GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 18, 2022

Carol Del Raso
Maple Lake Assisted Living
677 Hazen
Paw Paw, MI 49079

RE: License #: AH800315846
Investigation #: 2022A1028063
Maple Lake Assisted Living

Dear Ms. 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
Cell (616) 204-4300

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

I. IDENTIFYING INFORMATION

License #:	AH800315846
Investigation #:	2022A1028063
Complaint Receipt Date:	07/07/2022
Investigation Initiation Date:	07/11/2022
Report Due Date:	09/06/2022
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:	Christine McClellan
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:	09/18/2021
Expiration Date:	09/17/2022
Capacity:	64
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Residents are not receiving care in accordance with their service plans.	No
Resident D's missing medications were stored improperly in the administrator's office.	Yes
Resident D's and Resident E's medications were stolen out of the administrator's office.	Yes
Additional Findings	No

III. METHODOLOGY

07/07/2022	Special Investigation Intake 2022A1028063
07/11/2022	Special Investigation Initiated - Letter
07/11/2022	APS Referral APS made referral to HFA and is already investigating.
07/21/2022	Inspection Completed On-site Inspection completed on-site due to investigation.
07/21/2022	Contact - Face to Face Interviewed Admin/Kristen Mitchell at the facility.
07/21/2022	Contact - Face to Face Interviewed Employee A at the facility.
07/21/2022	Contact - Face to Face Interviewed Employee B at the facility.
07/21/2022	Contact - Face to Face Interviewed Employee C at the facility.
07/21/2022	Contact - Face to Face Interviewed Employee D at the facility.

07/21/2022	Contact - Document Received Received Resident A's and Resident B's, and Resident C's service plans, record notes, MARs from Admin/Kristen Mitchell.
08/02/2022	Contact – Document Requested Requested Resident D and Resident E's MAR, facility medication policy, and service plans from Admin/Kristen Mitchell.
08/03/2022	Contact – Document Received Received Resident D and Resident E's MAR, facility medication policy, and service plans from facility staff.
10/18/2022	Exit – Report sent to AR/Carol Del Raso and Interim Admin/Bobbie Huizen.

This special investigation will only address allegations that apply to licensing violations. The allegation about the facility being short staffed is addressed in special investigation 2022A1028062.

ALLEGATION:

Resident D's missing medications were stored improperly in the administrator's office.

INVESTIGATION:

On 7/7/2022, the Bureau received the allegations from an anonymous complainant through the online complaint system.

On 7/11/2022, Adult Protective Services (APS) made HFA referral to Centralized Intake.

On 7/21/2022, I interviewed the facility administrator, Kristen Mitchell, at the facility. Ms. Mitchell reported Resident D's and Resident E's medications were stored in her office under lock and key in her desk due to the "medication carts being full". Ms. Mitchell reported larger medication carts were ordered from the pharmacy but had not arrived yet and overflow of medications were being stored in her office temporarily. Ms. Mitchell reported the facility pharmacy just switched the medications to punch packs resulting in an overflow of resident medications. Ms. Mitchell reported the medications being stored in the office were in bottles and "due to the switch to pill packs, staff did not want to have to count those pills out anymore. We just switched over to the packs instead". Ms. Mitchell reported the med techs are aware the overflow medications are being stored in her office temporarily and have access if needed. When questioned about the overflow of medications not being sent

back to the pharmacy for disposal, Ms. Mitchell reported it will be determined if the medications can be returned once the new med carts arrive. I requested the facility medication administration policy from Ms. Mitchell along with Resident D's and Resident E's service plan and MAR from June 2022 to July 2022.

On 7/21/2022, I interviewed Employee A at the facility who reported knowledge of the overflow medications being stored in Ms. Mitchell's office due to the facility pharmacy switching from pill bottles to pill packs. Supervisors on shift have access to the medications if needed, but Resident D and Resident E have an overflow of medications and the med cart is currently full.

On 7/21/2022, I interviewed Employee B at the facility who reported no knowledge of any missing resident medications. Employee B also reported no knowledge of any medications being temporarily stored in Ms. Mitchell's office due to overflow.

On 7/21/2022, I interviewed Employee C at the facility who reported knowledge of medications being stored in the administrator's office but did not know who had access, how to access the medications, or which medications were in Ms. Mitchell's office.

On 7/21/2022, Employee D's statements are consistent with Ms. Mitchell's and Employee A's statements.

On 8/2/2022, I reviewed Resident D's medication administration record from June 2022 to July 2022 with the service plan. The review revealed Resident D passed away on 7/7/2022 and no other concerns noted with medication administration.

I also requested Resident E's MAR, the facility medication policy, and Resident D's and Resident E's service plans again from the facility.

On 8/3/2022, I received Resident E's MAR, the facility medication policy, and Resident D's and Resident E's service plans from facility staff.

On 8/8/2022, I reviewed the facility medication policy which revealed the following:

- All controlled medications must be in blister/individual unit packaging.
- All prescribed medications, any over the counter medications, dietary supplements, or treatments shall be given to staff on duty for proper storage as directed by licensing and regulation. Medications shall be secured in an approved locked storage container.
- Medications that are no longer in use shall be disposed of per policy QS 707 for non-controlled substances and QS 706 for controlled substances. All discontinued controlled substances (for any reason including death) will be destroyed.

On 8/8/2022, I reviewed Resident E's MAR from June 2022 to July 2022 which revealed no concerns noted with medication administration. I also revealed Resident D's and Resident E's service plans.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1)(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:	Interviews, on-site inspection, and review of documentation reveal an overflow of resident medications were stored in the administrator's office due to the facility switching from pill bottles to pill packs. Larger medication carts were ordered due to the overflow of medications from the switch but had not yet arrived. However, by storing overflow medications in the administrator's desk drawer, the facility did not take appropriate measures to ensure medication storage in accordance with the facility medication policy and program. The policy read *all prescribed medications shall be given to staff on duty for proper storage [sic] and shall be secured in an approved locked storage container.* The administrator's desk drawer cannot not be considered an approved storage container for resident medications; therefore, the facility is in violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents are not receiving care in accordance with their service plans.

INVESTIGATION:

On 7/21/2022, Ms. Mitchell reported care staff follow all resident service plans to ensure appropriate care. Ms. Mitchell reported service plans are routinely reviewed and revised to ensure resident care levels. Ms. Mitchell reported there have been no complaints from residents, resident families, hospice, or care staff about residents not being bathed or residents not wearing clean clothes or briefs and/or residents sitting in soiled clothing resulting in bed sores. Ms. Mitchell provided me a copy of

Resident A's, Resident B's, and Resident C's service plans with record notes for my review.

On 7/21/2022, Employee A reported no knowledge of any resident not being bathed or wearing soiled clothes resulting in bed sores. Employee A reported resident service plans are followed daily by care staff and the service plans are routinely updated to ensure appropriate care levels. Employee A reported Resident C has a bed sore, but facility staff and hospice continue to monitor it, and it is not decubitus. Resident C has a history of skin issues, but no open bed sores. Employee A reported there is a shower schedule for each unit posted in the facility and that at minimum residents receive two showers weekly. Employee A reported some residents receive additional showering if needed due to an accident or if they request it.

On 7/21/2022, Employee B at reported Resident C has a "bed sore but it is not open or decubitus. Hospice and staff here currently monitor it". Employee B reported all residents are on a shower schedule and receive at minimum two showers per week and there is a shower schedule posted in each unit. Employee B reported no knowledge of residents of any residents not showering or sitting in soiled clothing or briefs. Employee B reported to [their] knowledge, there have been no complaints or concerns from residents, resident families, facility staff or hospice concerning resident care. Employee B reported if resident families or hospice had a concern about the care facility staff provided residents, it would "definitely be heard and addressed with the facility and doctor".

On 7/21/2022, I interviewed Employee C at the facility. Employee C reported resident service plans are reviewed consistently and all care staff are trained to follow the service plans. Employee C confirmed Resident C has a history of bed sores and currently has a small bed sore, but it is not decubitus. It is monitored daily by facility staff and hospice staff. Employee C reported all residents are on a shower schedule and receive at minimum two showers per week unless a resident requires additional showering due to an accident and/or additional showering is requested by the resident. Employee C reported no knowledge of any resident sitting in soiled clothing or briefs and "that type of care would not be tolerated here."

On 7/21/2022, I interviewed Employee D at the facility whose statements were consistent with Ms. Mitchell's, Employee A's, Employee B's, and Employee C's statements.

On 7/21/2022, I completed an inspection of the facility which revealed the facility was clean and residents observed were clean, content, and/or being assisted by staff. A weekly shower schedule was posted at each med station. No smell of urine or uncleanliness was detected.

On 7/28/2022, I reviewed Resident A's, Resident B's, and Resident C's service plans with record notes. No concerns were noted during the review.

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 care was not provided in accordance with resident service plans. Interviews, on-site inspection, along with review of documentation reveal there is no evidence to support this allegation Care staff are providing care consistent with resident service plans.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident D's medications were stolen out of the administrator's office.

INVESTIGATION:

On 7/21/2022, Ms. Mitchell reported Employee E broke into her office at 1:30am on 7/2/2022 and stole Resident D and Resident E's medications. Medications stolen were controlled substances. Employee E was not scheduled to work that shift and entered the building. Employee E popped the lock on the office door using a credit card and subsequently broke the desk lock to steal the medications. Ms. Mitchell reported "other staff caught Employee E in the office and asked why [they] were in the office and Employee E told the staff [they] had permission from me, which was not true". Ms. Mitchell reported instead of being terminated, Employee E resigned via text message and did not return to the facility. Ms. Mitchell reported a police report was filed, the resident and their authorized representatives were notified of the incident, as well as the licensing department. Ms. Mitchell reported the facility corporate management is not filing charges against Employee E, but resident and their families were notified they could file charges. Ms. Mitchel provided me a copy of the internal investigation with the police report information for my review.

On 7/21/2022, Employee A reported Employee E broke into the office over the fourth of July holiday weekend and stole Resident D and Resident E's medications, along with some other items. Employee A reported Employee E had not demonstrated any unusual behavior until the incident in which Employee E was witnessed as being "hyped up on something". Employee A reported Employee E was a med tech but was not working the night of the incident and after Employee E was caught in the administrator's office, Employee E did not return to the facility. Employee A reported

a police report was filed, residents and their authorized representatives were notified, and the licensing department was notified of an internal investigation. Employee A reported to [their] knowledge, the stolen medications were not recovered.

On 7/21/2022, Employee C reported Employee E stole resident's medications on 7/2/2022 from the administrator's office. Employee C reported Employee E entered the building and was not scheduled to work that night. Employee C reported to [their] knowledge the police, residents and their authorized representatives were notified, and the licensing department were notified of the incident. Employee C reported an internal investigation was completed as well and Employee E has not returned to the facility.

On 7/21/2022, I inspected the administrator's office and observed the broken desk lock.

On 7/28/2022, I reviewed the incident report and the internal investigation report which revealed Employee E was not scheduled to work the night of the incident. The review also revealed a delay in staff reporting to management that Employee E had been discovered in the administrator's office. Staff did not report the incident to management until the next morning. It was also revealed Resident D had a full card of Lorazepam missing from the medication cart on first shift after the incident. The medication had been present during the medication count from second to third shift and went missing during third shift.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(5) A home shall take reasonable precautions to ensure or assure that prescription medication is not used by a person other than the resident for whom the medication is prescribed.

ANALYSIS:	Interviews, on-site inspection, and review of documentation reveal: • Employee E broke into the administrator's office on 7/2/2022 and stole Resident D and Resident E's controlled medications. • Employee E was a med technician for the facility but was not on schedule to work the night of the incident. • Facility staff that caught Employee E in the administrator's office did not report it to management until hours later the next morning. • Resident D was missing a full card of Lorazepam from the medication cart on third shift. It cannot be determined how Employee E accessed the medication cart. Employee E was able to access the administrator's office and the medication cart to steal Resident D's and Resident E's controlled medications. The facility did not take appropriate measures to ensure resident medications were secured and safe to prevent theft.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Julie Viviano

8/8/2022

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Julie Viviano Date
Licensing Staff

Approved By:

Andrea L. Moore

10/05/2022

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