STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 6, 2023

Carol Del Raso
Maple Lake Assisted Living & Memory Care
677 Hazen Street
Paw Paw, MI 49079

RE: License #: AH800412723
Investigation #: 2023A1028075
Maple Lake Assisted Living & Memory Care

Dear Carol 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

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

I. IDENTIFYING INFORMATION

License #:	AH800412723
Investigation #:	2023A1028075
Complaint Receipt Date:	07/01/2023
Investigation Initiation Date:	07/03/2023
Report Due Date:	08/31/2023
Licensee Name:	Senior Living Maple Lake LLC
Licensee Address:	7927 Nemco Way, Ste 200 Brighton, MI 48116
Licensee Telephone #:	(810) 220-0200
Administrator:	Marianne Love
Authorized Representative:	Carol Del Raso
Name of Facility:	Maple Lake Assisted Living & Memory Care
Facility Address:	677 Hazen Street Paw Paw, MI 49079
Facility Telephone #:	(269) 657-0190
Original Issuance Date:	08/02/2023
License Status:	TEMPORARY
Effective Date:	08/02/2023
Expiration Date:	02/01/2024
Capacity:	70
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Residents are not provided appropriate care in accordance with service plans.	Yes
The facility is short staffed.	No
Additional Findings	Yes

III. METHODOLOGY

07/01/2023	Special Investigation Intake 2023A1028075
07/03/2023	Special Investigation Initiated - Letter
07/03/2023	APS Referral APS made referral to HFA through Centralized Intake.
07/11/2023	Contact - Face to Face Interviewed the facility Admin/Marianne Love at the facility.
07/11/2023	Contact - Face to Face Interviewed Employee A at the facility.
07/11/2023	Contact - Face to Face Interviewed Employee B at the facility.
07/11/2023	Contact - Document Received Received resident records from Admin/Marianne Love at the facility.

ALLEGATION:

Residents are not provided appropriate care in accordance with service plans.

INVESTIGATION:

On 7/3/2023, the Bureau received the allegations through the online complaint system.

On 7/11/2023, I interviewed the facility administrator, Marianne Love, at the facility who reported there are 27 residents in assisted living and 14 residents in memory care. Ms. Love reported there was a recent fall in assisted living in early June 2023 but there have not been any since. Ms. Love also reported no residents at the facility have bed sores and residents are provided showers and assisted with all other care in accordance with service plans. Ms. Love reported no knowledge of any resident being left in urine or feces and stated that would not be tolerated at the facility. Ms. Love reported no knowledge of any care not being provided in a timely manner either. Ms. Love provided me Resident A's, Resident B's, Resident C's, and Resident D's record for my review.

On 7/11/2023, I interviewed Employee A at the facility who reported no residents in the facility have any bed sores or none are bedbound. Employee A confirmed a resident in assisted living fell in early June 2023, but there have not been any falls at the facility since. Employee A reported no knowledge of care not being provided in a timely manner or residents not receiving care in accordance with the service plans. Employee A reported there are at least 14 residents in assisted living that are independent with care and do not require assistance. Employee A reported no knowledge of any resident being left to sit in urine or feces and that "it would not be tolerated here. Plus, you would be able to smell that as soon as you walked in here."

On 7/11/2023, I interviewed Employee B at the facility whose statements were consistent with Ms. Love's statements and Employee A's statements.

On 7/11/2023, I completed an on-site inspection of the facility due to this special investigation. The facility was clean, and no smell of feces or urine was detected. Residents observed were clean and groomed.

On 7/18/2023, I reviewed Resident A's service plan and fall report which revealed the following:

- Resident A has occasional confusion and some difficulty recalling details. Staff will reorient as needed.
- Independent with upper and lower body dressing, toileting, feeding, oral care, and mobility.
- Requires reminders for grooming.
- *Requires stand by assist for shower. Requires continuous supervision and cueing.*
- Resident A has had no falls*. Remind resident to use call light.*
- Resident A incurred a fall on 6/9/2023 in the bathroom while taking a shower unassisted.

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

- Resident B *has occasional confusion and some difficulty recalling details. Needs occasional prompting and orientation. Resident can carry on a conversation well with others…frequently believes [spouse] is still alive.*

Family request that we do not redirect this and let [Resident B] think [spouse] is still living with at their farm.

- Requires stand by assistance with grooming, oral care, upper and lower body dressing, and meal set up in dining room.
- Requires *stand by assistance with showering. Requires continuous supervision and cueing.*
- Requires assistance with shaving and toileting due to episodes of incontinence. Resident B is on a two-hour toileting schedule due to incontinence.

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

- Resident C is oriented x 3.
- Independent with oral care, toileting and mobility using walker for short distances.
- Requires set up for grooming.
- Requires stand by assistance with upper and lower body dressing and showering with continuous supervision and cueing.

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

- Resident C is oriented x 3.
- Requires reminders for grooming.
- Independent with oral care, upper and lower body dressing, toileting, and mobility with use of walker for long distances.
- Requires set up of bathing supplies.

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 staff do not provide care in a timely manner or in accordance with service plans resulting in bed sores, uncleanliness of residents, and falls. Interviews, onsite investigation, and review of documentation revealed no evidence of residents having bed sores and no evidence of residents or the facility being unclean. However, Resident A fell on 6/9/2023 while taking a shower unassisted. Resident A's service plan states staff will provide stand by assist for bathing while providing continuous supervision and cueing. Resident A was not provided supervision, cueing, or care in accordance with the service resulting in a fall with a skin tear to the right forearm and elbow. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility is short staffed.

INVESTIGATION:

On 7/11/2023, Ms. Love reported there are 27 residents in assisted living and 14 residents in memory care at the facility. Ms. Love reported staff members are trained as medication techs and provide care assistance to residents as well. Ms. Love reported there is one staff member on each of the three hallways in assisted living with one float staff member to assist between the three hallways in assisted living. In memory care there are two staff members to assist the 14 residents in the unit and an additional float staff member available to assist as well. There are no two person assist in the assisted living but memory care has two residents that require two person assist with care. Ms. Love reported out of the 27 residents in assisted living, 14 residents do not require assistance with care routines other than medication administration due to the facility administering all resident medication. Ms. Love reported the facility has mandation in place if a call-in occurs, management will stay to help, and the facility utilizes agency staff as well. There is also an on-call system that is used for staff to pick up shifts if call-ins occur. Ms. Love reported the number of current care staff is based on the acuity of the residents and the facility has a large number of residents that do not require assistance. Ms. Love reported if the number of residents requiring assistance were to increase, then staffing would increase as well, but the facility has four new employees currently onboarding. Ms. Love provided me the working staff schedule for my review.

On 7/11/2023, Employee A reported the facility is not short staffed, but call-ins do occur occasionally. When a call-in occurs mandation is required. Management, agency staff, and on-call facility staff will stay to prevent a shift shortage as well. Employee A reported there is one care staff for each of the three hallways in assisted living with an additional care staff that floats between the three hallways. Employee A also reported assisted living has 14 residents that do not require assistance with care routines other than medication administration. Assisted living also does not have any residents that require a two person assist with mobility or care. Employee A reported memory care has 14 residents with two residents requiring two person assist with mobility and care. Memory care has two care staff members at all times with additional float care staff available as well. Employee A reported there are also four new employees currently onboarding at the facility to help reduce the use of agency staff.

On 7/11/2023, Employee B's statements were consistent with Ms. Love's statements and Employee A's statements.

On 7/11/2023, I observed one care staff member on each hallway in assisted living and two care staff members in the memory care unit.

I also reviewed the working staff schedule for June 2023 to July 2023 while on site. No concerns were noted.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	It was alleged the facility is short staffed. Interviews, onsite investigation, and review of documentation reveal there is no evidence to support this allegation. The facility utilizes a mandation policy, agency staff, and on-call staff. The facility also currently has four new care staff onboarding. The current staff to resident ratio is appropriate to meet the needs of the residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

Additional Findings:

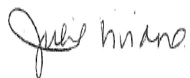
On 7/18/2023, review of Resident C's medication administration record (MAR) revealed the following:

- On 6/23/2023, Resident C was to be administered 1 tablet of Calcium/D3 TAB 500-600 by mouth at 8:00pm. The MAR is blank for this entry. It cannot be determined if Resident C received, refused, or missed medication administration due to the incomplete record.
- On 6/23/2023, Resident C was to be administered 1 spray in each nostril of Fluticasone SPR 50MCG at 8:00pm. The MAR is blank for this entry. It cannot be determined if Resident C received, refused, or missed medication administration due to the incomplete record.
- On 6/23/2023, Resident C was to be administered 1 capsule of Gabapentin CAP 100MG by mouth at bedtime. The MAR is blank for this entry. It cannot be determined if Resident C received, refused, or missed medication administration due to the incomplete record.
- On 6/23/2023, Resident C was to be administered 1 drop in both eyes of SOD Chloride SOL 5% OP at 8:00pm. The MAR is blank for this entry. It cannot be determined if Resident C received, refused, or missed medication administration due to the incomplete record.
- On 6/23/2023, Resident C was to be administered 2 puffs of Ventolin HFA AER everyday at bedtime. The MAR is blank for this entry. It cannot be determined if Resident C received, refused, or missed medication administration due to the incomplete record.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	Review of Resident C's MAR revealed several missed medications on 6/23/2023. The MAR is blank for these medications and there are no accompanying notes in the record. It cannot be determined if Resident C received, refused, or missed medication administration due to the incomplete record. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



7/3/2023

Julie Viviano — Date
Licensing Staff

Approved By:

10/30/2023

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