GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 17, 2022

Danielle Gill
Christian Care Assisted Living
1530 McLaughlin Avenue
Muskegon, MI 49442-4191

RE: License #: AH610236765
Investigation #: 2022A1028060
Christian Care Assisted Living

Dear Ms. Gill.:

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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
Cell (616) 204-4300

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

I. IDENTIFYING INFORMATION

License #:	AH610236765
Investigation #:	2022A1028060
Complaint Receipt Date:	07/01/2022
Investigation Initiation Date:	07/05/2022
Report Due Date:	08/31/2022
Licensee Name:	Christian Care Inc.
Licensee Address:	1530 McLaughlin Ave. Muskegon, MI 49442
Licensee Telephone #:	(231) 722-7165
Authorized Representative/Administrator:	Danielle Gill
Name of Facility:	Christian Care Assisted Living
Facility Address:	1530 McLaughlin Avenue Muskegon, MI 49442-4191
Facility Telephone #:	(231) 777-3494
Original Issuance Date:	01/01/2000
License **Status:**	REGULAR
Effective Date:	07/07/2022
Expiration Date:	07/06/2023
Capacity:	105
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Facility care staff are not providing care consistent with Resident A's service plan resulting in multiple falls.	Yes
Additional Findings	No

III. METHODOLOGY

07/01/2022	Special Investigation Intake 2022A1028060
07/05/2022	Special Investigation Initiated - Letter 2022A1028060
07/05/2022	APS Referral APS referral emailed to Centralized Intake.
07/11/2022	Inspection Completed On-site 2022A1028060
07/11/2022	Contact - Face to Face Interviewed AR/Admin/Danielle Gill at the facility.
07/11/2022	Contact - Face to Face Interviewed Employee A at the facility.
07/11/2022	Contact - Face to Face Interviewed Employee B at the facility.
07/11/2022	Contact - Face to Face Interviewed Employee C at the facility.
07/11/2022	Contact - Face to Face Interviewed Resident A at the facility.
10/17/2022	Exit – Report sent to AR/Admin/Danielle Gill.

ALLEGATION:

Facility care staff are not providing care consistent with Resident A's service plan resulting in multiple falls.

INVESTIGATION:

On 7/11/2022, the Bureau received the allegations from the online complaint system.

On 7/11/2022, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 7/11/2022, I interviewed facility authorized representative/administrator, Danielle Gill, at the facility. Ms. Gill reported Resident A has recently been demonstrating a decline and incurred several falls at the facility. Ms. Gill reported Resident A's service plan is in the process of being revised due to Resident A requiring increased care and supervision because of the demonstrated functional decline. Resident A was also assessed for a urinary tract infection and subsequently was signed up with home health services as well due to recent increase of falls. Ms. Gill reported no knowledge of pools of urine being left uncleaned in Resident A's bathroom causing the falls. Resident A incurred a fall in the bathroom due to attempting to shower without care staff assistance. Care staff remind Resident A to use the call light and to wait for assistance, but Resident A is not compliant. Ms. Gill reported Resident A intermittently uses the call light to request assistance from care staff and is demonstrating an increase with impulsive behaviors, requiring an increase in supervision. Ms. Gill reported the facility has been in consistent communication with Resident A's physician and authorized representative to determine the next best step in care for Resident A to include possibly a discharge from the facility to a more appropriate setting with increased supervision. Ms. Gill reported the facility recommended one to one supervision for Resident A, but Resident A's authorized representative is unable to provide this supervision. Ms. Gill reported the facility contacted APS as well to assist Resident A's authorized representative in finding a new authorized representative (AR) for Resident A due to the current AR expressing difficulty with being able to handle Resident A's affairs and to assist with placement into a more appropriate setting. Ms. Gill provided me Resident A's service plan with record notes for my review.

On 7/11/22, I interviewed Employee A at the facility who reported Resident A has demonstrated an increase in falls, requiring an increase with care and supervision. Resident A has home health staff working with [them] as well to help reduce falls, but Resident A is also demonstrating an increase in impulsivity. Resident A intermittently uses the call light to request assist from facility care staff despite frequent reminders to do so. Employee A reported that while Resident A can "physically do a lot of [their] own care, [they] are a fall risk and require increased supervision". Employee A reported no knowledge of pools of urine on the bathroom floor causing falls. Employee A reported Resident A often attempts to shower [their self] daily without staff assistance, resulting increased care and supervision from care staff. Employee A reported Resident A requires supervision when dressing to

prevent falls, but Resident A is never left with soiled clothing and/or a brief. Employee A reported Resident A requires supervision for toileting and safety and Resident A's brief is changed as needed throughout the day. Employee A reported Resident A has been caught on multiple occasions leaving the building to walk around outside without staff supervision. Resident A requires reminders to not leave without staff supervision but has not been compliant.

On 7/11/22, I interviewed Employee B at the facility who reported Resident A was "pretty independent when [they] first arrived" at the facility but has recently demonstrated a decline. Employee B reported Resident A requires increased supervision and assist due to several falls recently. Resident A is non-compliant with use of call light despite frequent reminders and redirection from staff. Resident A is easy to redirect but continues to requires increased supervision. Employee B reported Resident A does attempt to shower self without assistance. Resident A is provided care staff assistance to shower, dressing, and toilet due to requiring increased supervision for safety. Employee B reported Resident A's bathroom does not have pools of urine on the floor and no knowledge of Resident A wearing soiled clothing or briefs. Employee B reported Resident A's service plan is reviewed by care staff regularly due Resident A requiring an increase in care and supervision. Employee B reported Resident A has left the building on several occasions without staff supervision and/or assistance. Resident A is reminded to not leave without staff supervision but is not compliant.

On 7/11/22, I interviewed Employee C at the facility who reported Resident A has demonstrated a recent decline, requiring increased supervision from care staff. Employee C reported Resident A has had several falls due to being impulsive and non-compliant with using call light to request assistance. Resident A receives frequent reminders from care staff to wait for assistance but continues to be non-compliant. Employee C reported no knowledge of pools of urine in Resident A's bathroom or Resident A wearing soiled clothes and/or briefs. Employee C reported Resident A is assisted with dressing and toileting due to increased fall risk. Employee C reported knowledge of Resident A's service plan being updated to address increase of care and supervision, but that Resident A has been caught leaving the building without care staff assist and/or supervision. Employee C reported Resident A will let the front desk person know [they] are going outside but that has been inconsistent.

On 7/11/22, I interviewed Resident A at the facility who reported [they] fell in the bathroom about a week ago trying to get into the shower. Resident A admitted they tried to shower without assistance from care staff. Resident A was able to explain use of the call light and that [they] need to wait for staff assistance. However, Resident A demonstrated confusion as to why [they] do not wait for care staff assistance. Resident A reported [they] are having a lot of falls but "[staff] is helping me get better".

I inspected Resident A's room and bathroom. No pools of urine were noted, there was no smell of urine, and the call lights were working and within Resident A's reach. Resident A's room was clean and Resident A was clean, groomed and content. No concerns noted during inspection.

On 7/18/22, I reviewed Resident A's service plan with record notes which revealed the following:

- Resident A *can make needs known.*
- Requires assistance with meals, housekeeping, laundry, and medications.
- Resident is independent with toileting, grooming and dressing. However, there was a note attached demonstrating that these cares were being reviewed for increased staff assistance and reminders.
- Resident A requires *supervision and/or assistance to evacuate the building. Provide verbal cues and physical assistance, as necessary. Daily as needed.*
- A toilet riser was ordered for Resident A due to falls.

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.

ANALYSIS:	Interviews with the facility authorized representative/administrator, care staff and Resident A reveal Resident A demonstrates an increase in falls. Resident A also demonstrates inconsistency with using the call light and waiting for staff assistance despite frequent reminders from care staff. There is evidence care staff are aware Resident A is requiring an increase with care and supervision due to the recent increase of falls and decline in function. There is evidence that Resident A's service plan is being updated and that therapy was ordered to help reduce falls as well. However, interviews with care staff revealed Resident A was caught outside of the facility on multiple occasions without care staff assist and/or supervision. Resident A's service plan reads Resident A requires *supervision and/or assistance to evacuate the building. Provide verbal cues and physical assistance, as necessary. Daily as needed.* Given Resident A's recently increased fall history, Resident A is at further risk of falls with injury if unsupervised and/or unassisted by care staff while outside the facility. Resident A is not being provided care in accordance with the service plan due to Resident A being able to exit the facility on multiple occasions with no supervision.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the receipt of an approved corrective action plan, I recommend this license remain unchanged.

Julie Viviano

7/18/2022

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Julie Viviano Date
Licensing Staff

Approved By:

10/05/2022

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Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section