GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 16, 2024

Jennifer Brown
Hope Network Rehabilitation Serv
1490 E Beltline SE
Grand Rapids, MI 49506

RE: License #: AL410083024
Investigation #: 2024A0583013
Wildwood Residential Services

Dear Mrs. Brown:

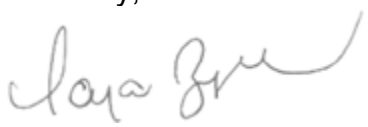
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410083024
Investigation #:	2024A0583013
Complaint Receipt Date:	12/26/2023
Investigation Initiation Date:	12/26/2023
Report Due Date:	01/25/2024
Licensee Name:	Hope Network Rehabilitation Serv
Licensee Address:	1490 E Beltline SE Grand Rapids, MI 49506
Licensee Telephone #:	(616) 643-3977
Administrator:	Jennifer Brown
Licensee Designee:	Jennifer Brown
Name of Facility:	Wildwood Residential Services
Facility Address:	3492 Lake Drive SE Grand Rapids, MI 49546-4338
Facility Telephone #:	(616) 356-0183
Original Issuance Date:	02/26/1999
License Status:	REGULAR
Effective Date:	08/10/2023
Expiration Date:	08/09/2025
Capacity:	16
Program Type:	PHYSICALLY HANDICAPPED, DEVELOPMENTALLY DISABLED, MENTALLY ILL, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Facility staff failed to provide Resident A and Resident B with adequate care.	Yes

III. METHODOLOGY

12/26/2023	Special Investigation Intake 2024A0583013
12/26/2023	APS Referral
12/26/2023	Inspection Completed On-site
01/08/2024	Contact – Telephone Staff Morgan Gustman
01/16/2024	Exit Conference Licensee Designee Jennifer Brown

ALLEGATION: Facility staff failed to provide Resident A and Resident B with adequate care.

INVESTIGATION: On 12/26/2023 I received a voicemail message from Licensee Designee Jennifer Brown. Ms. Brown's voicemail stated that Resident A was recently observed by facility staff on the floor of bedroom with no pants on. Resident A was observed as cold with his feeding tube open and leaking bile. On that same morning, Resident B was observed in her bed covered in feces and urine. Ms. Brown stated that it is believed that third shift staff Morgan Gustman was assigned to complete Resident A and Resident B's third shift care which consisted of every two-hour bed checks and routine brief changes. Special Investigation 2024A0583013 was opened in accordance with suspected quality of care rule violation R 400.15303 (2).

On 12/26/2023 I emailed the complaint allegations to Adult Protective Services Centralized Intake.

On 12/26/2023 I completed an unannounced onsite investigation at the facility and privately interviewed staff Holly Erb and staff Kristina Canterbury.

While onsite I visually observed the wellbeing of Resident A. Resident A was unable to complete an interview given his disabilities. Resident A was observed to utilize a wheelchair and feeding tube. Resident A was observed clean with adequate hygiene.

While onsite I visually observed the wellbeing of Resident B. Resident B was unable to complete an interview given her disabilities. Resident B was observed clean and with adequate hygiene.

While onsite I observed Resident A's Assessment Plan, signed 11/08/2023, states Resident A requires assistance with all personal care and cannot communicate his needs. This document states Resident A requires staff assistance with his feeding tube, utilizes a wheelchair, and is incontinent.

While onsite I observed Resident B's Assessment Plan, signed 06/15/2023, states Resident B is incontinent and requires, "changes every two hours or more often as needed".

Staff Holly Erd stated that on 12/23/2023 at approximately 7:00 AM she entered the facility and spoke briefly with staff Morgan Gustman who had worked the previous third shift from 12/22/2023 11:00 PM until 12/23/2023 7:00 AM. Ms. Erb stated that Ms. Gustman had been assigned to provide Resident A and Resident B's care during the previous shift. Ms. Erb stated that Ms. Gustman reported that Ms. Gustman had completed bed checks for Resident A and Resident B "every two hours" with the last bed check occurring at 5:30 AM. Ms. Erb stated Ms. Gustman left the facility shortly after 7:00 AM and Ms. Erb immediately proceeded to check on Resident A and Resident B in their respective bedrooms at approximately 7:10 AM. Ms. Erb stated that she observed Resident A was lying on his bedroom floor with no pants or adult briefs on. Ms. Erb stated that Resident A was "cold to the touch" and his adult brief was observed near him. Ms. Erb stated that Resident A's feeding tube was "open" and leaking bile onto Resident A's shirt. Ms. Erb stated that she proceeded to Resident B's bedroom and Resident B was observed in her bed "covered in feces and urine". Ms. Erb stated that Resident B's bedding, clothing, and floor contained Resident B's urine and feces. Ms. Erb stated that she has previously observed Resident A and Resident B with urine-soaked adult briefs and bedding recently after Ms. Gustman had worked third shift. Ms. Erb stated that she had informed "administration" that it appeared Ms. Gustman was not providing adequate personal care to residents while working third shift and Ms. Erb was informed that Ms. Gustman had been provided feedback from "administration".

Staff Kristina Canterbury stated that on 12/23/2023 she worked from 7:00 AM until 3:00 PM with staff Holly Erb. Ms. Canterbury stated that staff Morgan Gustman had worked the previous third shift from 12/22/2023 11:00 PM until 12/23/2023 7:00 AM. Ms. Canterbury stated that at approximately 7:10 AM Ms. Canterbury observed Resident A on the floor of his bedroom without pants or his adult briefs on. Ms. Canterbry stated that Resident A was observed as cold and shaking with his feeding tube leaking bile. Ms. Canterbury stated she subsequently observed Resident B in her bed covered in feces and urine. Ms. Canterbury stated that she did not talk with Ms. Gustman on 12/23/2023.

On 01/08/2024 I interviewed staff Morgan Gustman via telephone. Ms. Gustman started that she worked third shift from 12/22/2023 11:00 PM until 12/23/2023 7:00 AM and oversaw Resident A and Resident B's care. Ms. Gustman stated that she visually checked Resident A and Resident B at "midnight". Ms. Gustman stated that she changed Resident A's adult brief at midnight and Resident B was "fine and dry". Ms. Gustman stated that she changed Resident B's adult brief at 2:00 AM because it was wet and at 5:30 AM because it was wet. Ms. Gustman stated she last checked on Resident A at 5:30 AM before leaving the facility at 7:00 AM. Ms. Gustman stated that she changed Resident A's adult brief at 5:00 AM because it was wet for the second time during the shift. Ms. Gustman stated that she last checked on Resident A at 5:00 AM before leaving the facility at 7:00 AM. Ms. Gustman stated that during the evening she did have to reposition Resident A twice because Resident A was observed to have "rolled almost completely off his bed". Ms. Gustman stated that she provided adequate resident care to Resident A and Resident B and stated she completed resident checks every two hours. Ms. Gustman stated that she never observed Resident A or Resident B in any distress.

On 01/16/2024 I completed an Exit Conference with Licensee Designee Jennifer Brown via telephone. Ms. Brown stated that she agreed with the Special Investigation finding and staff Mogan Gustman has been terminated from employment with the facility.

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:	Staff Morgan Gustman stated that she provided adequate care to Resident A and Resident B and completed resident checks "every two hours". Ms. Gustman stated that she never observed Resident A or Resident B in any distress. Resident A's Assessment Plan states Resident A requires assistance with all personal care and cannot communicate his needs. This document states Resident A requires staff assistance with his feeding tube, utilizes a wheelchair, and is incontinent. Resident B's Assessment Plan states Resident B is incontinent and requires "changes every two hours or more often as needed". On 12/23/2023, staff Holly Erb stated that she observed Resident A lying on his bedroom floor with no pants or adult

	briefs on. Ms. Erb stated that Resident A was "cold to the touch" and his adult brief was observed near him. Ms. Erb stated that Resident A's feeding tube was "open" and leaking bile onto Resident A's shirt. Ms. Erb stated that she proceeded to Resident B's bedroom and Resident B was in her bed "covered in feces and urine". Ms. Erb stated that Resident B's bedding, clothing, and floor contained Resident B's urine and feces. Staff Kristina Canterbury stated that at approximately 7:10 AM Ms. Canterbury observed Resident A on the floor of his bedroom without pants or his adult briefs on. Ms. Canterbry stated that Resident A was cold and shaking with his feeding tube leaking bile. Ms. Canterbury stated she subsequently observed Resident B in her bed covered in feces and urine. A preponderance of evidence was discovered during the Special Investigation to substantiate violation of the applicable rule; Staff Morgan Gustman did not provide Resident A and Resident B with appropriate care.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend the license remain unchanged.

01/16/2024

Toya Zylstra — Date
Licensing Consultant

Approved By:

01/16/2024

Jerry Hendrick — Date
Area Manager