GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 14, 2022

Karen Yens
Satchell's Christian Retirement Home, Inc.
2662 East Caro Rd
Caro, MI 48723

RE: License #: AL790284241
Investigation #: 2022A0580009
Satchell's Christian Retirement Home

Dear Mrs. Yens:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.
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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.

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 #:	AL790284241
Investigation #:	2022A0580009
Complaint Receipt Date:	11/24/2021
Investigation Initiation Date:	11/29/2021
Report Due Date:	01/23/2022
Licensee Name:	Satchell's Christian Retirement Home, Inc.
Licensee Address:	2662 East Caro Rd Caro, MI 48723
Licensee Telephone #:	(989) 673-3329
Administrator:	Karen Yens
Licensee Designee:	Karen Yens
Name of Facility:	Satchell's Christian Retirement Home
Facility Address:	2662 East Caro Rd Caro, MI 48723
Facility Telephone #:	(989) 673-3329
Original Issuance Date:	03/12/2007
License Status:	REGULAR
Effective Date:	09/28/2021
Expiration Date:	09/27/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
On 11/01/2021, Resident A walked to the door, went through 2 doors to get outside. Resident was found lying on the pavement outside.	No
Resident A was tied to a Geri Chair so he could not get out. They put him in the chair to keep him in one place. While in bed he had bed rails on both sides.	Yes
The bathroom there had urine all over the floor.	No
Resident A's bed was found to be soaked w/urine through to the mattress.	No
Additional Findings	Yes

III. METHODOLOGY

11/24/2021	Special Investigation Intake 2022A0580009
11/29/2021	Special Investigation Initiated - Telephone A call was made to Satchell's AFC. Contact made with staff, Ms. Candi Schmotzer.
12/06/2021	Contact - Document Received A copy of the AFC Assessment Plan, Health Care Appraisal and other documents requested were received.
12/06/2021	Contact - Telephone call made A call was made to licensee, Ms. Karen Yens.
12/08/2021	Inspection Completed On-site A virtual inspection was conducted at Satchell's due to Covid-19 positive residents.
01/10/2022	Contact - Telephone call made A call was made to Compassus Hospice and Palliative Care, located in Cass City, MI.
01/12/2022	Contact - Telephone call made A call was made to Relative Guardian A.

01/12/2022	Contact - Document Received An email containing various photos of Resident A while at Satchell's AFC was received.
01/13/2022	Contact - Telephone call made A call was made to the licensee, Ms. Karen Yens.
01/13/2022	Contact - Document Received A faxed copy of a Physician Modification Orders for Resident A was received.
01/13/2022	Exit Conference An exit conference was held with the licensee, Ms. Karen Yens.

ALLEGATION:

On 11/01/2021, Resident A walked to the door, went through 2 doors to get outside. Resident was found lying on the pavement outside.

INVESTIGATION:

On 11/24/2021, I received a complaint via BCAL Online complaints.

On 11/29/2021, I spoke with direct staff, Ms. Candi Schmotzer. She indicated that Resident A was admitted as a fall risk resident who was receiving hospice services. She recalled that Resident A did get out the door to the outside and fell in the parking lot. His guardian and hospice were contacted. Resident A went to the hospital as a result. An incident report was completed.

On 12/06/2021, I spoke with the licensee, Ms. Karen Yens. On Ms. Yens indicated that Resident A was admitted as a fall risk, not a flight risk. She stated that the family never indicated that Resident A tries to escape. She confirmed that Resident A did have a fall while in the parking lot, after having gotten outside. She recalled that Resident A was sitting in a Geri Chair while in the dining area. As staff went to assist other residents, he got up and went outside. She indicated that he could not have been outside for more than a few minutes before it was discovered that he had gotten out. An incident report was completed and sent on the same day.

The incident report received on 11/02/2021 was reviewed. The report, dated 11/01/2021, states that 3 aides put Resident A in a Geri Chair while they answered other call lights for toileting and putting pajamas of other residents. Resident A has to be watched every minute if tray table is not on the Geri Chair. Resident A figured out how to undue the tray and took off and went outside looking for his wife. Once the door

alarm went off staff took off after him, however, he had fallen while outside. Resident A was helped inside the house with several abrasions. Resident A complained of pain. Resident A's guardian along with hospice were contacted. Resident A was sent to the hospital for x-rays. Resident A was diagnosed with a broken right hip and a broken right arm. Corrective measures include placing an alarm pad under Resident A and 1 staff to stay with Resident A at all times.

On 12/06/2021, I received a faxed copy of the AFC Assessment Plan and Care Agreement for Resident A. The AFC Care Agreement indicates that Resident A was placed in the facility on 10/22/2021. The AFC plan indicates that Resident A does not move independently in the community as he ambulates unstable with a walker. For walking and mobility, the plan indicates that Resident needs the assistance and requires the use of a walker. The assessment plan does not indicate that Resident A is at risk for AWOL (absent without leave). The Health Care Appraisal, completed on 10/22/2021 indicates that Resident A is a fall risk.

On 01/12/2022, I spoke with Relative Guardian A. She confirmed that she received a call from the licensee, Ms. Karen Yens, on 01/11/2021, indicating that Resident A had gotten outside to the parking lot and fell on the pavement. Ms. Yens also informed her that she had contacted hospice and Resident A had been transported to Hillsdale Hospital in Cass City, MI. Guardian A indicated that she was under the impression that this facility would be able to provide 24-hour supervision and care. Guardian A also shared that per her last call to the funeral home on 01/10/2022, the death certificate for Resident A has not yet returned.

On 01/12/2022, I received an emailed copy of photos of Resident A. The photos depict Resident A lying in bed. His right arm was black, blue, and bruised from the shoulder to the wrist.

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 walked to the door, went through 2 doors to get outside. Resident was found lying on the pavement outside. Direct staff, Ms. Candi Schmotzer recalled that Resident A did have a fall in the parking lot, after where he able to get outside. His guardian and hospice were contacted. Resident A went to the hospital as a result. An incident report was completed.

	Licensee, Ms. Karen Yens, indicated that Resident A was admitted as a fall risk, not a flight risk. She stated that the family never indicated that Resident A tries to escape. She confirmed that Resident A did have a fall while in the parking lot, after having gotten outside. An incident report was completed the same day and faxed the following day. The incident report dated 11/01/2021 was reviewed. The AFC plan indicates that Resident A does not move independently in the community as he ambulates unstable with a walker. For walking and mobility, the plan indicates that Resident needs the assistance and requires the use of a walker. The assessment plan does not indicate that Resident A is at risk for AWOL. The Health Care Appraisal, completed on 10/22/2021 indicates that Resident A is a fall risk. Relative Guardian A confirmed that she was notified of Resident A's fall in the parking lot. Guardian A indicated that she was under the impression that this facility would be able to provide 24-hour supervision and care. Photos of Resident A depict Resident A lying in bed. His right arm was black, blue, and bruised from the shoulder to the wrist. 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 was tied to a Geri Chair so he could not get out. They put him in the chair to keep him in one place. While in bed he had bed rails on both sides.

INVESTIGATION:

On 12/06/2021, I spoke with the licensee, Ms. Karen Yens. Ms. Yens shared that the Geri Chair belongs to the facility. She indicated that Resident A did not have a prescription for the use of a Geri Chair.

The incident report received on 11/02/2021 was reviewed. The report, dated 11/01/2021, states that 3 aides put Resident A in a Geri Chair while they answered other call lights for toileting and putting pajamas of other residents. Resident A has to be watched every minute if tray table is not on the Geri Chair. Resident A figured out

how to undue the tray and took off and went outside looking for his wife. Once the door alarm went off staff took off after him, however, he had fallen while outside.

On 12/06/2021, I received a faxed copy of the Health Care Appraisal and Hospice Care plan for Resident A. The AFC Assessment plan identifies special equipment for Resident A as a walker and a wheelchair. The hospice care plan was completed by Compassus Hospice and Palliative Care, dated 10/19/2021. It indicates that Resident A requires the use of a Walker (wheeled) a Wheelchair and a Hoyer Lift.

On 01/10/2022, I spoke with Ms. Kassundra Jones, RN, of Compassus Hospice and Palliative Care, located in Cass City, MI. She indicated that per her manager, she could not share any information with me without a release of information.

On 01/12/2022, I spoke with Relative Guardian A. She has photos of Resident A while sitting in a Geri Chair in the AFC home, which she did not authorize. Guardian A indicated that she has photos of Resident A having been tied to the chair.

On 01/12/2022, I received emailed copies of photos of Resident A. A photo observed depicts Resident A in a Geri Chair, with the type written caption indicating, “Trying to serve supper so we put in Geri chair and I had him help me open tool box”. Six different photos of Resident A sitting throughout the facility. One photo depicts Resident A sitting in his walker, with what appears to be a Gait Belt around his waist. Two of the photos show Resident A sitting in a wheelchair, with what appears to be a Gait Belt around his waist. The other three photos show Resident A sitting in armchairs, with what appears to be a sheet woven throughout the arms of the chair, tied around his waist.

On 01/13/2022, I spoke with the licensee regarding the use of the bed rails for Resident A. She shared that the bed rails were ordered by hospice after Resident A’s fall.

On 01/13/2022, I received a faxed copy of a Physician Modification order for Resident A, completed by Compassus Hospice. The order, dated 11/01/2021, indicates that Resident A was prescribed full bed rails to both sides of the bed.

APPLICABLE RULE	
R 400.15308	**Resident behavior intervention prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any other person who lives in the home shall not do any of the following: **(d) Confine a resident in an area, such as a room, where egress us prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.**
ANALYSIS:	It was alleged that Resident A was tied to a Geri Chair so he could not get out. They put him in the chair to keep him in one place.

	Licensee indicated that the bed rails were ordered by hospice after Resident A's fall. A Physician Modification order for Resident A, completed by Compassus Hospice. The order, dated 11/01/2021, indicates that Resident A was prescribed full bed rails to both sides of the bed. Licensee, Ms. Karen Yens shared that the Geri Chair they used on Resident A belongs to the facility. Resident A did not have a physician prescription for the use of a Geri Chair nor was it indicated in Resident A's assessment plan. The incident report submitted by the facility confirms they were using the Geri Chair to confine Resident A. Relative Guardian A indicated that she did not authorize the use of a Geri Chair for Resident A. I observed a photo of Resident A sitting in a Geri Chair, which confirm the Geri Chair, along with sheets, and gait belt were utilized to confine Resident A to this chair. Based on the information gathered throughout the course of this investigation, there is sufficient evidence to support the rule violation, based on the use of the Gait belt and sheet used, confining Resident A to the chair.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The bathroom there had urine all over the floor.

INVESTIGATION:

On 12/06/2021, I spoke with Ms. Karen Yens, licensee. Ms. Yens denied that Resident A's bathroom had urine all over the floor. She indicated that Resident A wore briefs and did not use the private located in his room.

On 12/06/2021, I received a faxed copy of the AFC Assessment Plan and the Hospice Assessment. The plan indicates that Resident A requires assistance with toileting. The hospice assessment indicates that Resident A required the use of at least pull-ups to be used in 24 hours for incontinence.

On 12/08/2021, I conducted a virtual onsite inspection of Satchell's AFC. A virtual inspection of the private bathroom located in Resident A's room was conducted. The bathroom appeared to be clean. No urine was observed on the floor.

On 12/08/2021, I spoke with direct staff, Ms. Candy Schmotzer. She indicated that Resident A did not use the private bathroom located in his room due to wearing briefs. She denies the allegations of urine being on the floor.

On 01/10/2022, I spoke with Ms. Kassundra Jones, RN, of Compassus Hospice and Palliative Care, located in Cass City, MI. She indicated that per her manager, she could not share any information with me without a release of information.

On 01/12/2022, I spoke with Relative Guardian A. Guardian A indicated that she was informed of the urine on the bathroom floor by Compassus hospice staff. Guardian A expressed that upon entry to the facility, she was informed that Resident A would be taken to the toilet every 2 hours. He did use depends prior to his arrival at the facility.

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 the bathroom there had urine all over the floor. Ms. Yens denied that Resident A's bathroom had urine all over the floor. She indicated that Resident A wore briefs and did not use the private located in his room. The AFC Assessment Plan and the Hospice Assessment. The plan indicates that Resident A requires assistance with toileting. The hospice assessment indicates that Resident A required the use of at least pull-ups to be used in 24 hours for incontinence. A virtual onsite inspection of the private bathroom located in Resident A's room was conducted. The bathroom appeared to be clean. No urine was observed on the floor. Direct staff, Ms. Candy Schmotzer, denies the allegations of urine being on the bathroom floor. Ms. Kassundra Jones, RN, of Compassus Hospice and Palliative Care, located in Cass City, MI, indicated that per her manager, she could not share any information with me without a release of information.

	Relative Guardian A indicated that upon entry to the facility, she was informed that Resident A would be taken to the toilet every 2 hours. He did use depends prior to his arrival at the facility. Relative Guardian A indicated that she was informed of the urine on the bathroom floor by Compassus hospice staff. 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's bed was found to be soaked with urine through to the mattress.

INVESTIGATION:

On 12/06/2021, I spoke with the licensee, Ms. Karen Yens. She denied that Resident A's bed was urine soaked. She indicated that his linens were changed as needed.

On 12/08/2021, I conducted a virtual onsite inspection of Satchell's AFC. I observed the bed that was previously occupied by Resident A during his stay at the home. Upon staff lifting the covers and mattress, no urine was observed.

On 12/08/2021, I spoke with direct staff, Ms. Candy Schmotzer. She denied that Resident A's bed/mattress was urine soaked during his stay.

On 01/10/2021, I spoke with Ms. Kassundra Jones, RN, of Compassus Hospice and Palliative Care, located in Cass City, MI. She indicated that per her manager, she could not share any information with me without a release of information.

On 01/12/2021, I spoke with Relative Guardian A. She shared that hospice staff reported to her that once Resident A passed away, the padding underneath him was removed and found soaked with urine and fecal stains.

On 01/13/2022, I spoke with the licensee, Ms. Yens. She shared that normally when a Resident passes away the staff would clean the resident in preparation for the coroner. She stated that when Resident A passed away the family would not allow them to touch him until the coroner arrived. She adds that it is known that at times when people pass away their bowel and or bladder excretes. She denied that they did not change his bed.

APPLICABLE RULE	
R 400.15411	**Linens.**
	(1) A licensee shall provide clean bedding that is in good condition. The bedding shall include 2 sheets, a pillow case, a minimum of 1 blanket, and a bedspread for each bed. Bed linens shall be changed and laundered at least once a week or more often if soiled.
ANALYSIS:	It was alleged that Resident A's bed was found to be soaked w/urine through to the mattress. Licensee, Ms. Karen Yens, indicated that when a Resident passes away the staff would clean the resident in preparation for the coroner. When Resident A passed away the family would not allow them to touch him until the coroner arrived. A virtual onsite inspection of the bed that was previously occupied by Resident A during his stay at the home depicted no urine on the bed or mattress. The bed contained proper linens. Direct staff, Ms. Candy Schmotzer, denied that Resident A's bed/mattress was urine soaked during his stay. Ms. Kassundra Jones, RN, of Compassus Hospice and Palliative Care, indicated that per her manager, she could not share any information with me without a release of information. Relative Guardian A indicated that hospice staff reported to her that once Resident A passed away, the padding underneath him was removed and found soaked with urine and fecal stains. Based on the information gathered throughout the course of this investigation, there is insufficient evidence to support the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESITGATON:

On 12/06/2021, I spoke with the licensee, Ms. Karen Yens. Ms. Yens shared that the Geri Chair belongs to the facility. She indicated that Resident A did not have a prescription for the use of a Geri Chair.

On 12/06/2021, I received a faxed copy of the Health Care Appraisal and Hospice Care plan for Resident A. The AFC Assessment plan identifies special equipment for Resident A as a walker and a wheelchair. The hospice care plan was completed by Compassus Hospice and Palliative Care, dated 10/19/2021. It indicates that Resident A requires the use of a Walker (wheeled) a Wheelchair and a Hoyer Lift. There were no physician orders for the use of a gait belt or Geri Chair in Resident A's records.

On 01/12/2022, I spoke with Relative Guardian A. She has photos of Resident A while sitting in a Geri Chair in the AFC home, which she did not authorize.

On 01/12/2022, I received emailed copies of photos of Resident A. A photo observed depicts Resident A in a Geri Chair, with the type written caption indicating, "Trying to serve supper so we put in Geri chair and I had him help me open tool box". Six different photos of Resident A sitting throughout the facility. One photo depicts Resident A sitting in his walker, with what appears to be a Gait Belt around his waist. Two of the photos show Resident A sitting in a wheelchair, with what appears to be a Gait Belt around his waist. The other three photos show Resident A sitting in armchairs, with what appears to be a sheet woven throughout the arms of the chair, tied around his waist.

On 01/13/2022, I spoke with the licensee, Ms. Karens Yens regarding the use of the Gait Belt on Resident A. She did not have a prescription for its use.

APPLICABLE RULE	
R 400.15306	**Use of assistive devices.**
	(2) An assistive device shall be specified in a resident's written assessment plan and agreed upon by the resident or the resident's designated representative and the licensee. **(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization.**

ANALYSIS:	Licensee, Ms. Karen Yens shared that the Geri Chair they used on Resident A belonged to the facility. Ms. Yens confirmed she did not have a physician's order for the use of the gait belt or Geri Chair that was used on Resident A. There are also photos to confirm the gait belt and Geri Chair were used on Resident A. The guardian of Resident A did not authorize the use of the Geri Chair. Resident A's records did not indicate a gait belt and Geri Chair were to be utilized for the care of Resident A. The Geri Chair and gait belts were further used on Resident A without the required physician's order. There is substantial evidence to confirm violation of these rules.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 01/13/2022, I conducted an exit conference with the licensee, Ms. Karen Yens. Ms. Yens was informed of the licensing rule violations found. A corrective action plan was requested in 15 days.

IV. RECOMMENDATION

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

January 14, 2022

Sabrina McGowan Date
Licensing Consultant

Approved By:

January 14, 2022

Mary E Holton Date
Area Manager