GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 6, 2022

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

RE: License #: AH700236875
Investigation #: 2022A1028043
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, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
Cell (616) 204-4300

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AH700236875 |
| | |
| **Investigation #:** | 2022A1028043 |
| | |
| **Complaint Receipt Date:** | 05/13/2022 |
| | |
| **Investigation Initiation Date:** | 05/16/2022 |
| | |
| **Report Due Date:** | 07/12/2022 |
| | |
| **Licensee Name:** | Resthaven |
| | |
| **Licensee Address:** | 948 Washington Ave.<br>Holland, MI 49423 |
| | |
| **Licensee Telephone #:** | (616) 796-3500 |
| | |
| **Administrator:** | Tiffany Ziemba |
| | |
| **Authorized Representative:** | Deedre Vriesman |
| | |
| **Name of Facility:** | Resthaven Maple Woods |
| | |
| **Facility Address:** | 49 E 32nd St.<br>Holland, MI 49423 |
| | |
| **Facility Telephone #:** | (616) 796-3700 |
| | |
| **Original Issuance Date:** | 06/01/1999 |
| | |
| License **Status:** | REGULAR |
| | |
| **Effective Date:** | 07/31/2021 |
| | |
| **Expiration Date:** | 07/30/2022 |
| | |
| **Capacity:** | 101 |
| | |
| **Program Type:** | AGED<br>ALZHEIMERS |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| The facility is consistently short staffed. | Yes |
| Additional Findings | Yes |

## III. METHODOLOGY

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|---|---|
| 05/13/2022 | Special Investigation Intake<br>2022A1028043 |
| 05/16/2022 | Special Investigation Initiated - Letter<br>2022A1028043 |
| 05/16/2022 | APS Referral<br>2022A1028043 |
| 05/31/2022 | Contact - Face to Face<br>Interviewed Administrator, Tiffany Ziemba, at the facility. |
| 05/31/2022 | Contact - Face to Face<br>Interviewed Employee A at the facility. |
| 05/31/2022 | Contact - Face to Face<br>Interviewed Employee B at the facility. |
| 05/31/2022 | Contact - Face to Face<br>Interviewed Employee C at the facility. |
| 05/31/2022 | Contact - Face to Face<br>Interviewed Employee D at the facility |
| 05/31/2022 | Contact - Face to Face<br>Interviewed Employee E at the facility. |
| 10/06/2022 | Exit Interview |

**ALLEGATION:**

**The facility is consistently short staffed.**

**INVESTIGATION:**

On 5/13/22, the Bureau received this complaint from the online complaint system.

On 5/16/22, an APS referral was made to Centralized Intake.

On 5/31/22, I interviewed administrator, Tiffany Ziemba, at the facility. Ms. Ziemba reported there are 10 care staff scheduled for first and second shift and five care staff scheduled for third shift. Ms. Ziemba reported the facility does experience call-ins often from facility staff, but float staff, management and/or other care staff at the facility work over to fill the call-in vacancy when it occurs. Ms. Ziemba reported the facility does not utilize agency staff because the facility is able to borrow staff from other buildings when shift vacancies occur.

On 5/31/22, I interviewed Employee A at the facility. Employee A reported the facility is short staffed and call-ins occur often. Employee A reported there is float staff that will assist at times, but it is not consistent, even when assist is requested by care staff due to shift shortages. Assisted living currently has 43 residents with three residents being a one to two person transfer during care routines. Employee A reported there has been multiple occasions with one care staff only during second and third shifts to assist all 43 residents. One care staff person has also had to manage both medication carts on second and third shifts due to being the only one on the shifts. Care staff have voiced concerns to supervisors and management and while management has assisted intermittently, the facility continues to remain short staffed during second and third shifts.

On 5/31/22, I interviewed Employee B at the facility. Employee B while ideally 10 care staff are scheduled for first and second shifts and 5 are scheduled for third shift, the second and third shifts are short staffed due to call-ins, employees leaving early or employees not reporting to work. Employee B reported some care staff are working 16 hour shifts to cover the shift vacancies due to the call-ins, but current care staff are “burned out from working that much”. Employee B reported there is usually one to two care staff working between the assisted living and memory care unit on the first floor during second and third shifts, but ideally there needs to be two to three care staff working on each unit for second and third shifts. Employee B reported the second-floor supportive care unit should have two to three care staff working each shift as well but there is often only one care staff working second and third shift. Employee B reported management tries to fill the vacancies with other staff or by assisting intermittently, but the facility continues to remain short staffed and current staff are overwhelmed due to this.

On 5/31/22, I interviewed Employee C at the facility. Employee C reported that recently there has only been one to two care staff total on second and third shifts between the assisted living and memory care unit on the first floor of the facility. There has only been one care staff for the second-floor supportive care unit during second and third shifts. No agency staff is utilized, and care staff are working 16-hour shifts to cover the shift vacancies. Management assists intermittently during the week on first shift with shift vacancies, but there is no assistance on second or third shifts during the week or during the weekend.

On 5/31/22, I interviewed Employee D and Employee E at the facility. Employee D and Employee E's statements were consistent with Employee A's, Employee B's and Employee C's statements in that the facility continues to remain short staffed for the number of residents on each floor despite care staff working 16-hour shifts to fill shift vacancies.

On 5/31/22, I completed an on-site inspection of the facility. I observed only six care staff on duty between the first and second floors. It was also noted second shift was going to be short staffed that day due to call-ins. The scheduling staff was working to rectify the shift shortage during my inspection.

On 5/31/22, I reviewed the staff schedule for May 2022 along with employee time reports. This review revealed multiple second and third shift shortages throughout May 2022.

I also reviewed documentation that showed residents who require a one to two person assist with transfers from care staff. There are 17 one-person assists with transfers between assisted living and the supportive care unit. There are two one-person assists with transfers in the memory care unit. There are two two-person assists with transfers in assisted living and one two-person assist in the memory care unit.

| **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.** |

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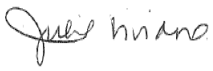
|---|---|
| **ANALYSIS:** | Interviews and review of staff schedules along with resident transfer assist documentation demonstrates that there is not enough staff present during second and third shifts to assist residents safely and to provide appropriate assistance in accordance with service plans. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

Contingent upon an approved corrective action plan, I recommend the status of this license remain the same.



6/7/2022

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Julie Viviano Date
Licensing Staff

Approved By:

10/05/2022

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