GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 18, 2022

Carol Del Raso
Maple Lake Assisted Living
677 Hazen
Paw Paw, MI 49079

RE: License #: AH800315846
Investigation #: 2022A1028066
Maple Lake Assisted Living

Dear Ms. Del Raso:

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
Cell (616) 204-4300

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

I. IDENTIFYING INFORMATION

License #:	AH800315846
Investigation #:	2022A1028066
Complaint Receipt Date:	07/18/2022
Investigation Initiation Date:	07/18/2022
Report Due Date:	09/17/2022
Licensee Name:	Maple Lake Assisted Living, LLC
Licensee Address:	Suite 200 3196 Kraft Avenue Grand Rapids, MI 49512
Licensee Telephone #:	(616) 719-5598
Administrator:	Kristen Mitchell
Authorized Representative:	Christine McClellan
Name of Facility:	Maple Lake Assisted Living
Facility Address:	677 Hazen Paw Paw, MI 49079
Facility Telephone #:	(269) 657-0190
Original Issuance Date:	10/31/2012
License Status:	REGULAR
Effective Date:	09/18/2021
Expiration Date:	09/17/2022
Capacity:	64
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Visiting children were left unsupervised in the memory care unit.	Yes
Care staff do not follow Resident A or Resident B's service plans.	No
Additional Findings	No

III. METHODOLOGY

07/18/2022	Special Investigation Intake 2022A1028066
07/18/2022	Special Investigation Initiated - Letter 2022A1028066
07/18/2022	APS Referral APS referral made to centralized intake.
07/21/2022	Contact - Face to Face Interviewed Admin/Kristen Mitchell at the facility.
07/21/2022	Contact - Face to Face Interviewed Employee A at the facility.
07/21/2022	Contact - Face to Face Interviewed Employee B at the facility.
07/21/2022	Contact - Face to Face Interviewed Employee C at the facility.
07/21/2022	Contact - Face to Face Interviewed Employee D at the facility.
07/21/2022	Contact - Document Received Received Resident A's service plan from Ms. Mitchell.
08/03/2022	Contact - Document Received Received requested Resident B's service plan from facility staff.
08/08/2022	Contact - Telephone call made 2022A1028066 - Called complainant to interview. No answer. Left detailed voicemail requesting return phone call.

08/08/2022	Contact – Document Requested Requested the facility visitor policy from Ms. Mitchell.
08/08/2022	Contact – Telephone Call Received Received return phone call from the complainant.
08/09/2022	Contact – Document Requested Requested a copy of Resident A's signed service plan upon admission from Ms. Mitchell.
08/11/2022	Contact – Document Received Received facility visitor policy from the facility.
10/18/2022	Exit – Report sent to AR/Carol Del Raso and Interim Admin/Bobbie Huizen.

This special investigation will only address allegations that apply to licensing violations. The allegation about the facility being short staffed is addressed in special investigation 2022A1028062.

ALLEGATION:

Visiting children were left unsupervised in the memory care unit.

INVESTIGATION:

On 7/18/2022, the Bureau received the allegations from Adult Protective Services (APS) through the online complaint system.

On 7/18/2022, APS made referral to Centralized Intake for referral to HFA.

On 7/21/2022, I interviewed the facility administrator, Kristen Mitchell, at the facility. Ms. Mitchell reported children are allowed in the building as visitors and confirmed there were children in the building the evening of 7/17/2022. Ms. Mitchell reported the children belonged to a staff member and are familiar with being in the building and Resident B's behavior. Ms. Mitchell reported "at no time were the children ever assigned or instructed to watch [Resident B]." The children belonged to a staff member who had permission prior to the children entering the facility. The children were dropped off at the facility at the end of the staff member's shift. Ms. Mitchell reported the children were not running around the memory care unit but were in the memory care unit common area waiting for the staff member to finish up.

On 7/21/2022, I interviewed Employee A at the facility who reported no knowledge of children being in the memory care unit on 7/17/2022. Employee A reported children are allowed in the facility but “do not run around. That would not be tolerated here”.

On 7/21/2022, I interviewed Employee B at the facility who reported no knowledge of children being in the memory care unit recently but reported seeing children visit residents in the past. Employee B reported children are supervised when in the facility and “children running around or acting up would not be allowed here”.

On 7/21/2022, I interviewed Employee C at the facility who reported no knowledge of children being in the memory care unit recently but reported children are allowed to visit with supervision. Employee C reported no children would ever be assigned to “watch residents. That would never happen here”.

On 7/21/2022, I interviewed Employee D at the facility who reported children were in the memory care unit recently but were not running around and were not instructed to watch any resident in the facility. The children were in the common area waiting for a staff member at the end of [their] shift.

On 8/8/2022, I requested the facility visitor policy from Ms. Mitchell.

On 8/8/2022, I interviewed the complainant by telephone who reported the overall care for residents at the facility has decreased since May 2022. The complainant reported on 7/14/22, there were three children who belonged to a care staff member that were left unsupervised in the memory care unit. Resident B was wandering into other resident rooms and one of the children stated [they] were watching Resident B so Resident B would not enter other resident’s rooms. While the children seemed familiar with Resident B, the complainant found this to be very concerning. The complainant reported “the executive director was in the office on the phone with the door shut while this occurred. There were no care staff around. I assume they were helping other residents then”. The complainant reported only after it was realized by care staff that [they] were in the memory care unit visiting [their] relative did care staff attempt to redirect Resident B for the evening care routine. The complainant reported Resident A was moved from the facility in July 2022 to a more appropriate placement.

On 8/11/2022, I received the facility visitor policy and reviewed it. The review revealed the following:

- *Per SVM Handbook:*
  VISITORS IN THE WORKPLACE
  In order to keep the Company professional, all employees, including leaders, must refrain from engaging in social visits from relatives and friends or conducting personal business during working hours. This is to ensure that all employees will stay on task and be free from distractions or nonwork-related conversations.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1)(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:	It was alleged that an employee's children were left unsupervised in the memory care unit. Interviews, on-site inspection, and review of documentation reveal the employee was granted permission from the facility administrator to allow the children in the facility at the end of the working shift. It cannot be determined how long the children were in the memory care unit, but there is evidence the children were left unsupervised. This also contradicts the facility's employee visitation policy of *refraining from engaging in social visits from relatives and friends or conducting personal business during working hours.* Violation found.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Care staff do not follow Resident A or Resident B's service plans.

INVESTIGATION:

On 7/21/2022, Ms. Mitchell reported Resident A demonstrates confusion and difficulty with orientation intermittently. Resident A requires reminders and assist from care staff but does not demonstrate wandering. Ms. Michell reported Resident B has a history of wandering and using curse words, but the words are not aggressively used towards others. Ms. Mitchell reported Resident B is not physically aggressive with others but due to significant dementia and wandering, Resident B has a history of entering other resident's rooms and will push past barriers in the facility that are in place to help deter this behavior. Resident B requires increased supervision and redirection from staff due to wandering. I requested Resident A and Resident B's service plans with record notes from Ms. Mitchell for my review.

On 7/21/2022, Employee A reported Resident A has difficulty with orientation and demonstrates intermittent confusion. Resident does not have a history of wandering but requires prompting and assistance with care routines. Employee A reported Resident B has dementia and a history of wandering. Resident B is known to wander into other resident rooms despite staff redirection and barriers to help deter this

behavior. Employee A reported Resident B uses curse words but is not aggressive towards others with language and has not been physically aggressive with care staff and/or other residents. Resident B requires increased supervision and redirection along with assist from care staff to complete care routines. Employee A reported despite Resident B's wandering, "[Resident B] is typically easy to redirect". Employee A reported care staff consistently follow resident service plans, and the service plans are routinely reviewed for any necessary changes.

On 7/21/2022, Employee B reported Resident A demonstrates intermittent confusion at times and requires reminders and assistance with care routines. Resident A does not have a history of wandering. Employee B reported Resident B has advanced dementia with a history of wandering into other resident rooms. Resident B does use curse words intermittently, but it is not directed at anyone. Resident B is not aggressive but has pushed past barriers in place at the facility to deter wandering. Employee B reported Resident B requires increased supervision and assistance due to dementia but is compliant when staff redirect. Employee B reported staff follow all resident service plans and the service plans are updated routinely to ensure appropriate care.

On 7/21/2022, Employee C reported Resident A demonstrates confusion and difficulty with orientation intermittently, requiring reminders and assist from care staff for completion of care routines. Resident A does not have a history of wandering. Resident B requires increased supervision and assistance due to dementia and history of wandering. Resident B uses curse words intermittently, but the language is not directed at anyone, and Resident B does not have a history of physical aggression. Resident B has pushed past the facility barriers in place when wandering, but Resident B can easily be redirected by care staff. Employee C reported resident service plans are reviewed routinely and followed to ensure residents receive appropriate care.

On 7/21/2022, Employee D's statements were consistent with Ms. Mitchell's, Employee A's, Employee B's, and Employee C's statements.

On 7/21/2022, I completed an inspection of the facility. Residents observed to include Resident A were clean, groomed, content, and/or being assisted by care staff.

On 8/8/2022, I reviewed Resident A's service plan which revealed the following:

- Last service plan update occurred 3/28/2022.
- Demonstrates occasional confusion and requires occasional prompting.
- Demonstrates occasional difficulty with orientation, requiring prompting.
- Able to follow directions.
- Does not wander or exit seek.
- Requires cuing, supervision, and/or assist with grooming, oral care, dressing, bathing, and medication management.
- Independent with transfers and ambulation.

I also reviewed Resident B's service plan which revealed the following:

- Last service plan update 7/18/2022.
- Demonstrates occasional confusion and staff to reorient as needed.
- Follows simple directions.
- Requires hourly supervision.
- Wanders intrusively, but easily redirected.
- Exhibits resistive behaviors intermittently.
- Does not have disruptive verbal or physical behaviors.
- Requires supervision, redirection, prompting, and/or assist with grooming, oral care, dressing, bathing.
- Independent with transfers and ambulation.

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 care was not provided in accordance with resident service plans. Interviews, on-site inspection, along with review of documentation reveal care staff are providing care consistent with resident service plans. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

On 8/8/2022, Resident A's authorized representative reported [they] never participated in the development of Resident A's service plan and "never even saw a service when [Resident A] was there. I did not sign any service plan either".

On 8/9/2022, I requested a copy of Resident A's signed service plan upon admission from Ms. Mitchell.

On 8/9/2022, I received a copy of Resident A's signed evaluation determining the level of care Resident A was to receive at the facility.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(2c) The admission policy shall specify all of the following: That the individual seeking admission and his or her authorized representative, if any, shall participate in the development of the individual's service plan.
ANALYSIS:	There is evidence Resident A's authorized representative participated in the development of the service plan for Resident A and signed the original service plan at admission. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, I recommend this license remain unchanged.

Julie Viviano

8/15/2022

_____

Julie Viviano Date
Licensing Staff

Approved By:

Andrea L Moore

10/05/2022

_____

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