GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 20, 2024

Toni LaRose
AH Spring Lake Subtenant LLC
6755 Telegraph Rd Ste 330
Bloomfield Hills, MI 48301

RE: License #: AL700397742
Investigation #: 2024A0350033
AHSL Spring Lake Timberbrook

Dear Toni LaRose:

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) 356-0100.

Sincerely,

Ian Tschirhart, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 644-9526

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL700397742
Investigation #:	2024A0350033
Complaint Receipt Date:	05/14/2024
Investigation Initiation Date:	05/14/2024
Report Due Date:	06/13/2024
Licensee Name:	AH Spring Lake Subtenant LLC
Licensee Address:	One SeaGate, Suite 1500 Toledo, OH 43604
Licensee Telephone #:	(248) 203-1800
Administrator:	Toni LaRose
Licensee Designee:	Toni LaRose
Name of Facility:	AHSL Spring Lake Timberbrook
Facility Address:	17383 Oak Crest Parkway Spring Lake, MI 49456
Facility Telephone #:	(616) 844-2880
Original Issuance Date:	03/18/2019
License Status:	REGULAR
Effective Date:	09/18/2023
Expiration Date:	09/17/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
There was only one staff member working for most of the first shift on 5/11/24, but the required staffing for this building is a minimum of two staff members.	Yes

III. METHODOLOGY

05/14/2024	Special Investigation Intake 2024A0350033
05/14/2024	Special Investigation Initiated - Telephone I spoke with the complainant
05/14/2024	Contact - Document Sent I sent an email to Toni LaRose, Licensee Designee
05/14/2024	Contact - Document Received I received an email from Ms. LaRose
05/15/2024	Contact - Telephone call received I spoke with Ms. LaRose
05/15/2024	Contact - Telephone call made I spoke with Demetria, staff
05/15/2024	Contact - Document Sent I sent an email to Toni LaRose, Licensee Designee, requesting information
05/15/2024	Contact - Document Received I received an email from Ms. LaRose with the information I requested
05/15/2024	Contact - Document Sent I sent an email to Toni LaRose, Licensee Designee, requesting copies of 3 residents' Assessment Plans
05/16/2024	Contact - Document Received I received an email from Ms. LaRose with the Assessment Plans I requested attached
05/17/2024	Exit conference – Held with Toni LaRose, Licensee Designee

ALLEGATION: There was only one staff member working for most of the first shift on 5/11/24, but the required staffing for this building is a minimum of two staff members.

INVESTIGATION: On 05/14/2024, I received a call from Damyiah Thompson, Direct Care Worker (DCW). She informed me that two staff members called in sick and she was left to work the majority of her 12-hour shift alone. Ms. Thompson did say that she called two other DCWs, Demaria Morgan and Ne'asha Sargant, who came in, but were only there between approximately 11 a.m. to 1 p.m., leaving her by herself from about 1 p.m. to 7 p.m.

On 05/14/2024, I sent an email to Toni LaRose, Licensee Designee, asking her to verify facility staffing levels on 05/11.

On 05/14/2024, Ms. LaRose sent me an email stating that she would call me about this on the morning of 05/15.

On 05/15/2024, Ms. LaRose called me and we discussed this allegation. Ms. LaRose informed me that two staff members called in sick and that Dametria Holt, Scheduler/Medication Technician, said that she would come in to work, but she was able to get two other DCWs to come in, Felicity Gring and Ne'asha Sargant. However, Ms. Gring only worked from approximately 7 a.m. to 11 a.m. and Ms. Sargant from about 11 a.m. to 1:30 p.m., which left Damyiah Thompson, DCW, to work alone from about 1:30 p.m. to 7 p.m. Ms. LaRose stated that Ms. Holt was working at Stoneybrook, which is right next to Timberbrook, and Ms. Thompson was supposed to call her if she needed another staff member to help, but she didn't.

On 05/15/2024, I called and spoke with Ms. Holt, who told me that two staff members did not show up or call in sick for their shifts, and that she was able to get two other staff members to fill in, Ms. Sargant and Demaria Morgan, DCW. However, they were both only there from about 10:30 a.m. to 2 p.m. Ms. Holt added that Ms. Gring stayed over from her shift for four hours, from about 7 a.m. to 11 a.m. This, therefore, left Ms. Thompson to work alone from about 2 p.m. to 7 p.m. Ms. Holt said that she was working at Stoneybrook and called over to Timberbrook to see if they needed additional help. She told me she spoke with Ms. Morgan who told her that they did not require additional staffing at that time. Ms. Holt confirmed that Timberbrook required at least two staff members at all times. She further reported that she was training two new hires, answering residents' call lights, and responding to text messages, but realized she should have checked back with Timberbrook to see if they needed additional staff. Ms. Holt informed me that she apologized to Ms. LaRose and to Ms. Thompson for neglecting to do so.

On 05/15/2024, I sent a couple of emails to Ms. LaRose requesting whether there any residents who resided at Timberbrook who required two-person assistance and how many residents currently lived there.

On 05/15/2024, I received an email response from Ms. LaRose stating, “We actually have three persons who are listed on their care plan to be two-person assists, but we are reassessing them because they have had improvements in their condition and truly aren't two-person assists or it also depends on how their day is going. Like one day they only need one assist because they are feeling good, but tomorrow may not feel so well and require 2 persons. I have Ashley reassessing them and indicating this on their care plan.” In a second email from Ms. LaRose, she informed me that there were currently 19 residents living at Timberbrook.

On 05/15/2024, I sent an email to Ms. LaRose, Licensee Designee, requesting copies of three residents’ Assessment Plans.

On 05/16/2024, I received an email from Ms. LaRose with the Assessment Plans I requested attached. I observed that Resident A, Resident B, and Resident C each require two-person assistance while being transferred.

On 05/17/2024, I called and held an exit conference with Toni LaRose. I informed Ms. LaRose that I was not citing violation of this rule. Ms. LaRose thanked me for letting her know and had no further comment.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	On 05/11/2024, there was only one staff member working in this facility from approximately 2 p.m. to 7 p.m. This facility is a dementia unit and has three residents who require two-person assistance. It states in Resident A, Resident B and Resident C’s Assessment Plans that they each require two-person assistance while being transferred. My findings support that this rule had been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend that the status of this facility's license remain unchanged, and that this special investigation be closed.

May 20, 2024

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Ian Tschirhart — Date
Licensing Consultant

Approved By:

May 20, 2024

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Jerry Hendrick — Date
Area Manager