GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 12, 2024

Toni LaRose
AH Spring Lake Subtenant LLC
Ste 1600
1 Towne Sq
Southfield, MI 48076

RE: License #: AL700397744
Investigation #: 2024A0579029
AHSL Spring Lake Pebblebrook

Dear Ms. 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) 356-0183.

Sincerely,

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(269) 615-5050

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL700397744
Investigation #:	2024A0579029
Complaint Receipt Date:	06/24/2024
Investigation Initiation Date:	06/24/2024
Report Due Date:	08/23/2024
Licensee Name:	AH Spring Lake Subtenant LLC
Licensee Address:	Ste 1600, 1 Towne Sq, Southfield, MI 48076
Licensee Telephone #:	(248) 203-1800
Administrator:	Toni LaRose
Licensee Designee:	Toni LaRose
Name of Facility:	AHSL Spring Lake Pebblebrook
Facility Address:	17387 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

II. ALLEGATION(S)

	Violation Established?
Direct Care Worker, Tameka Ball, mistreated Resident A.	Yes

III. METHODOLOGY

06/24/2024	Special Investigation Intake 2024A0579029
06/24/2024	Special Investigation Initiated – Telephone Kortney Post, Probate Court
06/24/2024	Contact - Telephone call made Victor Bancino, Wellness Director
06/24/2024	APS Referral Denied
07/03/2024	Contact- Face to face Shamavia Williams, Direct Care Worker
08/07/2024	Contact- Telephone call made Resident A Victor Bancino, Wellness Director
08/07/2024	Contact- Documentation sent Victor Bancino, Wellness Director
08/07/2024	Contact- Telephone call made Tameka Ball, Former Direct Care Worker
08/09/2024	Contact- Telephone call made Resident A Relative A
08/09/2024	Contact- Documentation sent Victor Bancino, Wellness Director
08/09/2024	Contact- Documentation sent Toni LaRose, Licensee Designee
08/09/2024	Contact- Telephone call made Francis Griswold, Direct Care Worker

08/09/2024	Exit Conference Toni LaRose, Licensee Designee

ALLEGATION: Direct Care Worker, Tameka Ball, mistreated Resident A.

INVESTIGATION: On 6/24/24, I received this referral which alleged Resident A requires two-person assistance with transferring and on 6/20/24, Direct Care Worker (DCW) Tameka Ball was observed aggressively sitting Resident A up on his bed. This caused Resident A to hit his head on his bedframe. Ms. Ball was reportedly swearing at Resident A and threw a television remote at him, striking him in the stomach. She then picked up his bed crank handle and threw it toward Resident A, but it missed him. Resident A did not obtain injuries from this incident. Resident A's family and physician were made aware. Ms. Ball was terminated.

On 6/24/24, Licensing Consultant Toya Zylstra completed a telephone interview with Kortney Post from Probate Court confirming that Resident A does not have a legal guardian.

On 6/24/24, Ms. Zylstra completed a telephone interview with AHSL Spring Lake Pebblebrook Wellness Director, Victor Bancino, who confirmed Ms. Ball was terminated after an internal investigation was completed by AHSL personnel regarding these allegations.

On 7/3/24, I completed an unannounced on-site investigation. An interview was completed with DCW Shamavia Williams who denied witnessing any DCW mistreat Resident A or ever witnessing Resident A with marks or bruises that appeared to be from mistreatment. She stated she heard rumors that there was an incident of mistreatment to Resident A, but she could not speak about it because she does not have direct knowledge of what occurred. She reported if she witnessed concerning treatment of residents or a concerning mark or bruise on a resident, she would report it to her supervisor.

Ms. Williams reported Resident A was placed in this home to recover from a medical incident and his condition appears to be continuing to improve. She reported he was on an outing and not available at this time. She reported she believes he could be interviewed via telephone if needed.

On 8/7/24, I completed a telephone interview with Mr. Bancino. He reported an investigation was done by AHSL personnel and it was determined the allegations were true. He stated another DCW witnessed the incident, and it was reported appropriately which is how he became aware. He stated he does not recall the name of the DCW who witnessed the incident but agreed he would assist with obtaining that information.

On 8/7/24, I attempted a telephone interview with Resident A with the assistance of Mr. Bancino. Mr. Bancino took my contact information and reported he would place a return phone call if the call was dropped. The call was dropped, and a return phone call was not received.

On 8/7/24, I attempted a telephone interview with Ms. Ball. An automated message immediately played stating, “Sorry, the number you requested could not be dialed.” There was no option to leave a voicemail message.

On 8/7/24, I sent an email to Mr. Bancino providing my contact information again, requesting the contact information for the DCW who witnessed this incident, and agreeing to attempt to speak to Resident A another day since it was toward the end of the day.

On 8/9/24, I sent a follow up email to Mr. Bancino regarding the email I sent on 8/7/24.

On 8/9/24, I attempted a telephone interview with Resident A. A DCW answered and reported Relative A was present and I should speak to her. Relative A reported Resident A cannot hear without his hearing aids and cannot see without his glasses, so she does not believe he knew what happened during the incident because it was at night when Resident A was not wearing his hearing aids or glasses. She stated she asked him what happened the day it occurred, and he did not know. She stated he would likely be willing to speak to me about other matters, but he would not discuss what occurred as he does not know.

Relative A reported she was present when third shift staff, including Ms. Ball, arrived the night of the incident. She stated Ms. Ball was a “bossy type of person” from what she witnessed. She stated the next day, she was told what had happened and that it had been reported to Mr. Bancino. She stated it was her understanding that since Resident A did not have his hearing aids in, he did not hear Ms. Ball as she was giving him directions, so she became frustrated and “jostled him” which made him hit his head on the bedframe. She stated it was reported Ms. Ball was yelling profanity at Resident A too, although she believes it is unlikely Resident A heard this since he cannot hear without his hearing aids. She stated aside from this one incident, she has not had any concerns about Resident A’s care and overall DCWs do a good job considering how challenging their job is.

On 8/9/24, I sent an email to Ms. LaRose requesting assistance with the contact information for the DCW worker who witnessed the incident. Ms. LaRose provided the contact information for Francis Griswold and a copy of the AHSL investigation that she reported was sent on 6/21/24 to the previous licensing consultant, who has retired, so it was not received by me.

The AHSL investigation included an *Incident/Accident Report* form that detailed their investigation. It was noted Mr. Bancino reported to Ms. LaRose at 7:37 a.m. on

6/20/24, that it was reported there was an incident of abuse to Resident A by Ms. Ball, that Ms. Ball had left the campus, and Ms. Ball did not have access to residents.

Mr. Bancino and Ms. LaRose interviewed Ms. Griswold at 8:00 a.m. and Ms. Griswold reported Ms. Ball aggressively pulled Resident A up in bed hitting his head his bedframe. Resident A reportedly yelled as if this hurt. Ms. Ball then moved the bed and the bed crank fell to the floor. Ms. Ball picked up the crank, threw it toward Resident A, and it landed on his bed. Ms. Ball then picked up a television remote and threw it toward Resident A which hit his abdomen. Ms. Ball began swearing at Resident A and Ms. Griswold.

This was reported to AHSL corporate, and Ms. Ball was suspended at 9:35 a.m. on 6/20/24. Resident A's physician was notified at 10:57 a.m. and Relative A was notified at 10:54 a.m. on 6/20/24. An elder abuse questionnaire was completed with all residents in the home on 6/20/24 to ensure they felt safe in the home. An in-service on abuse was started for all DCWs working on the home's campus on 6/20/24 and was reported to be ongoing.

Ms. Ball was interviewed at 11:34 a.m. on 6/20/24 and without prompting stated, "I didn't abuse anyone, and I never cursed at anyone." Ms. Ball began discussing what occurred during the shift around 5:00 a.m. and stated she and Ms. Griswold went to assist Resident A, Ms. Ball moved Resident A to make him more comfortable and, "No head was bumped. Nothing happened." It was noted there was no previous discussion of Resident A's head being bumped, Ms. Ball said this unprompted.

Resident A was checked for injury and observed by DCWs and his family all morning on 6/20/24. Resident A reported no recollection of the incident. Resident A did not present with injuries or signs of distress. Resident A was placed on increased supervision for 72 hours following the incident.

It was determined the allegations of abuse were substantiated by AHSL personnel and Ms. Ball's employment was terminated on 6/21/24. Adult Protective Services and licensing was notified on 6/21/24.

On 8/9/24, I completed a telephone interview with Ms. Griswold. She reported on 6/20/24 at approximately 5:00 a.m. or 6:00 a.m., Ms. Ball requested her assistance with positioning Resident A. She reported Ms. Ball was attempting to lift Resident A up in his bed, Ms. Ball was agitated, and Ms. Ball was swearing at Resident A. She stated she was turning the corner and heard "thud" and Resident A yell and saw Resident A's head against his bedframe. She stated Resident A was then positioned by Ms. Ball and Ms. Griswold and he appeared comfortable, but Ms. Ball still had not calmed down. She stated Ms. Ball noticed Resident A's manual bed crank handle fell on the floor and Ms. Ball threw it toward Resident A, landing near him on his bed. She stated Ms. Ball then intentionally threw Resident A's remote at him, striking him on the abdomen. She stated Ms. Ball was swearing at and threatening her so since

their shift was almost over, for her safety and the safety of residents, she waited until the shift ended and Ms. Ball left to report the incident to Mr. Bancino. She stated Mr. Bancino and Ms. LaRose immediately responded and started an investigation. She stated Ms. Ball was terminated and she has not worked with Ms. Ball since that occasion.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Direct care worker (DCW) Ms. Griswold reported witnessing DCW Ms. Ball forcefully positioning Resident A causing him to strike his head on his bedframe. Ms. Griswold reported Ms. Ball was swearing at Resident A during this incident. Mr. Bancino verbally reported, and Ms. LaRose confirmed via written investigation by AHSL completed by Ms. LaRose and Mr. Bancino, that Ms. Ball had mistreated Resident A as Ms. Griswold reported. Relative A confirmed the incident was reported to her as Ms. Griswold reported. Interviews were attempted with Resident A. It was reported by Relative A and the AHSL investigation report, that Resident A did not have knowledge of the incident. An interview was attempted with Ms. Ball but was unsuccessful. Based on the interviews completed and documentation reviewed, there is sufficient evidence that Resident A was mistreated by being exposed to physical and emotional harm by former DCW, Ms. Ball.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 8/9/24, I completed an exit conference with Ms. LaRose. It was noted Ms. LaRose immediately responded once she was aware of the allegation and implemented safety measures such as ensuring Ms. Ball was off the campus and did

not have access to residents, suspending Ms. Ball pending investigation, and terminating Ms. Ball's employment following the investigation. It was noted an in-service was initiated with DCWs following the reporting of this incident and is ongoing. It was noted increased supervision was provided for Resident A to ensure his safety for 72 hours following the incident and his physician and family was notified at the beginning of Ms. LaRose's investigation. It was noted Ms. LaRose responded quickly and appropriately to this matter once she was made aware.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of corrective action, I recommend the status of the license remain the same.

Cassandra Duursma 08/09/2024

Cassandra Duursma Date
Licensing Consultant

Approved By:

Jerry Hendrick 08/12/2024

Jerry Hendrick Date
Area Manager