GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 14, 2023

Catherine Reese
The Lodge of Durand Memory Care, LLC
5720 Williams Lake Road
Waterford, MI 48329

RE: License #: AL780360984
Investigation #: 2023A0584019
Lodge of Durand MC North

Dear Ms. Reese:

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.

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. If I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9727.

Sincerely,

Candace Coburn, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL780360984
Investigation #:	2023A0584019
Complaint Receipt Date:	01/06/2023
Investigation Initiation Date:	01/06/2023
Report Due Date:	03/07/2023
Licensee Name:	The Lodge of Durand Memory Care, LLC
Licensee Address:	5720 Williams Lake Road Waterford, MI 48329
Licensee Telephone #:	(989) 288-6561
Administrator:	Jeri Birchmeier
Licensee Designee:	Catherine Reese
Name of Facility:	Lodge of Durand MC North
Facility Address:	8800 E. Monroe Road Durand, MI 48429
Facility Telephone #:	(989) 288-6561
Original Issuance Date:	10/21/2015
License Status:	REGULAR
Effective Date:	04/21/2022
Expiration Date:	04/20/2024
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On the evening of 1/3/2023 Resident A, who has a diagnosis of dementia, was not supervised appropriately when she wandered into Resident B's bedroom and was physically assaulted. As a result of this incident, Resident A sustained injuries and subsequently was hospitalized.	No
ADDITIONAL FINDING	Yes

METHODOLOGY

01/06/2023	Special Investigation Intake 2023A0584019. Special Investigation Initiated – Letter to Rebbeca Shalow, Adult protective services worker (APS) Shiawassee County Michigan Department of Health and Human Services (MDHHS).
01/23/2023	Contact - Telephone interview with Adult Protective Services Specialist Rebbeca Shalow.
02/09/2023	Inspection Completed On-site Face to face interview with direct care staff member Eliot Dunsmore, Resident A, and administrator Jeri Birchmeier
03/06/2023	Contact - Telephone interview with direct care staff member Kelli St. James.
03/10/2023	Exit Conference via a telephone contact with Catherine Reese, licensee designee.

ALLEGATION:

On 1/3/2023 Resident A, who has a diagnosis of dementia, was not supervised appropriately when she wandered into Resident B's bedroom and was physically assaulted. As a result of this incident, Resident A sustained injuries and subsequently was hospitalized.

INVESTIGATION:

On 1/6/2023, the Bureau of Community and Health Systems (BCHS) received the above allegation via the BCHS online complaint system.

On 1/23/2023, I conducted a telephone interview with Adult Protective Services Specialist Rebbeca Shalow who also investigated the allegation. Ms. Shalow stated she had visited Resident A in the hospital to view her injuries. Ms. Shalow stated she did not substantiate physical abuse against either of the residents and would be closing her investigation.

On 2/9/2023, I conducted an unannounced investigation at the facility and conducted separate face to face interviews with direct care staff member Eliot Densmore, administrator Jeri Birchmeier, and Resident A.

Mr. Densmore stated that on the evening of 1/3/2023, he worked at the facility with direct care staff members Kelli St. James and Lindsay Potter. According to Mr. Densmore, he was in the kitchen of the facility training with Ms. St. James when they heard Ms. Potter yell for help. Mr. Densmore stated Ms. St. James instructed him to stay in the kitchen while she went to assist Ms. Potter.

During my interview with Resident A, she was unwilling or unable to answer any questions. I did not observe any scars, scabs, or marks left from her injuries sustained in the incident. Resident A was observed to be in a combative disposition and the interview was terminated.

Ms. Birchmeier stated Ms. Potter was no longer employed by the facility and her dismissal was the result of work tardiness. Ms. Birchmeier confirmed that on the evening of 01/3/2023, Mr. Densmore, Ms. St. James, and Ms. Potter worked together at the facility, along with direct care staff member Hailey Adkison. According to Ms. Birchmeier, she was also present in the “south wing” of the facility on the evening of 01/03/2023. Ms. Birchmeier confirmed Resident A has a dementia diagnosis. According to Ms. Birchmeier, on the evening of 01/03/2023 Resident A wandered into Resident B’s bedroom and was subsequently physically assaulted by Resident B. Ms. Birchmeier stated that following the incident, she assisted in contacting Resident A and B’s relatives and arranging transportation for Resident A and B to the hospital for medical evaluations. Ms. Birchmeier provided the following written statements of the incident:

Kelli St. James wrote: 1/3/23.
“At about 10:30pm, I was doing dishes and heard Lindsey scream help Kelli there is blood everywhere. I yelled for Michelle and Jeri to come to 200 hall right now. I ran down 200 hall to find [Resident A] covered in blood. I started to access her and saw [Resident B] on her knees. I got into [Resident B’s] door there was blood and hair

everywhere. Jeri and I helped [Resident B] get up and onto her chair. [Resident B] started to say someone came into her room and she started to whale on them. [Resident A] stated she had knocked her down. After talking with [Resident B] to see what had happened I went back to [Resident A] did her vitals and started a skin assessment to document all her injuries then EMT's showed up".

Lindsey Potter wrote: 1/3/23.
"I had just put [Resident A] in bed, stepped outside to smoke a cigarette, then I came in and put my stuff in my locker, proceeded to make my way to the kitchen to get the broom. I was sweeping 200 hall and [Resident B] opened her door screaming help, my coworker halie (sic) had just got down 200 hall to chart right before the incident. Halie and I ran to [Resident B's] door and [Resident A] was beat up".

Hailey Adkison wrote:
"Around 10:30 I was in the kitchen washing tables. I then walked to 200 hall to complete my daily task documentation. It was about 2 minutes after sitting down that me and my coworker heard [Resident B] scream for help. When I got to [Resident B's] room, I did not see any other signs of another resident, I only saw [Resident B] on the floor naked. Shortly after that I saw [Resident A] with blood on her face. My coworker ran for help while I stayed with the injured residents. 1/3/2023".

I reviewed Resident A's *Health Care Appraisal, BCAL – 3947*, dated 11/8/22, that documents under *Mental/Physical Status and Limitations – section 11 "pt has advanced dementia".*

I reviewed Resident A's *Assessment plan for AFC Residents BCAL- 3265,* (assessment plan), dated 12/22/2022. There was no documentation on Resident A's assessment plan indicating concerns about Resident A's wandering behavior, mobility, or other concerns about her orientation and advanced dementia diagnosis.

On 3/6/2023, I conducted a telephone interview with Ms. St. James, who confirmed that on the evening of 01/03/2023, she was the assigned medication passer and was training Mr. Densmore when the incident occurred. Ms. St. James stated that prior to the incident occurring on 01/03/2023, Resident A wandered a lot in the facility that evening before they managed to help her back to her room and into bed.

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:	Based upon my investigation, which consisted of interviews of facility staff members and Resident A, as well as a review of relevant facility documentation, it has been established that on the evening of 1/3/2023 Resident A, who has a diagnosis of

	advanced dementia, wandered into Resident B's bedroom and was physically assaulted. As a result of this incident, Resident A sustained injuries and subsequently was hospitalized. However, there is not enough evidence to substantiate the allegation that Resident A was not supervised appropriately when the incident occurred.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

During my unannounced investigation on 02/09/2023, I reviewed Resident A's assessment plan. There was no documentation on Resident A's assessment plan indicating concerns about her wandering behavior and the methods of services and/or supervision to be provided to Resident A to address this behavior.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.** **(b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.** **(c) The resident appears to be compatible with other residents and members of the household.**
DEFINITIONS:	**"Assessment plan" means a written statement which is prepared in cooperation with a responsible agency or person and which identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical and behavioral needs and well-being and the methods of providing the care and services, taking into account the preferences and competency of the individual.**

ANALYSIS:	Based upon my investigation, which consisted of interviews of facility staff members and Resident A, as well as a review of relevant facility documentation, it has been established that Resident A had a diagnosis of advanced dementia, as well as a history of wandering. However, there was do documentation on Resident A's assessment plan indicating this, nor was there any documentation identifying specific services and/or supervision to address this behavior, as well as the methods of providing these services/supervision.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

After receiving an acceptable correction action plan, I recommend no change in the status of this license.

3/13/2023

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Candace Coburn Date
Licensing Consultant

Approved By:

03/14/2023

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Michele Streeter Date
Area Manager