GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 17, 2022

Deedre Vriesman
Resthaven Maple Woods
49 E 32nd St.
Holland, MI 49423

RE: License #: AH700236875
Investigation #: 2023A1028001
Resthaven Maple Woods

Dear Ms. Vriesman:

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

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|---|---|
| **License #:** | AH700236875 |
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| **Investigation #:** | 2023A1028001 |
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| **Complaint Receipt Date:** | 09/29/2022 |
| | |
| **Investigation Initiation Date:** | 10/03/2022 |
| | |
| **Report Due Date:** | 11/29/2022 |
| | |
| **Licensee Name:** | Resthaven |
| | |
| **Licensee Address:** | 948 Washington Ave.<br>Holland, MI 49423 |
| | |
| **Licensee Telephone #:** | (616) 796-3500 |
| | |
| **Administrator:** | Jill Schrotenboer |
| | |
| **Authorized Representative:** | Deedre Vriesman |
| | |
| **Name of Facility:** | Resthaven Maple Woods |
| | |
| **Facility Address:** | 49 E 32nd St.<br>Holland, MI 49423 |
| | |
| **Facility Telephone #:** | (616) 796-3700 |
| | |
| **Original Issuance Date:** | 06/01/1999 |
| | |
| License **Status:** | REGULAR |
| | |
| **Effective Date:** | 07/31/2022 |
| | |
| **Expiration Date:** | 07/30/2023 |
| | |
| **Capacity:** | 101 |
| | |
| **Program Type:** | ALZHEIMERS<br>AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Staff did not administer Resident A's medications in accordance with physician orders. | Yes |
| Additional Findings | No |

## III. METHODOLOGY

| | |
|---|---|
| 09/29/2022 | Special Investigation Intake<br>2023A1028001 |
| 10/03/2022 | Special Investigation Initiated - Letter |
| 10/03/2022 | APS Referral<br>APS referral made to Centralized Intake |
| 10/26/2022 | Inspection Completed On-site<br>Onsite inspection completed due to special investigation. |
| 10/26/2022 | Contact - Face to Face<br>Interviewed Admin/Jill Schrotenboer at the facility. |
| 10/26/2022 | Contact - Face to Face<br>Interviewed AR/Deedre Vriesman at the facility. |
| 10/26/2022 | Contact - Face to Face<br>Interviewed Employee A at the facility. |
| 10/26/2022 | Contact - Face to Face<br>Interviewed Employee B at the facility. |
| 11/17/2022 | Exit – Telephone call made to AR/Deedre Vriesman. Voicemail left requesting return phone call if needed. Report sent to Ms. Vriesman and Admin/Jill Schrotenboer. |

**ALLEGATION:**

**Staff did not administer Resident A's medications in accordance with physician orders.**

**INVESTIGATION:**

On 9/29/2022, the Bureau received the allegations anonymously from the online complaint system.

On 10/3/2022, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 10/26/2022, I interviewed the facility administrator, Jill Schrotenboer, at the facility. Ms. Schrotenboer reported Resident A was only at the facility about a month before moving to another facility. Resident A was [their] own person and had concerns about medications that Resident A reported to her. Ms. Schrotenboer reported she and other medication administration staff reviewed and addressed Resident A's medication concerns. Ms. Schrotenboer reported the medication in question was a time released PRN medication. Resident A would request the medication outside of the timeframe and parameters it could not be administered due to the medication being time released. Ms. Schrotenboer reported it was explained multiple times to Resident A that the medication was time released and it could only be given within a certain time frame and parameters. Ms. Schrotenboer reported Resident A's physician was consulted as well about Resident A's medication and staff followed physician orders. Resident A was also enrolled in the PACE medication program and Resident A's medications were monitored closely by this program as well. Ms. Schrotenboer provided me a copy of Resident A's medication administration record (MAR) and record onsite for my review.

On 10/26/2022, I interviewed the facility authorized representative, Deedre Vriesman, at the facility who reported Resident A was not at the facility very long and Resident A brought concerns about [their] medications to staff and Ms. Schrotenboer. Ms. Vriesman reported Resident A was [their] own person and was provided education on medication administration concerning the time released PRN medication. Resident A was also a participant in the PACE medication program and medications were monitored closely by this program as well. Resident A's physician was also consulted due to Resident A's concerns. Ms. Vriesman reported staff followed Resident A's medication administration in accordance with physician orders.

On 10/26/2022, I interviewed Employee A at the facility who reported Resident A expressed concerns about medication administration and would repeatedly request the time released medication when it could not be administered due to its parameters. Employee A reported Resident A was provided education by staff and management on multiple occasions about medication administration. Employee A reported Resident A's medications were monitored by the PACE program and Resident A's physician was consulted about the PRN time release medication as well. Employee reported to their knowledge all staff administering medications followed Resident A's physician orders.

On 10/26/2022, I interviewed Employee B at the facility. Employee B's statements are consistent with Ms. Schrotenboer's statements, Ms. Vriesman's statements, and Employee A's statements.

On 10/26/2022, I completed an on-site inspection of the facility due to this investigation. Residents observed were clean and content. The facility was clean as well. No concerns noted during my inspection.

I attempted to make contact with Resident A but Resident A exited the facility on 10/1/2022. Resident A could not be reached by phone either.

I also reviewed Resident A's September 2022 MAR with record notes onsite which revealed the following:

- On 9/20/22, it cannot be determined if Resident A received *topical application of Tiger Balm that was to be applied the affected area three times daily*, as the record is blank on the MAR.
- On 9/20/22, it cannot be determined if Resident A received 1 tablet of Amlodipine Besylate 5 mg to be taken by mouth once daily, as the record is blank on the MAR.
- On 9/20/22, it cannot be determined if Resident A received 1 tablet of Atorvastatin 40mg to be taken by mouth once daily, as the record is blank on the MAR.
- On 9/20/22, it cannot be determined if Resident A received 2 capsules of Tamsulosin HCL 0.4mg to be taken by mouth once daily, as the record is blank on the MAR.
- On 9/20/22, it cannot be determined if Resident A received 2 tablets of Acetaminophen 500mg caplet to be taken every 8 hours by mouth, as a portion of the record is blank.

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1932** | **Resident medications.** |
| | **(3) If a home or the home's administrator or direct care staff member supervises the taking of medication by a resident, then the home shall comply with all of the following provisions:**<br>**(a) Be trained in the proper handling and administration of medication.** |

| | |
|---|---|
| **ANALYSIS:** | It was alleged Resident A did not received medications in accordance with physician orders. Onsite inspection, interviews, and review of documentation determined Resident A was administered their PRN medications in accordance with physician orders.<br><br>However, review of Resident A's September 2022 MAR revealed that on 9/20/22 it cannot be determined if Resident A received the following:<br>• Topical application of Tiger Balm.<br>• 1 tablet of Amlodipine Besylate 5 mg to be taken by mouth once daily.<br>• 1 tablet of Atorvastatin 40mg to be taken by mouth once daily.<br>• 2 capsules of Tamsulosin HCL 0.4mg to be taken by mouth once daily.<br>• 2 tablets of Acetaminophen 500mg caplet to be taken every 8 hours by mouth.<br><br>The MAR is blank for each of these medications on 9/20/22. There is no documentation in the MAR of Resident A refusing these medications and no documentation as to why the record is blank. Therefore, the facility is in violation of this rule. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

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

Julie Viviano

11/10/2022

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Julie Viviano Date
Licensing Staff

Approved By:

Andrea L Moore

11/17/2022

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