GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 12, 2023

Rochelle Lyons
Grandhaven Living Center LLC
Suite 200
3196 Kraft Avenue SE
Grand Rapids, MI 49512

RE: License #: AL330378741
Investigation #: 2023A0577008
Grandhaven Living Center (Harbor)

Dear Ms. Lyons:

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 (231) 922-5309.

Sincerely,

Bridget Vermeesch, Licensing Consultant
Bureau of Community and Health Systems
1919 Parkland Drive
Mt. Pleasant, MI 48858-8010
(989) 948-0561

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL330378741
Investigation #:	2023A0577008
Complaint Receipt Date:	11/30/2022
Investigation Initiation Date:	12/01/2022
Report Due Date:	01/29/2023
Licensee Name:	Grandhaven Living Center LLC
Licensee Address:	Suite 200 3196 Kraft Avenue SE Grand Rapids, MI 49512
Licensee Telephone #:	(517) 420-3898
Administrator:	Brandy Shumaker
Licensee Designee:	Rochelle Lyons
Name of Facility:	Grandhaven Living Center (Harbor)
Facility Address:	3145 West Mt. Hope Lansing, MI 48911
Facility Telephone #:	(517) 485-5966
Original Issuance Date:	08/07/2017
License **Status:**	REGULAR
Effective Date:	02/07/2022
Expiration Date:	02/06/2024
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
On November 28, 2022 Resident A was found unresponsive and medical attention was not sought in a timely manner.	No
Resident B was not administered medications as prescribed due to medications not being refilled by the facility.	Yes

III. METHODOLOGY

11/30/2022	Special Investigation Intake 2023A0577008
12/01/2022	APS Referral made to Penny Howard, Ingham Co APS.
12/01/2022	Special Investigation Initiated – Telephone made to Penny Howard, Ingham Co APS.
12/13/2022	Inspection Completed On-site
01/03/2023	Contact - Telephone call made to Relative A1
01/04/2023	Inspection Completed-BCAL Full Compliance
01/05/2023	Exit Conference with Rochelle Lyons
01/09/2023	Contact-Telephone call made to Corso Care Pharmacy

ALLEGATION: On November 28, 2022 Resident A was found unresponsive and medical attention was not sought in a timely manner.

INVESTIGATION:

On November 30, 2022, a complaint was received alleging Resident A was found unresponsive during first and second shift on November 28, 2022. The complaint further alleged Resident A missed her 3:00pm medications due to being unresponsive and at approximately 5:30pm Resident A was sent to the hospital after being unresponsive for two and half hours.

On December 01, 2022, I contacted Penny Howard, Adult Protective Service Specialist (APS) with Ingham County, who reported receiving a referral pertaining to Resident A on November 28, 2022. Ms. Howard stated the referral reported Resident A regularly uses a wheelchair and is diagnosed with cerebral palsy and that on November 28,

2022, around 3:00pm Resident A was found in bed unresponsive, pale, and did not respond to sternum rubs. The APS referral documented Executive Director SarahKate Vanauker was informed Resident A was not responding to staff and Ms. Vanauker replied, “Can you take her vitals or something because I am doing payroll and I am not trained in care anyway?” The APS referral reported that around 6:00pm Resident A was taken to Sparrow Medical Hospital. Ms. Howard reported she went to the facility on November 30, 2022 and spoke with Bobbie Huizen, Operations Specialist, who showed Ms. Howard text messages from direct care staff (DCS) member Ariana Shaw from November 28, 2022 at 5:25pm documenting Resident A being found unresponsive and needing medical attention. Ms. Howard reported Ms. Huizen stated 911 was contacted at that time and Resident A was taken to the hospital where Resident A remains as of this interview.

On December 13, 2022, I reviewed an *AFC Licensing Division-Incident/Accident Repor*t (IR) that had been sent to the assigned Adult Foster Care Consultant and filed in the Licensing and Regulatory Affairs AFC file. This IR received from the facility on November 29, 2022, documented that on November 28, 2022, at 5:20pm DCS Arianna Shaw upon shift change was advised Resident A stated after lunch she was not feeling well and was going to rest. The IR documented that later in the shift DCS Shaw observed Resident A to be lethargic and hard to awaken. The IR documented staff reported concerns to leadership, obtained Resident A vitals and determined it was necessary to call 911 for Resident A to be transported to the hospital for evaluation and treatment.

December 02, 2022, I interviewed DCS Ariana Shaw who reported on November 28, 2022, at 2:30pm shift change DCS Shaw was told by first shift staff Resident A was really tired due to having physical therapy and was in her bedroom resting. DCS Shaw reported a little after 3:00pm, she tried to pass Resident A her medications but could not wake her. DCS Shaw reported from 3:00pm-5:00pm Resident A was checked on by multiple staff due to needing medications at 3:00pm and 4:00pm and continued to present as lethargic and would not respond to staff other than by opening her eyes. DCS Shaw reported around 4:45pm she attempted to contact Resident A’s Durable Power Of Attorney to discuss these concerns but was unsuccessful in making contact. DCS Shaw reported she sent Bobbi Huizen, Operations Specialist, a text message notifying Ms. Huizen of Resident A being unresponsive and missing medications. DCS Shaw reported she was advised by Ms. Huizen to take Resident A’s vitals and do a Covid Test. DCS Shaw reported Resident A did not open her eye while her vitals were being taken or when the Covid test was taken. DCS Shaw reported 911 was contacted and Resident A was taken to the hospital. DCS Shaw denied that either Ms. Huizen or Executive Director Sarah Kate VanAuker refused to assist with this incident because they were busy with other tasks such as payroll.

On December 13, 2022, I completed an unannounced onsite investigation and I interviewed Resident A and Relative A1 who both reported not having any concerns regarding Resident A’s care. Resident A and Relative A1 both reported direct care staff are responsive and attentive when assistance is needed. Resident A denied being left

unattended by any direct care staff member. Resident A reported she had family visiting that day, she had completed physical therapy and was simply very tired. Resident A reported when staff became concerned they called for an ambulance right away. Relative A1 reported another family member had visited with Resident A on November 28, 2022 and during this visit Relative A1 spoke with Resident A and family on the telephone. Relative A1 reported she spoke with Resident A by telephone around 2:30pm and Resident A was alert and talking at this time but did say she was tired and family was getting ready to leave. Relative A1 reported she spoke with her family who had been visiting after their visit and they had no concerns to reports regarding Resident A needing medical attention while they were visiting. Relative A1 reported she received a call from the facility around 6:00pm on November 28, 2022, advising Relative A1 Resident A was being taken to the hospital due being lethargic and unresponsive.

On December 13, 2022, I interviewed Executive Director Sara Kare VanAuker who reported she was working with Bobbie Huizen, Operations Manager, in the office when Ms. Huizen received a text message from a direct care staff member regarding Resident A. Ms. VanAuker reported she did not specifically speak with any staff about Resident A. Ms. VanAuker reported about 10 minutes after Ms. Huizen received the text message, Ms. Huizen reported to Ms. VanAuker they were sending Resident A to the hospital. Ms. VanAuker reported all care and communication regarding Resident A's needs were done between DCS Arianna Shaw and Bobbie Huizen, Operations Manager.

On December 13, 2022, I interviewed Bobbie Huizen, Operations Manager by telephone. Ms. Huizen reported on November 28, 2022 Resident A had physical therapy in the morning and family visiting in the afternoon. Ms. Huizen reported the first time any concerns regarding Resident A were reported to her were by DCS Arianna Shaw through a text message around 5:15pm. Ms. Huizen reported the text message from DCS Shaw discussed Resident A not waking up to take her medications at 3PM, then attempted again at 4PM and third time at 5PM with Resident A not responding. Ms. Huizen reported she advised DCS Shaw to take Resident A's vitals, complete a Covid Test, and if still no response call for an ambulance. Ms. Huizen reported this is what transpired.

On December 13, 2022, I interviewed DCS Aniyah Caldwell and Takeria Taylor who both reported they worked first shift on November 28, 2022 and recalled Resident A was pretty tired that day. DCS Caldwell reported Resident A stayed in her room for most of the day and had family visiting. DCS Caldwell reported Resident A seemed tired, but nothing alarming or causing concern. DCS Taylor reported Resident A said she was not feeling well after her family left so she was going to rest. DCS Taylor reported she took Resident A's vitals and they were in the normal range. DCS Taylor reported she checked in on Resident A few times and found Resident A sleeping. DCS Taylor reported as shift changed she notified Arianna Shaw of Resident A reporting she was not feeling well so DCS Shaw could keep an eye on Resident A. DCS Taylor reported Resident A did not show any signs of distress or concerns, Resident A just reported she was not feeling well.

During my onsite investigation on December 13, 2022, I reviewed Resident A's *Charting Notes* for November 28, 2022, which documented no concerns regarding Resident A's health during first shift. I observed DCS Arianna Shaw documented Resident A was not responsive to taking her medications at 3:00pm and 5:00pm when vitals were taken and an ambulance was called.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Based on the information gathered during the investigation, I found that on November 28, 2022, Resident A was not feeling well during first shift, this information was passed along to second shift and during second shift Resident A became lethargic and unresponsive. At this time an ambulance was called and Resident A was taken to the hospital. Consequently, needed care was obtained immediately once an adverse change in Resident A's physical condition was observed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident B was not administered medications as prescribed due to medications not being refilled by the facility.

INVESTIGATION:

On December 01, 2022, a second complaint was received alleging Resident B is prescribed a medication patch to be administered in the morning and removed at night. The complaint alleged Resident B has had the same patch on since November 17, 2022, because the pharmacy refused to refill the prescription.

On December 13, 2022, during my unannounced onsite investigation I reviewed Resident B's *Medication Administration Records* (MAR) and physicians orders for the months of November until December 13, 2022. Per Resident B's physician orders, Resident B is prescribed a Lidocaine Pad 5% to be administered for 12 hours on and 12 hours off. Per Resident B's MAR's it is documented the Lidocaine Pad is administered daily at 8:00pm and then removed at 8:00am. Resident B is also prescribed Rivastigmine Disc, a patch that is applied daily. Per Resident B's MAR the Rivastigmine Disc is applied at 8:00am. Resident B's November 2022 MAR

documented Resident B did not her Rivastigmine Disc from November 22-November 28, 2022 “due to waiting on pharmacy to refill the prescription”.

On December 13, 2022, I interviewed DCS Takeria Taylor who reported Resident B receives two forms of medications through a patch, Lidocaine which is administered at night and removed in the morning and Rivastigmine which is administered in the morning. DCS Taylor reported there was a time in which the pharmacy would not refill Resident B’s Rivastigmine due to the prescription ending and the physician not willing to write a new order.

On December 13, 2022, I interviewed DCS Celeste Weakly who reported around November 17, 2022 she noticed Resident B was getting low on her Rivastigmine and submitted a refill through their electronic system and the refill request was accepted. DCS Weakly reported the Rivastigmine was not delivered the next day as requested so DCS Weakly stated she contacted the pharmacy to see when the medication was going to be filled and delivered. DCS Weakly stated she was told the prescription had no refills and the doctor was not returning the pharmacy’s request for new prescription. I also interviewed DCS Takeria Taylor who reported Resident B ran out of her Rivastigmine patch due to the prescription having no refills. DCS Taylor reported she left multiple messages for Resident B’s primary care physician requesting a new prescription with no return phone call or new prescription being written.

On December 13, 2022, I interviewed Executive Director Sara Kate VanAuker who reported Bobbie Huizen, Operations Manager, oversees the resident medications so she was not sure of specifics but does know the medication was called in for a refill. Ms. VanAuker stated she understood the pharmacy could not fill it due to no refills, and both the pharmacy and facility attempted to call the doctor multiple times requesting a refill with it taking a few days for the doctor to respond.

On January 09, 2023, I interviewed Chloe Vickrey, Pharmacist with Corsocare Pharmacy, who reported Resident B is prescribed Lidocaine Pad 5% which was requested to be refilled by the facility on November 06, 2022 and was delivered on November 07, 2022. Ms. Vickrey reported their system shows no delays in deliveries of any medication for Resident B in the month of November 2022 due to not having refills, stating “what I see from our system all medications were delivered timely to the facility for [Resident B].” Ms. Vickrey reported Resident B’s Rivastigmine patch was requested for refill by a facility direct care staff member on Sunday, November 27, 2022, when the pharmacy is closed but was then delivered on Monday, November 28, 2022. Ms. Vickrey reported Resident B did not need a new prescription to fill this request so it could have been filled earlier had it been requested earlier. Ms. Vickrey stated, “when I pull up the administration history in the E-MAR it shows the facility put ‘awaiting med from pharmacy’ but there are no refill requests in the system prior to 11/28 for the month of November pertaining to Rivastigmine.”

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the information gathered during the investigation, it has been found Resident B did not receive her Rivastigmine Disc from November 22-November 28, 2022, even though there were refills available. It has been found Resident B's medication was not given as prescribed per the label instructions.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, it is recommended that the current status of the license remains unchanged.

Bridget Vermeesch 01/11/2023

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Bridget Vermeesch Date
Licensing Consultant

Approved By:

Dawn Timm 01/12/2023

_____

Dawn N. Timm Date
Area Manager