GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 18, 2022

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

RE: License #:	AL730398656
Investigation #:	2022A0872028
	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 (517) 284-9730.

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 #:	2022A0872028
Complaint Receipt Date:	03/31/2022
Investigation Initiation Date:	03/31/2022
Report Due Date:	05/30/2022
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 02/19/22, Resident A was admitted to the hospital with a severe UTI, dirty brief, awful hygiene, and a bed sore.	Yes

III. METHODOLOGY

03/31/2022	Special Investigation Intake 2022A0872028
03/31/2022	Special Investigation Initiated - Letter I emailed Relative A1
04/07/2022	Inspection Completed On-site Unannounced
05/02/2022	Contact - Telephone call made I interviewed Kristy McCarthy
05/03/2022	Contact - Telephone call made I interviewed Relative A1
05/04/2022	Contact - Document Sent I faxed a medical records request to Ascension St. Mary's hospital
05/18/2022	Contact - Telephone call made I interviewed staff Amber Biskner
05/18/2022	Contact - Telephone call made I interviewed staff Trisha Holloway
05/18/2022	Exit Conference I conducted an exit conference with the licensee designee, John Winden, via telephone

ALLEGATION: On 02/19/22, Resident A was admitted to the hospital with a severe UTI, dirty brief, awful hygiene, and a bed sore.

INVESTIGATION: On 3/31/22, I exchanged emails with Relative A1. According to Relative A1, Resident A was admitted to St. Mary's hospital on 2/19/22 and he died on 3/11/22. She said that according to his death certificate, his cause of death was sepsis secondary to UTI and acute respiratory failure. Relative A1 stated that she believes Resident A's death was caused by the condition he was in when he was hospitalized. Relative A1 said that Resident A did not have a power of attorney or guardian, but his wife was listed as his emergency contact person on Adult Foster Care paperwork obtained by Close to Home Assisted Living Side 2.

On 4/07/11, I conducted an unannounced onsite inspection of Close to Home Assisted Living Side 2. I interviewed the facility manager, Stacey Rinnert. Ms. Rinnert confirmed that Resident A was a resident of Close to Home Assisted Living Side 2 until he was hospitalized on 2/19/22. Ms. Rinnert said that Resident A did not have a POA or guardian. She said that he was involved with the PACE program who oversaw the majority of his care.

According to Ms. Rinnert, a PACE nurse went to the facility approximately two times per week to check on Resident A. He had a catheter, and the PACE nurse would clean and/or change his catheter. Ms. Rinnert said that Resident A did not wear a brief. When he did not have a catheter, he would let staff know when he had to use the bathroom and they would assist him. When he did have the catheter in place, he would notify staff if he needed to defecate, and staff would assist him. She said that he rarely had accidents.

Ms. Rinnert said that "nine times of out ten," Resident A would refuse showers from AFC facility staff. She said that every time he refused, staff would document it and notify his PACE nurse who would then encourage him to bathe. Ms. Rinnert confirmed that because of Resident A's shower refusals, his hygiene was poor. Ms. Rinnert said that Resident A would get up out of bed every day and she does not believe that he had any bedsores while a resident of this facility.

On 05/02/22, I reviewed Adult Foster Care paperwork related to Resident A. Resident A was admitted to Close to Home Assisted Living Side 2 on 05/28/20. According to his Assessment Plan dated 01/04/22, he uses a wheelchair, commode, and a walker. He requires assistance with toileting, bathing, grooming, dressing, and personal hygiene. I reviewed Resident A's shower schedule from 11/29/21 through 02/19/22. According to the schedule, staff offered Resident A a shower approximately two times per week and he typically refused at least once per week.

I reviewed Resident A's nursing notes from 10/16/21 through 02/19/22. Staff documented on numerous occasions Resident A's refusal of showers. I noted that typically, staff offered Resident A a shower more than once before documenting his refusal. His nursing notes documented the following:

- 01/19/22: “Called PACE to let them know that (Resident A) has a decrease in urine output. Also let the nurse know that (he) has been refusing showers and is starting to smell.”
- 02/02/22: Resident A “refused a shower 3x’s. Stated too cold. PACE aware.”
- 02/08/22, “(Resident A) rang a lot today. Wanting help with lighting his cigarettes, which he usually does by himself. (He) seemed very weak today.”
- 02/12/22: “(Resident A) was very tired today. Barely went out to smoke. Went out maybe 2 times versus 8-9 times. Barely ate at mealtimes. Did not seem himself.”
- 02/18/22: “(Resident A was) very mean today. Rude to all staff. Refused lunch.”
- 02/19/22: “(Resident A) was sent to St. Mary’s today. He wasn’t responding well and didn’t look himself.”

I reviewed an Incident/Accident Report (IR) dated 11/29/21. According to the IR, “Staff observed resident on the floor. Resident stated he thought wheels were locked and leaned forward and fell.” Staff checked his vitals and examined him for injuries. He had a small bump on his forehead. He said he was not in any pain, but he was “very weak.” The corrective measures taken were, “Remind resident to use call button and to wait for help when needing transferred and reminded to always double check brakes.”

I reviewed an Incident/Accident Report (IR) dated 2/19/22. According to the IR, Resident A appeared lethargic, so staff called paramedics and PACE and Resident A was sent to St. Mary’s hospital.

On 05/02/22, I interviewed Kristy McCarthy, social worker with Great Lakes PACE program. Ms. McCarthy said that she began working with Resident A in 2019. She said that Resident A was seen at PACE on a weekly basis for wound care, due a wound on his coccyx. Ms. McCarthy confirmed that Resident A was resistant to showers at his AFC facility, so PACE staff typically showered him once per week when he went to their agency for wound care. Ms. McCarthy confirmed that Resident A had a chronic UTI and required assistance with all his ADL’s. Ms. McCarthy said that staff at Close to Home Assisted Living Side 2 would report incidents to PACE staff having to do with Resident A’s care. Ms. McCarthy said that PACE staff was notified on 2/19/22 that Resident A was sent to the emergency room. I asked Ms. McCarthy if Resident A's nurses ever expressed concerns about the care he was receiving at Close to Home AFC. She said that typically, if a nurse has concerns, she will address it with the AFC facility staff and if the concerns become chronic, they will make a complaint to Adult Protective Services. According to Ms. McCarthy, although Resident A’s nurses noted concerns at times, the concerns did not rise to the level of having to be reported due to suspected abuse or neglect.

On 05/03/22, I interviewed Relative A1 via telephone. Relative A1 said that approximately 3-4 years ago, Resident A had a stroke and a minor heart attack. Shortly after that, he was placed in an AFC facility. Relative A1 said that she last saw Resident A at his AFC facility in December 2021. According to Relative A1, she was told that Resident A fell out of his wheelchair on 2/19/22 and was sent to the hospital. Relative

A1 said that she was told by hospital staff that Resident A presented with a dirty brief, “awful” hygiene, a UTI, and a bedsore. Upon his admittance, he was coherent and responsive to family. He was able to talk and interact with hospital staff and family. He remained in the hospital and received treatment for his bedsore and his UTI, and his condition remained stable.

Resident A said that on 2/24/22, she was called by hospital staff and told that Resident A had fallen out of his hospital bed and was unresponsive. Hospital staff ran numerous tests, but they could find no reason for his unresponsiveness. After that time, his condition continually worsened. Relative A1 said that Resident A’s bedsore turned into an ulcer and his UTI turned into sepsis. Resident A’s condition continued to decline, and he died on 3/11/22. Relative A1 said that she feels Resident A’s death is a result of PACE staff and/or Close to Home staff not caring for Resident A properly.

On 05/04/22, I faxed a medical records request to Ascension St. Mary’s Hospital’s medical records division. As of 05/18/22, I have not received copies of Resident A’s medical records.

On 05/18/22, I interviewed staff Amber Biskner via telephone. Ms. Biskner said that she has worked at this facility for approximately two years, and she was very familiar with Resident A. According to Ms. Biskner, Resident A’s condition began to steadily decline over the three months leading up to his hospitalization. She said that he used to be able to wheel himself around in his wheelchair and would go outside every hour or so by himself. By 02/19/22, he was only going outside two to three times a day and would require staff assistance. Ms. Biskner stated that Resident A began refusing medications and was refusing showers as well as assistance with any of his ADL’s. I asked Ms. Biskner about Resident A’s hygiene and she said that it was poor because of his bathing refusals. Staff would consistently try to prompt him to shower but he would refuse. He had an odor, and his body had visible dead skin that needed to be bathed but he continuously refused. He would not allow staff to brush his teeth and would only allow them to wash him up occasionally. Ms. Biskner said that staff always documented his refusals and would notify PACE staff as well. I asked her approximately how long the longest was that Resident A went without a shower and she estimated approximately four weeks.

On 05/18/22, I interviewed staff Trisha Holloway via telephone. She said that she has worked at this facility for approximately 2.5 years and had regular contact with Resident A. Ms. Holloway said that on 02/19/22, after being off work for a few days, she went to work and immediately noticed that Resident A “did not seem himself.” When she saw him on 02/19/22, she noted that he appeared weak, and he was slumping over in his wheelchair, so she got his permission to send him to the hospital. Ms. Holloway confirmed that prior to his hospitalization, Resident A was refusing showers and ADL assistance from staff. She said that Resident A had a chronic UTI and would go from having a catheter to not having one, depending on his condition. According to Ms. Holloway, when Resident A did not have a catheter, he sometimes wore a brief and other times would alert staff when he needed to use the bathroom. I asked Ms.

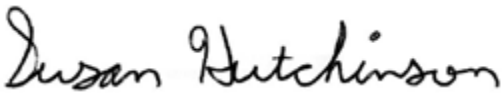
Holloway about Resident A's hygiene on the day he was admitted to the hospital. Ms. Holloway said that his hygiene "wasn't the greatest" and confirmed that although staff offered him showers on a regular basis, he consistently refused. She said that staff always documented his refusals and notified PACE staff.

On 05/18/22, 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 400.15303	**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:	On 02/19/22, Resident A was admitted to the hospital. According to Relative A1, hospital staff reported that he had a severe UTI, dirty brief, awful hygiene, and a bed sore. According to Resident A's Assessment Plan, he required staff assistance with toileting, bathing, grooming, dressing, and personal hygiene. According to Close to Home Assisted Living (CTH) Nurses notes, staff Stacey Rinnert, Amber Biskner, and Trisha Holloway Resident A often refused showers and therefore, he had poor hygiene and at times had an odor. All individuals reported that Resident A's refusals were documented and reported to PACE staff. PACE social worker, Kristy McCarthy confirmed that Resident A often refused showers and ADL assistance from CTH staff and PACE staff would try to shower him at least once per week. I conclude that there is sufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

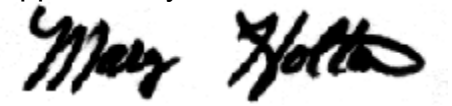
Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.



May 18, 2022

Susan Hutchinson Licensing Consultant	Date

Approved By:



May 18, 2022

Mary E Holton Area Manager	Date