GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 12, 2021

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

RE: License #: AH510404870
Investigation #: 2021A1028036
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 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 that 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
(616) 204-4300

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

I. IDENTIFYING INFORMATION

License #:	AH510404870
Investigation #:	2021A1028036
Complaint Receipt Date:	08/05/2021
Investigation Initiation Date:	08/13/2021
Report Due Date:	09/04/2021
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:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility did not ensure Resident A received appropriate services in accordance with their service plan.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/05/2021	Special Investigation Intake 2021A1028036
08/13/2021	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
08/13/2021	APS Referral APS referral emailed to Centralized Intake
09/07/2021	Contact - Telephone call made Called complainant, no answer. Left detailed voicemail requesting return phone call.
09/07/2021	Contact - Telephone call made Called facility AR, no answer. Voice mailbox full, unable to leave message. Instead emailed AR, requesting return phone call due to being unable to leave voice message.
09/08/2021	Contact - Telephone call made Interviewed AR/Admin. Rachel Bartlett by telephone.
09/08/2021	Contact – Telephone call received Interviewed complainant by telephone.
09/09/2021	Contact - Telephone call made Interviewed staff Jenifer Walsh and David Tuka by telephone.
09/09/2021	Contact – Document received Received Resident A's MAR, record notes, internal incident report, admission contract, and service plan from Jenifer Walsh.

09/14/2021	Contact – Telephone call made Telephone calls made to care staff Jessica Beaudrie, Sadie Enguall, Alexandria Stocki, Becky Torres, and Karen Adamski. Left detailed voicemails requesting return phone calls.
09/14/2021	Contact – Telephone call received Interviewed care staff Karen Adamski by telephone
09/14/2021	Contact – Telephone call received Interviewed care staff Becky Torres by telephone
09/14/2021	Contact – telephone call received Interviewed care staff Sadie Enguall by telephone
09/15/2021	Contact – document received Received staff schedules and attendance policy from health and wellness director Jenifer Walsh
09/15/2021	Contact – Telephone call made Interviewed Northern Home Health administrator Kelsey Bruno by telephone
09/17/2021	Contact – Telephone call received Interviewed care staff Alexandria Stocki by telephone
10/12/2021	Exit Interview

ALLEGATION:

The facility did not ensure Resident A received appropriate services in accordance with their service plan.

INVESTIGATION:

On 8/12/21, the Bureau received the allegations from Adult Protective Services (APS).

On 9/8/21, I interviewed administrator Rachel Bartlett by telephone. Ms. Bartlett reported Resident A was supposed to receive home health care services from Northern Home Health due to Resident A having a foley catheter and history of urinary tract infections (UTI). Ms. Bartlett reported Resident A's authorized representative set up the home health services. Ms. Bartlett reported difficulty with Northern Home Health providing Resident A services and the company did not show

up to provide Resident A services as scheduled. Ms. Bartlett reported the facility health and wellness director followed up with Resident A's authorized representative about Northern Home Health not providing services to Resident A in a timely manner.

On 9/8/21, I interviewed the complainant by telephone. The complainant reported Resident A has resided at the facility since July 2021 and has a history of chronic UTI, so [they] set up Northern Home Health services at the facility for Resident A. The complainant reported the home health company was supposed to provide occupational therapy, physical therapy, and nursing services to address Resident A's deconditioning and foley catheter while residing at the facility. The complainant reported the facility was aware Resident A was to receive home health services while at the facility. The complainant reported the home health company did not provide appropriate services for Resident A in the facility and would often not show up to scheduled service visits for Resident A. The complainant reported approaching Ms. Walsh, and Ms. Bartlett about seeking other home health services for Resident A at the facility. The complainant reported the facility never contacted [them] about Northern Home Health not providing Resident A services or about seeking new services for Resident A to ensure appropriate care, especially concerning the foley catheter. The complainant reported the foley catheter needed to be routinely changed by a nurse and the facility care staff could not do that. The complainant reported there was no communication from the facility unless it was initiated by [them] on behalf of Resident A. At the time of this interview, the complainant reported Resident A is currently in the hospital due to UTI, low sodium, and A-fib.

On 9/8/21, I interviewed Resident A's authorized representative by telephone. The authorized representative's statements are consistent with the complainant's statements. The authorized representative reported Resident A has a history of chronic UTIs and requires routine catheter care.

On 9/9/21, I interviewed health and wellness director, Jenifer Walsh by telephone. Ms. Walsh reported the facility did not set up the home health services for Resident A, that Resident A's authorized representative set up the services. Ms. Walsh reported the facility was unaware home health services had even been set up for Resident A until Resident A's authorized representative inquired with care staff if Northern Health Home had been providing routine services for Resident A in the facility. Ms. Walsh reported Northern Home Health did not come into the facility to provide services to Resident A. Ms. Walsh reported upon learning Northern Home Health failed to attend to Resident A's care, she recommended a different home health agency to the authorized representative. Ms. Walsh reported Resident A now uses Munson Home Health and this agency is seeing Resident A as scheduled. Ms. Walsh reported staff provided "excellent peri-care" for Resident A but did not complete direct care with the changing of the foley catheter for Resident A. At the time of this interview, Ms. Walsh confirmed Resident A is currently hospitalized and has not returned to the facility.

On 9/9/21, I interviewed executive director David Tuka by telephone. Mr. Tuka reported Resident A has a history of falls and UTI with Northern Home Health being assigned to address this care. Mr. Tuka reported the facility did not set up the home health services, and the facility was not aware home health services were set up for Resident A until the authorized representative inquired if the home health agency had been into the facility yet to provide Resident A services. Mr. Tuka reported the complainant obtained a different home health agency due to Northern Home Health "never showing up and there seem to be no issues with the new home health agency providing services to [Resident A]." Mr. Tuka reported the facility care staff provided peri-care for Resident A but did not provide direct care for the foley catheter.

On 9/14/21, I interviewed care staff person (CSP) Karen Adamski by telephone. Ms. Adamski reported knowledge that Resident A was to receive home health care services from Northern Home Health for catheter care, but Northern Home Health "never came into the facility" to provide Resident A services. Ms. Adamski reported she never saw anyone from the home health agency for Resident A in the facility.

On 9/14/21, I interviewed CSP Becky Torres by telephone. Ms. Torres reported Resident A was supposed to receive home health nursing services for catheter care, but Northern Home Health never came into the facility to provide Resident A services. Ms. Torres reported Resident A had a catheter that needed to be routinely changed by a nurse and facility care staff provided Resident A peri care but did not change the catheter. Ms. Torres reported Resident A later received nursing care from a different home health company before being recently placed on hospice.

On 9/14/21, I interviewed CSP Sadie Enguall by telephone. Ms. Enguall's statements were consistent with Ms. Walsh's, Ms. Adamski's, and Ms. Torres' statements. Ms. Enguall reported care staff monitored Resident A's peri-care very closely and would empty the catheter bag, but staff did not change the foley catheter. Ms. Enguall reported she "never saw a nurse come in to change [Resident A's] catheter". Ms. Enguall confirmed Resident A later received home health services from Munson Home Health before recently being placed on hospice.

On 9/14/21, I interviewed home health coordinator Marsha Schultz from Munson Home Health Care who confirmed they provided nursing services for Resident A at the facility from 8/7/21 until 9/7/21. Ms. Schultz reported Resident A was discharged from their services on 9/7 due to being placed on hospice services.

On 9/14/21, I reviewed Resident A's service plan which revealed Resident A was dependent for toileting and catheter care. The service plan did not identify any home health services for catheter care or who is responsible to change the foley catheter routinely.

On 9/15/21, I interviewed Northern Home Health administrator Kelsey Bruno by telephone. Ms. Bruno reported Resident A's authorized representative set up home care services for Resident A beginning 6/5. Ms. Bruno reported Resident was

hospitalized from 6/8 to 7/8. Ms. Bruno reported Resident A was seen for three visits on 7/8, 7/16, and 7/22 before discharge was requested by the authorized representative on 8/3. However, Ms. Bruno reported their home health nurse on Resident A's case failed to communicate appropriately with Resident A's authorized representative and Northern Home Health agency resulting in Resident A missing service visits once Resident A returned from the hospital on 7/8. Ms. Bruno reported the home health nurse was terminated from the home health agency due to improperly handling of Resident A's services. Ms. Bruno reported the facility never communicated with Northern Home Health about services for Resident A and all communication was with Resident A's authorized representative only.

On 9/17/21, I interviewed CSP Alexandria Stocki by telephone. Ms. Stocki's statements are consistent with Ms. Walsh's statements, Ms. Adamski's statements, Ms. Torres' statements, and Ms. Enguall's statements.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	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.**
For Reference: **R 325.1901**	**(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.**
ANALYSIS:	Interviews with facility staff, Resident A's authorized representative, the complainant, and the home health agencies along with review of Resident A's service plan and record notes reveal Resident A had a history of chronic urinary tract infections that required peri care and catheter care. The facility had knowledge of Resident A having a foley catheter that required routine care and changing by a trained individual. While there is evidence the facility provided Resident A routine

	peri-care, there is no evidence the facility reasonably ensured appropriate services were in place for the routine care of Resident A's foley catheter as identified in her service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

Additional Findings:

INVESTIGATION:

On 9/9/21, Ms. Walsh reported if any incidents occur, staff document the incident and report the information directly to her. Ms. Walsh then reports it to Mr. Tuka or to Ms. Bartlett. Ms. Wash reported she was uncertain if Ms. Bartlett forwards the incident reports to the department.

Mr. Tuka's statements are consistent with Ms. Walsh's statements. Mr. Tuka's reported he was not certain if Ms. Bartlett reported incidents to the department and "did not know that incidents were supposed to be reported to [the department] as well".

On 9/14/21, Ms. Adamski reported care staff document and report resident incidents to Mr. Tuka or Ms. Walsh but is "unsure where it goes it from there." Ms. Adamski reported care staff do not directly report incidents to the department.

Ms. Torres' statements are consistent with Ms. Walsh's statements and Ms. Adamski's statements.

Ms. Enguall's statements are Ms. Walsh's statements, Ms. Adamski's statements, and Ms. Torres' statements.

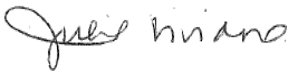
On 9/14/21, I reviewed the internal facility incident report concerning Resident A that was provided to me by Ms. Walsh. The review revealed the facility contacted Resident A's authorized representative. However, the physician and department contact information lines are blank on the incident report and it cannot be determined if the physician was contacted for this incident. The department was also not contacted about this incident report. Further investigation of the department file for the facility revealed the facility has not reported any incidents to the department.

On 9/17/2021, Ms. Stocki's statements are Ms. Walsh's statements, Ms. Adamski's statements, Ms. Torres' statements and Ms. Enguall's statements.

APPLICABLE RULE	
R 325.1924(3)	**Reporting of incidents, accidents, elopement.**
	3. The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.
ANALYSIS:	Staff interviews and review of internal facility incident reports along with the facility licensing file reveals the facility is not compliant with the reporting of incidents. The department does not have any incident reports for any resident from the facility, let alone the change in condition Resident A had that required hospitalization.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend this license remained unchanged.



9/21/21

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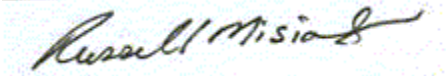
Julie Viviano Date
Licensing Staff

Approved By:



10/11/21

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Russell B. Misiak Date
Area Manager