GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 10, 2024

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

RE: License #: AH700236875
Investigation #: 2024A1028010
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 #:	2024A1028010
Complaint Receipt Date:	10/24/2023
Investigation Initiation Date:	10/26/2023
Report Due Date:	12/23/2023
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 facility did not follow Covid-19 protocols resulting in Resident A testing positive for Covid-19.	No
The facility is not providing care in accordance with Resident A's service plan.	Yes
Additional Findings	No

III. METHODOLOGY

10/24/2023	Special Investigation Intake 2024A1028010
10/26/2023	Special Investigation Initiated - Letter
10/26/2023	APS Referral No APS referral. APS made referral to HFA through Centralized Intake.
11/14/2023	Contact - Face to Face Interviewed Admin/Jill Schrotenboer at the facility.
11/14/2023	Contact - Face to Face Interviewed Employee A at the facility.
11/14/2023	Contact - Face to Face Interviewed Employee B at the facility.
11/14/2023	Contact - Document Received Received Resident A's record from Admin/Jill Schrotenboer.
11/14/2023	Inspection Completed On-site Inspection completed onsite due to special investigation.

The duplicate allegations of short staffing and bed bugs were recently investigated in special investigation 2023A1028085.

ALLEGATION:

The facility did not follow Covid-19 protocols resulting in Resident A testing positive for Covid-19.

INVESTIGATION:

On 10/25/2023, the Bureau received the allegations anonymously through the online complaint system.

On 10/25/2023, Adult Protective Services (APS) made a referral to Homes for the Aged (HFA) through Centralized Intake.

On 11/14/2023, I interviewed the facility administrator, Jill Schrotenboer, at the facility who reported the facility did have Covid-19 cases in September 2023, but it was contained and there was not an outbreak. Ms. Schrotenboer reported if a resident or staff member began to demonstrate symptoms, then a Covid-19 test was given. Ms. Schrotenboer reported the positive Covid-19 cases were in the second-floor locked memory care unit. Staff that tested positive were sent home to quarantine and follow the current standard Covid-19 protocols in accordance with the local health department guidelines. Residents that tested positive were quarantined on the second floor of the unit, but some of the residents have wandering behaviors, so lock-down quarantining to [their] rooms was not always possible, but staff increased supervision of residents who tested positive to prevent an outbreak. Only a handful of residents tested positive for Covid-19 in the second-floor memory care unit. Ms. Schrotenboer reported staff also did not cross between units to prevent cross-contamination within the facility. Ms. Schrotenboer reported Resident A resides in the second-floor memory care unit and began to demonstrate Covid-19 symptoms on or around 9/20/2023, so Resident A was given a Covid-19 test resulting in a positive result. Resident A's physician and family were notified of the positive result. There was also personal protective equipment provided before entrance to the second-floor unit and throughout the facility to include the entrances and exits as well. There was signage placed on all floors and at the entrances and exits concerning the positive Covid-19 cases in the building. Ms. Schrotenboer reported the facility also communicated with the local health department to ensure current Covid-19 guidelines and protocols. Ms. Schrotenboer provided me Resident A's record and facility infection control procedures and protocols for my review.

On 11/14/2023, I interviewed Employee A and Employee B at the facility whose statements were consistent with Ms. Schrotenboer's statements.

On 11/14/2023, I reviewed Resident A's record which revealed Resident A was tested for Covid-19 on 9/20/2023 due to demonstrating symptoms. Resident A's physician and family were notified of the test and the test results. It also revealed Resident A has a history of wandering on the second-floor memory care unit due to advanced dementia.

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:	It was alleged the facility had an outbreak of Covid-19 and did not follow protocols resulting in Resident A testing positive for Covid-19. Interviews, onsite investigation, and review of documentation reveal there were positive Covid-19 cases in the facility in September 2023, with Resident A testing positive as well but there was not an outbreak. The facility followed current infection control protocols and health department guidelines for the health and safety of residents, staff, and visitors. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility is not providing care in accordance with Resident A's service plan.

INVESTIGATION:

On 11/14/2023, Ms. Schrotenboer reported there was an incident that occurred on 10/4/2023 on the second-floor memory care unit in which staff heard a loud noise. Staff investigated and found Resident A on the floor with another resident on top of [them]. Staff reported both residents were holding onto an item, and it appeared neither would let go of the item, so they both fell to the floor. The residents were assisted up from the floor and assessed for any injury. Resident A reported the other resident punched and pushed [them], but Ms. Schrotenboer reported both residents are poor historians and there was no evidence the other resident punched or pushed Resident A. Neither resident had incurred any injuries and there have not been any additional incidents involving either resident since. Both families of the residents were notified of the incident and an incident report was completed as well. Ms. Schrotenboer also reported Resident A demonstrated behaviors in the second-floor memory care unit to include wandering and agitation with confused thoughts and delusions. Ms. Schrotenboer reported Resident A would intermittently "trash" [their] room due to agitation or delusions, but she recommended moving Resident A to the first-floor memory care unit to provide more opportunity to engage with others more

frequently in the common area. Ms. Schrotenboer reported Resident A's family agreed to the move and Resident A has had no wandering behaviors or agitation since the move and no longer "trashes" [their] room. Ms. Schrotenboer reported staff complete rounds every two hours to check on Resident A's safety and to assist with toileting. Staff also complete a documentation of care rounds for each resident. Ms. Schrotenboer reported no knowledge of Resident A not being assisted with toileting in a timely manner. Ms. Schrotenboer provided me Resident A's service plan, incident report, and care round logs for September 2023 to October 2023 for my review.

On 11/14/2023, I interviewed Employee A and Employee B at the facility whose statements were consistent with Ms. Schrotenboer's statements.

On 11/14/2023, I completed an onsite inspection of the facility due to this special investigation and observed Resident A in the first-floor memory care unit. Resident A was well groomed, content, and participating in an activity in the common area with other residents. I also inspected Resident A's room and observed no concerns. The room was clean and orderly.

On 11/14/2023, I reviewed Resident A's service plan which revealed the following:

- Independent with bed mobility, toileting, and eating.
- Requires cueing and supervision for bathing/showering, dressing, and personal hygiene.
- Is an elopement risk and wanders due to advanced dementia.
- Requires cueing to locate room.
- Has impaired cognition and communication due to advanced dementia.
- Requires time to process information and answer questions. Do not rush Resident A.
- Requires tasks broken down into 1-2 step directions.
- Is continent and independent with toileting.
- Receives weekly housekeeping services.
- The facility manages all medications.

I reviewed the care round log for September 2023 which revealed the following:

- On 9/3/2023, 9/6/2023, 9/28/2023 the log is blank for assistance and cueing for dressing.
- Resident A receives prompting for toileting every two hours while awake. Resident A's room is also checked for soiled linens and toileting appropriately in the bathroom only.
- There are multiple shifts across September 2023 in which the prompting for toileting was not consistently provided. There are no notes documenting if Resident A refused, was unavailable, or asleep.

I reviewed the care round log for October 2023 which revealed the following:

- On 10/12/2023, 10/18/2023, 10/22/2023, 10/21/2023, 10/22/2023, 10/25/2023, 10/27/2023 the log is blank for assistance and cueing for toileting.

- There are multiple shifts across October 2023 in which the prompting for toileting was not consistently provided. There are no notes documenting if Resident A refused, was unavailable, or asleep.

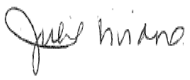
I reviewed the incident report from 10/4/2023 which revealed staff heard a loud noise and found another resident on top of Resident A in the dining room. Both residents were assisted up from the floor and assessed for any injury. No injuries were found. Resident A reported the resident punched, pushed, and tackled [them], but there was no evidence to support the allegation.

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 the facility did not provide care or supervision in accordance with the service plan. Resident A had behaviors while residing on the second-floor memory care unit to include “trashing” [their] room and an altercation with another resident. Interviews, onsite investigation, and review of documentation reveal the facility recommended to move Resident A to the first-floor memory care unit to help reduce behaviors and to provide more opportunity for recreation and community interaction. Resident A's behaviors significantly reduced with Resident A’s room remaining clean and orderly since the move from second floor to first-floor memory care. The facility appropriately took action to address Resident A’s behaviors. The facility confirmed an incident occurred on 10/4/2023 between Resident A and another resident. Both were separated and assisted immediately by staff. Neither resident incurred any injury and there were no more incidents between the residents since. The facility provided appropriate response to the incident in a timely manner. However, when comparing the service plan and the care round logs, there are discrepancies. The service plan states Resident A is independent for toileting, but the September 2023 and October 2023 care logs show Resident A receives prompting assistance as needed for toileting every two hours while awake. Resident A’s room is also checked for soiled linens and toileting appropriately in the bathroom only during care rounds. Also, the September 2023 and October 2023 care rounds logs have either blank or missing entries and demonstrate inconsistency of timely care rounds completed by facility staff. There are also no notes in the care logs documenting if Resident A refused, was unavailable, or asleep pertaining to the blank or missing care log entries, so it cannot be determined if Resident A received the care round checks or not. The facility demonstrates a discrepancy of services provided between the service plan and the care logs. Due to this discrepancy, it cannot be determined if Resident A is receiving care consistent with the service plan concerning toileting, therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



11/28/2023

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Julie Viviano Date
Licensing Staff

Approved By:

01/09/2024

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