GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

May 8, 2023

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

RE: License #: AH700236875
Investigation #: 2023A1028049
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

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AH700236875
Investigation #:	2023A1028049
Complaint Receipt Date:	04/28/2023
Investigation Initiation Date:	05/03/2023
Report Due Date:	06/28/2023
Licensee Name:	Resthaven
Licensee Address:	948 Washington Ave., 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., 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:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility did not provide Resident A appropriate supervision during a behavioral incident in relation to safety of self and safety of staff.	Yes
Additional Findings	No

III. METHODOLOGY

04/28/2023	Special Investigation Intake 2023A1028049
05/03/2023	Special Investigation Initiated - Letter 2023A1028049
05/03/2023	APS Referral APS referral made to Centralized Intake.
05/04/2023	Contact - Face to Face Interviewed Admin/ill Schrotenboer at the facility.
05/04/2023	Contact - Face to Face Interviewed Employee A at the facility.
05/04/2023	Contact - Document Received Received Resident A's record from Admin/Jill Schrotenboer.
05/04/2023	Contact - Telephone call made Interviewed Employee B by telephone.
05/04/2023	Inspection Completed On-site Completed on-site inspection due to special investigation.

ALLEGATION:

The facility did not provide Resident A appropriate supervision during a behavioral incident in relation to safety of self and safety of staff.

INVESTIGATION:

On 4/28/2023, the Bureau received the allegations through the online complaint system.

On 4/28/2023, a referral was made to Adult Protective Services (APS) through Centralized Intake.

On 5/4/2023, I interviewed the facility administrator, Jill Schrotenboer, at the facility who reported Resident A has a diagnosis of Huntington's disease with behaviors but is his own person and makes [their] own decisions. Resident A has resided at the facility in the locked memory care unit since January 2023 and has had intermittent behavioral outbursts since admission. On 3/11/2023, Resident A had a behavioral incident in which Resident A grabbed a third shift staff member from behind and put scissors to the staff member's neck and threatened harm to the staff member. This occurred in the dining room a little after 1:00 am. Ms. Schrotenboer reported the staff member was able to talk their way out of the hold Resident A had on them by speaking calmly and offering Resident A food. Resident A let the staff member go and took a seat at a dining room table. Once out of the hold, the staff member went to the staff office, locked the door behind them and immediately called the supervisor for help. The supervisor instructed the staff member to call 911. Another staff member secured the other resident rooms to ensure Resident A did not enter those rooms and for overall safety of everyone on the unit. Ms. Schrotenboer reported while the staff member was on the phone with 911 services, Resident A threatened to kill everyone if the police were called. Ms. Schrotenboer reported the 911 operator heard Resident A's threat and the police were dispatched immediately to the facility. Ms. Schrotenboer reported the police took Resident A into custody and left the facility. Ms. Schrotenboer reported Resident A's family and physician were notified of the incident. Resident A's day program and department was also notified in a timely manner. The family later notified Ms. Schrotenboer that Resident A was being charged with felonious assault. Ms. Schrotenboer reported she is unsure why Resident A is being charged because the staff member involved, and the facility did not press charges. Ms. Schrotenboer also reported Resident A was compliant and calm with police instruction when being taken into custody and did not resist. Ms. Schrotenboer reported she explained to the family that the facility followed proper protocols in calling 911 for help during Resident A's behavioral incident and that 911 services heard Resident A's threat to harm everyone in the facility. Ms. Schrotenboer reported she also explained to the family the threat may have been why Resident A was taken into custody and why the police were sent instead of emergency services. Ms. Schrotenboer reported "we have no control over who 911 sends to the facility during an emergency, but staff involved followed protocol to deescalate the situation and prevent anything else". When questioned about where the scissors came from, Ms. Schrotenboer reported the facility was unable to determine how Resident A obtained the scissors. Ms. Schrotenboer also reported a fire extinguisher was found in Resident A's room after Resident A was taken into

police custody. Resident A did not return to the facility after the incident. Ms. Schrotenboer provided me Resident A's record for my review.

On 5/4/2023, I interviewed Employee A at the facility who reported Resident A has resided at the facility since January 2023 and behavioral related incidents have occurred at the facility due to Resident A's Huntington's disease diagnosis. Employee A reported knowledge that Resident A grabbed a third shift staff member from behind and put scissors to the staff member's throat threatening harm around 1:00 am on 3/11/2023. Employee A reported the staff member was able to deescalate the incident by speaking calmly and distracting Resident A with the offer of food. Employee A communicated to the supervisor immediately and was instructed to call 911; and while on the phone Resident A made a threat to "kill everyone" at the facility if the police were called. Employee A reported the threat was overheard by the 911 operator on the phone. While the police were in route to the facility, staff secured the other resident rooms on the unit for safety while keeping Resident A calm seated at a dining room table. Employee A reported the police arrived and took Resident A into custody. Employee A reported Resident A's family, physician, and day program were called later to notify them of the incident. Employee A reported knowledge that family later reported to the facility that Resident A was being charged with felonious assault, however, the staff involved, and the facility did not press charges. Employee A reported [they] are unsure where or how Resident A obtained the scissors and/or the fire extinguisher found in Resident A's room after the incident.

On 5/4/2023, I interviewed Employee B by telephone whose statements were consistent with Ms. Schrotenboer's statements and Employee B"s statements. Employee B also reported no knowledge as to how Resident A obtained the scissors and/or the fire extinguisher found in Resident A's room after the incident.

On 5/4/2023, I completed an on-site inspection of the unit to include the area the incident took place. Residents observed were clean, content, and being appropriately assisted by staff. Resident A's room was cleared out and was locked.

On 5/8/2023, I reviewed Resident A's service plan which revealed the following:

- Resident A is his own responsible party.
- Resident A has a diagnosis of Huntington's disease, major depressive disorder (recurrent severe without psychotic features), generalized anxiety disorder, obstructive sleep apnea, celiac disease, dysphagia (oropharyngeal phase), dysarthria and anarthria.
- Resident A required assist with toileting, grooming, dressing, eating, and bed mobility.
- The facility manages Resident A's housekeeping and laundry.
- Resident A is a fall risk and required assist to ensure glasses were within reach, prompts to take to small steps when ambulating with walker, and to use walker safely.
- The facility managed all medication administration.

- Resident A exhibited mood/behaviors and anxiety. Interventions and tasks were in place for staff to assist Resident A during mood/behavior outbursts.

I also reviewed the record notes which revealed the following:

- Resident A demonstrated behavioral outbursts on 1/30/2023, 1/31/2023, 2/1/2023, and 2/10/2023.
- On 2/17/2023, Resident A became upset with a staff member because he did not want to wait to get coffee with Resident A ramming [their] walker into the staff member.
- Evidence Resident A pacing halls without walker and/or using walker inappropriately with staff providing redirection 1/30/2023 and 2/17/2023.
- On 2/20/2023, there is evidence of Resident A declining medications with staff suspicions that Resident A is not taking medication appropriately. Staff alerted physician.
- On 3/11/2023, there is evidence staff notified Resident A's family, physician, and day program in a timely manner after the incident after incident in which Resident A put a pair of scissors to a staff member's throat and threatened the staff member.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) 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.**

ANALYSIS:	It was alleged the facility did not provide Resident A appropriate supervision during a behavioral incident resulting in a third shift staff member being assaulted; and Resident A being charged with felonious assault. Interviews, on-site inspection, and review of documentation reveal the facility demonstrated good understanding of Resident A's Huntington disease diagnosis, shifts in mood with behaviors, and demonstrated anxiety. Resident A's service plan demonstrates appropriate interventions and tasks for staff to assist Resident A appropriately during mood shifts with demonstrated behaviors. Also, even though Resident A is [their] own responsible party, the facility still notified family, Resident A's physician, and day program of the incident within a timely manner. However, interviews completed revealed that it could not be determined how Resident A obtained the scissors used in the incident or why a fire extinguisher was found later in Resident A's room. Scissors and a fire extinguisher pose a potential risk of harm for a person with impaired cognition. Also, review of the service place details interventions to address Resident A's mood and behaviors but does not designate a level of supervision which is imperative for a person with impaired cognition. The facility has a duty to protect Resident A from harming themselves or others and to prevent access to potentially harmful items placing Resident A, other residents, and staff at potential risk of great harm. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Julie Viviano

5/8/2023

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Julie Viviano Date
Licensing Staff

Approved By:

08/17/2023

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