GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 27, 2025

Robert Norcross
Medilodge of Grand Rapids
2000 Leonard Street
Grand Rapids, MI 49505

RE: License #: AH410413805
Investigation #: 2025A1028021
Medilodge of Grand Rapids

Dear Robert Norcross:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 #:	AH410413805
Investigation #:	2025A1028021
Complaint Receipt Date:	12/23/2024
Investigation Initiation Date:	12/23/2024
Report Due Date:	02/22/2025
Licensee Name:	Grand Rapids Opco, LLC
Licensee Address:	2000 Leonard St. NE Grand Rapids, MI 49505
Licensee Telephone #:	(618) 458-1133
Administrator:	Mary Martin
Authorized Representative:	Robert Norcross
Name of Facility:	Medilodge of Grand Rapids
Facility Address:	2000 Leonard Street Grand Rapids, MI 49505
Facility Telephone #:	(616) 458-1133
Original Issuance Date:	09/01/2022
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	103
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was left unattended in the dining room on 12/21/2024 from 9:00 pm to 6:00 am and has bed sores due to staff not assisting Resident A.	No
Additional Findings	No

III. METHODOLOGY

12/23/2024	Special Investigation Intake 2025A1028021
12/23/2024	Special Investigation Initiated - Letter
12/23/2024	APS Referral APS referred complaint back to HFA.
01/07/2025	Contact - Face to Face Interviewed the Administrator at the facility.
01/07/2025	Contact - Face to Face Interviewed Employee 1 at the facility.
01/07/2025	Contact - Face to Face Interviewed Employee 2 at the facility.
01/07/2025	Contact - Document Received Received requested documentation from the Administrator.

ALLEGATION:

Resident A was left unattended in the dining room on 12/21/2024 from 9:00 pm to 6:00 am and has bed sores due to staff not assisting Resident A.

INVESTIGATION:

On 12/23/2024, the Bureau received the allegations through the online complaint system.

On 12/23/2024, Adult Protective Services (APS) made referral to Homes for the Aged (HFA) through Centralized Intake.

On 1/7/2025, I interviewed the administrator at the facility who reported no knowledge of Resident A being left unattended in the dining room on 12/21/2024. The administrator reported that Resident A and other residents may choose to sit in the dining room area if they like even if meals are not being served. The administrator also reported many residents like to use the dining room to socialize or relax and the dining room is an open floor plan, so it would be difficult for staff to not notice Resident A or any other resident sitting in the dining room for hours without staff walking by or checking on the resident(s). The administrator reported that to [their] knowledge, Resident A is active and does not have any bed sores. The administrator provided me with the requested documentation for my review.

On 1/7/2025, I interviewed Employee 1 at the facility who reported no knowledge of Resident A, or any other resident being left in the dining room unattended on 12/21/2024 from 9:00pm to 6:00am. Employee 1 reported Resident A is very active and often uses the dining room to socialize with other residents or relax. Employee 1 confirmed the dining room is an open floor area and staff routinely walk by it throughout all shifts, so it would be very difficult to not see a resident sitting in the dining room. Also, the dining room is next to the medication station, so staff have good sight lines of the area as well. Employee 1 reported that Resident A does not have any bed sores and only has a developing rash on the lower left leg that the physician has been notified about. Employee 1 also reported Resident A does not require any assistance for ambulation and does not use a device.

On 1/7/2025, I interviewed Employee 2 at the facility and [their] statement was consistent with the administrator's statement and Employee 1's statement.

On 1/7/2025, I completed an inspection of the facility due to this special investigation which revealed the dining room that Resident A uses is an open area with clear and visible sight lines. Several residents were observed using the dining room to socialize. Resident A was also observed, and no concerns were noted during the observation. No other concerns were noted during the inspection.

On 1/7/2025, I reviewed the requested documentation which revealed the following:

- Resident A requires reminders self-care such as oral care, grooming, and to layer clothing appropriately for the season.
- Requires stand by assist to 1-person assist with bathing.
- May require reminders for toileting every 4 hours.
- May need reminders and directions to meals.
- Independent with ambulation and transfers.
- Does not demonstrate behaviors.
- On 1/2/2/2024, there is evidence the physician was notified that a rash and swelling was observed on Resident A's left leg.

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 that Resident A was left unattended in the dining room on 12/21/2024 from 9:00pm to 6:00 am and has bed sores due to staff not assisting Resident A. Interviews, on-site investigation, and review of documentation reveal there is no evidence to support this allegation. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

I recommend the status of this license remain the same.

Julie Viviano

1/13/2025

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Julie Viviano Date
Licensing Staff

Approved By:

Andrea L. Moore

01/24/2025

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