GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 4, 2022

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

RE: License #:	AL730398656
Investigation #:	2022A0872023
	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,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL730398656
Investigation #:	2022A0872023
Complaint Receipt Date:	02/16/2022
Investigation Initiation Date:	02/16/2022
Report Due Date:	04/17/2022
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 02/08/22, staff pulled Resident A's pants down in front of two individuals and cleaned her bottom without respect to her privacy. Staff was also observed acting and speaking to some of the residents in an inappropriate manner.	Yes

III. METHODOLOGY

02/16/2022	Special Investigation Intake 2022A0872023
02/16/2022	Special Investigation Initiated - On Site Unannounced
02/16/2022	APS Referral This complaint was referred by APS but was not assigned for investigation
03/24/2022	Contact - Document Sent I exchanged emails with APS Worker, Katrice Humphrey
04/01/2022	Contact - Telephone call made I interviewed former staff, Julie Hoag
04/01/2022	Contact - Telephone call made I interviewed Relative A1
04/01/2022	Exit Conference I conducted an exit conference with the licensee designee, John Winden, via telephone
04/01/2022	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: On 02/08/22, staff pulled Resident A's pants down in front of two individuals and cleaned her bottom without respect to her privacy. Staff was also observed acting and speaking to some of the residents in an inappropriate manner.

INVESTIGATION: On 2/17/22, I conducted an unannounced onsite inspection of Close to Home Assisted Living Side 2. I interviewed the licensee designee, John Winden, and the Facility Manager, Stacey Rinnert. I also visually inspected Resident A's room and interacted with her while she was in the dining room. Due to Resident A's dementia, I did not interview her, but I did observe her to be clean and dressed appropriately.

Mr. Winden and Ms. Rinnert said that they are aware that allegations were made against one of their staff, Julie Hoag, being inappropriate with Resident A. Mr. Winden said that he conducted an investigation regarding the allegations and terminated Ms. Julie's employment, effective today. He also sent me an Incident/Accident Report earlier this morning. Ms. Rinnert said that Ms. Hoag has worked at this facility for over a year, and she has not been accused of allegations such as this in the past. However, Ms. Rinnert and Mr. Winden felt there was truth to the allegations which is why Ms. Hoag was let go. Ms. Rinnert agreed to email me information related to this complaint.

I conducted a visual inspection of Resident A's room and found it to be clean. Resident A was sitting at a table in the dining room. She was dressed appropriately, and she appeared clean. I spoke with Resident A briefly and she smiled and was pleasant but not able to answer any of my questions.

I reviewed an Incident/Accident Report dated 2/16/22. According to the report, "It was brought to Close to Home's attention that one of our employees wasn't being compassionate while talking to such resident. Also, didn't give resident accurate peri-care and the privacy while doing it." The corrective measures taken were, the employee was terminated, and in-services were scheduled for existing staff regarding privacy, peri-care, and resident communication.

According to Resident A's Assessment Plan, she becomes confused and does not always know where she is. She understands words but has trouble communicating with others.

According to Resident A's Health Care Appraisal, she is diagnosed with dementia. In addition, Resident A is "confused, requires redirection and assistance with all ADL's."

I reviewed an email from the referral source regarding the allegations. According to the referral source, on 2/08/22, Witness 1 observed staff Julie Hoag acting rushed with several residents. She asked one of the residents to "be quiet" so she could hear what someone was saying. Ms. Hoag was observed grabbing Resident A's arm and guiding her into her room "in a little forceful and in a hurried fashion." Ms. Hoag then pulled down Resident A's brief to show a lump on her abdomen and she did not close the door before doing so. Resident A had had a bowel movement, so Ms. Hoag cleaned her up while in the presence of Witness 1 and Witness 2, without paying attention to Resident A's privacy. Witness 1 told the referral source that Resident A appeared uncomfortable during this situation, and she grabbed at her groin area. According to the referral source, Witness 1 has witnessed Ms. Hoag interact with the residents on numerous

occasions and does not feel that she acts in a “caring, kind, and compassionate manner.”

I reviewed an email written by Witness 2 who was present with Witness 1 on 2/08/22. According to Witness 2, she heard staff Julie Hoag say to a resident, “Shut your mouth, I need to listen to the nurse.” Witness 2 also observed Ms. Hoag pull Resident A’s pants down, without closing the door first. Resident A had on two visibly soiled briefs and Ms. Hoag then began cleaning Resident A up in the presence of Witness 1 and Witness 2 even though Resident A “was visibly upset and humiliated.” Witness 2 did not feel that Ms. Hoag was appropriately hygienic while cleaning Resident A’s bottom.

On 04/01/22, I interviewed former staff, Julie Hoag via telephone. Ms. Hoag confirmed that she was employed by Close to Home Assisted Living for over a year and was fired due to allegations made against her regarding Resident A. Ms. Hoag said that one day in February 2022, a hospice nurse and nursing student came to the facility to provide services to Resident A. Ms. Hoag said that she did not think anything about the visit except more than a week later, the facility manager, Stacey Rinnert called to tell her they had received a complaint about the way she was interacting with Resident A. Ms. Hoag said that Ms. Rinnert read the allegations to her and she denied that the allegations are true.

According to Ms. Hoag, she would never tell a resident to “shut up” and she is not rough with any of the residents. She said that she does recall pulling Resident A’s pants down in front of the nurse and nursing student, but she did not feel this was inappropriate since both individuals are medical professionals. Ms. Hoag also said that she may have left the door to Resident A’s room open while she went to get wipes, but she does not remember doing so. Ms. Hoag also said that she does not put more than one brief on a resident at a time. Ms. Hoag told me, “I took care of them like I would want to be taken care of.”

On 04/01/22, I interviewed Relative A1 via telephone. Relative A1 said that she is aware of the complaint made regarding staff Julie Hoag and Resident A. Relative A1 told me that she has witnessed Ms. Hoag interact with Resident A on multiple occasions and she never found her actions inappropriate. Relative A1 said that the facility manager, Stacey Rinnert read her the allegations and told her that Ms. Hoag was let go as a result of the complaint.

On 04/01/22, I conducted an exit conference with the licensee designee, John Winden, via telephone. I discussed the results of my investigation and explained which rule violation I am substantiating. Mr. Winden agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	On 02/08/22, Witness 1 and Witness 2 observed staff Julie Hoag pull Resident A's pants down and clean her bottom with her bedroom door open, not taking her privacy into consideration. Both Witnesses said that Resident A appeared uncomfortable, upset, and/or humiliated when this incident occurred. Witnesses also overheard Ms. Hoag talking inappropriately to another resident. Staff Julie Hoag said that she did pull Resident A's pants down in front of two individuals, but they were both medical personnel and she did not feel it was inappropriate. Ms. Hoag also said that she may have left Resident A's door open while she went to get wipes, but she does not remember doing so. I conclude that there is sufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

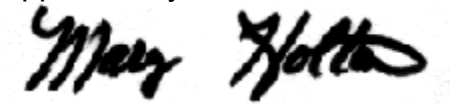
IV. RECOMMENDATION

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

April 4, 2022

Susan Hutchinson Licensing Consultant	Date

Approved By:



April 4, 2022

Mary E Holton Area Manager	Date