GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 29, 2024

Jonathan Brook
AH Jenison Subtenant LLC
6755 Telegraph Rd Ste 330
Bloomfield Hills, MI 48301

RE: License #: AL700397745
Investigation #: 2024A0467013
AHSL Jenison Maplewood

Dear Mr. Brook:

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 #:	AL700397745
Investigation #:	2024A0467013
Complaint Receipt Date:	01/02/2024
Investigation Initiation Date:	01/02/2024
Report Due Date:	03/02/2024
Licensee Name:	AH Jenison Subtenant LLC
Licensee Address:	One SeaGate, Suite 1500 Toledo, OH 43604
Licensee Telephone #:	(248) 203-1800
Administrator:	Jonathan Book
Licensee Designee:	Jonathan Book
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?
Resident A was not checked on during 3rd shift on 12/27/23 and was covered in urine and dried vomit the morning of 12/28/23.	Yes

III. METHODOLOGY

01/02/2024	Special Investigation Intake 2024A0467013
01/02/2024	Special Investigation Initiated - Telephone Spoke to complainant via phone.
01/08/2024	Inspection Completed On-site
02/28/2024	APS Referral – sent via email
02/28/2024	Exit conference completed with licensee designee, Jonathan Book.

ALLEGATION: Resident A was not checked on during 3rd shift on 12/27/23 and was covered in urine and dried vomit the morning of 12/28/23.

INVESTIGATION: On 1/2/24, I received a complaint via phone stating that Resident A was found covered in urine, feces, and vomit on the morning of 12/28/23 due to 3rd shift staff not checking on her throughout the night as required. The complainant stated that Resident A is now in Zeeland Hospital due to a stomach bug/vomiting. The complainant stated that Resident A's daughter was at her bedside from the early morning on 12/27/23 until 6:30 pm. The complainant stated that Resident A's daughter left around 6:30 pm due to Resident A appearing to be doing better. The complainant stated that Resident A's daughter requested that staff keep an eye on Resident A throughout the night due to her symptoms throughout the day.

Despite this, the complainant stated that Resident A was found the morning of 12/28/23 covered in vomit and soaked in urine. The complainant stated that the 3rd shift staff member "covered her (Resident A) with sheets and blankets all the way up to her shoulders. The complainant stated that when first shift staff came on shift on the morning of 12/28/23, they discovered Resident A covered in "a mess," referring to the vomit and urine found on her. The complainant stated that staff members Ally Terryn and Ashley Hill cleaned Resident A up and confirmed that she had dried vomit on herself and her pillow. The complainant also stated that Resident A's adult depend was full with urine and feces and her mattress was soaked.

On 1/8/24, I made an unannounced onsite investigation at the facility. Upon arrival, I spoke to licensee designee, Jill Lajoie and she agreed to discuss case allegations. Mrs. Lajoie stated that she was made aware of the incident by Resident A's daughter. Mrs. Lajoie stated that she walked to Resident A's apartment with her daughter on the morning of 12/28/23, which is when she observed a dried round spot on Resident A's blanket. Mrs. Lajoie stated that Resident A's mattress pad was not soaked, and her room was clean. Mrs. Lajoie shared that an internal investigation was completed for this incident. The incident occurred on 12/28/23. The night prior, 12/27/23, staff member Diamond Hayes was working with Resident A into the morning of 12/28/23. Ms. Hayes reportedly completed rounds on Resident A at 12:00 am, 2:00 am, 4:00 am, 6:00 am, and 7:20 am on the morning of 12/28/23 prior to ending her shift. Per Mrs. Lajoie, Ms. Hayes stated that she did not observe any vomit during her routine checks throughout her shift. Resident A was eventually sent to the hospital due to being severely dehydrated and pneumonia, per Mrs. Lajoie. Mrs. Lajoie provided me with a copy of Resident A's assessment plan, which states that Resident A requires "frequent nighttime rounding to ensure safety and support of incontinence episodes."

Mrs. Lajoie also provided me with a written statement from AFC staff member, Diamond Hayes. In the written statement, Ms. Hayes stated that on 12/27/23 she was made aware of (Resident A's) illness during shift change. Per Ms. Hayes, Resident A pulled her alarm and she responded and noticed vomit on her bedsheets. Ms. Hayes reportedly took Resident A to the bathroom where she began to vomit into a pink pale while sitting on the toilet with diarrhea. Ms. Hayes stated that she changed Resident A's sheets as well as Resident A. Ms. Hayes stated that she called Resident A's daughter, Linda around 2:00 am and she was not able to come into the facility due to her husband having surgery. Per Ms. Hayes, Linda asked her to call her sister, Kim, which she did. Per Ms. Hayes, at or around 3:00 am, Resident A's daughter Kim came to the facility and spent the night with her. The written statement added, "family decided not to send mom out."

On 12/28/23, Ms. Hayes stated that Resident A's daughter wanted her mom's apartment inspected as she felt that her mother was not cared for during the prior night. Per Ms. Hayes, Mrs. Lajoie and Resident A's daughter inspected her apartment and there was discoloration and urine on her bed sheets, pad, and wet pajamas hanging on her hamper. At this time, Mrs. Lajoie reportedly called Ms. Hayes to collect her statement and Ms. Hayes stated the following: "Diamond Hayes was informed upon shift change that (Resident A) was still not feeling well from the day/night before." Ms. Hayes stated that she checked on Resident A when she made rounds at approximately 12:00 am, 2:00 am, 4:00 am, 6:00 am, and again before she left for the day around 7:20 am. Ms. Hayes stated that she observed Resident A on her back sleeping. Ms. Hayes stated that Resident A's covers were half on and half way off because the room was warm. Ms. Hayes stated that she did not observe any vomit. Ms. Hayes stated that she administered Resident A's morning medication at 6:00 am and had to sit her upright due to it being difficult for her to swallow. At approximately 7:20 am, Ms. Hayes checked on Resident A again

and observed her asleep and no vomit was observed. Ms. Hayes stated that EMS arrived at the facility at approximately 9:00 am to transport Resident A to the hospital. Ms. Lajoie was thanked for her time as this interview concluded.

On 1/9/24, I spoke to AFC staff member, Ally Terryn via phone and she agreed to discuss the case allegation. Ms. Terryn confirmed that she worked on the morning of 12/28/23 and she arrived sometime between 7:00 am and 7:15 am. When she arrived at work, she received report from 3rd shift staff stating that Resident A had a good night and "nothing was wrong." Ms. Terryn stated that she and her colleague checked on Resident A at least twice before 8:30 am but she was not quite sure of the specific times. "Checking" on Resident A prior to 8:30 am reportedly consisted of opening her door, walking in her room to making sure she was still in bed and not needing anything. During those two checks, Ms. Terryn stated that Resident A was still asleep. Ms. Terryn stated that she did not smell urine or vomit when she walked in the room. However, she was wearing a mask due to the facility having a covid outbreak and she could not smell anything through her mask. During the first two checks on Resident A, Ms. Terryn stated that Resident A was covered with her blankets, and she did not pull them off due to Resident A sleeping. Ms. Terryn stated that Resident A typically awakes herself, but she occasionally needs reminders. Ms. Terryn stated that the extra checks on Resident A occurred on the morning of 12/28/23 due to being aware of Resident A not feeling well the previous day. Despite third shift staff telling Ms. Terryn that Resident A had a good night, she reviewed the "24-hour report sheet" that stated Resident A was "very sick", which was different from the verbal report she received from 3rd shift. Ms. Terryn stated that AFC staff member, Diamond Hayes was the 3rd shift staff member that provided her with the verbal report for Resident A.

Due to Resident A not feeling well the previous day and not being awake by 8:30 am, Ms. Terryn went into Resident A's room and pulled back her sheets, which is when she quickly noticed that Resident A was "covered in vomit (including underneath her pillow), she was soaking wet and not in good condition." Ms. Terryn stated that she called EMS because Resident A's oxygen level was low, and she was struggling to breathe and talk. Ms. Terryn stated that the vomit that was on the bed and on Resident A was "dried up and she was soaked in urine." Ms. Terryn denied Resident A lying in feces. Ms. Terryn stated that she could not say for certain, but she would assume the vomit that Resident A was found lying in occurred before she arrived at the facility due to it being dried up when it was noticed at 8:30 am. Ms. Terryn confirmed that 3rd shift staff are supposed to do frequent checks. Ms. Terryn added that when she first began working for American House in 2019, she was initially told to complete checks on residents every two hours starting at 10:00 pm. Now, staff are being told to do "frequent checks" so she is unsure as to how often staff are actually required to do regarding checks. When staff members complete rounds, they are supposed to chart it and 3rd shift is supposed to sign a book that confirms they've completed checks.

Ms. Terryn stated that she has never seen Resident A in the condition she observed

her in on the morning of 12/28/23. Ms. Terryn stated that when she left the facility last week Thursday (1/4/24), Resident A was still in the hospital. Ms. Terryn stated that agency staff member, Ashley Hill was working with her on the morning of 12/28/23. She also stated a 3rd staff member was working but she was unable to recall who. Ms. Terryn stated that Ms. Hill went into Resident A's room with her at 8:30 am and observed her condition. Ms. Terryn stated that Ms. Hill told her that Resident A appeared to have some apnea occurring/struggling to breathe. This led to both staff members going into the room, and this is when both Ms. Terryn and Ms. Hill observed the conditions that Resident A was in. Resident A's daughter came into the facility on this morning. As Ms. Terryn and Ms. Hill were getting Resident A cleaned up, her daughter went to speak to Jill Lajoie, the executive director and Ms. Lajoie came to ask her questions about Resident A's independence within the community. Ms. Terryn stated that she gave Ms. Lajoie her story and "that was that." Ms. Terryn was thanked for her time as this interview concluded.

On 1/9/24, I spoke to agency staff member, Ashley Hill via phone and she agreed to discuss the case allegation. Ms. Hill is employed through Career Staff Unlimited Agency. Ms. Hill confirmed that she worked with AFC staff member, Ally Terryn on the morning of 12/28/23. Ms. Hill worked from 6:30 am until 3:00 pm. Ms. Hill was asked to share what occurred on the morning of 12/28/23 and the condition that Resident A was found in prior to being sent to the hospital. Ms. Hill stated that she cared for Resident A the day prior (12/27/23), and she was visibly ill, vomiting, unable to hold down liquids and unable to eat anything. Due to this, Ms. Hill put Resident A in bed on her side and asked staff to rotate her on her sides throughout the night and not lay her on her back. Ms. Hill made this request due to her fear of Resident A aspirating because of how much she had been vomiting. When Ms. Hill arrived at work at 6:30 am on 12/28/23, the report she was given was that "everyone was fine," including Resident A. Ms. Hill could not recall the name of the staff member that gave her report. At approximately 6:45 am on 12/28/23, Ms. Hill stated that she did her visual rounds on Resident A and "peaked in" at her. Ms. Hill stated that at first glance of looking in the room, "it looked okay without turning the lights on." Ms. Hill stated that she completed the rest of her visual checks on the other residents and eventually made her way back to Resident A's room to check on her again. When she checked on Resident A, Ms. Hill stated that there were a lot of towels laid out to catch vomit for Resident A if needed. When Ms. Hill removed the towels, she immediately noticed that "there was vomit everywhere." Ms. Hill stated that the towels that were on Resident A's bed were laid over "already dried vomit and she (Resident A) herself was covered in dried vomit as well."

This led to Ms. Hill going to get the medication tech, who was identified as Ms. Terryn to visualize the incident so she could make a note of it. Ms. Hill stated that Ms. Terryn helped her get Resident A cleaned up. In addition to lying in dried vomit, Ms. Hill stated that Resident A was also in "a puddle of urine" and lying on her back although she specifically asked staff not to lay Resident A on her back. Ms. Terryn stated that she noticed Resident A in this state at or around 7:15 am. After Ms. Hill expressed her concerns to Ms. Terryn, she reportedly contacted the appropriate

parties and she continued to make sure Resident A was cleaned appropriately. Ms. Hill stated that she asked Ms. Terryn to make the request that Resident A be sent to the hospital due to her condition. Ms. Hill stated that Ms. Terryn called Resident A's daughter and she arrived and assessed the situation and Resident A was taken to the hospital. Based on how Ms. Hill found Resident A, she was adamant that 3rd shift staff on 12/27/23 into the morning of 12/28/23 did not do what was necessary to ensure Resident A was cared for appropriately. Ms. Hill stated that she doesn't work 3rd shift, but she knows 2-hour checks are mandatory per American House policy. Ms. Hill is unsure if 2-hour checks are documented by in-house staff. As an agency staff member, she does not document in the American House charting system. Ms. Hill stated that she provides care to the residents at American House often and staff are typically good. In Ms. Hill's experience, this incident regarding Resident A is an isolated incident to her knowledge. Ms. Hill has been at American House just short of a year and never had this type of incident occur. Ms. Hill believes this incident is directly related to the staff that worked the night of 12/27/23 as opposed to American House as a whole. Ms. Hill was thanked for her time as this interview concluded.

On 02/28/24, I conducted an exit conference with licensee designee, Jonathan Book. Mr. Book confirmed that he is the permanent licensee designee moving forward as Mrs. Lajoie has returned to a different facility within American House. Mr. Book 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 400.15303	**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:	The verbal report given to Ms. Terryn and Ms. Hill on the morning of 12/28/23 was that all residents were "fine" including Resident A, despite the 24-hour report sheet stating that Resident A was very sick. However, staff members Ally Terryn and Ashley Hill both confirmed that Resident A was observed lying in dried vomit and soaked in urine on the morning of 12/28/23. AFC staff member, Diamond Hayes provided a written statement stating that she completed rounds on Resident A every two hours from 12:00 am to 7:20 am on the morning of 12/28/23 and did not observe any vomit. Resident A's assessment plan states that she requires "frequent nighttime rounding to ensure safety and support of incontinence."

	Based on the condition that Resident A was found in on the morning of 12/28/23, it is apparent that adequate rounds were not completed during the night and Resident A was not adequately monitored and cared for. Therefore, a violation of the applicable rule is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

02/28/2024

Anthony Mullins — Date
Licensing Consultant

Approved By:

02/29/2024

Jerry Hendrick — Date
Area Manager