GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 25, 2019

Shannon VanHouten
Maple Lake Assisted Living
677 Hazen
Paw Paw, MI 49079

RE: License #: AH800315846
Investigation #: 2020A0784005
Maple Lake Assisted Living

Dear Ms. VanHouten:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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. 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 (810) 787-7031.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
4809 Clio Road
Flint, MI 48504
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH800315846
Investigation #:	2020A0784005
Complaint Receipt Date:	10/16/2019
Investigation Initiation Date:	10/17/2019
Report Due Date:	12/16/2019
Licensee Name:	Maple Lake Assisted Living, LLC
Licensee Address:	Suite 200 3196 Kraft Avenue Grand Rapids, MI 49512
Licensee Telephone #:	(616) 719-5598
Administrator:	Kristen Mitchell
Authorized Representative:	Shannon VanHouten
Name of Facility:	Maple Lake Assisted Living
Facility Address:	677 Hazen Paw Paw, MI 49079
Facility Telephone #:	(269) 657-0190
Original Issuance Date:	10/31/2012
License Status:	REGULAR
Effective Date:	09/18/2019
Expiration Date:	09/17/2020
Capacity:	64
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A did not have an adequate safety plan	No
Additional Findings	Yes

III. METHODOLOGY

10/16/2019	Special Investigation Intake 2020A0784005
10/17/2019	Special Investigation Initiated - Letter Referral To APS
10/17/2019	APS Referral
10/23/2019	Contact - Telephone call made Interview conducted with administrator Kristen Mitchell. Documents requested
10/23/2019	Contact - Document Sent Email sent to Ms. Mitchell with details regarding requested documentation
10/23/2019	Contact - Document Received Email received from administrator Kristen Mitchell with requested documents
10/25/2019	Exit Conference – Telephone Attempted with authorized representative Shannon VanHouten

ALLEGATION:

Resident A did not have an adequate safety plan

INVESTIGATION:

On 10/16/19, the department received this complaint

On 10/17/19, I made a referral to adult protective services (APS).

According to the complaint, Resident A had an unwitnessed fall on “on or after” 10/12/19 of which staff was notified by Resident A’s husband who found her. Resident A was sent to the hospital, evaluated and found to have a subdural hematoma. Resident A was taken back to the facility and placed on hospice care. Resident passed away on 10/15/19.

I conducted a google search of the term “subdural hematoma”. According to the website webmd.com, “in a subdural hematoma, blood collects between the layers of tissue that surround the brain” and further indicated that “pressure on the brain causes a subdural hematoma’s symptoms”.

On 10/23/19, I interviewed administrator Kristen Mitchell by telephone. Ms. Mitchell confirmed that Resident A fell out of bed on 10/12/19. Ms. Mitchell stated this was not a common occurrence for Resident A as she was able to transfer and ambulate on her own. Ms. Mitchell stated she is not certain what caused Resident A to fall. Ms. Mitchell stated staff was notified by Resident A’s husband who was the first to observe her on the floor next to her bed. Ms. Mitchell stated Resident A’s husband is also a resident at the facility. Ms. Mitchell stated emergency medical services (EMS) was contacted immediately for Resident A. Ms. Mitchell stated that upon initial evaluation, EMS workers indicated that it appeared to them Resident A had a stroke. Ms. Mitchell stated she did not know if Resident A was found to have had a stroke. Ms. Mitchell stated Resident A returned to the facility and passed aware under hospice care on 10/14/19.

I reviewed Resident A’s “discharge planning” documentation from *BRONSON* hospital, provided by Ms. Mitchell. Review of this document revealed consistency with the reporting provided in the complaint as it pertains to the circumstances of Resident A’s fall on 10/12/19, diagnosis and subsequent return to the facility on 10/14/19 while being placed on hospice care.

I reviewed Resident A’s service plan, provided by Ms. Mitchell. Under a section titled *Ambulation/Mobility*, the plan read “propels self with wheelchair”. Under a section titled *Transferring*, the plan read, in part, “transfers self independently”. Under a section titled *Repositioning*, the plan read “repositions self independently”.

I reviewed *Resident Documentation/Notification Flow Sheet* documentation provided by Ms. Mitchell. Ms. Mitchell stated that these documents represent staff progress notes pertaining to Resident A. The notes were dated from 7/29/19, indicated on the documentation as Resident A’s admission date to the facility, to 10/15/19, the date of Resident A’s passing. The notes documented by staff are consistent with statements provided by Ms. Mitchell and Resident A’s service plan as it pertains to Resident A’s ability to ambulate and transfer independently.

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:	Review of the investigators report, staff notes and Resident A's medical documentation and service plan as well as statements provided by the administrator do not support that Resident A had an inadequate safety plan. Based on the findings the facility is complaint with this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of the facility licensing file revealed no incident report regarding Resident A's fall and subsequent hospital visit on 10/12/19 at which time she was found to have an injury.

Ms. Mitchell was unable to provide evidence that the facility attempted to provide an incident report in reference to Resident A's fall and subsequent injury.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.
For Reference: **R 325.1901**	**Definitions**

	(17) "Reportable incident/accident" means an intentional or unintentional event in which a resident suffers harm or is at risk of more than minimal harm, such as, but not limited to, abuse, neglect, exploitation, or unnatural death.
ANALYSIS:	Resident A had a fall on 10/12/19 which resulted in a subdural hematoma. Resident passed away on 10/15/19. The department did not receive an incident report in reference to either of these incidents. While Resident A was on hospice care when she passed, based on the circumstances leading up to her passing, an incident report would have been expected in reference to this occurrence. Based on the findings, the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/25/19, I left a telephone message with authorized representative Shannon VanHouten regarding the outcome of the investigation with an invitation for a return call.

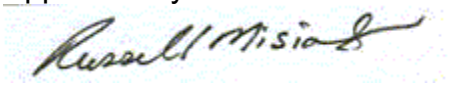
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

10/25/19

Aaron Clum Date
Licensing Staff

Approved By:



10/25/19

Russell B. Misiak Date
Area Manager