STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

December 10, 2024

Lauren Gowman
Appledorn Assisted Living Center
727 Apple Avenue
Holland, MI 49423

RE: License #: AH700236753
Investigation #: 2025A1028011
Appledorn Assisted Living Center

Dear Lauren Gowman:

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 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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AH700236753 |
| | |
| **Investigation #:** | 2025A1028011 |
| | |
| **Complaint Receipt Date:** | 11/13/2024 |
| | |
| **Investigation Initiation Date:** | 11/14/2024 |
| | |
| **Report Due Date:** | 01/13/2025 |
| | |
| **Licensee Name:** | Appledorn Living Center LLC |
| | |
| **Licensee Address:** | 950 Taylor Ave.<br>Grand Haven, MI 49417 |
| | |
| **Licensee Telephone #:** | (616) 842-2425 |
| | |
| **Administrator:** | Morgan Jones |
| | |
| **Authorized Representative:** | Lauren Gowman |
| | |
| **Name of Facility:** | Appledorn Assisted Living Center |
| | |
| **Facility Address:** | 727 Apple Avenue<br>Holland, MI 49423 |
| | |
| **Facility Telephone #:** | (616) 392-4650 |
| | |
| **Original Issuance Date:** | 03/01/2000 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 08/04/2024 |
| | |
| **Expiration Date:** | 08/03/2025 |
| | |
| **Capacity:** | 174 |
| | |
| **Program Type:** | AGED<br>ALZHEIMERS |

## II. ALLEGATION(S)

| | Violation Established? |
|---|---|
| Facility staff did not provide care in accordance with the service plan from 11/9/204 to 11/11/2024. | Yes |
| The facility was short staffed from 11/9/204 to 11/11/2024. | No |
| Additional Findings | No |

## III. METHODOLOGY

| | |
|---|---|
| 11/13/2024 | Special Investigation Intake<br>2025A1028011 |
| 11/14/2024 | Special Investigation Initiated - Letter |
| 11/14/2024 | APS Referral |
| 11/18/2024 | Contact - Face to Face<br>Interviewed Employee A at the facility. |
| 11/18/2024 | Contact - Face to Face<br>Interviewed Employee B at the facility. |
| 11/18/2024 | Contact - Document Received<br>Received requested documentation from Employee A. |
| 11/26/2024 | Contact - Telephone call made<br>Telephone call made to the administrator for interview and to request call-light logs. |
| 11/29/2024 | Contact - Document Received<br>Received requested call-light logs from the administrator. |

This investigation will only address allegations pertaining to potential violations of the rules and regulations for Homes for the Aged (HFA).

**ALLEGATION:**

**Facility staff did not provide care in accordance with the service plan from 11/9/204 to 11/11/2024.**

**INVESTIGATION:**

On 11/13/2024, the Bureau received the allegations through the online complaint system.

On 11/14/2024, Adult Protective Services (APS) made referral to Homes for the Aged (HFA) through Centralized Intake.

On 11/18/2024, I interviewed Employee A at the facility who reported Resident A was toileted in a timely manner during the weekend of 11/9/2024 to 11/11/2024 and was also showered in accordance with the service plan. Employee A reported [they] attempted to speak with Resident A's spouse on 11/10/2024 to address concerns of Resident A allegedly being left on the toilet for 30 minutes on 11/9/2024 and for allegedly not receiving a shower as well, but the spouse did not want to speak with anyone at the facility. The spouse refused to speak with facility staff and management and would only speak with someone at the corporate office. Employee A reported [they] reviewed Resident A's shower log and care log to ensure timely care was provided and determined staff followed Resident A's care plan and provided care in a timely manner as well. Employee A also reported to [their] knowledge, Resident A was not left on the toilet for 30 minutes because that would not be tolerated at the facility. Employee A reported the average call light time is typically no more than 5 minutes. Employee A provided me with the requested documentation for my review but reported [they] could not provide call light logs due to not having access to those.

On 11/18/2024, I interviewed Employee B at the facility whose statement was consistent with Employee A's statement.

On 11/18/2024, I reviewed the requested documentation which revealed the following:

- Resident A requires assistance with showering, dressing, peri-care, toileting, and assistance with transfers using a Sara Stedy device.
- Resident A is independent with mobility using power wheelchair.
- Evidence Resident A received a shower on 11/10/2024 as scheduled within the service plan.

On 11/26/2024, I interviewed the administrator by telephone who reported knowledge of the allegations, and that the shift supervisor along with facility management attempted to address Resident A's spouse's concerns, but the spouse refused to speak with any facility staff including management. The administrator reported the spouse expressed [their] concerns to the corporate office and would

only speak with corporate staff about the concerns, despite attempts by the facility to address the concerns. The administrator reported [they] are following up with the corporate office to ensure the spouse's concerns were addressed and resolved. The administrator also reported Resident A's service plan was followed, and Resident A was provided care in a timely manner. I requested the call light records from 11/9/2024 to 11/11/2024 for Resident A and the administrator reported [they] would request them from the corporate office, as [they] do not have access to the logs.

On 11/29/2024, I received the call light logs from the administrator.

On 12/2/2024, I reviewed the call light log times which revealed the following:

- On 11/9/2024 from 9:58 am to 10:27 am, the call light was activated for 29 minutes.
- On 11/10/2024 from 7:05 am to 7:35 am, the call light was activated for 30 minutes.
- On 11/10/2024 from 7:49 am to 11:34 am, the call light was activated for 3 hours and 45 minutes.
- On 11/10/2024 from 12:30 pm to 1:09 pm, the call light was activated for 39 minutes.
- On 11/11/2024 from 10:43 am to 11:03 am, the call light was activated for 20 minutes.

| **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: | It was alleged the facility did not provide care in accordance with the service plan. Interviews, on-site investigation, and review of documentation reveal Resident A received a shower in accordance with the service plan on 11/10/2024. However, review of call light logs revealed the following:<br>• Call light times ranged from 20 minutes to 3 hours and 45 minutes from 11/9/2024 to 11/11/2024.<br>• On 11/9/2024, a 29-minute call light time was documented on the call light log, which substantiates the allegation that Resident A was left sitting on the toileting without staff assistance for almost 30 minutes.<br><br>Due to the varying and long call light log times, the facility did not provide Resident A care within a reasonable time frame in accordance with the service plan. Therefore, the facility is in violation. |
|---|---|
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION:**

**The facility was short staffed from 11/9/204 to 11/11/2024.**

**INVESTIGATION:**

On 11/18/2024, Employee A reported the facility is not short staffed and was not short staffed the weekend of 11/9/2024 to 11/11/2024. Employee A reported there are currently 93 residents in the facility and that the facility is staffed appropriately to meet the needs of the residents. Employee A reported knowledge of two staff members that called-in during the weekend of 11/9/2024 to 11/11/2024 but the facility was appropriately staffed to manage the call-ins to prevent a short shift. Employee A reported if a call-in occurs, staff with stay over and cover or on-call staff will fill the shift to prevent a shift vacancy. Management will also stay to cover to prevent a shift shortage. Employee A provided me the working staff schedules for my review.

On 11/18/2024, Employee B’s statement was consistent with Employee A’s statement.

On 11/18/2024, I reviewed the working staff schedules which revealed the following:

- Employee C was a no call/no show on 11/9/2024 for the 6:00am to 2:00pm shift.
- Employee C was a no call/no show on 11/10/2024 for the 6:00am to 2:00pm shift.

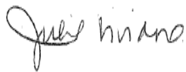
- Employee D called in on 2:00pm to 10:30pm shift on 11/11/2024.
- Evidence of appropriate number of staff members scheduled and working on 11/9/2024 and 11/10/2024 to cover Employee C’s no calls/no shows and on 11/11/2024 to cover Employee D’s call in.

On 11/26/2024, the administrator’s statement was consistent with Employee A's statement and Employee B's statement.

| APPLICABLE RULE | |
|---|---|
| **R 325.1931** | **Employees; general provisions.** |
| | **(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.** |
| **ANALYSIS:** | It was alleged the facility was short staffed from 11/9/2024 to 11/11/2024. Interviews, on-site investigation, and review of documentation reveal that while 3 call-ins occurred from 11/9/2024 to 11/11/2024, the facility had an appropriate number of staff scheduled and working to prevent a shift shortage. No violation found. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

## IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend the status of this license remain the same.



12/5/2024

Julie Viviano Date
Licensing Staff

Approved By:

12/09/2024

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