GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 12th, 2025

Matthew Maletich
Maple Ridge Manor of Manistee
1967 Maple Ridge Dr.
Manistee, MI 49660

RE: License #: AH510404870
Investigation #: 2025A1021053
Maple Ridge Manor of Manistee

Dear Matthew Maletich:

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) 335-5985.

Sincerely,
Kimberly Horst

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 #:	2025A1021053
Complaint Receipt Date:	04/08/2025
Investigation Initiation Date:	04/11/2025
Report Due Date:	06/08/2025
Licensee Name:	HM Land Holdings of Manistee, LLC
Licensee Address:	8661 Conservation St NE Ada, MI 49301
Licensee Telephone #:	(989) 903-5405
Administrator:	Kimberly Miller
Authorized Representative:	Matthew Maletich
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:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	87
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Residents' care needs are not met.	Yes
Additional Findings	No

III. METHODOLOGY

04/08/2025	Special Investigation Intake 2025A1021053
04/11/2025	Special Investigation Initiated - Telephone interviewed SP1
04/30/2025	Inspection Completed On-site
05/07/2025	Contact-Telephone call made Interviewed administrator
05/12/2025	Exit Conference

The complainant alleged inappropriate comments have been made about a resident. This allegation was investigated under AH510404870_SIR_2025A1021049. The complainant identified some concerns that were not related to home for the aged licensing rules and statutes. Therefore, only specific items pertaining to homes for the aged provisions of care were considered for investigation. The following items were those that could be considered under the scope of licensing.

ALLEGATION:

Residents' care needs are not met.

INVESTIGATION:

On 04/08/2025, the licensing department received a complaint with allegations that resident care needs are not met. The complainant alleged staff sleep on shift and have used drugs while at work. The complainant alleged residents have had blood dripping from their bedsore. The complainant alleged residents are left in soiled briefs for long periods of time.

On 04/11/2025, I interviewed the complainant by telephone. The complainant alleged Resident A has had a significant bedsore and the bedsore is not managed. The complainant alleged Resident B was yelled at by staff to go to the restroom and

has not been assisted with using the restroom. The complainant alleged Resident C was told to go to the bathroom in her brief because caregivers did not want to use the Hoyer Lift. The complainant alleged Resident D also has a bedsore. The complainant alleged Resident E was also yelled at by care staff.

On 04/30/2025, I interviewed facility administrator Kimberly Miller at the facility. The administrator reported Resident D does not have a bedsore. The administrator reported Resident A does have a bedsore and the family takes Resident A to the wound clinic. The administrator reported that when a resident's family takes a resident to an outside physician, they have a communication form that is to be completed by the physician and provided to the facility to ensure the orders are followed. The administrator reported Resident A's wound is being managed by over-the-counter ointment and Resident A's legs are also being wrapped as needed. The administrator reported Resident A does not like to sleep in her bed and caregivers are to encourage Resident A to use the bed to help with pressure relief. The administrator reported it was brought to their attention that caregivers did not want to put Resident C in the Hoyer Lift. The administrator reported education was provided to care staff on using the proper equipment and assisting residents to use the restroom. The administrator reported Resident B made a complaint to their family about being yelled at by care staff to hurry up and that he must wait an extended time for assistance. The administrator reported they encouraged the family to get a nanny camera to be able to see more of what is going on at the facility. The administrator reported the average call light response time for Resident B is under three minutes. The administrator reported she has not received any complaints from Resident E or Resident E's family.

On 05/07/2025, I interviewed the administrator by telephone. The administrator reported she has had two reports of employees sleeping on the job. The administrator reported a few weeks ago an employee was terminated for sleeping on the job and another employee recently completed a Performance Improvement Plan for sleeping on the job. The administrator reported on 03/20/2025 that an employee was terminated for using a dap pen at the facility.

On 04/30/2025, I interviewed Resident C at the facility. Resident C reported she tries to be as independent as possible and not use her call pendent. Resident C reported care staff will assist her when requested.

On 04/30/2025, I interviewed Resident B at the facility. Resident B reported the care staff are okay, but it can be difficult to get assistance on third shift. Resident B reported care staff have not been rude to him.

On 04/30/2025, I interviewed Resident E at the facility. Resident E reported he is treated well at the facility. Resident E reported everyone is very nice to him. Resident E reported no concerns with living at the facility.

On 04/30/2025, I interviewed Resident A at the facility. Resident A reported care staff treat her well and she has no concerns.

On 04/30/2025, I interviewed staff person 6 (SP6) at the facility. SP6 reported Resident C is taken to the restroom multiple times on her shift. SP6 reported Resident C has reported concerns with third shift not assisting her. SP6 reported she has reported to her shift and observed Resident C to be in urine dried soaked sheets. SP6 reported she has reported this to management.

On 04/30/2025, I interviewed SP7 at the facility. SP7 reported Resident C has reported to her that care staff on third shift have told her to urinate in her brief. SP7 reported Resident B also reported that care staff hurry and at times do not assist him to the restroom.

On 04/30/2025, I interviewed SP8 at the facility. SP8 statements were consistent with those made by SP6 and SP7.

I reviewed the facility internal messaging system. A message dated 03/18/2025 read,

“I had (Relative B1) of (Resident B) come to me today and tell me that 2 people on night shift are not helping (Resident B) and making him walk unassisted to the bathroom and telling him he can do things himself. This is unacceptable. I am aware of the one person as he was able to identify, however, he says there is a second. Additionally, he told her his light goes for extended periods of time. I do realize this may feel like it is if he needs to use the restroom. I have Summit coming to download a report of call lights/times. He is scared of retaliation from staff for saying something. How awful to be elderly and at our mercy and feel this way. I was so embarrassed. If not guilty, disregard. If this is you, please do better.”

I reviewed facility documentation on family communication. The documentation was dated 04/22/2025 read,

“Received a phone call on 04/21/2025 regarding (Resident B)’s care with 2 of the midnight staff. (Relative B1) stated that her father is “terrified” of them, and wants to talk to the owners, and they should be fired. I asked what she meant by terrified, and she could not elaborate or share a specific episode that made her dad feel this way. She further stated that there was “notes that staff shared with her” stating he is afraid of them. During the conversation I reviewed the observation notes and saw on 4/7 stating “resident brought up third shift again, he stated “They’re not so nice” and “They’re attitudes are like “We were here 30 minutes ago what do you need.”” Further discussion with Relative B1 focused on care staff, (SP9) and she mentioned she has never met her, does not know what kind of person she is. I offered to set up a meeting for her to talk with (SP9) but she declined. The conversation ended with an agreement for me to have a conversation with her dad to determine how he feels about the care staff on the midnight shift.

On Tuesday April 22 (SP5) accompanied me to (Resident B)'s room. I asked (Resident B) if he was having any issues with the midnight shift and if they are helping him when requested. (Resident B) stated all staff work differently some are better than others. I asked if he was terrified of any of the staff. He stated that no (Relative B1) was incorrect in saying this. He again stated all staff work differently. Some are more efficient than others. He mentioned that (SP9) and (SP2) do not work well with each other but do work well with other staff. He did share with us that he chose not to push his call light pendent last night and got himself to the restroom. I told him I don't want him to feel like he cannot use his call light at night as that is when he should be using it the most. He does feel that if he complains about anyone that the attitude of the staff will be worse. I tried to assure him I will not share this conversation with staff. I told him that I will adjust the schedule so that (SP9) and (SP2) do not work in the same area together. They may be on the same day but assigned to different areas. (Resident B) agreed with this arrangement, and we will follow up next week to see how things are going."

I reviewed SP8 performance review. The review read,

"While (SP9) is a dependable employee, she lacks self-motivation and chooses to do the minimum amount of work that is required. Recently there have been complaints from family members related to the neglectful care that occurred during her shift. Resident and family members stating that assistance was denied, call lights being ignored and telling a resident to get himself to the bathroom and another one to "go in her brief." This is not an acceptable attitude and reflects poorly on the facility as a whole. (SP9) is to provide assistance to all residents whether she feels it necessary or not. She is expected to review care plans and provide the care that is listed. All residents can ask for assistance at anytime and if not care planned can be provided as a single care. If single cares becoming consistent then the care plan will be updated appropriately. (SP9) works in an assisted living facility. all the residents are here because they may need assistance at any time and it is required that she provide that assistance."

I reviewed Resident A's medication administration record (MAR) for April 2025. The MAR revealed Resident A was prescribed Triad Hydrophilic Gel with instructions to administer twice a day. This was not initialed that this was completed on 04/15/2025 at 6:00am.

I reviewed Resident A's service plan. The service plan omitted all information on Resident A's skin breakdown on her bottom, leg swelling, or the need for pressure relief by encouraging Resident A to transfer to the bed.

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 review of documentation revealed there have been multiple concerns from residents, resident family members, and staff members on lack of care. While the facility has communicated these concerns to staff members, these concerns have continued to occur, and the actions already taken by the facility have not resolved the concerns. Additionally, Resident A's service plan lacked specific details to ensure appropriate and necessary care is provided, including ensuring that all medications are given or applied as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

05/07/2025

Kimberly Horst Date
Licensing Staff

Approved By:

05/09/2025

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