GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 20, 2023

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

RE: License #: AL700397745
Investigation #: 2023A0467061
AHSL Jenison Maplewood

Dear Mrs. Bursley:

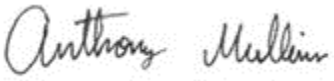
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AL700397745
Investigation #:	2023A0467061
Complaint Receipt Date:	09/21/2023
Investigation Initiation Date:	09/21/2023
Report Due Date:	11/20/2023
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 Maplewood
Facility Address:	887 Oak Crest Lane Jenison, MI 49428
Facility Telephone #:	(616) 457-3576
Original Issuance Date:	03/11/2019
License Status:	REGULAR
Effective Date:	09/11/2023
Expiration Date:	09/10/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
There is concern that the meals lack nutritional value and are being served cold.	Yes
The facility does not have enough staff to appropriately address resident needs.	Yes
Additional Findings	Yes

III. METHODOLOGY

09/21/2023	Special Investigation Intake 2023A0467061
09/21/2023	Special Investigation Initiated - Telephone
09/25/2023	Inspection Completed On-site
11/20/2023	APS referral sent via email.
11/20/2023	Exit conference completed with Katrina Aleck, regional wellness director.

ALLEGATION: There is concern that the meals lack nutritional value and are being served cold.

INVESTIGATION: On 9/21/23, I received a BCAL online complaint stating that there are ongoing concerns regarding the lack of nutritional value of the meals being served. The complaint stated that on several occasions, Resident A has complained of the lack of fresh fruits, vegetables, and palatable food. One day in particular, the complainant's sister observed lunch that consisted of green jello, noodles with sauce (no protein), and less than ¼ cup of over-cooked cauliflower. This issue was reportedly brought to the attention of staff multiple times with no results.

On 9/21/23, I spoke to the complainant via phone. The complainant stated that 9/16/23 was the date that Resident A was served lunch that consisted of green jello, noodles with sauce (no protein), and less than ¼ cup of over-cooked cauliflower. The complainant stated that management is aware of the concerns and the issue has not been addressed. The complainant stated that management told her that the food that is served at the facility is all driven by **"**corporate**"** and that they have no control over it. The complainant stated that Resident A has been served cold food with no fresh fruits or vegetables. The complainant stated that the food that Resident A and others in the facility are eating is not nutritious and not well-prepared.

On 9/25/23, I made an unannounced onsite investigation at the facility. Upon arrival, staff assisted me to Resident A's room and introductions were made. Resident A stated that she has resided at the facility for approximately six months, and she has concerns regarding the food. Resident A stated that she's "fussy" about the food and have told staff that she doesn't want bread or too much hamburger. Resident A stated that staff do not abide by her wishes regarding food. Resident A stated that last night the facility served cornbread and chili. Resident A stated that she tried to eat the meal but was unable to due to not liking chili. This past Saturday Resident A stated that she was supposed to have chicken with noodles. However, when she received the meal, it was a small portion and did not appear to have chicken in it. Resident A stated the food at the facility is "more or less hospital food" as it does not have any salt, pepper, or seasoning and is bland. Resident A also stated that the facility does not serve fresh fruits or vegetables. When she does receive fruit, Resident A stated that it is typically "tough" and not ripe to the point where she is unable to use a fork to eat it. Resident A stated that on weekends, "you get what they serve" as there are no alternative food options available. As a result of this, Resident A drinks Ensure to supplement her food intake. Resident A stated, "out of all the places I've been, this place has been the worst." Regarding the food temperature, Resident A stated that she's had to ask for food to be sent back to be warmed up. Resident A stated that, "sometimes the food is very warm and other times, it's mediocre."

After speaking to Resident A, I spoke to the executive director, Theresa Bursley regarding the allegations. Mrs. Bursley stated that Resident A's daughter has called in the past to express concerns regarding the food at the facility, which included Resident A's preferences. This concern was then addressed with the culinary team. Since the issue was brought to the culinary team's attention, Mrs. Bursley stated that the culinary team checks with the serving staff, checks food temperatures out of the steamer, warming food up for residents if/when needed, and checking with residents when food is served to make sure they approve of the food. Mrs. Bursley stated that the last time Resident A was asked about her concerns regarding the food, she stated things were "fine." Mrs. Bursley confirmed that the facility doesn't offer alternative food options on the weekends. Mrs. Bursley stated that residents have expressed a desire for fresh fruits and vegetables in the past. Mrs. Bursley stated the facility usually has bananas, apples, and other fruits available for residents.

While onsite, I reviewed the Fall/Winter 2023 food menu provided by staff. I noticed that approximately ½ cup of fruit was offered to residents daily during dinner. Per the menu, fruit offered was not always fresh. Residents were only receiving ½ cup fruit per day when the United States Department of Agriculture (USDA) recommends 1.5 to 2 cups daily.

It should be noted that while myself, Mrs. Bursley and Mrs. Hicks were leaving the facility, I noticed a staff member loading prepared/cooked food into the trunk of her personal vehicle and transporting it to another facility on campus. The staff member

introduced herself as Darci Tibbetts. Ms. Tibbets acknowledged that she has transported food to other facilities on campus for “awhile” without using food warmers due to it being too heavy for her to transport by herself. With the food not being properly stored, there is no way to regulate the temperature.

On 11/20/23 I conducted an exit conference with Katrina Aleck, regional wellness director on behalf of the facility. 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 400.15313	**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:	Resident A stated that food portions provided to her are small, the food is bland, the food temperature is often “mediocre” and the facility is not providing enough fresh fruits and vegetables. Resident A also stated that the facility does not provide alternative food options on the weekends. Mrs. Bursley confirmed that residents have complained about the lack of fresh fruits and vegetables in the past and this concern was addressed with the culinary team. Per Mrs. Bursley, changes occurred including staff checking with residents to make sure they approve of the food. I reviewed the fall/winter menu and noted that residents are receiving approximately ½ cup of fruit per day although the USDA recommends 1.5 to 2 cups per day. Based on the lack of fresh fruits provided to residents, food being transported in the trunk of personal vehicles without food warmers, and concerns listed from Resident A above, there is a preponderance of evidence to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: The facility does not have enough staff to appropriately address resident needs.
INVESTIGATION: On 9/21/23, I received a BCAL online complaint stating that there are ongoing concerns regarding the level of staffing at the facility. The complaint alleged that because of the lack of staffing, Resident A’s needs are not being met, such as not receiving water as scheduled.

On 9/21/23, I spoke to the complainant via phone, and she confirmed the allegation.

On 9/25/23, I made an unannounced onsite investigation at the facility. Upon arrival, staff assisted me to Resident A's room. Resident A expressed her concerns with staffing at the facility. Resident A stated that she requested water at 9:30 am today and has yet to receive it, more than two hours later. Resident A stated that this happens "quiet often" at the facility. I observed Resident A's water cup sitting empty next to her. Resident A stated that she typically gets her water refilled at or around 7:00 pm "but nothing else" despite requesting it. Resident A also stated that she has requested staff open her blinds for her this morning and this request has not been addressed either.

Resident A also shared that this past Friday, 9/22/23, she fell to the floor while trying to use the bathroom and urinated on herself. Resident A stated that when she fell, there was only one staff member working at the facility. The unknown staff member attempted to help her off the floor but was unable to do so by herself. The staff member had to call over to another facility to ask a staff member to assist, which she did per Resident A. Resident A stated that she also had a fall approximately six months ago. During her previous fall, there were two staff members to assist her. Due to this, Resident A assumed that there would be two staff members readily available to assist during the fall this past Friday.

After speaking to Resident A, I spoke to the executive director, Theresa Bursley and the wellness director, Jennifer Hicks regarding Resident A's needs not being met as it relates to staffing. Mrs. Bursley and Mrs. Hicks stated that this was the first time that they had heard of Resident A not receiving water when requested. Mrs. Bursley confirmed that AHSL Jenison Maplewood has approximately six residents who require a two-person assist for their care needs. Due to this, Mrs. Bursley is aware that the facility is required to have two staff members working on each shift. I informed Mrs. Bursley that Resident A reported falling this past Friday and there was only one staff member in the building at the time. Mrs. Bursley and Mrs. Hicks denied any knowledge of Resident A falling this past weekend. Mrs. Bursley did not have any knowledge of the facility having only one person working on the day in question.

I reviewed the staff schedule with Mrs. Bursley and Mrs. Hicks from this past weekend, which showed that AFC staff member Mika Sullivan worked at the facility by herself on 9/22/23 from 3:15 pm to 7:30 am. Mrs. Bursley and Mrs. Hicks shared that if they had an agency staff member working with Ms. Sullivan, it wouldn't show in their system. Mrs. Hicks agreed to email a copy of the six residents that require a two-person assist. On 9/26/23, I received an email from Mrs. Hicks that included six assessment plans as requested. The assessment plans indicate that Resident B requires a one-person assist. However, Resident C, Resident D, Resident E, Resident F, and Resident G all require a two-person assist and "utilization of a mechanical lift with transfers." It appears that Mrs. Bursley and Mrs. Hicks misspoke

about the number of residents who require a two-person assist as there are five residents as opposed to six who require a two-person assist.

On 10/9/23, I received a call from the complainant stating that Resident A was recently sent to the ER due to being dehydrated. This is important to note due to Resident A expressing her concerns on 9/25/23 about staff members not refilling her water when requested.

On 11/20/23, I conducted an exit conference with Katrina Aleck, regional wellness director on behalf of American House. 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 was adamant that her care needs were not being met as it was reportedly difficult to get water when requested. Resident A also stated that when she fell on 9/22/23, there was only one staff member working in the facility who was unable to assist Resident A off the floor without calling over to another facility to request additional help. Mrs. Bursley confirmed that the facility has residents who require a two-person assist. I reviewed six assessment plans, five of which pertained to residents who require a two-person assist. The staff schedule was reviewed for 9/22/23 and confirmed that only one staff member worked at the facility. Therefore, there is a preponderance of evidence to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: While investigating the allegations listed above, it was brought to my attention by the complainant that Resident A has reportedly missed scheduled doses of her levothyroxine medication in the past. The complainant was unable to give a specific date as to when the medication was missed but did confirm this occurred sometime this year. Resident A also confirmed that she has missed doses of medications during her time at the facility. While onsite, executive director

Theresa Bursley showed me Resident A's medication administration records (MARs) for the year. While reviewing the MARs, I confirmed that Resident A missed her Levothyroxine medication on 2/7/23 and 2/8/23. The documented explanation provided as to why the medication was missed was "med not ordered so none in cart" and "on order."

In April 2023, Resident A missed four total doses of the following medications: Pregabalin 50 MG Capsule, Gemtesa Oral Tablet 75MG, Vitamin D3, 2,000 Unit tablet, and Ear Drops 6.5%. The documented explanations provided as to why the medications were missed are, "med not available, could not find, has not come in from pharmacy, and waiting on pharmacy."

In June 2023, Resident A missed total doses of the following medications: Preservision Areds 2 Cap, MAPAP 500 MG Caplet, Gemtesa Oral Tablet 75MG, Omega-3 Ethyl Esters 1GM C, and Metformin HCL 1,000 MG Tablet. The documented explanations provided as to why the medications were missed are "LOA with family and awaiting refill."

In July 2023, Resident A missed a total of three doses of the following medications: Reguloid Capsule (Psyllium), Betaxolol Hcl Ophthalmic Solution 0.5%, and Ketoconazole 2% foam. The documented explanations provided as to why the medications were missed were, "out with her daughter and awaiting refill."

On 11/20/23, I conducted an exit conference with Katrina Aleck, regional wellness director on behalf of American House. 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 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident A confirmed that she has missed scheduled doses of medications during her time at the facility. Her Mars were reviewed and confirmed her statement. The explanations provided as to why Resident A missed scheduled doses of medications in February, April, June, and July 2023 are not acceptable reasons. Therefore, there is a preponderance of evidence to support the allegations.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: While investigating the allegations listed above, I compared the food menu to the food that was prepared for the day. The menu indicated that

residents are offered soup at lunch and dinner daily. However, kitchen staff informed me that soup is only served during dinner time, despite the menu indicating otherwise.

On 11/20/23, I conducted an exit conference Katrina Aleck, regional wellness director on behalf of the facility. She was informed of the investigative findings and aware that a corrective action plan is due within 15 days of receipt of the facility.

APPLICABLE RULE	
R 400.15313	**Resident nutrition**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.
ANALYSIS:	The facility's food menu states that residents are offered soup daily at lunch. However, kitchen staff informed me that soup is only offered during dinner. Changes to the menu are to be noted. However, this was not done. 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.

Anthony Mullins

11/20/2023

Anthony Mullins Date
Licensing Consultant

Approved By:

Jerry Hendrick

11/20/2023

Jerry Hendrick Date
Area Manager