GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 21, 2023

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

RE: License #: AL780360984
Investigation #: 2023A0584028
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.

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 #:	2023A0584028
Complaint Receipt Date:	03/06/2023
Investigation Initiation Date:	03/06/2023
Report Due Date:	05/05/2023
Licensee Name:	The Lodge of Durand Memory Care, LLC
Licensee Address:	5720 Williams Lake Road Waterford, MI 48329
Licensee Telephone #:	(989) 288-6561
Administrator:	Catherine Reese
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 ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Due to not following safety protocols when providing Resident A with bathing assistance, Resident A had multiple falls in the facility spa.	Yes

III. METHODOLOGY

03/06/2023	Special Investigation Intake 2023A0584028. Special Investigation Initiated – Letter to Jeri Birchmeier, administrator.
04/13/2023	Contact - Face to Face Interviews with Resident A, direct care staff member Jessica Kerry, and administrator Jeri Birchmeier.
04/18/2023	Exit Conference via telephone with licensee designee Catherine Reese.

ALLEGATION:

Due to not following safety protocols when providing Resident A with bathing assistance, Resident A had multiple falls in the facility spa.

INVESTIGATION:

On 3/6/2023, the Bureau of Community and Health Systems (BCHS) received the above allegation via the BCHS online complaint system.

On 4/13/2023, I conducted an unannounced investigation at the facility and interviewed Resident A, facility staff member Jessica Kerry, and administrator Jeri Birchmeier.

Resident A stated she is feeling well, has no complaints to report, and appeared well groomed.

Ms. Kerry stated that on 3/3/2023, she and facility staff member Kathy McCarell helped Resident A shower in her bedroom and not in the facility's spa room. Ms. Kerry stated when she was assisting Resident A with sitting in the shower chair, Resident A missed the seat and slowly "slipped down" and sat on the floor. Ms. Kerry stated she and Ms. McCarell were able to help Resident A back into the shower chair. Ms. Kerry stated that upon assessment, there were no injuries

observed on Resident A, nor did Resident A report any injuries. According to Ms. Kerry she did not work at the facility on two prior occasions when Resident A slipped in the spa room and fell.

Ms. Birchmeier stated that according to three internal incident reports, Resident A fell at the facility, specifically in the spa, on 1/27/2023, 2/27/2023, and in her own shower on 3/3/2023. Ms. Birchmeier stated facility staff members Kelly McCarell and Jessica Reume were present during the 1/27/2023 and 2/272/2023 incidents and have been terminated for unrelated reasons. Ms. Birchmeier provided me with a document, dated 3/15/2023, that was signed by all current facility staff members, confirming they received training on how to properly secure the spa tub chair to prevent unnecessary resident injuries.

According to documentation on two facility incident reports dated 1/27/2023 and 2/27/2023, following her falls in the facility spa, Resident A was assessed to have normal vitals and no injuries. Documentation on the IRs confirmed Resident A's falls on 1/27/2023 and 2/27/2023 occurred due to staff not properly securing the spa tub chair.

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 an interview with Resident A, and multiple facility staff members, as well as a review of documentation related to the allegation, it has been established that due to not following safety protocols when providing Resident A with bathing assistance, Resident A had multiple falls in the facility spa.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 4/18/2023, I contacted licensee designee Catherine Reese via telephone and shared with her the findings of this investigation.

IV. RECOMMENDATION

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

4/21/2023

Candace Coburn — Date
Licensing Consultant

Approved By:

4/21/2023

Michele Streeter — Date
Area Manager