GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 14, 2024

Betty Kortman
Cranberry Park of Grand Rapids
1900-32nd Street, SE
Grand Rapids, MI 49508-1583

RE: License #: AH410236832
Investigation #: 2024A1010083
Cranberry Park of Grand Rapids

Dear Licensee:

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 authorized representative and a date.

If you desire technical assistance in addressing these issues, please feel free to 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 (517) 241-1970.

Sincerely,
Lauren Wohlfert

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa NW Unit 13, 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410236832
Investigation #:	2024A1010083
Complaint Receipt Date:	09/06/2024
Investigation Initiation Date:	09/20/2024
Report Due Date:	11/06/2024
Licensee Name:	Optalis Grand Rapids MC Opco LLC
Licensee Address:	25500 Meadowbrook Rd Novi, MI 48375
Licensee Telephone #:	(616) 452-4470
Authorized Representative/ Administrator:	Betty Kortman
Name of Facility:	Cranberry Park of Grand Rapids
Facility Address:	1900-32nd Street, SE Grand Rapids, MI 49508-1583
Facility Telephone #:	(616) 452-4470
Original Issuance Date:	02/15/1994
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	61
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident D has a bruise on her head and a missing tooth.	No
Additional Findings	Yes

III. METHODOLOGY

09/06/2024	Special Investigation Intake 2024A1010083
09/20/2024	Special Investigation Initiated - Letter Emailed administrator
09/26/2024	Inspection Completed On-site
09/26/2024	Contact - Document Received Received resident service plan
11/14/2024	Exit Conference

ALLEGATION:

Resident D has a bruise on her head and a missing tooth.

INVESTIGATION:

On 9/6/24, the Bureau received the allegations from Adult Protective Services (APS). The complaint was not assigned for APS investigation. The complaint read, "[Resident D] has a bruise on her head and a missing tooth that occurred overnight on 8/29-8/30. No one is sure how it happened. [Resident D] can't remember what happened."

On 9/20/24, I emailed the administrator and requested a copy of the incident report.

On 9/26/24, I interviewed nurse manager Mary Mazurek at the facility. Ms. Mazurek reported Staff Person 1 (SP1) informed SP2 the morning of 8/30/24 that she observed a tooth on Resident D's floor and a bruise on Resident D's forehead while she was getting her ready for the day. Ms. Mazurek stated SP3 worked third shift the evening of 8/29/24 into the early morning hours on 8/30/24. Ms. Mazurek said SP3 reported she observed a tooth in Resident D's bed; however she did not observe any bruising on Resident D's face. Ms. Mazurek stated SP3 reported Resident D did

not have any known falls during her shift and nothing unusual happened regarding Resident D.

Ms. Mazurek explained Resident D had a history of falling out of her bed. Ms. Mazurek reported as a result, Resident D received a physician ordered hospital bed that is lowered to the floor with a fall mat beside it. Ms. Mazurek stated Resident D is currently receiving hospice services from Gentiva Hospice. Ms. Mazurek said when Resident D fell out of her bed in the past, she hit her nearby nightstand. Ms. Mazurek stated the furniture in Resident D's room was re-arranged to ensure she would not hit it if she fell or rolled out of bed.

Ms. Mazurek stated her internal investigation into the incident determined the cause of Resident D's missing tooth and bruise on her forehead is unknown. Ms. Mazurek said Resident D's responsible person and law enforcement were notified of the incident. Ms. Mazurek reported she contacted law enforcement to report the incident after she received permission to do so from Resident D's authorized representative. Ms. Mazurek said an officer was at the facility to follow up on the incident, however she was not present when he arrived. Ms. Mazurek reported she did not know if law enforcement opened an investigation into the incident.

Ms. Mazurek said Resident D is primarily bed bound, however depending on her energy level, staff do sometimes sit her in her wheelchair. Ms. Mazurek reported Resident D has a history of attempting to stand up while in her wheelchair and falling.

Ms. Mazurek provided me with a copy of Resident D's service plan for my review. The *MOOD PROBLEMS R/T: disease process* section of the plan read, "Assist [Resident D] to her room to lay down when she wants to go to her room. Make sure that the bed is low and mat is near the bed. If I am crying out or appear anxious, please offer me Xanax to decrease my anxiety." The *Mobility; Requires assistance* section of the plan read, "The resident requires from verbal cues to complete assistance by 1 care team members [sic] to turn and reposition in bed during rounds, every two hours and as necessary." The *FALLS poor safety awareness* section of the plan read, "bed in lowest position when alone in room with bedside fall mat on the floor next to her bed. I am ok to lay on the blue mat next to my bed or scoot around her room. Resident is a moderate fall risk."

On 9/6/24, I interviewed Staff Person 1 (SP1) at the facility. SP1's statements were consistent with Ms. Mazurek. SP1 reported she informed SP2 that she found a tooth, believed to be Resident D's, on Resident D's nightstand. SP1 stated she also observed a bruise above Resident D's eye. SP1 said she informed SP2 immediately after she observed this. SP1 explained during shift change, the third shift staff person who cared for Resident D did report that she found a tooth in Resident D's bed during her shift. SP1 said Resident D does have a prior history of attempting to get out of bed and roll in her bed by herself.

On 9/6/24, I interviewed SP2 at the facility. SP2's statements were consistent with Ms. Mazurek and SP1. SP2 reported she was present and spoke with the responding law enforcement officer. SP2 said the officer attempted to speak to Resident D and took pictures of her.

On 9/6/24, I attempted to interview Resident D at the facility. I was unable to engage Resident D in meaningful conversation. I observed Resident D in her bed that was in the lowest position near the floor with her mat next to it. I observed Resident D's nightstand was not within distance of her body to hit if she rolled off her bed. I observed Resident D also had a hospice ordered "wing mattress" to prevent her from rolling onto the floor. I observed the bruising on Resident D's face was healed and was no longer present.

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:	The interviews with Ms. Mazurek, SP1, and SP2 revealed Resident D lost a tooth and obtained a bruise on her forehead at some time during the early morning hours on 8/30/24. Staff reported it is unknown how Resident D lost her tooth and obtained the bruise. Resident D does have a prior history of attempting to roll herself in bed and sometimes rolling onto the floor. I observed Resident D is service planned to have her bed in the lowest position on the floor with a fall mat next to her bed. On 9/6/24, I observed Resident D in bed with her bed in the lowest position and her fall mat next to the bed as outlined in her plan. I observed Resident D did not have any furniture or items near her bed that she could hit if she rolled out of bed and onto her floor mat. There is insufficient evidence to suggest staff are not providing care to Resident D consistent with her plan.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 9/6/24, Ms. Mazurek reported Resident D's authorized representative and hospice staff were notified of the incident. Ms. Mazurek said she spoke with Resident D's authorized representative regarding the incident. Ms. Mazurek stated Resident D's authorized representative gave her permission to report the incident to

law enforcement. Ms. Mazurek stated a formal written incident report regarding Resident D's missing tooth and the bruise on her face was not completed. Ms. Mazurek said this is not consistent with the facility's incident reporting policy and procedure.

On 9/6/24, SP1 stated she followed the facility's incident reporting policy and procedure by notifying SP2 of the incident. SP1 reported medication technicians (MTs) or management staff who are notified of a resident incident are responsible for writing the incident report and informing the resident's authorized representative and physician.

On 9/6/24, SP2 said she reported the incident to Resident D's hospice nurse at approximately 11:00 am on 8/30/24. SP2 reported she did not complete a written incident report regarding the incident.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, quality review program.**
	(7) The facility must have a policy and procedure to ensure that an incident, once known by facility staff, is reported as soon as possible, but not later than 48 hours after the incident, to a resident's authorized representative or designated health care professional, as appropriate. Verbal or written notification must be documented in the resident's record to reflect the date, time, name of staff who made the notification, and name of the representative or professional who was notified.
ANALYSIS:	The interviews with Ms. Mazurek and SP2 revealed an incident report regarding Resident D's missing tooth and the bruise on her forehead was not completed. There was no written documentation to in Resident D's record to reflect the date, time, name of staff who made the notification, and name of the representative or professional who was notified. As a result, the facility was not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with the licensee authorized representative on 11/14/24.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

11/04/2024

Lauren Wohlfert Date
Licensing Staff

Approved By:

11/13/2024

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