GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 6, 2024

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

RE: License #: AL700397745
Investigation #: 2024A0583020
AHSL Jenison Maplewood

Dear Mrs. Bursley:

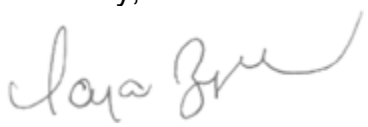
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



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 #:	AL700397745
Investigation #:	2024A0583020
Complaint Receipt Date:	02/15/2024
Investigation Initiation Date:	02/16/2024
Report Due Date:	03/16/2024
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:	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 does not receive adequate care at the facility.	No
Additional Findings	Yes

III. METHODOLOGY

02/15/2024	Special Investigation Intake 2024A0583020
02/16/2024	Special Investigation Initiated - Telephone Complainant
02/16/2024	Inspection Completed On-site
02/21/2024	APS Referral
03/06/2024	Exit Conference Licensee Designee Jonathan Book

ALLEGATION: Resident A does not receive adequate care at the facility.

INVESTIGATION: On 02/15/2024 I received complaint allegations from the BCAL online reporting system. The complaint stated that on 9/23/23 Resident A "fell and broke her left hip area/leg, was hospitalized". The complaint alleged that "there was someone standing next to her, and she fell over on the 9/23/23 incident but there have been many occasions she uses a walker, and she walks herself and no one is assisting her".

On 02/16/2024 I interviewed the complainant via telephone. The complainant stated that Resident A is coherent and makes her own decisions. The complainant stated that on 09/23/2023 Resident A was hospitalized due to a broken hip sustained at the facility. The complainant stated that Resident A reported that on 09/23/2023, Resident A was standing in her bedroom by her closet picking out a dress to wear. Resident A reported that a staff member was located nearby Resident A before she fell but the complainant was unsure if Resident A's walker was nearby. Resident A reportedly informed the complainant that she lost her balance and fell causing her to sustain a left broken hip. The complainant stated there is concern regarding the level of care Resident A receives. The complainant stated that Resident A is paying for the "highest level of care" and facility staff may not be providing it as evidenced by the 09/23/2023 fall. The complainant stated that Resident A's care requires staff to always walk right next to her while she is ambulating with her walker. The

complainant stated that facility staff are required to always be standing next to Resident A when Resident A is not seated.

On 02/16/2024 I completed an unannounced onsite investigation at the facility and privately interviewed Resident A, Resident B, staff Brianna Navetta, and staff Kylie Berghorst.

Resident A presented as coherent and well groomed. Resident A was oriented to time and place and able to answer all interview questions. Resident A stated that on 09/23/2023 she was standing in her bedroom in front of her closet picking out a dress to wear to a wedding. Resident A stated that during the incident an "agency staff member" whose name Resident A could not recall was standing next to Resident A on her right side and Resident A's walker was located to her left side. Resident A stated that she lost her balance and fell to her left side and onto the floor. Resident A stated that the fall resulted in a broken hip. Resident A stated that facility staff immediately sought medical attention and the incident was an accident. Resident A stated that facility staff always stand next to her while she is standing. Resident A stated that when she is ambulating certain staff place a gait belt around her waist while Resident A ambulates with her walker. Resident A stated that other facility staff do not use the gait belt but always stand close behind her while she is ambulating with her walker. Resident A stated that she always has facility staff assist her while standing and ambulating. Resident A stated that she is happy with the level of care provided.

Resident B stated that he has only observed Resident A ambulating with staff closely following behind her. Resident B stated that he has never observed Resident A fall and he is happy with the level of care provided.

Staff Brianna Navetta stated that she has worked at the facility for approximately five years. Ms. Navetta stated that she had no knowledge of the 09/23/2023 incident. Ms. Navetta stated that Resident A requires staff assistance with standing and ambulating. Ms. Navetta stated that she follows close behind Resident A while Resident A ambulates with her walker. Ms. Navetta stated that she never observed Resident A standing or ambulating without facility staff assistance.

Staff Kylie Berghorst stated that she has worked at the facility since October 1st 2023. Ms. Berghorst stated that she had no knowledge of the 09/23/2023 incident. Ms. Berghorst stated that Resident A requires staff assistance with standing and ambulating. She stated that she places a gait belt around Resident A's waist and follows behind Resident A while Resident A ambulates with her walker. Ms. Berghorst stated that she never observed Resident A standing or ambulating without facility staff assistance.

On 02/22/2024 I received and reviewed an email from licensee designee Jonathan Book. The email contained Resident A's Assessment Plan and an Incident Report completed on 09/23/2023 by LPN Jennifer Hicks. The Incident Report stated, "Staff

was getting clothes from resident's closet when resident fell onto floor on her left side" and "EMS to ER for evaluation". The Incident Report identified an "agency staff" was assisting Resident A on 09/23/2023 however the document does not identify the name of the staff. Resident A's Assessment Plan was completed on 06/02/2023 by Kerri Quist but is not signed by any parties. The document stated Resident A requires the use of a "walker and wheelchair long distances".

On 02/26/2024 I interviewed Wellness Director Jennifer Hicks via telephone. Ms. Hicks stated that although she signed the Incident Report, she was not involved in the 09/23/2023 incident involving Resident A. Ms. Hicks confirmed that she no longer works at the facility.

On 03/06/2024 I completed an Exit Conference with licensee designee Jonathan Book. Mr. Book stated that he agreed with the findings.

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:	Resident A stated that on 09/23/2023 she was standing in her bedroom in front of her closet picking out a dress. Resident A stated a staff member was standing next to her on her right side and Resident A's walker was located to her left side. Resident A stated that she lost her balance and fell to her left side and onto the floor. Resident A stated that the fall resulted in a broken hip. Resident A stated that facility staff obtained immediate medical attention and the incident Resident was an accident. Resident A stated that she always has facility staff assist her while standing and ambulating and she is happy with the level of care provided. Staff Brianna Navetta stated that Resident A requires staff assistance with standing and ambulating. Ms. Navetta stated that she follows close behind Resident A while Resident A ambulates with her walker. Ms. Navetta stated that she never observed Resident A standing or ambulating without facility staff assistance. Staff Kylie Berghorst stated that Resident A requires staff assistance with standing and ambulating. She stated that she places a gait belt around Resident A's waist and follows behind Resident A while Resident A ambulates with her walker. Ms.

	Berghorst stated that she has never observed Resident A standing or ambulating without facility staff assistance. A preponderance of evidence was not discovered to substantiate violation of the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS: Resident A's Assessment Plan lacks required signatures.

INVESTIGATION: On 02/22/2024 I received and reviewed an email from licensee designee Jonathan Book which included Resident A's Assessment Plan. I observed Resident A's Assessment Plan was completed on 06/02/2023 by Kerri Quist but was not signed by any parties. The document stated Resident A requires the use of a "walker and wheelchair long distances".

On 02/29/2024 I received and reviewed an email from licensee designee Jonathan Book which stated that he has been unable to locate the signatures pages for Resident A's Assessment Plan.

On 03/06/2024 I completed an Exit Conference with licensee designee Jonathan Book. Mr. Book stated that he agreed with the findings and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Resident A's Assessment Plan was completed on 06/02/2023 by Kerri Quist but was not signed by any parties. Licensee designee Jonathan Book stated that he has been unable to locate the signatures pages for Resident A's Assessment Plan.

	A preponderance of evidence was discovered to substantiate violation of the applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend no change to the license.

03/06/2024

Toya Zylstra Date
Licensing Consultant

Approved By:

03/06/2024

Jerry Hendrick Date
Area Manager