GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 17, 2023

Jamie Kunkel
Maple Ridge Living Center LLC
2575 W Houghton Lake Rd
Lake City, MI 49651

RE: License #: AL830395316
Investigation #: 2023A0870032
Maple Ridge Living Center Cadillac

Dear Jamie Kunkel:

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 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 (231) 922-5309.

Sincerely,

Bruce A. Messer, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 342-4939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL830395316
Investigation #:	2023A0870032
Complaint Receipt Date:	07/10/2023
Investigation Initiation Date:	07/10/2023
Report Due Date:	09/08/2023
Licensee Name:	Maple Ridge Living Center LLC
Licensee Address:	2575 W Houghton Lake Rd Lake City, MI 49651
Licensee Telephone #:	(269) 229-4416
Administrator:	Jamie Kunkel
Licensee Designee:	Jamie Kunkel
Name of Facility:	Maple Ridge Living Center Cadillac
Facility Address:	9072 S. Mackinaw Trail Cadillac, MI 49601
Facility Telephone #:	(231) 878-2823
Original Issuance Date:	07/01/2019
License Status:	REGULAR
Effective Date:	01/01/2022
Expiration Date:	12/31/2023
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
On July 7, 2023, Resident A became ill and was vomiting. During the nighttime, he fell from his bed to the floor. The overnight staff left him on the floor for approximately two hours and did not seek assistance.	Yes

III. METHODOLOGY

07/10/2023	Special Investigation Intake 2023A0870032
07/10/2023	APS Referral This referral was made by the Michigan Department of Health and Human Services, Adult Protective Services.
07/10/2023	Special Investigation Initiated - Telephone Case discussion with Wexford Co. MDHHS APS worker Glenda Brintnell.
07/10/2023	Contact - Telephone call made Telephone interview with Licensee Designee Jamie Kunkel.
07/11/2023	Inspection Completed On-site Interviews with Licensee Designee Jamie Kunkel and staff members.
07/12/2023	Contact - Telephone call made Telephone interviews with staff members.
07/17/2023	Exit Conference Completed with Licensee Designee Jamie Kunkel.
07/17/2023	Inspection Completed-BCAL Sub. Compliance
07/17/2023	Corrective Action Plan Requested and Due on 08/02/2023

ALLEGATION: On July 7, 2023, Resident A became ill and was vomiting. During the nighttime, he fell from his bed to the floor. The overnight staff left him on the floor for approximately two hours and did not seek assistance.

INVESTIGATION: On July 10, 2023, I spoke with Wexford County, MDHHS, Adult Protective Services (APS) worker Glenda Brintnell. Ms. Brintnell stated that she had received an APS referral with the above allegations. She noted that she had already conducted an on-site investigation and attempted to interview Resident A. Ms. Brintnell stated she was not able to conduct an interview with Resident A as, "he is pretty much nonverbal." She further stated that she had also spoken with Resident A's wife who informed her that, "she is very happy with the care (Resident A) receives" at Maple Ridge.

On July 10, 2023, I received, via email from AFC Consultant Rhonda Richards, an *AFC Licensing Division – Incident/Accident Report (BCAL-4607).* Ms. Richards noted that she had received this report on July 10, 2023, at 8:05 a.m. from Licensee Designee Jamie Kunkel. The report, written by staff member Linda Wybarro on July 8, 2023, states: "came in on my 7:00 a.m. shift and was told (Resident A) was on the floor and proceeded to call 911 after an attempt to lift him off the floor." The reports noted that staff members Ramona Dore, Angie Grant, Teresa Bailey and Rose Clay as being involved/witness.

On July 10, 2023, I spoke by telephone with Licensee Designee Jamie Kunkel and informed her of the above allegation. Ms. Kunkel stated she was informed by staff that Resident A had gotten out of bed at 5:15 a.m., that the staff put a chair in front of him, but he was not able to stand back up. At approximately 6:50 a.m., when day shift came in, they saw Resident A on the floor. Ms. Kunkle further noted that staff member Linda Wybarro called her at that time to inform her that Resident A was on the floor, and they were unable to get him back into bed. She stated she instructed Ms. Wybarro to call 911. Ms. Kunkel further stated that Resident A was coughing up phlegm the previous day. I asked Ms. Kunkle to have all involved staff present for interviews for the following day.

On July 11, 2023, I conducted an on-site special investigation at the Maple Ridge Living Center Cadillac AFC home. I met with Ms. Kunkel and reviewed our discussion from the previous day. She noted that staff members Teresa Bailey, Linda Wybarro and Rose Clay would be available, by telephone, for interviews and staff member Angela Grant and Ramona Dore were present in the facility and available for in person interviews.

On July 11, 2023, I conducted a telephone interview with staff member Teresa Bailey. Ms. Bailey stated she worked the overnight shift of July 7-8, 2023, from 11:00 p.m. to 7:00 a.m. She stated that Resident A "rolled out of bed" and that she and fellow staff member Angela Grant "tried to get him up." Ms. Bailey noted that this was approximately 5:15 a.m. on July 8, 2023. She stated that she and Ms. Grant attempted to lift Resident A by lifting under his arms, which was unsuccessful. She stated they then placed a chair in front of Resident A so he could use it to help him stand, but he did not have the strength to get up. Ms. Bailey stated that they then needed to attend to other facility residents and "we did not stay with him (Resident A) but did check on him." She further stated that neither she nor Ms. Grant

called 911 or any of the facility management staff, including Ms. Kunkel, for assistance or guidance. Ms. Bailey stated that at approximately 6:45 a.m. day shift staff members Linda Wybarro and Ramona Dore arrived at the facility, and they also attempted, unsuccessfully, to get Resident A up off the floor. She stated that Ms. Wybarro then called Licensee Designee Jamie Kunkel to inform her of the situation and then called 911 to have EMS respond. Ms. Bailey stated that shortly thereafter, EMS arrived and was attending to Resident A when her shift ended, and she left the facility. Ms. Bailey noted that Resident A has a history of falling out of bed and that staff previously were able to help him up off the floor by placing a walker or chair in front of him. She further noted that the facility has a Hoyer lift, and she is trained on its use, but they did not use the lift that morning with Resident A.

On July 11, 2023, I conducted an in-person interview with staff member Angela Grant. Ms. Grant stated that she worked the overnight shift from 11:00 a.m. on July 7, 2023, to 7:00 a.m. on July 8, 2023. She stated she worked this shift with staff member Teresa Bailey. Ms. Grant stated that she, and Ms. Bailey, heard Resident A fall out of bed onto the floor. She stated that she and Ms. Bailey went to Resident A's bedroom and found him lying on the floor. Ms. Grant noted that this was "close to the time residents start to get up." She stated that both she and Ms. Bailey attempted to lift Resident A off the floor by lifting him underneath his arms, but "we were unsuccessful" in lifting him up. Ms. Grant stated that they then placed a chair near Resident A so that he could use the chair to help him lift himself up off the floor. She noted that Resident A was unable to lift himself from the floor with the use of the chair. Ms. Grant noted that Ms. Bailey then went and obtained the facility Hoyer lift but decided that "we won't be able to use it." Ms. Grant stated that both she and Ms. Bailey then went to help other residents, as they were beginning to get up. She noted they left Resident A lying on the floor, checking on him periodically. She further stated that neither she, nor Ms. Bailey, called 911 or any facility management staff for assistance. Ms. Grant stated that "just prior to 7:00 a.m. as the day shift arrived" Ms. Bailey explained what was going on with Resident A to day shift staff member Linda Wybarro. She stated that Ms. Wybarro then called 911. Ms. Grant stated she departed the facility, as her shift had ended, as the EMS staff were placing Resident A in the ambulance.

On July 11, 2023, I conduced an in-person interview with staff member Ramona Dore. Ms. Dore stated that she worked at the facility on July 8, 2023, beginning her shift at 7:00 a.m. She stated that upon her arrival, staff member Teresa Bailey approached and informed her that Resident A had been on the floor for the past two hours. Ms. Dore stated she went with fellow day shift staff member Linda Wybarro to Resident A's bedroom and found him lying on the floor. She noted that Resident A was "cold and clammy" and had no covering or blanket on him. Ms. Dore further stated that Resident A's legs were twisted. She stated that she and Ms. Wybarro attempted to lift Resident A but could not do so. Ms. Dore stated she obtained a cool washcloth and wiped Resident A's face while Ms. Wybarro called Licensee Designee Jamie Kunkel. She noted that Ms. Kunkel instructed Ms. Wybarro to call 911, which she immediately did. Ms. Dore stated she stayed with Resident A until

the ambulance arrived. She further noted that Ms. Bailey commented to her, while she stood in the doorway, that "you guys deal with it" and then left the area. Ms. Dore stated that EMS arrived shortly after and transported Resident A to the hospital. She commented that the facility does have a Hoyer lift and all staff are trained on its use. Ms. Dore did not know why Ms. Bailey or Ms. Grant did not use the Hoyer lift with Resident A.

On July 12, 2023, I conducted a telephone interview with staff member Linda Wybarro. Ms. Wybarro stated that she worked the morning shift on July 8, 2023, arriving "shortly before" 7:00 a.m. She noted that upon her arrival, nighttime staff member Teresa Bailey approached her and informed her that "they had a rough night with (Resident A)" and that he had rolled out of bed, and they could not get him up. Ms. Wybarro stated she asked Ms. Bailey how long Resident A had been on the floor and Ms. Bailey responded "oh, a couple hours." She further asked Ms. Bailey "why didn't you call Jamie" (Licensee Designee Jamie Kunkel), and Ms. Bailey responded "oh, I didn't think of it." Ms. Wybarro stated that she and Ms. Dore attempted to lift Resident A but were unsuccessful. She stated that Resident A was sweaty, clammy and his legs were twisted. Ms. Wybarro further noted that Resident A was not covered by anything, no sheet or blanket. She stated that after her unsuccessful attempt to lift Resident A she called Ms. Kunkel and was instructed to call 911, which she immediately did. Ms. Wybarro noted that EMS arrived shortly after and transported Resident A to the hospital.

On July 12, 2023, I conducted a telephone interview with staff member Rose Clay. Ms. Clay stated she worked the day shift of July 8, 2023, arriving at approximately 6:50 a.m. Ms. Clay noted that the night staff, Ms. Bailey, told her that Resident A had been on the floor "all night." Ms. Day noted that she, Ms. Wybarro and Ms. Bailey went to Resident A's bedroom to check on him. She stated that she observed Resident A lying on the floor, he was cold and clammy, his face was pale. Ms. Clay further noted that Resident A was not covered and was "half sitting up" in his pajamas. Ms. Clay stated that she then went to attend to other facility residents, as both Ms. Wybarro and Ms. Bailey were present with Resident A in his bedroom. She noted that an ambulance showed up shortly after and believes Ms. Wybarro called Ms. Kunkel to inform her of the events.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Resident A fell, or rolled, from his bed at approximately 5:15 a.m. on July 8, 2023, per staff member Teresa Bailey.

	Staff members Ramona Dore, Linda Wybarro, and Rose Clay observed Resident A lying on the floor, cold, clammy and with his legs twisted upon their arrival at approximately 6:50 a.m. July 8, 2023. They noted he was uncovered, with no sheet or blankets. Emergency Services were not called for assistance until Ms. Wybarro called 911 between 6:50 a.m. and 7:00 a.m. July 8, 2023. Resident A was not treated with dignity, nor was he provided with protection and safety, when he was left lying on his bedroom floor, without any coverings, for approximately one hour and forty-five minutes.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Staff members Teresa Bailey and Angela Grant failed to obtain needed care for Resident A immediately when they were unable to transfer Resident A safely back into his bed following his fall.
CONCLUSION:	**VIOLATION ESTABLISHED**

On July 17, 2023, I conducted an exit conference with Licensee Designee Jamie Kunkel. I explained my findings as noted above. Ms. Kunkel noted that she understood the findings, had no further questions pertaining to this special investigation, and that she would submit a corrective action plan to address the cited rules.

IV. RECOMMENDATION

I recommend, contingent upon the submission of an acceptable corrective action plan, the status of the license remain unchanged.

July 17, 2023

Bruce A. Messer Date
Licensing Consultant

Approved By:

July 17, 2023

Jerry Hendrick Date
Area Manager