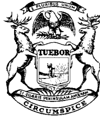

GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 11, 2024

Jennifer Herald
Glen Abbey Assisted Living, LLC
Suite 200
3196 Kraft Ave.
Grand Rapids, MI 49512

RE: License #: AH820372250
Investigation #: 2024A0784034
Glen Abbey Assisted Living

Dear Jennifer Herald:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Aaron L. Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820372250
Investigation #:	2024A0784034
Complaint Receipt Date:	02/15/2024
Investigation Initiation Date:	02/20/2024
Report Due Date:	04/15/2024
Licensee Name:	Glen Abbey Assisted Living, LLC
Licensee Address:	Suite 200 3196 Kraft Ave. Grand Rapids, MI 49512
Licensee Telephone #:	(616) 719-4332
Administrator:	Julie Edwards
Authorized Representative:	Jennifer Herald
Name of Facility:	Glen Abbey Assisted Living
Facility Address:	445 North Lotz Road Canton, MI 49512
Facility Telephone #:	(734) 981-9224
Original Issuance Date:	07/21/2017
License Status:	REGULAR
Effective Date:	01/21/2024
Expiration Date:	07/31/2024
Capacity:	64
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Inadequate care of Resident A.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/15/2024	Special Investigation Intake 2024A0784034
02/20/2024	Special Investigation Initiated - On Site
02/20/2024	Inspection Completed On-site
02/20/2024	Exit Conference Conducted with wellness director Elizabeth Mahoney and operations specialist Crystal Smith

ALLEGATION:

Inadequate care of Resident A.

INVESTIGATION:

On 2/15/2024, the department received this online complaint. A referral was made to adult protective services (APS).

According to the complaint, Resident A may have had a fall on or around the evening of 2/12/2024. Staff reported Resident A was complainant of right hip pain. Emergency medical services was contacted and came to the facility; however, they did not transport Resident A to the hospital at that time. The following day, Resident A was still complaining of hip pain and was ultimately brought to the hospital. The facility has not provided a clear understanding of what happened to cause Resident A her injury.

On 2/20/2024, I interviewed wellness director Elizabeth Mahoney and operations specialist Crystal Smith at the facility. Ms. Mahoney stated Resident A's fall happened at approximately 9pm on 2/11/2024. Ms. Mahoney stated the fall was "assisted" as it happened during an attempted transfer of Resident A by Associates 1 and 2 with Associate 3 also present. Ms. Smith stated Associate 3 helped Associates 1 and 2 to assist Resident A to the floor when Resident A started to go down during the transfer. Ms. Smith stated Resident A required a two person assist with a Hoyer and that Associates 1 and 2 did not use the Hoyer. Ms. Smith stated Associates 1 and 2 did not use the Hoyer because Resident A reportedly requested

an immediate transfer as she needed to use the restroom. Ms. Smith confirmed that EMS was contacted and came to the facility to transport Resident A to the hospital but did not do so as Resident A's authorized representative refused transport due to Resident A not reporting pain at that time. Ms. Smith stated a mobile X-Ray was ordered, however by approximately 9am the next morning, on 2/12/2024, Resident A was taken to the hospital as she was in pain and mobile X-ray had not arrived yet. Ms. Mahoney stated Resident A is currently still at rehab recovering from the fall.

I reviewed Resident A's service plan, provided by Ms. Smith. The plan read consistently with Ms. Smith's statements indicating Resident A required "2 Staff" for transfers and a "Hoyer lift with toileting or transfer sling".

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:	According to the complaint, Resident A had a fall and ultimately suffered hip pain and no clear understanding of what happened was provided. The investigation revealed Associates 1 and 2 attempted to transfer Resident A without a Hoyer lift as required by her service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

When interviewed, Ms. Mahoney stated that Julie Edwards, current appointed administrator, no longer works with the facility. Ms. Mahoney stated Ms. Edwards employment discontinued at the end of December 2023.

APPLICABLE RULE	
R 325.1913	**Licenses and permits; general provisions.**
	(2) The applicant or the authorized representative shall give written notice to the department within 5 business days of any changes in information as submitted in the application pursuant to which a license, provisional license, or temporary nonrenewable permit has been issued.

ANALYSIS:	The investigation revealed the facility has not had a newly appointed administrator although the currently appointed administrator reportedly stopped working at the facility at the end of December 2023. Based on the finding the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

When interviewed, Ms. Smith stated that Associates 1 and 2, as well as Associate 3 who were present at the time of the fall, had not been properly trained on transfers prior to attempting the transfer. Ms. Smith stated that prior to conducting any transfers, staff are supposed to do theory training within the facilities software training program called Relias, then receive a hands-on demonstration using staff and lastly those staff must conduct a hands-on training with other staff to demonstrate competency. Ms. Smith stated Associates 1, 2 and 3 had not completed any part of this training process before being scheduled to work on the floor with a resident who required transfers.

I reviewed training summary documents for Associates 1, 2 and 3 which read consistently with Ms. Smith statements.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	The investigation revealed associates 1 and 2 attempted the transfer of Resident A without proper training to do so. Additionally, associate 3 was also present during the transfer, helping in part, and was not trained for transfers revealing three staff having been scheduled to work with residents who require assistance with activities of daily living (ADLs) who were not fully trained to do so.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

When interviewed, Ms. Smith stated that prior to attempting the transfer with Resident A, Associate 1 did ask Associate 4, the shift supervisor, for assistance and was reportedly told “go ahead” and do it without her. Ms. Smith stated Associate 4 admitted to this instruction when asked about it.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(4) The supervisor of resident care on each shift shall do all of the following: **(b) Protect residents from accidents and injuries.**
ANALYSIS:	The investigation revealed Associate 4, supervisor on duty, was aware that Associates 1 and 2 were going to attempt a transfer of Resident A prior to the incident but declined to assist. Based on the findings, the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Aaron L. Clum 3/11/2024

Aaron Clum Date
Licensing Staff

Approved By:

03/12/2024

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