GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 3, 2023

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

RE: License #: AL730398655
Investigation #: 2023A0580027
Close to Home Assisted Living Saginaw Side 1

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) 643-7960.

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 #:	AL730398655
Investigation #:	2023A0580027
Complaint Receipt Date:	03/13/2023
Investigation Initiation Date:	03/16/2023
Report Due Date:	05/12/2023
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 1
Facility Address:	2142 N Center. Saginaw, MI 48603
Facility Telephone #:	(989) 778-2575
Original Issuance Date:	03/31/2020
License Status:	REGULAR
Effective Date:	09/30/2022
Expiration Date:	09/29/2024
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED

	TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Pictures posted to Facebook depicted Resident A lying in bed with feces-stained blankets.	Yes

III. METHODOLOGY

03/13/2023	Special Investigation Intake 2023A0580027
03/13/2023	APS Referral This complaint was denied by APS for investigation.
03/16/2023	Special Investigation Initiated - On Site An unannounced onsite inspection was conducted.
03/16/2023	Contact - Face to Face Interviewed Resident A.
03/16/2023	Contact - Document Received Received assessment Plan for Resident A.
04/18/2023	Inspection Completed On-site An unannounced onsite was conducted. Resident A's room was observed.
05/02/2023	Contact - Telephone call made Follow-up call to Ms. Rinnert.
05/03/2023	Contact - Telephone call made Call to Ms. Heather Reinboldt, Saginaw Co. Public Guardian.
05/03/2023	Exit Conference An exit conference was held with the licensee designee, Mr. Winden.

ALLEGATION:

Pictures posted to Facebook depicted Resident A lying in bed with feces-stained blankets.

INVESTIGATION:

On 03/13/2023, I received a complaint from BCAL Online complaints. The complaint depicts a photo of a resident lying in bed with feces-stained blankets. The mattress appears to be on the floor. The resident's face is not able to be seen. This complaint was denied by APS for investigation.

On 03/16/2023, I conducted an unannounced onsite inspection at Close to Home Assisted Living, Side 1. Contact was made with the home manger, Ms. Stacey Rinnert. Ms. Rinnert identified the photo as Resident A, residing in room 11. She stated that a staff member just recently quit and decided to put old camera footage and photos on Facebook as a means of retaliation. She stated that the photos were taken some time in October in 2022. Ms. Rinnert reported that Resident A wears a colostomy bag. When it gets full, he likes to take the bag and sling it off, often causing a mess for staff to clean. On this occasion, she recalls that when staff went to check on Resident A, he was found with feces all over his blanket. Resident A is responsible for his own toileting.

On 03/16/2023, while onsite, I observed and interviewed Resident A while sitting in his wheelchair in his room. He was observed as dressed appropriately. His room, bed and bedding were all observed as being clean. He stated that sometimes staff are busy, and he has to wait a little time for help, however, he has no complaints.

On 03/16/2023, I received and reviewed the AFC assessment plan for Resident A. It indicates that Resident A does not require assistance with toileting. This assessment was signed and dated 05/19/2022 by the licensee and Resident A.

On 04/18/2023, an unannounced onsite inspection was conducted at Close to Home Assisted Living, Side 1. A follow-up observation of Resident A's room was made while onsite. The room, bed and bedding were all observed as being clean.

On 05/02/2023, I spoke with Ms. Rinnert for clarification. She stated that Resident A was placed in the facility by APS and was using a colostomy bag at the time of placement. Resident A has always been responsible to maintain his own bag. Resident A is represented by Saginaw Guardianship Services.

On 05/03/2023, I spoke with Ms. Heather Reinboldt, of Saginaw Co. Public Guardian Office. She shared that Resident A was removed from his home due to his living conditions, in which his home was found littered with feces throughout. The guardianship began on 05/23/2022. Each time she has visited with Resident A he and his room were clean and she had no concerns. To her knowledge, Resident A is unable

to handle cleaning himself properly. She adds that she was led to believe that staff assists Resident A with his colostomy bag. He should not be doing it himself.

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:	Pictures posted to Facebook depicted Resident A lying in bed with feces-stained blankets. Home manger, Ms. Stacey Rinnert reported that Resident A wears a colostomy bag. When it gets full, he likes to take the bag and sling it off, often causing a mess for staff to clean. Staff to check on Resident A, he was found with feces all over his blanket. Resident A is responsible for his own toileting. Resident A stated that sometimes staff are busy, and he has to wait a little time for help, however, he has no complaints. The AFC assessment plan for Resident A indicates that Resident A does not require assistance with toileting. This assessment was signed and dated 05/19/2022 by the licensee and Resident A. Resident A, his room, as well as his mattress, bed, and bedding were all observed as being clean at 2 separate unannounced onsite inspections. Ms. Heather Reinboldt, of Saginaw Co. Public Guardian Office. She stated each time she has visited with Resident A he and his room were clean and she had no concerns. To her knowledge, Resident A is unable to handle cleaning himself properly. She adds that she was led to believe that staff assists Resident A with his colostomy bag. He should not be doing it himself.

	Based on the observation of the photos posted to Facebook, a review of the AFC Assessment plan, interviews with Resident A, Ms. Rinnert, home manager, public guardian, Ms. Reinboldt, there is enough evidence to determine that Resident A is not being 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.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 05/03/2023, I conducted an exit conference with the licensee designee, Mr. John Winden. Mr. Winden was informed of the findings of this investigation.

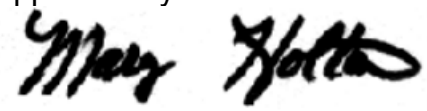
IV. RECOMMENDATION

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

May 3, 2023

Sabrina McGowan Date
Licensing Consultant

Approved By:



May 3, 2023

Mary E. Holton Date
Area Manager