GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 7, 2021

John Winden
Close To Home Assisted Living, Saginaw LLC
1805 South Raymond
Bay City, MI 48706

RE: License #: AL730398656
Investigation #: 2021A0580040
Close to Home Assisted Living Saginaw Side 2

Dear Mr. Winden:

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 that I am not available and you need to speak to someone immediately, please contact the local office at (906) 226-4171.

Sincerely,

Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 835-1019

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL730398656
Investigation #:	2021A0580040
Complaint Receipt Date:	08/19/2021
Investigation Initiation Date:	08/23/2021
Report Due Date:	10/18/2021
Licensee Name:	Close To Home Assisted Living, Saginaw LLC
Licensee Address:	1805 South Raymond Bay City, MI 48706
Licensee Telephone #:	(989) 401-3581
Administrator:	John Winden
Licensee Designee:	John Winden
Name of Facility:	Close to Home Assisted Living Saginaw Side 2
Facility Address:	2160 N. Center Rd Saginaw, MI 48603
Facility Telephone #:	(989) 778-2575
Original Issuance Date:	07/07/2020
License Status:	REGULAR
Effective Date:	01/07/2021
Expiration Date:	01/06/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED

	TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A often has crust around his mouth and dirty fingernails.	No
A couple weeks ago, Resident A's ankle was bleeding and had dried blood around it. Resident A's feet have been swollen and staff did not reach out Hospice.	No
Resident A's room smells.	Yes
There is an air conditioning unit in his room and one day, Resident A was shaking so badly and it's believed to be from the cold.	No

III. METHODOLOGY

08/19/2021	Special Investigation Intake 2021A0580040
08/19/2021	APS Referral This complaint was denied by APS for investigation.
08/23/2021	Special Investigation Initiated - Telephone A call was made to the complainant.
08/24/2021	Contact - Telephone call made A call was made to manager, Ms. Stacey Rinnert.
09/01/2021	Inspection Completed On-site An onsite inspection was conducted at the facility. Contact was made with the licensee and home manager.
09/01/2021	Contact - Face to Face A face-to-face contact was made with Resident A in his room.
09/01/2021	Contact - Document Received Copies of the AFC Assessment Plan and Hospice Care Assessment Plan were received.
09/27/2021	Contact - Telephone call made A call was made to Heart-to-Heart Hospice.
10/07/2021	Contact - Telephone call made A call was made to Guardian A.

10/07/2021	Exit Conference An exit conference was held with the licensee, Mr. John Winden.

ALLEGATION:

Resident A often has crust around his mouth and dirty fingernails.

INVESTIGATION:

On 08/19/2021, I received a complaint via BCAL Online Complaints. This complaint was denied by APS for investigation. On 08/23/2021, I made a call to the complainant requesting a return call.

On 08/24/2021, I spoke with Ms. Stacey Rinnert, manager at Close to Home. She denied the allegations that Resident A is not receiving proper hygiene care. She indicated that staff assist Resident A with grooming as needed. Ms. Rinnert shared that Resident A also receives Hospice Care via Heart-to-Heart Hospice, which includes personal care. Resident A is diagnosed with Alzheimer's. Resident A is unable to verbally communicate.

On 09/01/2021, I conducted an in-person contact with Resident A. While conducting a joint investigation with on a different case with Ms. Jessire Ramos of Saginaw County APS, she was also present while observing Resident A in his room. Resident A was observed in his room sleeping under the covers, at the time of the visit. Ms. Rinnert pulled the covers back to allow an observation of Resident A. Resident A did not have any crust around his mouth as alleged. His fingernails were noted as clean and cut short.

On 09/01/2021, A copy of the AFC Assessment plan and Heart to Heart Hospice Plan of Care were received. The AFC Plan for Resident A indicates that Resident A requires assistance with personal hygiene. It does not indicate how the need will be met by the facility.

On 09/27/2021, I spoke with Ms. Marty Northern of Heart-to-Heart Hospice, assigned hospice nurse for Resident A. Ms. Northern shared that Resident A began receiving hospice services on 03/17/2021. She initially began visits with Resident A 3 times a week. Currently she visits with Resident A once a week. Resident A is stable, eating well and gaining weight. He continues to receive personal care 2 times per week and social work services once per month. She denies any issues with Resident A being left in wet briefs or lack of personal hygiene care when she has visited, nor have any concerns been raised by other Heart to Heart staff visiting Resident A.

On 10/07/2021, I spoke with Relative A, assigned Power of Attorney for Resident A. She confirmed that she does not have guardianship, however, she has power of attorney over financial and medical decisions. She shared that she visits with Resident A once a week and has no concerns. She also does surprise visits to the facility. She adds that she most recently placed her mother in the facility, the past week as well. She shared that the staff there communicate with her often and she will communicate with them if she has concerns. She indicates that she has seen nothing but care and compassion from the staff at Close to Home. Relative A stated that she often looks Resident A over for bruises or marks, ensuring he is receiving proper care. Personal hygiene has not been a concern.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	It was alleged that Resident A often has crust around his mouth and dirty fingernails. Ms. Stacey Rinnert, manager at Close to Home, denied the allegations that Resident A is not receiving proper hygiene care. She shared that Resident A also receives Hospice Care via Heart-to-Heart Hospice, which includes personal care. The AFC Plan for Resident A indicates that Resident A requires assistance with personal hygiene. It does not indicate how the need will be met by the facility. At the in-person contact with Resident A, he did not have any crust around his mouth as alleged. His fingernails were noted as clean and cut short. Ms. Marty Northern, Heart to Heart Hospice nurse, shared that Resident A began receiving hospice services on 03/17/2021. Resident A receives personal care 2 times per week. She denies any issues with Resident A being left in wet briefs or lack of personal hygiene care when she has visited, nor have any concerns been raised by other Heart to Heart staff visiting Resident A.

	Relative A stated that she often looks Resident A over for bruises or marks, ensuring he is receiving proper care. Personal hygiene has not been a concern. Based on the information gathered in the course of this investigation, there is insufficient evidence to support the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

A couple weeks ago, Resident A's ankle was bleeding and had dried blood around it. Resident A's feet have been swollen and staff did not reach out Hospice.

INVESTIGATION:

On 08/24/2021, I spoke with Ms. Stacey Rinnert, manager at Close to Home. She denied the allegations, indicating that as soon as staff noticed the swelling and blood on his ankle, hospice staff was notified.

On 09/01/2021, I conducted an in-person contact with Resident A. While conducting a joint investigation with on a different case with Ms. Jessire Ramos of Saginaw County APS, she was also present while observing Resident A in his room. Resident A was observed in his room sleeping under the covers, at the time of the visit. Ms. Rinnert pulled the covers back to allow an observation of Resident A. His ankle was not bleeding or swollen.

On 09/27/2021, I spoke with Ms. Marty Northern of Heart-to-Heart Hospice. assigned hospice nurse for Resident A. Ms. Northern shared that the staff at Close to Home did inform her that Resident A’s ankle was swollen with dried blood. This medical need was addressed through Hospice care.

On 10/07/2021, I spoke with Relative A, assigned Power of Attorney for Resident A. Relative A shared that she and hospice were informed by Close to Home staff of Resident A’s feet being swollen. Hospice instructed staff to elevate his feet, which they did and the swelling went down. She believes that staff addressed the matter appropriately.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	It was alleged that Resident's feet have been swollen and staff did not reach out Hospice. Ms. Stacey Rinnert, manager at Close to Home. She denied the allegations, indicating that as soon as staff noticed the blood on his ankle, hospice staff was notified. At the in-person contact with Resident A, his ankle was not bleeding or swollen. Ms. Marty Northern of Heart-to-Heart Hospice. assigned hospice nurse for Resident A. Ms. Northern indicated that the staff at Close to Home did inform her that Resident A's ankle was swollen and with some dried blood. This medical need was addressed through Hospice care. Relative A shared that she and hospice were informed by Close to Home staff of Resident A's feet being swollen. Hospice instructed staff to elevate his feet, which they did and the swelling went down. She believes that staff addressed the matter appropriately. Based on the information gathered in the course of this investigation, there is insufficient evidence to support the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's room smells.

INVESTIGATION:

On 09/01/2021, I conducted an onsite at Close to Home AFC. Contact was made with Ms. Stacey Rinnert and the licensee, Mr. John Winden. He shared that Resident A resides in the memory care unit. He indicated that they do their best to keep up with the urine smell in that wing, however, he adds that Residents may urine in trash cans, the closets, and other unorthodox places due to urinate. They utilize full time housekeeping

and carpet cleaners. They are also in the process of replacing the carpet for vinyl flooring, making them easier to clean. Ms. Rinnert then showed me at least 1 room where the maintenance man was in the process if laying the new flooring.

On 09/01/2021, I conducted an in-person contact with Resident A. While conducting a joint investigation with on a different case with Ms. Jessire Ramos of Saginaw County APS, she was also present while observing Resident A while in his room. Resident A's room, along with entire memory care unit, consisting of 8-bedrooms, all reeked of urine. The lounge chair in Resident A's room was observed as being stained, with what appeared to be urine.

On 09/27/2021, I spoke with Ms. Marty Northern of Heart-to-Heart Hospice. assigned hospice nurse for Resident A. Ms. Northern agrees that the room reeks of urine.

On 10/07/2021, I spoke with Relative A, assigned Power of Attorney for Resident A. She is aware that the room smells of urine. She does know that when initially placed, Resident A urinated in the closet at least 3 times. Resident A has been placed for approximately one year. Relative A shared that Resident A's floor was recently replaced in hopes of alleviating the urine smell.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	It was alleged that Resident A's room smells. Licensee, Mr. John Winden indicated that they do their best to keep up with the urine smell in that wing, utilizing full time housekeeping and carpet cleaners. The facility is also in the process of replacing the carpet for vinyl flooring, making them easier to clean. At the in-person contact with Resident A, his room, along with entire memory care unit, consisting of 8-bedrooms, all reeked of urine. The lounge chair in Resident A's room was observed as being stained, with what appeared to be urine. Nurse, Ms. Marty Northern of Heart-to-Heart Hospice, agrees that the room reeks of urine.

	Relative A is aware that the room smells of urine. She shared that Resident A's floor was recently replaced in hopes of alleviating the urine smell. Based on the information gathered in the course of this investigation, there is sufficient evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

There is an air conditioning unit in his room and one day, Resident A was shaking so badly and it's believed to be from the cold.

INVESTIGATION:

On 08/24/2021, I spoke with Ms. Stacey Rinnert, manager at Close to Home. Ms. Rinnert stated that each room in the facility has its own air conditioning unit. Due to Resident A's inability to communicate, he can't indicate what temperature feels comfortable. She shared that someone could have mistakenly turned the air conditioning unit up higher than normal, however, the temperature can be adjusted accordingly. She shared that Resident A is provided with weather appropriate clothing and blankets when necessary.

On 09/01/2021, I conducted an in-person contact with Resident A. While conducting a joint investigation with on a different case with Ms. Jessire Ramos of Saginaw County APS, she was also present while observing Resident A in his room. Resident A was observed in his room sleeping under the covers, at the time of the visit. The room was noted at a comfortable temperature, between 68 and 72 degrees per the thermostat. The air conditioning unit was not on.

On 09/27/2021, I spoke with Ms. Marty Northern of Heart-to-Heart Hospice. assigned hospice nurse for Resident A. She stated that the room temperature has not been a problem.

On 10/07/2021, I spoke with Relative A, assigned Power of Attorney for Resident A. She stated that the room temperature has never been a concern and typically the window is open versus the air conditioning unit being used.

On 10/07/2021, I conducted an exit conference with the licensee, Mr. John Winden. Mr. Winden was informed that a violation was established for maintenance of premises based on the urine smell emitting from the memory care unit. A correction action plan was requested within 15 days. Mr. Winden shared that Resident A's room floor has been replaced. He will continue to replace the floors throughout the entire building.

APPLICABLE RULE	
R 400.15406	**Room temperature.**
	All resident-occupied rooms of a home shall be heated at a temperature range between 68 and 72 degrees Fahrenheit during non-sleeping hours. Precautions shall be taken to prevent prolonged resident exposure to stale, noncirculating air that is at a temperature of 90 degrees Fahrenheit or above. Variations from the requirements of this rule shall be based upon a resident's health care appraisal and shall be addressed in the resident's written assessment plan. The resident care agreement shall address the resident's preferences for variations from the temperatures and requirements specified in this rule.
ANALYSIS:	It was alleged that Resident A's room is too cold. Ms. Stacey Rinnert, manager at Close to Home, stated that each room in the facility has its own air conditioning unit. She shared that someone could have mistakenly turned the air conditioning unit up higher than normal, however, the temperature can be adjusted accordingly. She shared that Resident A is provided with weather appropriate clothing and blankets when necessary. While observing Resident A in his room, the room was noted at a comfortable temperature, between 68 and 72 degrees per the thermostat. The air conditioning unit was not on. Ms. Marty Northern of Heart-to-Heart Hospice. assigned hospice nurse for Resident A, stated that the room temperature has not been a problem. Relative A stated that the room temperature has never been a concern and typically the window is open versus the air conditioning unit being used. Based on the information gathered in the course of this investigation, there is insufficient evidence to support the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

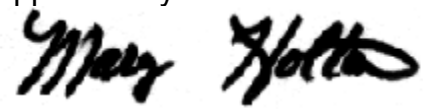
IV. RECOMMENDATION

Upon the receipt of an approved corrective action plan, no changes to the status of the license is recommended.

October 7, 2021

Sabrina McGowan — Date
Licensing Consultant

Approved By:



October 7, 2021

Mary E Holton — Date
Area Manager