GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 4, 2024

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

RE: License #: AH700236875
Investigation #: 2023A1028085
Resthaven Maple Woods

Dear Deedre 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

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

I. IDENTIFYING INFORMATION

License #:	AH700236875
Investigation #:	2023A1028085
Complaint Receipt Date:	09/20/2023
Investigation Initiation Date:	09/20/2023
Report Due Date:	11/20/2023
Licensee Name:	Resthaven
Licensee Address:	948 Washington Ave. Holland, MI 49423
Licensee Telephone #:	(616) 796-3500
Administrator:	Jill Schrotenboer
Authorized Representative:	Deedre Vriesman
Name of Facility:	Resthaven Maple Woods
Facility Address:	49 E 32nd St. Holland, MI 49423
Facility Telephone #:	(616) 796-3700
Original Issuance Date:	06/01/1999
License Status:	REGULAR
Effective Date:	07/31/2023
Expiration Date:	07/30/2024
Capacity:	101
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The second-floor memory care unit was short staffed on 9/4/2023.	Yes
The second-floor memory care unit air conditioning was broken on 9/4/2023.	No
The second-floor memory care unit has bed bugs.	No
Additional Findings	Yes

III. METHODOLOGY

09/20/2023	Special Investigation Intake 2023A1028085
09/20/2023	Special Investigation Initiated - Letter
09/20/2023	APS Referral APS referral made to Centralized Intake.
10/04/2023	Contact - Face to Face Interviewed Admin/Jill Schrotenboer at the facility.
10/04/2023	Contact - Face to Face Interviewed Employee A at the facility.
10/04/2023	Contact - Face to Face Interviewed Employee B at the facility.
10/04/2023	Contact - Face to Face Interviewed Employee C at the facility.
10/04/2023	Contact - Face to Face Interviewed Employee D at the facility.
10/04/2023	Contact - Document Received Received Resident A's record, staffing record, and pest control records from Admin/Jill Schrotenboer.

ALLEGATION:

The second-floor memory care unit was short staffed on 9/4/2023.

INVESTIGATION:

On 9/20/2023, the Bureau received the allegations anonymously through the online complaint system.

On 9/20/2023, a referral was made to Adult Protective Services (APS) through Centralized Intake.

On 10/4/2023, I interviewed the facility administrator, Jill Schrotenboer, at the facility. She reported that on 9/4/2023, there were two care staff on the second-floor memory care for all shifts. There were 20 residents in the unit that day. Ms. Schrotenboer reported there have been issues with staffing and there have been times when only one staff member has been on the second-floor memory care unit even though there are 20 residents in the unit. However, Ms. Schrotenboer reported the facility ensures there are enough staff on duty to provide care in accordance with service plans and acuity levels. Ms. Schrotenboer reported call-ins do occur at the facility but there is on-call staff, staff will stay over, and management will assist as well. The facility does not use agency staff. The facility is also actively hiring as well. Ms. Schrotenboer provided me the working staff schedule for my review.

On 10/4/2023, I interviewed Employee A who confirmed there were two employees on the second-floor memory care unit on 9/4/2023. Employee A confirmed there are 20 residents in the memory care and there have been times when the facility is short staffed and there is only one care staff member available to work on the second-floor memory care unit. Employee A reported the facility scheduler and management will work hard to bring extra staff in when there is a call-in but sometimes finding staff to cover is difficult, so the facility “will make it work with the staff in place if no one comes in”.

On 10/4/2023, I interviewed Employee B and Employee C at the facility whose statements were consistent with Ms. Schrotenboer’s statements and Employee A’s statements.

On 10/4/2023, I reviewed the working staff schedule for 9/4/2023 which revealed two care staff members were assigned to work first shift, second shift, and third shift. However, the two care staff members assigned to second shift and third shift were the same care staff members. Staff care member #2 left work at 2:00am, leaving staff care staff member #1 by [their] self on the second-floor memory care unit from 2:00am to 6:00am.

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.
ANALYSIS:	It was alleged the second-floor memory care unit in the facility was short staffed on 9/4/2023. Interviews, on-site investigation, and review of documentation revealed that while there were two care staff members assigned to second-floor memory care unit on 9/4/2023 for each shift. However, the same two care staff members were assigned to work both second and third shifts; and staff care member #2 left work at 2:00am, leaving staff care staff member #1 by [their] self on the second-floor memory care unit from 2:00am to 6:00am. There is no further documentation on the working staff schedule to support others assisting care staff member #1 after care staff member #2 left work for the day on 9/4/2023. It was also revealed during interviews there has only been one care staff member on the second-floor memory care unit intermittently to assist 20 residents. A one care staff member to 20 residents ratio is not appropriate. One care staff member cannot provide care in accordance with service plans, safe care, and/or timely care to 20 residents who reside on a lock down memory care unit due to impaired cognition. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The second-floor memory care unit air conditioning was broken on 9/4/2023.

INVESTIGATION:

On 10/4/2023, Ms. Schrotenboer reported there was an issue with the air conditioning in August 2023, but a service order was placed immediately, and it did not affect residents or staff. Ms. Schrotenboer reported there is more than on air conditioning unit for the second floor and there were also fans available if needed, but to her knowledge there no complaints from staff, residents, and/or resident families.

On 10/4/2023, Employee A reported knowledge of one the air conditioning units for the second floor required servicing and some new parts, but that it did not affect any residents or facilities duties while the unit was out f service. The facility addressed the issue immediately and it was fixed once the parts arrived. Employee A also confirmed there is more than one air conditioning unit that services the second floor and despite one of the units not working correctly, the facility was still an appropriate and comfortable temperature, and it did not affect care. Employee A reported no knowledge of any complaints from staff, residents, and/or resident families concerning the air-conditioning on the second floor.

On 10/4/2023, Employee B ‘s statements, Employee C’s statements and Employee D’s statements were consistent with Ms. Schrotenboer’s statements and Employee A’s statements.

APPLICABLE RULE	
R 325.1973	**Heating.**
	(1) A home shall provide a safe heating system that is designed and maintained to provide a temperature of at least 72 degrees Fahrenheit measured at a level of 3 feet above the floor in rooms used by residents. **(2) A resident's own room or rooms in the home shall be maintained at a comfortable temperature.**
ANALYSIS:	It was alleged the second-floor memory care unit air conditioning was broken on 9/4/2023 and residents and staff were hot or uncomfortable because of it. Interviews, on-site investigation, and review of documentation revealed that an air conditioning unit broke in late August 2023, but the facility took immediate action to address and resolve the situation. There is no evidence to support this allegation. No violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The second-floor memory care unit has bed bugs.

INVESTIGATION:

On 10/4/2023, Ms. Schrotenboer reported there was a recent case of bed bugs in the building in an apartment on the second-floor memory care unit. Ms.

Schrotenboer reported once discovered, the facility treated immediately. After the bed bugs were discovered, Resident A and other residents were provided regular skin checks, rooms were treated to include the tossing of some furniture and items, and all resident items were heat treated and/or chemically treated. The facility is also on a regular preventative infestation program as well to continue to treat for any infestation. Ms. Schrotenboer provided me the pest control records for my review.

On 10/4/2023, Employee A reported the facility had a recent case of bed bugs on the second-floor memory care unit, but it was treated immediately once discovered. Employee A confirmed Resident A and other residents were provided skin checks and rooms and resident's personal belongings were heat treated and chemically treated to ensure elimination of bed bugs. Employee A reported the facility continues to monitor and is on a regular preventative infestation program as well to continue to treat for any infestation.

On 10/4/2023, Employee B's statements, Employee C's statements and Employee D's statements were consistent with Ms. Schrotenboer's statements and Employee A's statements.

On 10/4/2023, I completed an inspection of the second-floor memory care unit to include Resident A's room. No concerns were noted during the inspection.

On 10/4/2023, I reviewed the pest control records which revealed the facility has a history of treatment services in place. Resident A's room was treated appropriately as well along with other rooms on the second-floor memory care unit as preventative maintenance.

APPLICABLE RULE	
R 325.1978	**Insect and vermin control.**
	(1) A home shall be kept free from insects and vermin.(2) Pest control procedures shall comply with MCL 324.8301 et seq.
ANALYSIS:	It was alleged the second-floor memory care unit has bed bugs. Interviews, on-site investigation, and review of documentation revealed bed bugs were discovered in an apartment on the second-floor memory care unit. The facility took immediate and appropriate action to address and resolve the situation. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

Additional Findings:

On 10/4/2023, during inspection it was discovered Resident A did not have a bed. Ms. Schrotenboer reported Resident A's family removed the bed from the room because Resident A likes to sleep in their recliner.

On 10/4/2023, I interviewed Resident A who confirmed family removed the bed from [their] room per [their] request. Resident A reported [they] like to sleep in [their] recliner.

APPLICABLE RULE	
R 325.1934	**Furniture.**
	(1) A home shall provide an individual bed at least 36 inches wide, with comfortable springs in good condition and a clean protected mattress not less than 5 inches thick, or 4 inches thick if of synthetic construction.
ANALYSIS:	Resident A's family removed the bed from Resident A's room per Resident A's request. Resident A reported [they] sleep in [their] recliner. However, a recliner is not considered a bed and the facility must provide Resident A a bed to remain in compliance with the rule. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved correction plan, I recommend the status of this license remains unchanged.

Julie Viviano

10/18/2023

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Julie Viviano Date
Licensing Staff

Approved By:

Andrea L. Moore

01/04/2024

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