



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

April 16, 2024

Carol DelRaso  
Maple Lake Assisted Living & Memory Care  
677 Hazen Street  
Paw Paw, MI 49079

RE: License #: AH800412723  
Investigation #: 2024A1010038  
Maple Lake Assisted Living & Memory Care

Dear Licensee:

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 authorized representative 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 that I am not available and you need to speak to someone immediately, please contact the local office at (517) 241-1970.

Sincerely,

A handwritten signature in blue ink that reads "Lauren Wohlfert".

Lauren Wohlfert, Licensing Staff  
Bureau of Community and Health Systems  
350 Ottawa NW Unit 13, 7th Floor  
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**

<b>License #:</b>	AH800412723
<b>Investigation #:</b>	2024A1010038
<b>Complaint Receipt Date:</b>	02/22/2024
<b>Investigation Initiation Date:</b>	02/22/2024
<b>Report Due Date:</b>	04/23/2024
<b>Licensee Name:</b>	Senior Living Maple Lake LLC
<b>Licensee Address:</b>	7927 Nemco Way, Ste 200 Brighton, MI 48116
<b>Licensee Telephone #:</b>	(810) 220-0200
<b>Administrator:</b>	Megan McGuire
<b>Authorized Representative:</b>	Carol DelRaso
<b>Name of Facility:</b>	Maple Lake Assisted Living & Memory Care
<b>Facility Address:</b>	677 Hazen Street Paw Paw, MI 49079
<b>Facility Telephone #:</b>	(269) 657-0190
<b>Original Issuance Date:</b>	08/02/2023
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	02/02/2024
<b>Expiration Date:</b>	07/31/2024
<b>Capacity:</b>	70
<b>Program Type:</b>	AGED ALZHEIMERS

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
Resident C did not get his prescribed medications from June 2023 to December 2023.	Yes

**III. METHODOLOGY**

02/22/2024	Special Investigation Intake 2024A1010038
02/22/2024	Special Investigation Initiated – Letter APS referral emailed to Centralized Intake
02/22/2024	APS Referral APS referral emailed to Centralized Intake
02/26/2024	Contact - Telephone call made Interviewed the complainant by telephone
02/28/2024	Inspection Completed On-site
02/28/2024	Contact - Document Received Received resident MARs and service plan
05/24/2024	Exit Conference

**ALLEGATION:**

**Resident C did not get his prescribed medications from June 2023 to December 2023.**

**INVESTIGATION:**

On 2/22/24, the Bureau received the allegations from the online complaint system. The complaint read, “[Resident C] is not getting his medications from June of last year to December event though it was documented that he was given the medications. The doctor of the resident plans on following up with the facility.”

On 2/22/24, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 2/26/24, I interviewed the complainant by telephone. The complainant reported staff did not administer Resident C's eyedrops, iron pills, and melatonin for several months. The complainant reported Resident C gets his medications prescribed through the Veteran's Administration (VA). The complainant said Resident C's family then picks the medications up from the pharmacy and brings them to staff in the facility.

The complainant reported the issue of Resident C's medications not being administered as prescribed was discovered because staff at the facility did not contact Resident C's family for refills of Resident C's medications. The complainant stated therefore, Resident C's family member had a surplus of Resident C's eye drops, melatonin, and iron pills. The complainant explained staff also incorrectly documented they administered Resident C's eye drops, iron pills, and melatonin on Resident C's medication administration record (MAR). The complainant said staff falsified Resident C's MAR.

The complainant stated Resident C is unable to communicate what medications he is prescribed and what medications he takes. The complainant reported staff at the facility administer all Resident C's prescribed medications.

On 2/28/24, I interviewed operations specialist Helen Sheets at the facility. Ms. Sheets reported Relative C1 brought the issue of Resident C's prescribed eye drops, iron pills, and melatonin not being administered to staff's attention on 2/23/24 during an onsite meeting. Ms. Sheets stated Relative C1 provided the bottles of extra eye drops, iron pills, and melatonin she had in her possession during the meeting at the facility on 2/23/24. Ms. Sheets explained Relative C1 had a surplus supply of Resident C's eye drops, melatonin, and iron pills because staff did not administer them as prescribed.

Ms. Sheets reported it was evident Resident C's prescribed eye drops, iron pills, and melatonin were not administered by staff due to the surplus amount Relative C1 had in her possession. Ms. Sheets Statements regarding the process in which Resident C's medications are prescribed and brought to the facility were consistent with the complainant. Ms. Sheets said Resident C's MARs were also reviewed and found to be inaccurate. Ms. Sheets explained staff did initial that Resident C's eye drops, iron pills, and melatonin were administered, however Relative C1's evidence correctly suggests they were not.

Ms. Sheets provided me with copies of Resident C's January and February MARs for my review. I observed the MARs incorrectly read Resident C's prescribed eye drops, iron pills, and melatonin were administered as prescribed. Ms. Sheets also provided me with a copy of Resident C's service plan for my review. The *Medication* section of the plan read, "Resident requires assistance with medication administration. Non-Contracted pharmacy used for medication management: VA Pharmacy."

Ms. Sheets said corrective measures have been taken to ensure all Resident C's medications are administered as prescribed by staff. Ms. Sheets explained when Relative C1 drops off Resident C's medications, the bottles are now labeled with the date they were opened and initialed by the staff who opened them. The pills are now counted and documented as well. Ms. Sheets reported staff were also re-educated on correctly documenting when resident medications were administered in their MARs.

On 2/28/24, I attempted to interview Resident C at the facility. I was unable to engage Resident C in meaningful conversation.

<b>APPLICABLE RULE</b>	
<b>R 325.1932</b>	<b>Resident medications.</b>
	<b>(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.</b>
<b>ANALYSIS:</b>	The interview with the complainant and Ms. Sheets revealed Resident C's prescribed eye drops, iron pills, and melatonin were not administered as prescribed. This was evident due to the surplus supply of eye drops, iron pills, and melatonin Relative C1 had in her possession. Relative C1 is responsible for picking Resident C's medications up from the pharmacy and delivering them to the facility. There is sufficient evidence to suggest the facility is not in compliance with this rule.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

I shared the findings of this report with licensee authorized representative Carol DelRaso on 5/24/24.

**IV. RECOMMENDATION**

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

04/16/2024

Lauren Wohlfert  
Licensing Staff

Date

Approved By:

*Andrea Moore*

05/23/2024

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

Date