact date but did state the reported incident with Resident A occurred in early August. Ms. Barrientos-Hinkle confirmed that Resident A told her that her arm was dislocated. However, she is not sure if that's true as the discharge paperwork that she reviewed did not disclose a fracture. Ms. Barrientos-Hinkle denied that Resident A told her a specific staff member caused the injury to her shoulder. However, Ms. Barrientos-Hinkle stated that Resident A mentioned to her that she was "extra sore" from physical therapy.

Ms. Barrientos-Hinkle stated that she has done this type of work for more than 20 years and at this specific facility for the past 8 months. During her time at the facility, she has worked alongside Ms. Stegehuis, and she has never had any concerns regarding how she provided care to Resident A or other residents. Ms. Barrientos-Hinkle stated that Resident A is not shy and will tell people if she doesn't like the care she received. Ms. Barrientos-Hinkle stated she has never heard Resident A make any concerning statements about the care she's received from Ms. Stegehuis.

Ms. Barrientos-Hinkle stated that Resident A is typically transferred with a gait belt and likes to be assisted from her back side. Ms. Barrientos-Hinkle stated that sometimes, Resident A can be transferred with one staff member. However, there have been times where she has needed a 2nd person to assist if she's feeling weak.

On 9/5/23, I spoke to AFC staff member Laura Baca via phone. Ms. Baca is aware of the reported injury that Resident A sustained in early August. Around this same time, Ms. Baca stated that Resident A complained of arm pain and said she was sore from working with PT. Later that week, Resident A went to the hospital to get her arm checked out. Although Resident A initially told Ms. Baca that her arm pain was from PT, she then told her that Ms. Stegehuis hurt her arm. Ms. Baca asked Resident A about her statement due to the discrepancies, at which point Resident A reportedly told Ms. Baca that she didn't want to talk about it any further."

Ms. Baca stated that this is the first time she has ever heard of Ms. Stegehuis being accused of harming a resident. Ms. Baca stated that she has been employed at the facility for nearly one year and she has worked with Ms. Stegehuis for the duration of her employment. Throughout her time at the facility, Ms. Baca has not had any concerns regarding the care that Ms. Stegehuis provides to Resident A or other residents. Ms. Baca stated that she has witnessed Ms. Stegehuis transfer Resident A several times and she used a gait belt and pulls her up from the seam of her pants or her bottom each time. Regarding Resident A's care needs, Ms. Baca stated that sometimes she and Ms. Stegehuis have transferred her together. Ms. Baca stated that this was when Resident A required a "sit to stand." Since she has started walking, Resident A has only needed a 1 – person assist. Ms. Baca was unsure as to how long Resident A required a 2-person assist but does not believe that it was long.

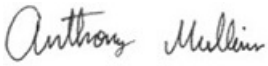
On 09/11/23, I conducted an exit conference with licensee designee, Theresa Bursley. She was informed of the investigative findings and agreed to complete a corrective action plan within 15 days of receipt of the report.

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:	Resident A stated that Ms. Stegehuis transferred her by grabbing and pulling her arm by herself without the use of a gait belt, causing her to have an injured left shoulder. Ms. Stegehuis acknowledged that she transferred Resident A by herself, but she was adamant that she used a gait belt. AFC staff member Mr. Mberwa did not witness the incident but stated that Resident A sustained her shoulder injury due to Ms. Stegehuis not being careful with Resident A's arm. AFC staff members, Ms. Barrientos-Hinkle and Ms. Baca both confirmed that Resident A told them that her arm was sore from physical therapy. Ms. Baca stated that Resident A later told her that Ms. Stegehuis hurt her, but she did not want to discuss it further when asked about the discrepancy from her initial statement. Resident A's medical records were reviewed and confirmed that she sustained a left rotator cuff tear and was given a sling to

	wear. Medical records also indicate that Resident A has age-related osteoporosis without current pathological fracture. Ms. Stegehuis confirmed that she transferred Resident A by herself. Resident A's assessment plan clearly indicates that she requires extensive assistance, including a gait belt and two-person assist with transfers. Therefore, there is a preponderance of evidence to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

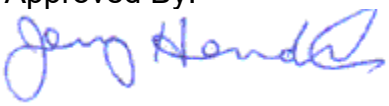
Upon receipt of an acceptable corrective action plan, I recommend no change to the current license status.



09/11/2023

Anthony Mullins Date
Licensing Consultant

Approved By:



09/11/2023

Jerry Hendrick Date
Area Manager