GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 3, 2021

Cynthia Duzenbury
Altam Inc
6300 Douglas Road
Riverdale, MI 48877

RE: License #: AM590091656
Investigation #: 2021A0582029
Pine Point

Dear Ms. Duzenbury:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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 the 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. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9727.

Sincerely,

Derrick Britton, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 284-9721

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM590091656
Investigation #:	2021A0582029
Complaint Receipt Date:	04/26/2021
Investigation Initiation Date:	04/27/2021
Report Due Date:	06/25/2021
Licensee Name:	Altam Inc
Licensee Address:	6300 Douglas Road Riverdale, MI 48877
Licensee Telephone #:	(989) 560-0292
Administrator:	Cynthia Duzenbury
Licensee Designee:	Cynthia Duzenbury
Name of Facility:	Pine Point
Facility Address:	6300 Douglas Road Riverdale, MI 48877
Facility Telephone #:	(989) 833-5274
Original Issuance Date:	03/01/2000
License Status:	REGULAR
Effective Date:	02/05/2020
Expiration Date:	02/04/2022
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, ALZHEIMERS, AGED

II. ALLEGATIONS

	Violation Established?
Resident A was improperly discharged from the home with no notice to Guardian A. Resident A was refused to return to back to the home.	No
Resident A was charged for the entire month of April 2021 for AFC payments, although he had not been at the facility since 04/05/2021.	No
Additional Findings	Yes

III. METHODOLOGY

04/26/2021	Special Investigation Intake 2021A0582029
04/27/2021	Special Investigation Initiated - Telephone
04/27/2021	Contact - Telephone call made With Eden Stephens, Case Manager
04/27/2021	Contact - Document Received Case Notes from Eden Stephens, Case Manager
05/19/2021	Inspection Completed On-site
05/19/2021	Contact - Face to Face With DCW Michelle Barber-Button
05/19/2021	Contact - Document Received Resident Care Agreement and Refund Policy
05/24/2021	Contact - Telephone call made With Guardian A
05/25/2021	Contact - Telephone call made With Deborah Chambers, RN Mid-Michigan Medical Center
06/01/2021	Contact - Telephone call made With Cynthia Duzenbury, Licensee Designee
06/02/2021	Exit Conference With Cynthia Duzenbury, Licensee Designee

06/02/2021	Inspection Completed-BCAL Sub. Compliance
06/02/2021	Corrective Action Plan Requested and Due on 06/18/2021

ALLEGATION:

Resident A was improperly discharged from the home with no notice to Guardian A. Resident A was refused to return to back to the home.

INVESTIGATION:

I received this complaint on 04/26/2021 and contacted Complainant on 04/27/2021. Complainant stated Resident A is currently in a nursing home in Ionia. Complainant stated Resident A had gall bladder surgery and initially returned to the home on 04/05/2021. Complainant stated Resident A was sent back to the hospital on the same day he returned to the home (04/05/2021) due to a stroke. Complainant stated that there was no communication from facility staff to Guardian A1 or the case manager regarding Resident A's hospitalization. Complainant stated once it was discovered Resident A was hospitalized, Pine Point staff refused to take him back. Complainant stated there was no formal eviction or discharge notice issued for Resident A. Complainant stated Cynthia Duzenbury, Administrator of Pine Point, stated she did not refuse to take Resident A back, but she did not have contact with the hospital about Resident A's status. Complainant stated Ms. Duzenbury assumed that Resident A was coming back to the facility.

On 04/27/2021 I contacted Eden Stephens, Case Manager from Montcalm Care Network. Ms. Stephens provided progress notes for her interactions regarding Resident A's case. I reviewed a contact note dated 04/22/2021, which documented the following:

> "[Eden Stephens] called [Guardian A1] at 9:32am who told [Eden Stephens] that he was unsure if his [Resident A] was transferred from the hospital or not yet. [Guardian A1] stated "I was notified from the hospital in Alma, a guy named Shawn that Pine Point was refusing to take [Resident A] back due to him being too weak and that they do not have 24 hour care."
>
> [Eden Stephens] asked [Guardian A1] if this was going to be a temporary or permanent home. [Guardian A1] stated "this is going to be a permanent home due to Pine Point refusing to take him back and that [Resident A] is currently refusing to work with rehab at this time. [Resident A] is needing more care than Pine Point can provide him." [Guardian A1] expressed that he did not receive an

> official eviction notice and was under the impression that the refusal was a strong suggestion/statement of what they were unable to accommodate."

I reviewed an additional contact note by Ms. Stephens dated 04/22/2021, which documented the following:

> "[Eden Stephens] called Cindy at Pine Point this afternoon to discuss whether or not if she refused [Resident A] coming back to the home and if so, why a formal eviction notice wasn't done. Cindy stated "I did not refuse to take him back just have been waiting for the hospital to call her back to see if he was able to bear weight because if he is not able to bear weight then we are not able to lift him". Cindy then made the comment "I called and requested the hospital to give me daily updates and I haven't heard from him." [Eden Stephens] asked if she has heard from them since I was out there 4/7/21 and Cindy stated "no." [Eden Stephens] let Cindy know at this time [Resident A] was not at the hospital and was transferred to SKLD nursing facility per guardian request."

On 05/19/2021 I conducted an unannounced, onsite inspection at the facility. I interviewed Direct Care Worker Michelle Barber-Button. Ms. Barber-Button stated she was not working during the time Resident A was hospitalized. Ms. Barber-Button stated she heard that Resident A pulled out a drain tube that was for his gall bladder and was sent back to the hospital the same day he returned to the home. Ms. Barber-Button stated that she was not aware if there was a discharge notice for Resident A. Ms. Barber-Button stated that Administrator Cynthia Duzenbury was at an appointment at the time I arrived at the facility.

On 05/24/2021 I interviewed Guardian A,1 who stated that Ms. Duzenbury told hospital staff that Resident A would not be able to return to the home if he was not strong enough. Guardian A1 stated that Resident A is to the point where he needs 24-hour care, and Pine Point is not suitable for him anymore. Guardian A1 stated that he never received written notification that Resident A could not return to the home and was told that Resident A could not come back if he was not strong enough. Guardian A1 stated that he went to the facility on 05/23/2021 to retrieve the remainder of Resident A's belongings.

On 05/25/2021 I interviewed Deborah Chambers, RN Case Manager from Mid-Michigan Medical Center. Ms. Chambers stated that she recalls Resident A being refused by staff to be admitted back to Pine Point if he could not walk or bear weight.

On 06/01/2021 I interviewed Cynthia Duzenbury, Licensee Designee. Ms. Duzenbury stated that she did not discharge Resident A. Ms. Duzenbury stated that Resident A was initially hospitalized in late March 2021 because there was concern that he was not eating. Ms. Duzenbury stated that Resident A had a psychiatric evaluation and was also found to have a gall bladder infection while hospitalized. Ms. Duzenbury stated that Resident A was discharged and brought back to the home by Guardian A on 04/05/2021. Ms. Duzenbury stated that it was evident after

a short time back in the home that Resident A was not well, as he could not stand or hold his head up. Ms. Duzenbury stated that Resident A appeared to be worse than when he was initially hospitalized. Ms. Duzenbury stated that it looked as if Resident A had a stroke and he also pulled out his drain tube for his gall bladder. Ms. Duzenbury stated that she contacted EMS and Guardian A for Resident A to be hospitalized on the same day he returned to the home. Ms. Duzenbury stated that she was receiving daily updates regarding Resident A's status. Ms. Duzenbury stated that the last call she received from hospital staff was to inform her that Resident A would be going to rehab. Ms. Duzenbury stated that she never denied Resident A could return to the home but did inform hospital staff that Resident A needs to be able to stand with assistance before returning. Ms. Duzenbury stated that she was not receiving updates from rehabilitation and did not know that Resident A was in a new facility until she received a call from the new placement towards the end of April.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(3) A licensee shall provide a resident and his or her designated representative with a 30-day written notice before discharge from the home. The written notice shall state the reasons for discharge. A copy of the written notice shall be sent to the resident's designated representative and responsible agency. The provisions of this subrule do not preclude a licensee from providing other legal notice as required by law.
ANALYSIS:	Based on interviews with Complainant, Ms. Stephens, Ms. Barber-Button, Guardian A, Ms. Chambers and Ms. Duzenbury, Resident A was hospitalized on 04/05/2021, which was his last day at Pine Point. Ms. Duzenbury stated that she did not discharge Resident A from the home while he was hospitalized and had an expectation that he would return after rehabilitation. While Ms. Duzenbury informed hospital staff that Resident A needed to bear weight before returning, there was no official discharge from the home. Guardian A1 noted that Pine Point was not suitable for Resident A any longer and found him a nursing home placement.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was charged for the entire month of April 2021 for AFC payments, although he had not been at the facility since 04/05/2021.

INVESTIGATION:

I received this complaint on 04/26/2021 and contacted Complainant on 04/27/2021. Complainant stated that Resident A was hospitalized on 04/05/2021. Complainant stated that Resident A was discharged from Mid-Michigan Health Rehab on 04/21/2021 but did not return to the facility. Complainant stated that Resident A's AFC payment was paid for the month of April 2021, but Resident A only spent one day at the facility. Complainant stated that Cynthia Duzenbury, Administrator at Pine Point, billed Resident A because she assumed that he was returning to the facility. Complainant stated that Ms. Duzenbury had not return phone calls to Guardian A1.

On 04/27/2021 I contacted Eden Stephens, Case Manager from Montcalm Care Network. Ms. Stephens provided progress notes for her interactions regarding Resident A's case. I reviewed a contact note dated 04/22/2021, which documented the following:

> "[Guardian A1] expressed his concern that April rent was paid in full on April 5, 2021, he has attempted to contact Cindy two separate time and left voicemails with no response. [Eden Stephens] also informed Cindy that [Guardian A1] is trying to get ahold of her and has some questions for her and she responded "I will call him when I have a chance."

On 05/19/2021 I conducted an unannounced, onsite inspection at the facility. I reviewed Resident A's *AFC-Resident Care Agreement* dated 03/21/2020, which documented an agreement to pay the basic fee of $1,200 monthly. I reviewed the facility's Refund Policy, which documented the following:

> In regard to admission and discharge, fees for service shall be prorated for the month up to and including date of admission or discharge. All resident personal funds shall be returned to resident or designated representative excluding any outstanding bills upon discharge.

On 05/24/2021 I interviewed Guardian A1, who stated that he paid Resident A's AFC payment for April 2021. Guardian A1 stated that Resident A went back to the hospital on 04/05/2021 and never returned to the home. Guardian A1 stated that he spoke with Case Manager Eden Stephens, who informed him that Resident A's payment would be prorated. Guardian A1 stated that he moved Resident A to nursing home.

On 06/01/2021 I interviewed Cynthia Duzenbury, Licensee Designee. Ms. Duzenbury stated that she never received any indication that Resident A was not

returning to the facility. Ms. Duzenbury stated that Resident A was AFC payment was paid through April. Ms. Duzenbury stated once she was not receiving communication from the rehabilitation center about Resident A's status, she tried contacting Guardian A1. Ms. Duzenbury stated that she was not getting an answer from Guardian A1. Ms. Duzenbury stated that she did finally have contact with Guardian A1, but it was after Resident A was moved. Ms. Duzenbury stated that Guardian A1 moved Resident A's belongings on Sunday, 05/23/2021.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(14) A licensee shall have a written refund agreement with the resident or his or her designated representative. The agreement shall state under what conditions a refund or the unused portion of the monthly charge that is paid to the home shall be returned to the resident or his or her designated representative. The refund agreement shall provide for, at a minimum, refunds under any of the following conditions: **(a) When an emergency discharge from the home occurs as described in R 400.14302.** **(b) When a resident has been determined to be at risk pursuant to the provisions of sections 11 and 11a to 11f of Act No. 280 of the Public Acts of 1939, as amended, being {400.11 and 400.11a to 400.11 of the Michigan Compiled Laws.** **(c) When a resident has been determined to be at risk due to substantial noncompliance with these licensing rules which results in the department taking action to issue a provisional license or to revoke or summarily suspend, or refuse to renew, a license and the resident relocates. The amount of the monthly charge that is returned to the resident shall be based upon the written refund agreement and shall be prorated based on the number of days that the resident lived in the home during that month.**

ANALYSIS:	Based on interviews with Complainant, Ms. Stephens, Guardian A1, and Ms. Duzenbury, Resident A's AFC payment was paid through the month of April 2021. Resident A was hospitalized on 04/05/2021 but did not return to the home. Ms. Duzenbury stated that she did not discharge Resident A from the home and his belongings were still in the home until 05/23/2021. The Refund Policy of the facility documented that "fees and service shall be prorated for the month up to and including date of discharge," however the discharge was decided by Guardian A1, not the licensee designee, to move Resident A to a nursing home.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

On 04/27/2021 I contacted Licensing Consultants Bridget Vermeesch and Jennifer Browning, who both reported that they did not receive an *Incident Report* for Resident A's hospitalizations. I checked the *Incident Report* folders and did not find a report for Pine Point. On 05/19/2021 I conducted an unannounced, onsite inspection at the facility and did not find an Incident Report for Resident A's hospitalizations. On 06/01/2021 I interviewed Licensee Designee Cynthia Duzenbury, who stated that she believes that an Incident Report was faxed, but she was not positive. Ms. Duzenbury stated that she could not find the *Incident Report* at that time.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(b) Any accident or illness that requires hospitalization.**
ANALYSIS:	Based on interviews with Ms. Duzenbury and Licensing Consultants Bridget Vermeesch and Jennifer Browning, there were no *Incident Reports* submitted for Resident A's hospitalizations. There were no Incident Reports for Pine Point found in the AFC shared drive.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.

06/02/2021

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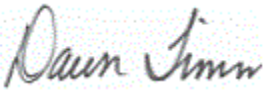
Derrick Britton Date
Licensing Consultant

Approved By:



06/03/2021

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Dawn Timm Date
Area Manager