GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 19, 2022

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

RE: License #: AH510404870
Investigation #: 2023A1021010
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 (517) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH510404870
Investigation #:	2023A1021010
Complaint Receipt Date:	11/02/2022
Investigation Initiation Date:	11/03/2022
Report Due Date:	1/02/2022
Licensee Name:	Maple Ridge Manor of Manistee LLC
Licensee Address:	12020 Foreman SE Lowell, MI 49331
Licensee Telephone #:	(989) 903-5405
Administrator/ Authorized Representative:	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:	REGULAR
Effective Date:	01/02/2022
Expiration Date:	01/01/2023
Capacity:	87
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Employees vaping within the facility.	Yes
Residents transferred using one person.	No
Residents treated disrespectfully.	No
Additional Findings	No

III. METHODOLOGY

11/02/2022	Special Investigation Intake 2023A1021010
11/03/2022	Special Investigation Initiated - Letter referral sent to APS
11/09/2022	Contact - Telephone call made spoke with APS worker
11/17/2022	Inspection Completed On-site
11/21/2022	Contact- Telephone call made Interviewed authorized representative Rachel Bartlett
11/21/2022	Contact-Telephone call made Interviewed SP1
11/21/2022	Contact-Telephone call made Interviewed SP2
11/21/2022	Contact-Telephone call made Interviewed SP3
12/02/2022	Contact-Telephone call made Interviewed SP4
12/02/2022	Contact-Telephone call made Interviewed SP5
12/02/2022	Contact-Telephone call made Interviewed SP6

12/02/2022	Contact-Telephone call made Interviewed SP7
12/02/202	Contact-telephone call made Interviewed SP8
12/02/2022	Contact-telephone call made Interviewed SP9
12/05/2022	Contact-telephone call made Interviewed health and wellness director Jean Anderson
12/05/2022	Contact-telephone call made Interviewed SP10
12/06/2022	Contact-document received Received smoking policy
12/19/2022	Exit Conference Exit conference with authorized representative Rachel Bartlett

ALLEGATION:

Employees vaping in the facility.

INVESTIGATION:

On 11/2/22, the licensing department received an anonymous complaint with allegations employees and management vape in the facility.

On 11/3/22, the allegations in this report were sent to centralized intake at Adult Protective Services (APS).

On 11/21/22, I interviewed authorized representative Rachel Bartlett by telephone. Ms. Bartlett reported months ago there was an employee that was fired because the employee was found vaping inside the facility. Ms. Bartlett reported there has been no additional concerns with employees vaping in the facility.

On 11/21/22, I interviewed staff person 2 (SP2) by telephone. SP2 reported employees vape inside the facility on first shift. SP2 reported the vaping occurs in common areas and at the nurse station. SP2 reported management is aware this occurs but no action has been taken.

On 12/2/22, I interviewed SP5 by telephone. SP5 reported employees vape in the facility in the common areas. SP5 reported there is a designated smoking area outside the facility for employees to utilize but vaping still occurs inside the facility. On 12/2/22, I interviewed SP6 by telephone. SP6 reported she has observed first shift employees vaping in common areas. SP6 reported employees are to vape outside. SP6 reported management is aware but no action has been taken.

On 12/2/22, I interviewed SP7 by telephone. SP7 reported she has observed employees vaping in hallways and at the nurse station. SP7 reported management is aware but no action has been taken.

On 12/2/22, I interviewed SP8 by telephone. SP8 statements were consistent with those made by SP6 and SP7.

On 12/2/22, I interviewed SP9 by telephone. SP9 statements were consistent with those made by pervious staff persons.

On 12/5/22, I interviewed SP10 by telephone. SP10 statements were consistent with those made by pervious staff persons.

I reviewed the facility smoking policy. The policy read,

> *"Maple Ridge Manor is a smoke free environment. Employees must smoke outside in designated areas. A 15-minute break is allowed for staff members each four hours worked. Breaks must not exceed that time period."*

APPLICABLE RULE	
MCL 333.21333	**Smoking policy.**
	2) A home for the aged policy governing smoking shall at a minimum provide that: **(e) Staff shall be permitted to smoke in designated areas only.**
ANALYSIS:	Interviews conducted revealed seven staff persons reported observing employees vaping in common areas and at the nurse station inside the facility. This practice of allowing vaping within the facility is in direct violation of the facility smoking policy.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents transferred using one person.

INVESTIGATION:

The complainant alleged residents that are a two-person assist are transferred using only one person. The complainant alleged transfer lifts are completed using one person. The complainant did not provide any resident names.

Ms. Bartlett reported there are two residents that are a two person assist transfer using a Hoyer or a sit-stand device. Ms. Bartlett reported she has not heard any concerns of residents transferred incorrectly. Ms. Bartlett reported residents that have a mechanical lift are transferred using two people. Ms. Bartlett reported caregivers are trained in mechanical lifts and are expected to use two people. Ms. Bartlett reported no concerns with lift transfers completed with only one person.

SP1 reported residents are transferred using the appropriate amount of people. SP1 reported there are two residents that require two people and there is always two people to transfer the resident. SP1 reported residents that have a mechanical lift are always transferred using two people.

SP2 reported there are two residents that require two people to transfer. SP2 reported at times it can be difficult to find an additional person to assist with the transfer but typically the resident is transferred using two people. SP2 reported if a resident is weak additional caregivers can assist, as needed. SP2 denied allegation residents transfers are completed incorrectly.

SP4 reported residents are transferred appropriately. SP4 reported no concerns with residents transferred using only one person when the transfer requires two persons. SP4 reported residents with mechanical lifts are to be transferred using two people.

On 12/5/22, I interviewed health and wellness director Jean Anderson by telephone. Ms. Anderson reported resident service plans are updated when changes occur. Ms. Anderson reported there are now three residents that require two people assist with transfers. Ms. Anderson reported if a resident has a mechanical lift, the transfer is completed using two people. Ms. Anderson reported residents are transferred appropriately.

I reviewed service plan for Resident B and D. The service plans revealed the residents required a two-person assist for transfers and this was appropriately written in the service plan.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the

	resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	Interviews conducted and service plan review revealed there are two residents that require a mechanical lift transfer using two people. Review of service plans for the residents revealed the service plan adequately described the responsibility of staff for the transfer.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

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:	Interviews conducted with caregivers revealed residents that are a two person assist transfer are completed using two staff people. There is lack of evidence to support the allegation transfers are completed incorrectly.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents treated disrespectfully.

INVESTIGATION:

The complainant alleged residents are mistreated at the facility by residents are yelled at, left in soiled linens, and left on toilets. The complainant did not provide any resident names.

On 11/17/22, I completed an on-site inspection at the facility. I observed multiple resident and staff interactions. I observed employees treating residents respectfully by assisting with transfers, assisting with activities, and having meaningful conversations with the residents.

On 11/17/22, I interviewed Resident A at the facility. Resident A reported he is happy to be living at the facility. Resident A reported the caregivers treat him like family and he is always treated with respect.

On 11/17/22, I interviewed Resident B at the facility. Resident B reported caregivers assist her with her daily cares. Resident B reported no concerns with living at the facility.

On 11/17/22, I interviewed Resident C at the facility. Resident C reported the staff treats her well. Resident C reported care staff assist her when needed. Resident C reported no concerns with living at the facility.

SP1 reported residents are treated with respect at the facility. SP1 reported residents are not cursed or yelled at. SP1 reported there are no residents with skin breakdown at the facility.

On 11/21/22, I interviewed SP2 by telephone. SP2 reported she has not observed any residents left in soiled depends on or have soiled linens. SP2 reported residents are not left on toilets.

On 11/21/22, I interviewed SP3 by telephone. SP3 reported no concerns with care provided to the residents. SP3 reported residents are treated respectfully at the facility.

On 12/2/22, I interviewed SP4 by telephone. SP4 reported residents are treated respectfully at the facility. SP4 reported no concerns with resident care.

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:	Interviews conducted and observations made revealed lack of evidence to support the allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 12/19/22, I conducted an exit conference with authorized representative Rachel Bartlett by telephone.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

12/6/22

Kimberly Horst Date
Licensing Staff

Approved By:

12/16/2022

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