GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 14, 2024

Tyler May
AH Holland Subtenant LLC
6755 Telegraph Rd Ste 330
Bloomfield Hills, MI 48301

RE: License #: AL700397726
Investigation #: 2024A0467020
AHSL Holland Bay Pointe

Dear Mr. May:

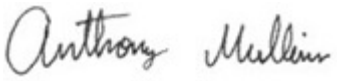
Attached is the Special Investigation Report for the above referenced facility. Due to the violation identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.

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 #:	AL700397726
Investigation #:	2024A0467020
Complaint Receipt Date:	02/13/2024
Investigation Initiation Date:	02/13/2024
Report Due Date:	04/13/2024
Licensee Name:	AH Holland Subtenant LLC
Licensee Address:	One SeaGate, Suite 1500 Toledo, OH 43604
Licensee Telephone #:	(616) 283-9221
Administrator:	Tyler May
Licensee Designee:	Tyler May
Name of Facility:	AHSL Holland Bay Pointe
Facility Address:	11899 James Street Holland, MI 49423
Facility Telephone #:	(616) 393-2174
Original Issuance Date:	04/08/2019
License Status:	REGULAR
Effective Date:	10/08/2023
Expiration Date:	10/07/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's needs are not being met.	Yes

III. METHODOLOGY

02/13/2024	Special Investigation Intake 2024A0467020
02/13/2024	Special Investigation Initiated - Telephone
02/20/2024	Inspection Completed On-site
02/20/2024	Contact – document received (Resident A's assessment plan).
02/21/2024	Contact – telephone call made to Shay Duflo, AFC staff member.
02/21/2024	Contact – telephone call made to Dominique Bothwell, AFC staff member.
02/22/2024	Contact – telephone call made to Shawn Jenkins, Director of Nursing.
03/14/2024	APS Referral – sent via email
03/14/2024	Exit conference with licensee designee, Tyler May.

ALLEGATION: Resident A's needs are not being met.

INVESTIGATION: On 2/13/24, I received a BCAL online complaint regarding Resident A's needs not being met. The complaint alleged that the facility lost several important items that Resident A needs, including her dentures, glasses, and one of her hearing aids. The complaint alleged that Resident A has falling numerous times and staff have not called her Power of Attorney (POA). There are also concerns that staff are not taking Resident A to the bathroom every two hours like her assessment plan requires.

On 2/13/24, I spoke to the complainant via phone. The complainant stated that Resident A's top/upper dentures and one of her hearing aids have been missing for a few months. As a result of Resident A missing her dentures, the complainant stated that she can't eat as well as she previously did. The complainant stated that the one hearing aid that the facility does have access to, staff do not assist Resident A to use it. It is unknown as to where the other hearing aid is currently. The complainant stated that Resident A is supposed to be taken to the toilet every two hours. The complainant stated that there have been multiple occasions when staff

likely went longer than two hours prior to changing her. The complainant is concerned for Resident A's quality of life while in the facility.

On 2/20/24, I made an unannounced onsite investigation at the facility. Upon arrival, I observed Resident A eating jello at the dining room table. Resident A did not have her dentures or hearing aids in at this time. Staff member Kimberly Hail stated that she just changed Resident A and brought her to the table to eat lunch. After briefly observing Resident A, introductions were made with Tyler May, interim executive director in his office. Mr. May has been in his current role since January 15 and stated that he was unaware of the concerns noted by the complainant. Mr. May stated that Shawn Jenkins, Director of Nursing would likely know more about this, but Ms. Jenkins is unavailable until Thursday, 2/22/24. I also spoke to AFC staff member, Ru Vanderlaan regarding the allegations. Ms. Vanderlaan stated that she was not aware of the allegations listed above. Ms. Vanderlaan and Mr. May confirmed that AFC staff members, Shay Duflo and Dominique Bothwell work with Resident A consistently and may be able to provide information regarding the allegations. Ms. Vanderlaan provided me with contact information for both staff members.

Mr. May escorted me back to Resident A's facility. Staff member, Darnecia Morris assisted Resident A to her room so I could attempt to interview her. Again, it should be noted that Resident A was not wearing any hearing aids, glasses, or her dentures. Ms. Morris stated that she has been employed through American House for one week and she was not aware of Resident A needing glasses or hearing aids. Ms. Morris stated that sometimes, other residents gain access to other rooms and take personal belongings of residents. In addition to Ms. Morris being unaware of Resident A needing her glasses and hearing aids, she was also unaware of Resident A needing or using dentures. In her time working at the facility, Ms. Morris stated that she has never seen Resident A's dentures. Ms. Morris stated that without teeth, Resident A takes longer to eat her food, but she can do it on her own.

While in Resident A's the room, Mr. May searched for her glasses, dentures, and hearing aids. Mr. May was able to locate one hearing aid that was sitting on the charger that was located on top of her dresser. Mr. May was unable to locate her glasses or dentures. Ms. Morris placed the individual hearing aid on Resident A's right ear, and I attempted to interview her. Resident A did not respond to any of my questions. This was not surprising given her current diagnosis. Mr. May stated that staff may need to keep Resident A's personal items on the medication cart, which would allow them to be readily available for her when needed.

Prior to concluding my onsite investigation, Mr. May emailed me a copy of Resident A's assessment plan. The assessment plan states that Resident A "is dependent on others to provide all grooming/personal hygiene needs," which includes partial dentures (upper). The assessment plan states that Resident A is to "wear glasses at all times" due to vision difficulties. It also states that "Resident has mild/moderate hearing impairment but can hear adequately with devices."

On 2/21/24, I spoke to AFC staff member, Shay Duflo via phone. Ms. Duflo stated that she is employed full-time and works at least 40 hours per week. Ms. Duflo stated that Resident A is assisted every two hours with toileting and the facility has toileting sheets that staff are to use throughout the day. When asked about falls, Ms. Duflo denied any recent falls for Resident A. During Resident A's last fall (exact day and time unknown), Ms. Duflo stated that she was sent to the hospital and there were discussions around her starting Hospice. However, Resident A's family declined to start her on hospice. Ms. Duflo stated that when a resident has a fall, staff typically notifies family members, their physician, and nurse within an hour or so. Ms. Duflo denied any knowledge of staff not informing Resident A's family after a fall and stated it should be documented in their computer system.

Ms. Duflo stated that she has been employed through American House since August 2023 and she has never seen Resident A wearing dentures or hearing aids. Ms. Duflo stated that the facility nurse mentioned that Resident A's family asked about her dentures and hearing aids last week and this was her first time hearing about them. Ms. Duflo stated that Resident A is on a mechanical soft diet, which means her food is broken down for her. Ms. Duflo stated typically, Resident A can eat on her own, but she does occasionally need help.

Regarding Resident A's glasses, Ms. Duflo stated that she has seen her wearing them in the past. However, they recently went missing. Ms. Duflo stated that other residents in memory care often wander into other people's rooms and things come up missing. At the time of this conversation, Ms. Duflo was adamant that Resident A is wearing her glasses, and she is unsure who located the glasses and where they were found. Ms. Duflo denied any concerns regarding Resident A's care aside from the family not initially placing her on hospice. However, just this past week, the family agreed to place Resident A on hospice.

On 2/21/24, I spoke to AFC staff member, Domnique Bothwell via phone. Ms. Bothwell stated that to her knowledge, Resident A has not had a fall in the last 1-2 months. Ms. Bothwell stated that it's standard for staff to notify family and document when a resident falls, which occurred anytime Resident A fell.

Ms. Bothwell stated that she has been employed at American House for nearly seven months. During her time employed at the facility, Ms. Bothwell stated that she has seen Resident A with her own teeth (as opposed to dentures) and hearing aids in the past. The last time seeing Resident A with both items was 1-2 months ago. Ms. Bothwell stated that one of Resident A's hearing aids went missing and her family was supposed to get a new one but never did. Ms. Bothwell was adamant that Resident A does not have dentures, despite her assessment plan indicating otherwise. Ms. Bothwell stated that staff cut Resident A's food for her and somedays, staff have to feed her if she is unable to do so herself.

When asked about glasses, Ms. Bothwell stated that she has seen Resident A with glasses in the past, and she is also wearing her glasses today. Ms. Bothwell stated

that the last time Resident A didn't wear her glasses was due to them being broken. Ms. Bothwell stated that Resident A's family took her glasses to get them fixed. Ms. Bothwell stated that this past Monday, Resident A did not have glasses on but when she arrived at work today, she was wearing glasses "so they must have been found." Ms. Bothwell stated that due to being in memory care, a lot of residents wander throughout the facility, including residents' rooms and take their personal belongings.

Ms. Bothwell confirmed that Resident A is toileted every two hours daily as opposed to be changed in her bed. Ms. Bothwell stated if Resident A has a bowel movement, staff are to document it. If Resident A simply urinates, staff do not have to document it.

On 2/22/24, I spoke to Shawn Jenkins, director of nursing at American House. Ms. Jenkins confirmed that when a resident has a fall, their family is notified. In addition to notifying family, the resident's PCP and herself as the director of nursing is notified. Per chart review, Ms. Jenkins stated that Resident A's last fall was on 12/24/23 and documentation supports that her daughter was notified. Ms. Jenkins stated that staff typically try to notify family as soon as possible but it's not always feasible to do it immediately. Per Ms. Jenkins, Resident A's last fall occurred on 12/24/23 at 9:00 am and her family was notified at 10:15 am. The falls prior to that occurred on 12/21/23 and 12/20/23 and her family was notified each time. Ms. Jenkins agreed to email me a copy of the incident reports regarding Resident A's most recent falls. Ms. Jenkins also stated that Resident A had a fall sometime in September 2023.

Ms. Jenkins was asked about Resident A's dentures and hearing aids that are reportedly missing. Ms. Jenkins stated that she started working at American House as an agency staff member in November 2023 and since starting the job, "I have never seen (Resident A) with teeth in her mouth, ever." Ms. Jenkins stated that she officially became staff of American House a few days ago. Ms. Jenkins stated that she knows Resident A has one hearing aid in her room and the other one has been lost for a long time. Ms. Jenkins added that when staff attempt to put the hearing aid in for Resident A, "most of the time she doesn't want it." Ms. Jenkins stated that occasionally, Resident A will allow staff to put the hearing aid in. Ms. Jenkins stated that "someone in (Resident A's) family is at the facility almost daily so there is no way that they can say they don't know what's going on, which is a good thing." Ms. Jenkins is aware that the I am unable to disclose who the complainant is, but she believes it to be a family member based on the allegations.

Ms. Jenkins stated that Resident A is on a mechanical soft diet, which is in place due to not having teeth/dentures. When asked about Resident A's glasses missing, Ms. Jenkins stated that she believes they were misplaced briefly. As of today, Resident A is wearing her glasses. Ms. Jenkins is unsure where the glasses were located and who found them.

On 2/22/24, Ms. Jenkins emailed me three incident reports for Resident A. The incident reports were dated 12/24/23, 12/21/23, and 12/20/23. All three reports were regarding falls for Resident A. Each report confirmed that Resident A's family was notified after a fall was reported.

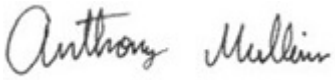
On 3/14/24, I received an email from Mr. May with Resident A's toileting report. The report indicated that Resident A was receiving assistance with toileting on each shift.

On 03/14/24, I conducted an exit conference with licensee designee, Tyler May. He 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:	Per Resident A's assessment plan, she is dependent on staff to provide all grooming/personal hygiene needs, which includes dentures. Resident A is to wear her glasses at all times and has mild/moderate hearing impairment "but can hear adequately with devices." During my onsite investigation, Resident A was not wearing her glasses, hearing aids, or dentures. Staff were unable to locate her dentures and glasses. One hearing aid was observed on the charger but the other one was lost. Ms. Morris had no knowledge of Resident A needing dentures, glasses, or hearing aids. Ms. Duflo has never seen Resident A wearing dentures or hearing aids. Ms. Bothwell was under the impression that Resident A had her own teeth as opposed to dentures, which is not accurate. Ms. Jenkins denied seeing Resident A with dentures since working at the facility. Multiple staff members were unaware of Resident A's care needs. Based on the information obtained through this investigation, a preponderance of evidence exists to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



03/14/2024

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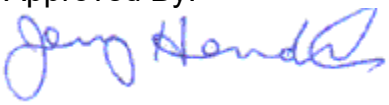
Anthony Mullins Date
Licensing Consultant

Approved By:



03/14/2024

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Jerry Hendrick Date
Area Manager