RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

September 10, 2018

Pamela Mohrhardt
Christian Care Assisted Living
1530 McLaughlin Avenue
Muskegon, MI 49442-4191

RE: License #: AH610236765
Investigation #: 2018A1010055
Christian Care Assisted Living

Dear Mrs. Mohrhardt:

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 #:	AH610236765
Investigation #:	2018A1010055
Complaint Receipt Date:	08/15/2018
Investigation Initiation Date:	08/15/2018
Report Due Date:	10/14/2018
Licensee Name:	Christian Care Inc.
Licensee Address:	1530 McLaughlin Ave. Muskegon, MI 49442
Licensee Telephone #:	(231) 722-7165
Administrator/ Authorized Representative:	Pamela Mohrhardt
Name of Facility:	Christian Care Assisted Living
Facility Address:	1530 McLaughlin Avenue Muskegon, MI 49442-4191
Facility Telephone #:	(231) 777-3568
Original Issuance Date:	01/01/2000
License Status:	REGULAR
Effective Date:	07/07/2018
Expiration Date:	07/06/2019
Capacity:	105
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
The facility did not give proper notice that Resident H could not return to the facility.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/15/2018	Special Investigation Intake 2018A1010055
08/15/2018	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
08/20/2018	Contact - Telephone call made Interviewed the complainant by telephone
08/20/2018	Inspection Completed On-site
08/20/2018	Contact - Document Received Received Resident H's service plan, staff notes, and signed admission contract
09/10/2018	Exit Conference Completed with licensee authorized representative Pam Mohrhardt

ALLEGATION:

The facility did not give proper notice that Resident H could not return to the facility.

INVESTIGATION:

On 8/15/18, the Bureau received the allegations from the online complaint system.

On 8/15/18, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 8/20/18, I interviewed the complainant by telephone. The complainant reported Resident H had a stroke and seizures while at the facility approximately one month ago. The complainant stated Resident H went to the hospital as a result. The the

Complainant said Resident H went to a skilled nursing facility for rehabilitation services after she was discharged from the hospital.

The complainant reported she received a telephone call from staff at the skilled nursing facility when Resident H was ready to be discharged. The complainant stated on 8/14, the skilled nursing facility informed her that the facility would not allow Resident H to return. The complainant said she never received a telephone call or information from the facility that Resident H could not return.

The complainant stated the facility was supposed to do an assessment on Resident H on 8/13 regarding her return to the facility. The complainant reported Resident H missed the assessment by 20 minutes because she was at an appointment. The complainant said as a result, the facility did not assess Resident H.

The complainant reported the facility told her Resident H could not return because of her behavioral issues. The complainant said the only behavioral issue the facility informed her of was that Resident H would not get up in the morning. The complainant denied knowledge regarding any additional behaviors Resident H had while residing at the facility.

On 8/20/18, I interviewed administrator Pam Mohrhardt at the facility. Ms. Mohrhardt reported she went to the skilled nursing facility where Resident H was admitted on 8/13 to complete her scheduled assessment to determine whether or not she could return to the facility. Ms. Mohrhardt explained Relative H1 was told the date and time of the assessment and that Resident H needed to be present at the skilled nursing facility. Ms. Mohrhardt stated Relative H1 took Resident H out of the skilled nursing facility even though she was told not to due to the scheduled assessment. Ms. Mohrhardt said she waited for Resident H at the skilled nursing facility for 45 minutes. Ms. Mohrhardt reported the assessment was not completed for that reason.

Ms. Mohrhardt reported that on 8/13, the facility decided Resident H could not return to the facility due to her behavioral issues and outstanding pharmacy bill. Ms. Mohrhardt stated Relative H1 came to the facility on 8/13 and told staff Resident H was going to discharge from the skilled nursing facility and reside with her in her home. Ms. Mohrhardt stated as a result, the facility did not have to discharge Resident H because Relative H1 said she would not be returning.

Ms. Mohrhardt stated while Resident H resided at the facility, she refused to get out of bed and flooded her room several times. Ms. Mohrhardt explained Resident H took paper towel and clogged the drain in her sink several times to purposefully flood her room. Ms. Morhardt reported Relative H1 was made aware of Resident H's behavioral issues. Ms. Morhardt said the facility was unable to get a hold of Relative H2 regarding Resident H's behaviors. Ms. Mohrhardt reported Resident H also has an outstanding and delinquent bill of $557 for mediations.

On 8/20/18, Ms. Mohrhardt provided me with Resident H's staff notes. Notes dated 1/1, 1/5, 1/15, 1/22, 1/29, 2/2, 2/19, 3/2, 3/5, 3/23, 4/6, 4/9, 4/30, 5/21, 6/1, 7/9, and 7/13 read Resident H refused to shower. Notes dated 1/2, 1/13, 1/17, 1/18, 1/25, 5/20, 6/29, 7/3, 7/6, 7/7, 7/9, 7/10, 7/11, 7/13 read Resident H refused to get up for meals. Notes dated 5/27, 6/11, and 7/5 read Resident H refused to get out of bed the entire day.

On 8/20/18, Ms. Mohrhardt provided me with a copy of Resident H's signed admission contract. The *TERMINATION OF AGREEMENT B. Discharge by the Community* section of the plan read, "The community may terminate this agreement and begin the discharge process as set forth below by giving (30) day written notice to you and/or your authorized representative. This notice will include the reason(s) for termination, the effective date of discharge, and a statement notifying you of the right to file a complaint with the Department of Human Services. The Community may terminate this Agreement for any of the following reasons: Change in your condition requiring care that is outside the scope of our ability to meet your needs, Impairment to the well-being and/or safety of yourself, Impairment to the well-being and/or safety of other residents and/or staff, Nonpayment of service rate and/or pharmacy charges." The contract was signed by Relative H2.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(13) A home shall provide a resident and his or her authorized representative, if any, and the agency responsible for the resident's placement, if any, with a 30-day written notice before discharge from the home. The written notice shall consist of all of the following: **(a) The reasons for discharge.** **(b) The effective date of the discharge.** **(c) A statement notifying the resident of the right to file a complaint with the department. The provisions of this subrule do not preclude a home from providing other legal notice as required by law.**

ANALYSIS:	Resident H had a valid resident admission contract signed by Relative H2 and a representative of the facility allowing her to reside at the facility. Resident H had a temporary absence from the facility due to her health. Despite this absence, Resident H and Relative H2 anticipated return to the facility under the terms of the signed resident admission contract. The resident admission contract outlines allowable reasons for the termination of the agreement and the written and verbal notification entitled to Resident H. While there does appear to have been good cause to warrant a discharge notice to Resident H, interview with Ms. Mohrhardt reveals the facility did not issue in writing their intent to discharge Resident H. Relative H2's decision to provide Resident H housing was based solely on verbal communication that Resident H was not able to return to the facility. The verbal communication of discharge without written notification is not consistent with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

Ms. Mohrhardt provided me with a copy of Resident H's service plan for review. The plan did not document Resident H's behavioral issues. The plan did not address Resident H's frequent noncompliance with care or what methods staff were to use address her noncompliance.

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.
For Reference: R 325.1901	**(21) "Service plan" means a written statement prepared by the home in cooperation with a resident and/or the resident's authorized representative or agency responsible for a resident's placement, if any, and that identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical, social, and behavioral needs and well-being and the methods of providing the care and services while taking**

ANALYSIS:	Review of Resident H's staff notes revealed she often refused to get out of bed, refused meals, and refused to bathe. These behaviors and how staff were to intervene were not outlined in Resident H's service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Pam Mohrhardt by telephone on 09/10/18. Ms. Mohrhardt and I discussed reviewing current service plans for residents with behaviors as part of the corrective action plan. Ms. Mohrhardt and I also discussed the discharge notice process for residents not appropriate for placement after receiving rehabilitation services.

IV. RECOMMENDATION

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

9/5/18

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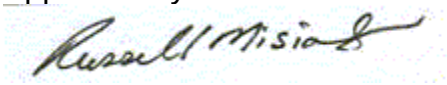
Lauren Wohlfert Date
Licensing Staff

Approved By:



9/5/18

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Russell B. Misiak Date
Area Manager