GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 21, 2022

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

RE: License #: AH800315846
Investigation #: 2023A1010002
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.

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 (616) 356-0183.

Sincerely,

Lauren Wohlfert

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 260-7781

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH800315846
Investigation #:	2023A1010002
Complaint Receipt Date:	10/11/2022
Investigation Initiation Date:	10/12/2022
Report Due Date:	12/10/2022
Licensee Name:	Maple Lake Assisted Living, LLC
Licensee Address:	Suite 200 3196 Kraft Avenue Grand Rapids, MI 49512
Licensee Telephone #:	(616) 719-5598
Administrator:	Bobbie Huizen
Authorized Representative:	Carl Del Raso
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:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident C did not receive proper care when he resided in the facility.	Yes

III. METHODOLOGY

10/11/2022	Special Investigation Intake 2023A1010002
10/12/2022	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
10/12/2022	APS Referral APS referral emailed to Centralized Intake
10/24/2022	Contact - Telephone call made Interviewed the complainant by telephone
10/24/2022	Inspection Completed On-site
10/24/2022	Contact - Document Received Received resident service plan and incident reports
11/21/2022	Exit Conference Completed with licensee authorized representative Carol Del Raso

ALLEGATION:

Resident C did not receive proper care when he resided in the facility.

INVESTIGATION:

On 10/11/22, the Bureau received the allegations from the online complaint system. The complaint read the facility failed “to report and act on a very quick decline in abilities. Resident’s DPOA stated concerns on 9/22, 9/23, and 9/24 and was dismissed each time with comments like ‘It is a bad day.’ Or ‘he is tired.’ Failure to report a stage two compression wound to family and primary care. Failure to properly care for stage two compression wound. No change to care plan after wound was found. Resident went to hospital for severe dehydration.”

On 10/12/22, I emailed an Adult Protective Services (APS) complaint to Centralized Intake.

On 10/24/22, I interviewed the complainant by telephone. The complainant's statements were consistent with the written complaint. The complainant stated Resident C's durable power of attorney (DPOA) was informed by hospital staff, not staff at that facility, that Resident C had a stage II pressure wound. The complainant said hospital staff said it appeared staff at the facility put some type of cream on the wound, therefore they were aware of it. The complainant reported before Resident C was sent to the hospital, he was observed weaker than usual, and he had more difficult ambulating. The complainant stated staff responded by stating he "was probably dehydrated." The complainant said it was not until Resident C was unable to stay awake and get out of bed when staff contacted emergency services at the urging of his DPOA.

The complainant also reported staff left the zinc barrier cream they applied to Resident C's buttocks unsecured in his room. The complainant reported Resident C had unsupervised access to the cream and expressed concern Resident C could have ingested it. The complainant said Resident C experienced memory loss and resided in the facility's secured memory care unit.

On 10/24/22, I interviewed administrator Bobbie Huizen at the facility. Ms. Huizen said Resident C resided in the facility's secured memory care unit. Ms. Huizen reported Staff Person 1 (SP1) documented a wound she observed on Resident C's buttocks on 9/21/22. Ms. Huizen stated this was the first-time staff observed the wound and SP1 instructed staff to start putting a "barrier cream" on the wound. Ms. Huizen explained it is the facility's procedure for staff to complete a "skin assessment sheet" anytime a bruise, wound, or mark is observed. Ms. Huizen reported the facility's wellness director then reviews the forms and makes the needed contacts, such as to the resident's responsible person and their physician.

Ms. Huizen stated SP1 did not complete a skin assessment form for the facility's wellness director to review after she observed Resident C's wound. Ms. Huizen reported SP1 was re-educated on the facility's process and procedure for reporting resident wounds on the skin assessment form. Ms. Huizen said to her knowledge, Resident C's physician was not informed of the wound SP1 observed.

Ms. Huizen reported on 9/25/22, Resident C stayed up until 2:00 am. Ms. Huizen stated when Resident C's DPOA came to visit him at the facility later that day, Resident C was tired because of staying up and could not stay awake. Ms. Huizen said Resident C's DPOA requested he be sent out. Ms. Huizen denied knowledge regarding Resident C being outside of his baseline. Ms. Huizen reported Resident C did not return to the facility after he was discharged.

Ms. Huizen provided me with a copy of Resident C's service plan for my review. The *Supervision Monitoring Frequency* section of the plan read, "Requires hourly supervision monitoring. Document where resident is hourly." The *Wandering behavior* section of the plan read, "Wanders in public areas, but not intrusive. Does not try to leave community. Alarm on door to monitor resident from 11pm to 6am will

reassess in two weeks. The *Topical/Eye Medications/TED hose/Treatments* section of the plan read, “Resident does not require any topical med or treatments OR self-administers them.”

Ms. Huizen provided me with a copy of Resident C’s *Charting Notes* for my review. A note written by SP1 dated 9/21/22 read, “[Resident C] has a open sore on his bottom. The crack of his bottom is real red as well. He will need reminder of giving his bottom rest. Have him lay on his side in bed after lunch. Started apply [sic] barrier cream to his bottom today. Needs to be applied multiple times a day.” A note written by SP1 dated 9/25/22 read, “Went to bed at 2am have noticed he cant get is [sic] body in his bed by himself. He is needing help reminding to change his brief and needing barrier cream 3 times a day. Reposition him to help him not be on his bottom all day. Lay in bed on his side will help.”

A note written by SP2 dated 9/25/22 read, “Resident was not responding when [Relative C1] come to visit him today. She said that he was not answering at all so she said that she things its better for us to send him out to get checked out so [sic] see if there is anything going on with him. Send him cross the street from here at Lake View in Paw Paw.”

On 10/24/22, I interviewed SP1 at the facility. SP1 said she is a resident care coordinator at the facility. SP1 reported that although she wrote Resident C’s had “an open sore on his bottom” in her *Charting Notes,* Resident C’s wound was not “open or oozing.” SP1 reported the mark was a “raw red spot” that was approximately the size of a time on his buttocks. SP1 explained the mark “looked more like a burn.” SP1 again stated that the wound “was not open.” SP1 stated she applied an over-the-counter zinc barrier cream to the area and instructed other staff to start applying it daily. SP1 stated Resident C “sits a lot” so she also instructed staff to get Resident C up and reposition him.

SP1 reported when she started at the facility, she was not trained how to report resident marks, injuries, or wounds. SP1 stated that as a result, she did not complete an incident report form or skin assessment document regarding the mark she observed on Resident C’s buttocks. SP1 said “a few days after” she observed the mark, she informed the facility’s former wellness director at the time. SP1 reported the former wellness director instructed her to apply barrier cream, however staff were already doing so.

SP1 stated she was not working the day Resident C was sent to the hospital, therefore she did not have any information regarding the incident. SP1 reported Resident C was often provided with water, however he preferred to drink pop and coffee. SP1 said staff often encouraged Resident C to drink water, however they could not force him to do so.

On 10/24/22, I interviewed SP2 at the facility. SP2’s statements were consistent with her *Charting Note* dated 9/25/22. SP2 stated after the mark was observed on

Resident C's buttocks, staff were instructed to apply the zinc barrier cream. SP2 reported she applied the cream to the area on Resident C's buttocks during her shifts. SP2 reported the over the counter zinc cream staff applied on Resident C's buttocks was kept on his bathroom counter, unsecured.

SP2 said she was trained to complete an incident report anytime a mark, bruise, or injury was observed on a resident. SP2 stated the wellness director then reviews them and contacts the required persons. SP2 reported she often gave Resident C water to drink. SP2 stated Resident C drank at least one to three cups of water for her during her shifts.

On 10/24/22, I was unable to interview Resident C because he no longer resides in the facility.

On 10/24/22, I observed the bathroom of a resident in the secured memory care unit. I observed a bottle of "Calazime Zinc" lotion that was unsecured on the resident's bathroom counter.

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:	The Interviews with Ms. Huizen and SP1 revealed SP1 did not follow the facility's policy and procedure regarding reporting a resident bruise, mark, wound, or injury after she observed a "raw red spot" on Resident C's buttocks. SP1 reported she did not inform the facility's wellness director of the area and the barrier cream staff were applying until "a few days after" she observed the area on Resident C's buttocks. Resident C's physician or responsible person were not notified. The interviews with the complainant and SP2 revealed the over-the-counter zinc cream staff applied to the area on Resident C's buttocks was left unsecured on his bathroom counter. Due to Resident C's cognitive deficits, allowing him to have unsupervised access to the zinc cream is not consistent with an organized program of protection.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	The interview with SP1, along with review of her *Charting Notes* revealed she observed a mark or wound on Resident C's buttocks and initiated the application of a zinc barrier cream to the area. Review of Resident C's service plan revealed he, "does not require any topical med or treatments." Resident C's service plan was inconsistent with SP1 and SP2's statements regarding staff applying a zinc barrier cream on his buttocks.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Carol Del Raso by telephone on 11/21/22.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

11/04/2022

Lauren Wohlfert Date
Licensing Staff

Approved By:

11/17/2022

Andrea Moore Date
Area Manager