GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 5, 2021

Rachel Bartlett
Maple Ridge Manor of Manistee
1967 Maple Ridge Dr.
Manistee, MI 49660

RE: License #: AH510404870
Investigation #: 2021A1010050
Maple Ridge Manor of Manistee

Dear Mrs. Bartlett:

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 (616) 356-0100.

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Sincerely,

Lauren Wohlfert

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa N.W. 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 #:	AH510404870
Investigation #:	2021A1010050
Complaint Receipt Date:	09/08/2021
Investigation Initiation Date:	09/08/2021
Report Due Date:	11/08/2021
Licensee Name:	Maple Ridge Manor of Manistee LLC
Licensee Address:	12020 Foreman SE Lowell, MI 49331
Licensee Telephone #:	(989) 903-5405
Authorized Representative/ Administrator:	Rachel Bartlett
Name of Facility:	Maple Ridge Manor of Manistee
Facility Address:	1967 Maple Ridge Dr. Manistee, MI 49660
Facility Telephone #:	(989) 903-5405
Original Issuance Date:	07/02/2021
License Status:	TEMPORARY
Effective Date:	07/02/2021
Expiration Date:	01/01/2022
Capacity:	87
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The door to the secured memory care and the medication room in the secured unit was unlocked.	No
Resident B was left soiled and did not receive proper care.	No
Staff in the secured memory care unit are not properly trained.	No
Additional Findings	Yes

III. METHODOLOGY

09/08/2021	Special Investigation Intake 2021A1010050
09/08/2021	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
09/08/2021	APS Referral APS referral emailed to Centralized Intake
09/22/2021	Contact - Telephone call made Message left for complainant, a call back was requested
09/22/2021	Inspection Completed On-site
09/22/2021	Contact - Document Received Received resident's service plan, staff notes, staff schedule, and staff training documents
09/29/2021	Contact – Telephone call made Interviewed the complainant by telephone
10/05/2021	Exit Conference Completed with licensee authorized representative Rachel Bartlett

Staffing was investigated and substantiated in special investigation report number 2021A1028036.

ALLEGATION:

The door to the secured memory care and the medication room in the secured unit was unlocked.

INVESTIGATION:

On 9/8/21, the Bureau received the allegations from the online complaint system. The complaint read, “dementia wing Unlocked door in dementia wing Unlocked unmonitored med closet with an open door.”

I emailed an Adult Protective Services (APS) complaint to Centralized Intake.

On 9/22/21, I interviewed executive director Dave Tuka at the facility. Mr. Tuka reported the door to the secured memory care unit is always locked. Mr. Tuka stated there was an incident in which the door to the secured memory care unit “swelled” in the heat of summer. Mr. Tuka explained as a result, the door did not fit properly in the door frame and so it did not shut entirely. Mr. Tuka said maintenance staff responded immediately when the issue was discovered and fixed the door so it would fit in the door frame and shut properly. Mr. Tuka reported no residents eloped from the secured memory care unit when the door did not secure properly.

Mr. Tuka denied knowledge regarding the medication room in the secured memory care unit being unlocked or “unmonitored.” Mr. Tuka reported the door to the medication room was always locked. Mr. Tuka stated residents in the secured memory care unit did not have access to the medication cart as a result.

On 9/22/21, I interviewed director of health and wellness Jennifer Walsh at the facility. Ms. Walsh’s statements were consistent with Mr. Tuka. Ms. Walsh reported the door to the medication room in the secured memory care unit locked automatically and staff needed a key to enter. Ms. Walsh stated the only time the medication room door would be open was when a staff member was in the room preparing to administer resident medications. Ms. Walsh reported staff were trained to ensure the door to the medication room was shut behind them when they left to administer a resident’s medication.

Ms. Walsh reported the only door in the secured memory care unit that was unlocked during the day was the door to the gated patio off the dining room. Ms. Walsh explained first shift staff unlocked the door and second shift staff locked it at 8:00 pm. Ms. Walsh said having this door unlocked allowed residents to step outside for “fresh air” as they need. Ms. Walsh said staff supervised the residents when they went outside, despite the high fence surrounding the patio.

On 9/22/21, I interviewed medication technician (med tech) Hannah Gutowski at the facility. Ms. Gutowski denied knowledge regarding any incidents in which the door to the secured memory care unit was unlocked or not secured. Ms. Gutowski also denied knowledge regarding any incidents in which the door to the medication room in the secured memory care unit was not locked or left open. Ms. Gutowski’s statements regarding the door to the medication room were consistent with Ms. Walsh.

On 9/22/21, I inspected the secured memory care unit in the facility. I observed the door to the unit was locked and required a code to be entered on the keypad for entrance. I observed the door to the medication room was also locked and required a key for entrance. I observed the door to the medication room automatically locked when it was shut.

The only door I observed that was not locked in the secured memory care unit was the door to the gated patio off the dining room. This was consistent with Ms. Walsh's statements.

On 9/29/21, I interviewed the complainant by telephone. The complainant reported there was an incident when staff "propped" the door to the secured memory care unit open at approximately 6:00 or 7:00 pm. The complainant stated it appeared staff "propped" the door open so they could supervise the residents in the secured memory care unit and in the general assisted living areas. The complainant said there were instances when he visited Resident B and there was only one staff person for the five residents in the secured memory care unit.

The complainant reported he also observed the door to the medication room was open during one of his evening visits. The complainant was unable to recall if he observed the medication cart in the room. The complainant was unable to state whether the medication cart was unlocked and unsupervised.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	The interviews with Mr. Tuka, Ms. Walsh, Ms. Gutowski, along with my inspection of the secured memory care unit revealed the main door and the door to the medication room are always secured. There was an incident during the heat of summer in which the secured memory care unit door did not fit inside the door frame. This was fixed and no residents eloped at that time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident B was left soiled and did not receive proper care.

INVESTIGATION:

On 9/8/21, the complaint read, “Resident was soiled/wet brief. On second visit at 7 walked resident to dining room after being there 2 hours with seeing no staff and Passed a staff member in hall and she said his dinner is in the frig never offered to help and never saw her again.” The complaint also read, “Never once did they shower change bedding feed or do hygiene care for this resident.”

On 9/22/21, Mr. Tuka denied knowledge regarding Resident B being intentionally left soiled by staff. Mr. Tuka stated Resident B had a history of being non-complaint with staff during the provision of his care. Mr. Tuka explained this led staff to leave Resident B and attempt to re-approach him when he became agitated. Mr. Tuka said staff were trained to change a resident’s brief if they found the resident soiled. Mr. Tuka reported he received one complaint from Resident B’s wife that he was soiled when she arrived at the facility. Mr. Tuka said it was unknown whether Resident B was incontinent as his wife entered the facility. Mr. Tuka explained staff completed “rounds” on residents every couple of hours.

Mr. Tuka said residents were given the opportunity to bathe at least once a week. Mr. Tuka explained residents can bathe as many times as they prefer. Mr. Tuka reported resident’s bedding was changed by staff on the days they bathed. Mr. Tuka stated staff were trained to change resident bedding as needed as well.

Mr. Tuka reported Resident B’s wife was at the facility often to assist when Resident B became combative during the provision of his care. Mr. Tuka stated Resident B’s wife was at the facility every day and assisted him at mealtimes. Mr. Tuka said Resident B was able to eat independently, however he needed some queuing and was most responsive to his wife. Mr. Tuka denied knowledge regarding a staff person not offering to help Resident B during a meal. Mr. Tuka reported all resident B’s care needs were met by staff consistent with his service plan and as he cooperated.

Mr. Tuka provided me with a copy of Resident B’s service plan for my review. The *Controls Aggressive Behavior* section of the plan read, “Most of the time doesn’t like laziness.” The *Eating/Feeding* section of the plan read, “Slow eater indp, cut up food, a lot of encouraging.” The *Other Difficulties* section of the plan read, “Encourage food – thinks it’s a restaurant.” The *Toileting* section of the plan read, “1 assist, wears depends for urination knows when he need a BM.”

Mr. Tuka provided me with a copy of Resident B’s staff notes for my review. Notes dated 7/28, 8/1, 8/2, 8/9, and 8/10, read Resident B was physically aggressive toward staff during the provision of his care.

On 9/22/21, Ms. Walsh's statements were consistent with Mr. Tuka.

On 9/22/21, Ms. Gutowski's statements were consistent with Mr. Tuka and Ms. Walsh. Ms. Gutowski reported there were several incidents when Resident B refused to eat with staff and his wife queuing him.

On 9/22/21, I was unable to interview Resident B because he no longer resided at the facility.

On 9/22/21, I observed the four residents who resided in the secured memory care unit. I was unable to engage the residents in meaningful conversation. I observed the residents were well groomed and were wearing clean clothing. I did not detect any foul odors in the secured memory care unit.

On 9/29/21, the complainant reported staff contacted Resident B's wife often and at all times of the night. The complainant stated staff called Resident B's wife and told her she needed to be at the facility to assist with Resident B's care needs. The complainant expressed concern that staff at the facility did not appropriately approach Resident B during the provision of his care, therefore he was noncompliant and combative. The complainant expressed concern that staff did not receive adequate training regarding how to work with residents with memory loss.

The complainant stated Resident B's wife did most of his care and she was at the facility every day. The complainant reported Resident B's wife also changed his bedding. The complainant said he did not observe Resident B soiled when he went to visit him, and he did not know if Resident B's wife helped change Resident B's briefs.

The complainant reported there was one incident when he went to visit Resident B during dinner. The complainant stated staff never went to Resident B's room to bring him to the dining room. The complainant said the staff person told them Resident B's dinner was in the refrigerator and they could heat it in the microwave. The complainant reported Resident B sometimes needed assistance eating meals.

APPLICABLE RULE	
R 3.25 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 Mr. Tuka, Ms. Walsh, Ms. Gutowski's, along with my review of Resident B's service plan and my observation of the four residents in the secured memory care unit revealed staff met resident care needs consistent with their service plans. Review of Resident B's staff notes revealed he was physically combative with staff during the provision of his care.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff in the secured memory care unit are not properly trained.

INVESTIGATION:

On 9/8/21, the complaint read, "staff very untrained in dementia care" and "this facility was not equipped with trained staff to open at this time."

On 9/22/21, Mr. Tuka stated staff received training regarding how to work with residents in the secured memory care unit upon hire. Mr. Tuka reported staff were trained how to re-approach and re-direct residents with memory loss.

On 9/22/21, Ms. Walsh's statements were consistent with Mr. Tuka. Ms. Walsh reported she completed training regarding how to work with residents with memory loss when she was hired at the facility.

Ms. Walsh provided me with a copy of Ms. Gutowski's training documents for my review. The documents read Ms. Gutowski passed her *INTRODUCTION TO DEMENTIA CARE, DEMENTIA CARE: AGGRESSIVE BEHAVIORS, DEMENTIA CARE: TIPS FOR ADLS, DEMENTIA CARE: DIGNITY AND SEXUALITY ISSUES,* and *DEMENTIA CARE: HEALTH COMPLICATIONS* competency exams.

On 9/22/21, Ms. Gutowski's statements were consistent with Mr. Tuka and Ms. Walsh. Ms. Gutowski stated she completed training regarding how to work with resident with memory loss when she was hired at the facility.

On 9/22/21, I observed Ms. Gutowski appropriately interact and redirect residents in the secured memory care unit.

On 9/29/21, the complainant expressed concern that staff were not properly trained regarding how to work with residents with memory loss because Resident B's wife was frequently contact by staff to complete Resident B's care needs. The complainant reported staff were unable to complete his care needs without him being noncompliant and becoming combative. The complainant said Resident B was

doing well at his new placement because staff received proper training regarding how to approach a resident with memory loss.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following: **(a) Reporting requirements and documentation.** **(b) First aid and/or medication, if any.** **(c) Personal care.** **(d) Resident rights and responsibilities.** **(e) Safety and fire prevention.** **(f) Containment of infectious disease and standard precautions.** **(g) Medication administration, if applicable.**
ANALYSIS:	The interviews with Mr. Tuka, Ms. Walsh, Ms. Gutowski, along with review of Ms. Gutowski's training documents, revealed staff received training regarding how to care for residents with memory loss and must pass a competency exam upon hire.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 9/22/21, I reviewed Resident B's service plan. I observed the plan did not address Resident B's aggressive behaviors. The plan also did not include how staff were to intervene when Resident B exhibited aggressive behavior. The *Controls Aggressive Behavior* section of Resident B's service plan read, "Most of the time doesn't like laziness." The plan did not elaborate as to what "doesn't like laziness" meant or how staff should intervene.

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.
For Reference:	

R 325.1901	**Definitions.**
	(21) "Service plan" means a written statement prepared by the home in cooperation with a resident and/or the resident's authorized representative or agency responsible for a resident's placement, if any, and that identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical, social, and behavioral needs and well-being and the methods of providing the care and services while taking into account the preferences and competency of the resident.
ANALYSIS:	Review of Resident B's service plan revealed his aggressive behavior and staff interventions were not outlined. The plan did not adequately address how staff were to provide care when Resident B became physically combative.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Rachel Bartlett by telephone on 10/5.

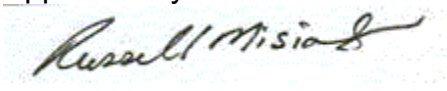
IV. RECOMMENDATION

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

9/28/21

Lauren Wohlfert — Date
Licensing Staff

Approved By:



9/29/21

Russell B. Misiak — Date
Area Manager