GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 26, 2023

Lauren Gowman
Appledorn Assisted Living Center
727 Apple Avenue
Holland, MI 49423

RE: License #: AH700236753
Investigation #: 2024A1028003
Appledorn Assisted Living Center

Dear Lauren 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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AH700236753
Investigation #:	2024A1028003
Complaint Receipt Date:	10/05/2023
Investigation Initiation Date:	10/09/2023
Report Due Date:	12/04/2023
Licensee Name:	Appledorn Living Center LLC
Licensee Address:	950 Taylor Ave. Grand Haven, MI 49417
Licensee Telephone #:	(616) 842-2425
Administrator:	Greg Hooson
Authorized Representative:	Lauren Gowman
Name of Facility:	Appledorn Assisted Living Center
Facility Address:	727 Apple Avenue Holland, MI 49423
Facility Telephone #:	(616) 392-4650
Original Issuance Date:	03/01/2000
License **Status:**	REGULAR
Effective Date:	05/12/2023
Expiration Date:	05/11/2024
Capacity:	174

Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A fell eight times resulting in injury and the facility did not follow Resident A's service plan.	Yes
Resident A missed medications.	No
Additional Findings	No

III. METHODOLOGY

10/05/2023	Special Investigation Intake 2024A1028003
10/09/2023	Special Investigation Initiated - Letter
10/09/2023	APS Referral APS made referral to HFA. Resident is deceased.
10/25/2023	Contact - Face to Face Interviewed Admin/Greg Hooson at the facility.
10/25/2023	Contact - Face to Face Interviewed Employee A at the facility.
10/25/2023	Contact - Document Received Received Resident A's record from Admin/Greg Hooson.

ALLEGATION:

Resident A fell eight times resulting in injury and the facility did not follow Resident A's service plan.

INVESTIGATION:

On 10/5/2023, the Bureau received the allegations through the online complaint system.

On 10/9/2023, Adult Protective Services (APS) made referral to Homes for the Aged (HFA) through Centralized Intake. Resident A is deceased.

On 10/25/2023, I interviewed facility administrator, Greg Hooson, at the facility who reported Resident A had a history of falls and demonstrated a significant decline in health. There was conflict between family members concerning Resident A's care and state guardian had to appointed due to the conflict. Mr. Hooson reported the facility followed Resident A's service plan, physician orders, and sent Resident A to the hospital in a timely manner. Mr. Hooson provided me Resident A's record for my review.

On 10/25/2023, I interviewed Employee A at the facility who reported there was conflict within Resident A's family concerning guardianship and that a state guardian had to be appointed due to the continued conflict. During this conflict, Resident A fell and one family member did not want Resident A sent to the hospital and another family did want Resident A sent to the hospital. Employee A reported Resident A was sent to the hospital regardless of the conflict to assess for potential injury. Employee A reported Resident A required full assist with bathing, dressing, grooming, toileting, and transfers. Resident A was significant fall risk and to their knowledge had three falls at the facility, not eight. Employee A reported Resident A was either sent to the hospital after each fall and/or the Resident A's physician assessed Resident A at the facility to include completing a mobile x-ray at the facility. Employee A reported anytime Resident A fell, a facility incident report was completed, and the appropriate authorized representative was notified as well. Employee A reported no knowledge of Resident A ever being found with dried feces, as Resident A was monitored very closely due to significant decline in health. Employee A reported facility staff followed all physician orders and the service plan to ensure appropriate care. Resident A was discharged from the facility on 9/18/2023 due to passing away.

On 10/25/2023, I reviewed Resident A's service plan which revealed the following:

- Required one person assistance with showering, dressing, hygiene and grooming.
- Required two person assistance with toileting and transfers.
- Had a special gluten and dairy-free diet.
- Required nightly visual checks 2 times per night daily.
- Could utilize call light.
- Facility managed meals, housekeeping, and medications.
- Staff monitored Resident A for medication side effects due to health history.

- Was an increased fall risk due to prior history of falls. Ambulated with wheeled walker but this increased fall risk as well and had difficulty in walking. Also, history of Vertigo.
- No history of behaviors.
- Used a mat alarm for safety.

I reviewed Resident A's record documentation which revealed the following:

- On 8/3/2023, Resident A's call light went off and Resident A was found sitting on the floor. Resident A did not complaints of pain and no injuries were noted. Resident A was assisted from the floor using a gait belt and was noted to not have any shoes on. Resident A did not use walker when attempting to get up from the bed.
- On 8/4/2023 and 8/5/2023, facility care staff completed post fall charting to continue to monitor Resident A. Facility care staff reassessed Resident A post fall with Resident A stating [they] *are doing well and no complaints of pain or discomfort.* Resident A's authorized representative was notified of fall.
- On 8/18/2023, Resident A was observed on the floor, stating [they] fell due to losing balance. Assessment was completed with no complaints of pain or discomfort. Resident A incurred a small skin tear on right leg and it was cleaned and bandaged. Resident A's authorized representative was notified of fall with the facility recommending a chair alarm and the authorized representative was in agreement of getting the chair alarm. Resident A's physician also notified.
- On 8/18/2023, post fall charting was completed by facility care staff with Resident A reporting [they[are a little sore from fall. Resident A administered Tylenol per physician orders.
- On 8/19/2023, post fall charting continued with Resident A reported pain from fall at 9:45am and again at 3:15pm. At 9:30pm, Resident A reports no more pain related to fall. Facility staff continue to monitor.
- On 8/20/2023 at 3:30am, Resident A *complained of leg pain all night and the pain has progressively gotten worse to the point [they] no longer feel capable of walking. [They] state pain starts at hip area and runs all the way down legs. She has no PRN left for pain.*
- On 8/20/2023 at 10:45am, Resident A had *complaints of pain, but unable to give PRN Tylenol as the max amount has been reached. Will continue to monitor.*
- On 8/22/2023, Resident A was restless during the night and demonstrated *difficulty transferring to/from toilet/bed due to weakness in bilateral LE. Required assist x 2 for transfers during the night. [Resident A] requested Trazadone for insomnia and Tylenol for pain to left shoulder. Will continue to monitor.*
- .On 8/23/2023, the facility received new physician orders to address Resident A's difficulty urinating, weakness, and falls.
- On 8/25/2023, the facility received updated physician orders for Tylenol and Lidocaine patch, and Sienna tablet/1 daily. Resident A *is very forgetful with*

receiving Tylenol. Lidocaine patch seems to be working a slight better than it has been.

- On 8/24/2023, facility received requested order from physician for x-rays of lumbar spine and left hip. Nursing and physical therapy also ordered by physician.
- On 8/25/2023, facility received radiology report for lumbar spine with loss of vertebral body height noted. Intervertebral discs spaces are narrowed. Compression deformity at L4 level, age indeterminate. Resident A's authorized representative notified by PCP office.
- On 8/28/2023, facility received new physician order to obtain and monitor Resident A's vitals twice daily for the next few days. Resident A to be seen by physician on Wednesday. Resident A's authorized representative notified.
- On 8/28/2023, Resident A diagnosed with lower respiratory infection and prescribed medication/antibiotics. Home health nursing and facility staff monitoring.
- On 9/18/2023 at 2:45am, Resident A alerting staff to assist with toileting, but requiring an increase with assist.
- On 9/1/2023 at 9:30am, Resident A *requesting staff assistance every 15 minutes and requiring increased assistance as well. Resident A claims [they] are unable to walk and requested medication every 30 minutes to an hour for pain. These are scheduled medications and they do not seem to help [Resident A] for pain relief.* Facility contacted physician for guidance.
- On 9/1/2023, the facility received updated physician orders for pain relief for Resident A.
- On 9/3/2023 at 11:15pm, Resident A alerted staff using the call light with staff arriving to find Resident A in bed covered in feces. Resident A was assisted to the bathroom and cleaned. Resident A's bedding was also cleaned.
- On 9/4/2023 at 2:15am, Resident A *wet the bed. Was assisted to the bathroom and did not have to urinate any further. Resident A was changed and cleaned up and assisted back to bed. Complaints of extreme pain in both legs.*
- On 9/4/2023 at 4:30am, Resident A continuing to demonstrate incontinence of urine.
- On 9/4/2023 at 1:45pm, Resident A's authorized representative conferenced with about Resident A's bed and fall prevention and Resident A's demonstrated difficulty with transferring. The authorized representative was in agreement with facility fall prevention and care recommendations.
- On 9/4/2023, Resident A's service plan was updated to two person assistance for transferring and toileting for safety. Resident A's authorized representative in agreement and conferenced with about potential future placement at a skilled facility.
- On 9/4/2023, facility care staff members attempted to assist Resident A to transfer from the bed to walk to the bathroom when Resident A got out of bed on own and said "Oh no! I can't stand on my legs" and the proceeded to drop to ground. Staff members present attempted to prevent fall but were unsuccessful. Resident A was assessed for injuries and none were found.

Resident A complained of pain in back. Resident A's physician and authorized representative notified.

- On 9/5/2023 at 4:45am, Resident A complained of extreme bi-lateral lower extremity pain. Resident A very incontinent. Resident A's physician notified and scheduled for facility visit later in morning.
- On 9/5/2023 at 11:30am, a large skin tear on Resident A's leg was observed by staff with Resident A unsure of it was obtained. Facility care staff assessed and cleaned and alerted supervisors along with home health nurse.
- On 9/5/2023 at 11:30am, Resident A complained of chest pain. No PRN meds for it. Resident A told to inform facility staff if pain worsens. Vitals were obtained with BP 100/50, Pulse 59, Temperature 97.5, and O2 97%. Supervisor notified and staff to check back in 30 minutes.
- On 9/5/2023 at 1:00pm, Resident A stating pain level is 7 and complains of pain in legs, back, hip, and right shoulder.
- On 9/5/2023 at 1:15pm, facility care staff checked on Resident A concerning chest pains. Resident A *stated it went away and [they] feel better now.*
- On 9/5/2023 at 6:45pm, the facility conferenced with the physician for recommendations due to Resident A's *consistent decline over the last few days. Resident A's authorized representative also aware of decline.*
- On 9/6/2023, Resident A continues to complain of pain and stated nothing was working for [pain relief]. Post fall charting was completed to document bruises on bilateral legs, lower back, left hip and right upper arm.
- On 9/6/2023 at 5:00pm, facility received new orders for Resident A's medications.
- On 9/7/2023 at 12:15pm, facility notified physician about redness underneath breast with a new order being sent to address it.
- On 97/2023 at 1:45pm, physician recommended hospice and hospital bed but it is dependent on authorized representative agreement.
- On 9/8/2023, Resident A's daughter and conservator came to take resident to hospital due to complaints of extreme pain in legs and hip. Facility care staff called AMR to bring resident to Holland hospital per family's request. Physician also notified.
- On 9/8/2023, the facility called Resident A's authorized representative to schedule care conference for Monday 9/11/2023. The authorized representative was in agreement and stated he was extremely happy with the facility care of Resident A but that his sister has not been. A court appointed guardian is now in place due to family disagreements over Resident A's care.
- On 9/8/2023 at 2:15pm, the court appointed guardian informed the facility upon discharge from the hospital, Resident A would be going to a skilled nursing facility.
- On 9/9/2023 at 4:45am, the facility learned Resident A was admitted to the hospital and that a partially healed right hip fracture and right rib fracture was found when the hospital completed x-rays. Resident A also has possible GI bleed but tests were being performed to confirm or not. Resident A was provided morphine in the hospital to address pain.

- On 9/18/2023, the facility was informed Resident A passed away on hospice care.

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:	It was alleged Resident A fell eight times resulting in injury and the facility did not follow Resident A's service plan. Interviews, onsite investigation, and review of documentation reveal it was documented Resident A fell four times, not eight as alleged. The physician and authorized representative was notified of each fall. On 8/24/2023, the facility also requested x-rays of Resident A's hip and back due to Resident A's complaints of pain. On 8/25/2023, the mobile x-ray was revealed the following: • Lumbar spine with loss of vertebral body height noted. • Intervertebral discs spaces are narrowed. • Compression deformity at L4 level, age indeterminate. Resident A's complaints of pain in the legs, hip, back, and shoulder began on 8/18/2023 and continued until Resident A was hospitalized on 9/8/2023. The facility demonstrated communication with Resident A's physician, home health team, and authorized representative to address pain and discomfort. However, it cannot be determined if Resident A's authorized representative was notified on 8/20/2023 and/or did not agree to send Resident A sent to the hospital after Resident A began complaining of *leg pain all night and the pain has progressively gotten worse to the point [they] no longer feel capable of walking. [They] state pain starts at hip area and runs all the way down legs.* On 8/20/2023 at 10:45am, Resident A continued to have complaints of pain, but facility staff was unable to give PRN Tylenol as the max amount has been reached. It cannot be determined if Resident A's authorized representative was notified of this and/or if the physician was notified of this as well to determine and/or recommend that Resident A be sent to the hospital for evaluation for injury due to fall and due to complaints of extreme pain. There is no evidence documented in the record that facility staff notified the physician or the authorized representative about Resident A's continued complaints of pain on 8/20/2023. Also, on 9/5/2023 at 11:30am, Resident A complained of chest pain with Resident A instructed by facility care staff to inform facility staff if pain worsens within the next 30 minutes. Vitals were obtained with BP 100/50, Pulse 59, Temperature 97.5, and O2 97%. The facility supervisor was notified, and staff were to check back in 30 minutes, but it could not be determined if Resident A's physician or authorized representative were notified of the complaint of chest pains. Also, it is not

	documented that staff checked on Resident A within 30 minutes after first complaint of chest pains. Facility staff did not document checking on Resident A until 1:15pm on 9/5/2023, which was 1 hour and 45 minutes after the initial complaint of chest pains. While the facility monitored Resident A and conferenced with the physician and authorized representative to address pain, falls, skin tears, and significant decline in health with potential referral for a skilled nursing placement, the facility did not provide appropriate assistance and protection because Resident A was not sent to the hospital after a fall on 8/20/2023 despite complaints of extreme pain or on 9/5/2023, after complaints of chest pain. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A missed medications.

INVESTIGATION:

On 10/25/2023, Employee A reported Resident A only missed medications due to being hospitalized on 9/8/2023 and/or due to one refusal to pass because of physician recommendation. Employee A reported Resident A had several physician ordered medication changes but Resident A did not miss any medications and the facility followed the physician medication orders for Resident A. Employee A provided me Resident A's medication record for my review.

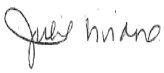
On 10/25/2023, I reviewed Resident A's medication record which revealed Resident A was refused 25mg of Pregabalin at 8:36pm due to conflict with vital parameters. It was recommended by the physician not to pass due to blood pressure concerns. There is no other evidence of Resident A missing medications.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.

ANALYSIS:	It was alleged Resident A missed medications. Interviews and review of documentation reveal there is no evidence to support this allegation. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, I recommend the status of this license remains the same.



10/26/2023

Julie Viviano Date
Licensing Staff

Approved By:

12/20/2023

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section