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 #: AL730398657
Investigation #: 2023A0580029
Close to Home Assisted Living Saginaw Side 3

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 #:	AL730398657
Investigation #:	2023A0580029
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 3
Facility Address:	2168 N. Center Rd. Saginaw, MI 48603
Facility Telephone #:	(989) 401-3581
Original Issuance Date:	09/02/2020
License Status:	REGULAR
Effective Date:	03/02/2023
Expiration Date:	03/01/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED

	TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
A video posted to Facebook shows a staff fighting with a resident, slamming him to the floor.	Yes

III. METHODOLOGY

03/13/2023	Special Investigation Intake 2023A0580029
03/16/2023	Special Investigation Initiated - On Site An unannounced onsite inspection was conducted.
03/16/2023	Contact - Face to Face Interview with Resident A.
03/17/2023	Contact - Document Received Incident report and staff written statement reviewed.
03/24/2023	APS Referral Email from Ms. Katrice Humphrey of APS in Saginaw County.
05/01/2023	Contact - Document Sent An email was sent to Ms. Katrice Humphrey of APS.
05/01/2023	Contact - Telephone call made Call to Ms. Jocelyn Malone, of Huron County Public guardian's office.
05/03/2023	Exit Conference An exit was conducted with the licensee designee, Mr. John Winden.
05/03/2023	Contact - Telephone call made A call was made to former staff, Ms. Pam Shaw.
05/03/2023	Contact - Document Sent An email was sent to home manager, Ms. Rinnert.

ALLEGATION:

A video posted to Facebook shows a staff fighting with a resident, slamming him to the floor.

INVESTIGATION:

On 03/13/2023 I received a complaint via BCAL Online complaints. The complaint depicted of a video taken inside Close to Home Assisted Living, which showed a staff member tussling with resident, eventually slamming a resident to the floor. The video had no sound.

On 03/16/2023, I conducted an unannounced onsite inspection. Contact was made with the manager, Ms. Stacey Rinnert. She stated that the incident in which Resident A was slammed to the floor by staff, identified as Ms. Pam Shaw, occurred in October of 2022. She stated that an incident report was sent on 10/08/2022. She adds that once the cameras were reviewed the following day, she and the licensee, Mr. John Winden contacted Ms. Shaw by speaker phone to address the matter, to which she had no response. Ms. Shaw was terminated and did not return to the facility. Ms. Rinnert also adds that a staff member just recently quit and decided to put old camera footage and photos on Facebook as a means of retaliation.

On 03/16/2023, while onsite, I conducted an interview with Resident A while in his room. Upon showing him the video, he confirmed that it was in fact him in the video. He also confirmed that it happened several months ago. He recalled on the day in question, staff, Ms. Pam Shaw entered his room fussing and complaining as she always did. He left his room to avoid the encounter. She then came out and followed him. He asked her to get away from him, however, she continued and then slammed him to the floor. He stated that she got fired as a result and did not return to work at the facility.

Resident A was observed while lying in his bed in his room. He was clothed appropriately and appeared to be receiving adequate care and supervision.
Other residents were observed either in their rooms or in the dining area preparing for lunch. The residents appeared to be receiving adequate supervision and care.

On 03/17/2023, I reviewed the incident report dated 10/07/2022. The report indicates that staff, Ms. Arnell Henderson stated Resident A was using racial slurs. Ms. Henderson observed staff, Ms. Pam Shaw and Resident A in a verbal disagreement. Resident A walked towards Ms. Shaw with his fists balled. Resident A was restrained. As a result of that restraint, Resident A fell to the ground. Staff actions were to help Resident A off the floor and check him over. Corrective measures included Resident A being provide with a 30-day notice and staff was terminated.

Also accompanying the incident report was a written statement from Ms. Shaw, signed and dated 10/07/2022. It states, “Say I need to get the quotation mark out of his room and spitting as he was talking so staff tried to redirect him and he just kept yelling and

threatening staff, so staff left and let him calm down". "Resident A started using racial slurs, walked up on me and started being aggressive with me. I restrained him because he grabbed my face and tried kicking me".

On 03/24/2023, I received an email from Ms. Katrice Humphrey of APS in Saginaw County. She stated that the referral has been opened by APS.

On 05/01/2023, I spoke with Ms. Jocelyn Malone, of Huron County Public guardian's office. She stated that she was made aware of the allegations when the incident occurred. It is her understanding that the staff was fired. Although the facility initially provided Resident A with a 30-day notice, ultimately, he was allowed to stay at the facility where he remains. There are no other concerns at this time.

On 05/02/2023, I received a follow up email from Ms. Katrice Humphrey indicating that she substantiated the case for neglect.

On 05/03/2023, I placed a phone call the last known number provided for former staff, Ms. Pam Shaw. The number is no longer in service.

On 05/03/2023, I placed a follow-up email to Ms. Rinnert confirming that the number provided is the last known number provided for former staff.

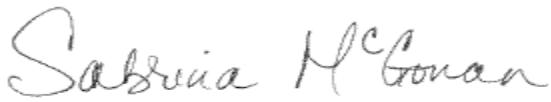
APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	It was alleged that a video posted to Facebook shows a staff fighting with a resident, slamming him to the floor. I observed a video, taken inside Close to Home Assisted Living, which showed a staff member, Ms. Pam Shaw tussling with Resident A, eventually slamming a resident to the floor. This video has no sound. Manager, Ms. Stacey Rinnert, stated that the incident occurred in October of 2022. Staff was identified as Ms. Pam Shaw. Ms. Shaw was terminated and did not return to the facility

	Resident A stated staff, Ms. Pam Shaw entered his room. He left his room to avoid the encounter. She then came out and followed him. He asked her to get away from him, however, she continued and then slammed him to the floor. I reviewed the incident report dated 10/07/2022. I reviewed Ms. Shaw's written statement from Ms. Shaw, signed and dated 10/07/2022. Public Guardian, Ms. Jocelyn Malone, of Huron County Public guardian's office, stated that she was made aware of the incident when it occurred. It is her understanding that the staff was fired. Resident A was allowed to stay at the facility where he remains. There are no other concerns at this time. Ms. Katrice Humphrey of APS in Saginaw County stated that she substantiated the case for neglect. Based on the video observed, the incident report and written statement from former staff, Ms. Pam Shaw, interviews with the manager, Ms. Rinnert, Resident A, and public guardian, Ms. Malone, there is enough evidence to support the rule violation that
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

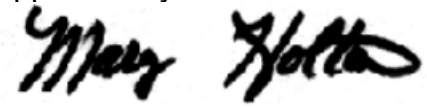
Upon the receipt of an approved corrective action plan, no change to the status of the license is recommended.



May 3, 2023

Sabrina McGowan — Date
Licensing Consultant

Approved By:



May 3, 2023

Mary E. Holton — Date
Area Manager