STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

October 4, 2021

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

RE: License #: AL730398656
Investigation #: 2021A0580037
Close to Home Assisted Living Saginaw Side 2

Dear Mr. Winden:

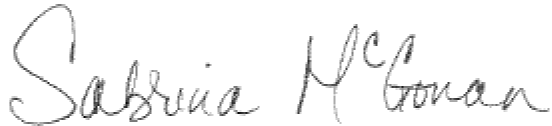
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	2021A0580037
Complaint Receipt Date:	08/05/2021
Investigation Initiation Date:	08/09/2021
Report Due Date:	10/04/2021
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?
On 7/28/2021, Resident A was in the ER (Emergency Room) from a fall that had happened 2 weeks prior. Resident A was admitted with a broken arm and hairline hip fracture.	No
Resident A reeks of urine along with her room and recliner.	No
Additional Findings	Yes

III. METHODOLOGY

08/05/2021	Special Investigation Intake 2021A0580037
08/05/2021	APS Referral An email with additional information was obtained from Ms. Jessire Ramos, APS Investigator, Saginaw Co.
08/09/2021	Special Investigation Initiated - Telephone A call was made to Ms. Stacey Rinnert, 1st shift manager.
08/10/2021	Contact - Document Received An email with scanned documents regarding Resident A were received.
08/16/2021	Contact – Telephone call received A phone call was received from Ms. Stacey Rinnert, 1st shift manager.
08/16/2021	Contact – Telephone call made A phone call was made to Ms. Jessire Ramos, APS Investigator, Saginaw County.
09/01/2021	Inspection Completed On-site An onsite inspection was conducted at the facility. Contact was made with the licensee and home manager.
09/29/2021	Contact - Telephone call received A call was received from Guardian A.
09/30/2021	Contact - Telephone call made A call was made to Ms. Nea Laury, direct staff.
09/30/2021	Contact - Telephone call made

	A call was made to Ms. Trisha Holloway, shift manager at Close to Home AFC.
10/01/2021	Exit Conference An exit conference was held with the licensee, Mr. John Winden.

ALLEGATION:

On 7/28/2021, Resident A was in ER from a fall that had happened 2 weeks prior. Resident A was admitted with a broken arm and hairline hip fracture.

INVESTIGATION:

On 08/05/2021, I received a complaint via BCAL Online complaints.

On 08/05/2021, I made email contact with Ms. Jessire Ramos, assigned APS investigator in Saginaw County. The email indicated that she knows of Resident A and her family based on prior 2019 APS investigation in which she petitioned to have Resident A removed from her family's care. She shared that Public Guardian, Guardian A was made her guardian at that time, while she has a separate conservator for her finances. Ms. Ramos confirmed that Resident A is currently in the hospital and has been diagnosed with an arm fracture. A joint visit to the facility was scheduled for 08/17/2021.

On 08/09/2021, I spoke with Ms. Stacey Rinnert, 1st shift manager at Close to Home 2 Saginaw Side regarding the allegations. Ms. Rinnert stated to the facilities knowledge, Resident A did not have a fall, nor did she report a fall. It is unknown how the injury occurred. She shared that Resident A initially complained of leg pain early in the month of July. The doctor, identified as Careline Physician Services, was called that same day, and recommended that she be given her PRN medication, Tylenol, treating it as if it were arthritis. A few days later, staff observed bruising on Resident A's arm. Upon contacting the doctor again, the doctor instructed staff to monitor the area and to call again if the area becomes larger. The following day staff noticed the bruise was bigger. Staff contacted management and Careline Physician Services once again. The doctor called back and recommended an ace bandage be placed on her arm for 6 hours and to stop her blood thinners for 5 days. Staff followed all directions. At the physician's onsite visit on 07/28/2021 an Xray for Resident A's arm was ordered. Mobile Xray arrived around 4pm. Around 7pm the physician called the facility with the results of the x-ray and requested Resident A be sent to the hospital because a hairline fracture was found in her arm.

Copies of the AFC Assessment Plan and physician instructions, and incident reports were requested.

On 08/10/2021, I received an emailed copy of the documents requested. The AFC Assessment Plan indicates that Resident A requires assistance with mobility, however, it does not describe the need and how the need will be met. The plan indicates that she uses a walker and a wheelchair as special equipment. This plan is signed and dated by Guardian A on 03/03/2020.

An incident report dated 07/24/2021, at 3:45pm, indicated that direct staff observed bruising on Resident A's right arm. Staff inquired if Resident A had fallen, to which she replied she did not. Resident A was checked over and no other injuries were observed. Staff contacted both the manager and Careline. Actions taken by staff include contacting management and Careline. The report indicates that Careline stated to "watch the bruise to make sure it doesn't get any larger" and to watch for changed behavior, contacting them if either occurs. For corrective measures, staff agreed to monitor and watch for changes in appearance or behavior as instructed by the healthcare provider.

Another incident report dated 07/28/2021, at 7:10am, indicated that X-Rays were ordered for Resident A. X-Ray results come back with a fractured arm. Staff dialed 911. Resident A's guardian was notified.

On 08/16/2021, I received a call from Stacey Rinnert. She indicated that a 3rd shift staff tested positive for Covid-19. As a result, the facility is under quarantine until 8/27/2021.

On 08/16/2021, I made a call to Ms. Jessire Ramos, APS, informing her that staff at the facility tested positive for Covid-19. As a result, the facility is under quarantine until 8/27/2021. The joint visit will be rescheduled.

On 09/01/2021, I, along with assigned APS investigator, Ms. Jessire Ramos conducted an onsite inspection at Close to Home AFC. Contact was made with both the licensee, Mr. John Winden and the 1st shift manager, Ms. Stacey Rinnert. Nurse notes, the July medication log and Careline Physician Services Summary Sheet for Resident A were obtained.

Nurse notes for Resident A indicate that on 07/06/2021, Resident A complained of left leg pain. Resident A was given her PRN Tylenol. Nurse notes on 07/07/2021 indicate that Resident A complained of left leg pain once again. Upon contacting the doctor, the facility was instructed to give Resident A her PRN of Tylenol as it is most likely arthritis. Nurse notes dated 07/24/2021 indicate that Resident A was observed with a bruise on her right arm. Upon contacting Careline the facility was instructed to give Resident A her PRN Tylenol and to follow up with them if it gets any larger. Nurse notes dated 07/25/2021 indicate that the bruise had gotten larger. Upon contacting Careline, staff were instructed to wrap Resident A's arm in a bandage, and to hold her medication, Eliquis for five days. Nurse notes dated 07/26/2021 indicate that an Ace Bandage was placed on Resident A's arm. Nurse notes dated 07/28/2021 indicate that Resident A complained that her leg and arm were hurting. Resident A was provided with a pain pill. The physician visited with Resident A that same day and ordered an Xray. Later that

evening Careline called the facility indicating that the Xray results showed a hairline fracture and Resident A should be sent to the hospital.

The July Medication Log for Resident A indicates that Resident A was given her PRN pain medication, 325 MG of Tylenol on twice on 7/7/2021. On 7/13/2021, Resident A was given her PRN medication, 25 MG of Tramadol. On 7/19, 7/20, 7/21, 7/22, 7/26, and 7/27/2021, Resident A was given her PRN pain medication, 325 MG of Tylenol. On 07/28/2021, Resident A was given her PRN medication, 345 MG of Naproxen.

Careline Physician Notes indicate that patient, Resident A was seen on 07/28/2021 at a home visit, conducted at Close to Home AFC. The report identifies Resident A as male, although Resident A is identified as a female. The notes indicate that the patient presented with pain in the right arm. The pain is described as acute and worsening. The complaint is moderate. Pertinent findings include joint pain and tenderness. For services ordered, the report indicates that an X-ray of the shoulder and the upper right arm was ordered, staff to provide patient with PRN Tramadol for pain control, Eliquis on hold for five days related to large, bruised area on right arm, and encourages frequent mobilization with assistance.

On 09/29/2021, I spoke with Guardian A regarding the allegations. Guardian A indicated that she is aware of the allegations being made regarding Resident A. She stated that she has a good relationship with the facility and has had residents placed in their facilities since 2008. She adds that she often makes unannounced visits to see her residents to ensure that they are receiving proper care. Guardian A shared that the staff at Close to Home are good about contacting her. She adds that the staff did make her aware that Resident A had been complaining of pain. She did not receive a call indicating that Resident A had a fall prior to the complaint of pain. Resident A is diagnosed with Dementia. Guardian A also expressed that she has spoken with both Careline staff and the treating Orthodontist regarding how the fracture may have occurred, however, neither have been able to pinpoint a determining factor. She adds that Resident A does not stand and requires the use of a wheelchair. Resident A usually is typically requiring a 2-person transfer into her wheelchair for mobility.

On 09/30/2021, I spoke with direct staff, Ms. Nea Laury. Ms. Laury recalled that she was the medication passer working on 07/24/2021. She recalled that direct staff, Ms. Anne Morales was preparing to transfer Resident A into her wheelchair when she noticed a bruise. Ms. Morales then alerted her and the manager on duty, Ms. Trisha Holloway that Resident A has a bruise on her right arm. She recalled Ms. Holloway contacted Careline Physician Services. They were instructed to circle the bruised area with a sharpie and to call back if the bruise got any larger. An incident report was completed. Ms. Laury indicated that did observe the bruise on Resident A’s arm, however, she is not the staff that initially observed the bruise.

On 09/30/2021, I spoke with Ms. Trisha Holloway, shift manager at Close to Home AFC. Ms. Holloway recalled that upon being informed by staff that Resident A had a bruise on her arm, she looked her over and asked her if she fell, to which she replied “no”. She

verifies that she contacted and spoke with Careline Physician Services, who then instructed them to watch the bruise and to call back if the bruise got any larger.

On 09/30/2021, I made a call to Ms. Jessire Ramos, APS Investigator. She shared that she will not be substantiating the allegations of neglect.

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 A was admitted to the hospital with broken arm and hairline hip fracture from a fall that had happened 2weeks prior. Manager, Ms. Stacey Rinnert stated to the facilities knowledge, Resident A did not have a fall, nor did she report a fall. It is unknown how the injury occurred. Nurse notes for Resident A indicate that on 07/06/2021, Resident A complained of left leg pain. Resident A was given her PRN Tylenol. Nurse notes on 07/07/2021 indicate that Resident A complained on left leg pain once again. Upon contacting the doctor, the facility was instructed to give Resident A her PRN of Tylenol as it is most likely arthritis. Nurse notes dated 07/24/2021 indicate that Resident A was observed with a bruise on her right arm. Upon contacting Careline the facility was instructed to give Resident A her PRN Tylenol and to follow up with them if it gets any larger. Nurse notes dated 07/25/2021 indicate that the bruise had gotten larger. Upon contacting Careline, staff were instructed to wrap Resident A's arm in a bandage, and to hold her medication, Eliquis for five days. Nurse notes dated 07/26/2021 indicate that an Ace Bandage was placed on Resident A's arm. Nurse notes dated 07/28/2021 indicate that Resident A complained that her leg and arm were hurting. Resident A was provided with a pain pill. The physician visited with Resident A that same day and ordered an Xray. Later that evening Careline called the facility indicating that the Xray results showed a hairline fracture and Resident A should be sent to the hospital.

	An incident report dated 07/24/2021, at 3:45pm, indicated that direct staff observed bruising on Resident A's right arm. Staff inquired if Resident A had fallen, to which she replied she did not. Resident A was checked over and no other injuries were observed. Staff contacted both the manager and Careline. Actions taken by staff include contacting management and Careline. The report indicates that Careline stated to "watch the bruise to make sure it doesn't get any larger" and to watch for changed behavior, contacting them if either occurs. For corrective measures, staff agreed to monitor and watch for changes in appearance or behavior as instructed by the healthcare provider. Another incident report dated 07/28/2021, at 7:10am, indicated that X-Rays were ordered for Resident A. X-Ray results come back with a fractured arm. Staff dialed 911. Resident A's guardian was notified. The July Medication Log for Resident A indicates that Resident A was given her PRN pain medication, 325 MG of Tylenol on twice on 7/7/2021. On 7/13/2021, Resident A was given her PRN medication, 25 MG of Tramadol. On 7/19, 7/20, 7/21, 7/22, 7/26, and 7/27/2021, Resident A was given her PRN pain medication, 325 MG of Tylenol. On 07/28/2021, Resident A was given her PRN medication, 345 MG of Naproxen. Careline Physician Notes indicate that patient, Resident A was seen on 07/28/2021 at a home visit, conducted at Close to Home AFC. The report identifies Resident A as male, although Resident A is identified as a female. The notes indicate that the patient presented with pain in the right arm. The pain is described as acute and worsening. The complaint is moderate. Pertinent findings include joint pain and tenderness. For services ordered, the report indicates that an X-ray of the shoulder and the upper right arm was ordered, staff to provide patient with PRN Tramadol for pain control, Eliquis on hold for five days related to large, bruised area on right arm, and encourages frequent mobilization with assistance. Guardian A stated she often makes unannounced visits to see her residents to ensure that they are receiving proper care. She adds Close to Home staff are good about contacting her regarding any concerns. She adds that the staff did make her aware that Resident A had been complaining of pain. She did not receive a call indicating that Resident A had a fall prior to the complaint of pain.

	Direct staff, Ms. Nea Laury indicated that she did observe the bruise on Resident A's arm, however, she is not the staff that initially observed the bruise. She recalled the shift manager, Ms. Trisha Holloway contacted Careline Physician Services. They were instructed to circle the bruised area with a sharpie and to call back if the bruise got any larger. An incident report was completed. Ms. Trisha Holloway, shift manager at Close to Home AFC recalled that upon being informed by staff that Resident A had a bruise on her arm, she looked her over and asked her if she fell, to which she replied "no". She indicated that she contacted and spoke with Careline Physician Services, who then instructed them to watch the bruise and to call back if the bruise got any larger. Ms. Jessire Ramos, APS Investigator indicated that she will not be substantiating the allegations of neglect. Based on the information gathered throughout the course of this investigation, there is insufficient evidence to support the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A reeks of urine along with her room and recliner.

INVESTIGATION:

On 09/01/2021, I, along with assigned APS investigator, Ms. Jessire Ramos conducted an onsite inspection at Close to Home AFC. Ms. Rinnert shared that Resident A was discharged from the hospital to a skilled care nursing facility, where she will remain. While onsite an observation or Resident A's room was made. Her room was observed as being fully furnished with many personal belongings and photos remaining throughout the room. The room was clean. Neither the room nor the recliner reeked of urine as alleged.

On 09/01/2021, other residents were observed in their rooms and moving about the facility. The residents were properly dressed and appeared to be receiving adequate care.

On 09/29/2021, I spoke with Guardian A regarding the allegations. Guardian A expressed that she has a good relationship with the facility and has had residents

placed in their facilities since 2008. She adds that she often makes unannounced visits to see her residents to ensure that they are receiving proper care. Guardian A indicated that she did not have any concerns that Resident A was not being cared for properly while placed at this facility.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	It was alleged that Resident A reeks of urine along with her room and recliner. An observation or Resident A's room determined that neither the room nor the recliner reeked of urine as alleged. Resident A is no longer in the home
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 08/10/2021, I received an emailed copy of the AFC Assessment Plan for Resident A. The plan indicates that Resident A requires assistance with mobility, however, it does not describe the assistance needed and how the need will be met. This plan is signed and dated by Guardian A on 03/03/2020.

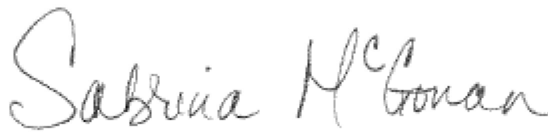
On 10/01/2021, I conducted an exit conference with the licensee, Mr. John Winden. Mr. Winden was informed that no licensing rule violations to the original allegations were found, however, an additional finding rue violation was established. A corrective action plan was requested within 15 days.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.

ANALYSIS:	The AFC Assessment plan does not describe how Resident A will be assisted with walking/mobility. Based on this information, there is sufficient evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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


October 4, 2021

Sabrina McGowan Date
Licensing Consultant

Approved By:

October 4, 2021

Mary E Holton Date
Area Manager