GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 4, 2023

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

RE: License #: AL780360984
Investigation #: 2024A0584001
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.
- 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) 284-9727.

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 #:	2024A0584001
Complaint Receipt Date:	10/04/2023
Investigation Initiation Date:	10/06/2023
Report Due Date:	12/03/2023
Licensee Name:	The Lodge of Durand Memory Care, LLC
Licensee Address:	5720 Williams Lake Road Waterford, MI 48329
Licensee Telephone #:	(989) 288-6561
Administrator:	Christine Marosi
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 8/7/2023, Staff did not properly lock a shower chair seat, which caused Resident A to slip off and to the floor.	No
Additional Findings	Yes

III. METHODOLOGY

10/04/2023	Special Investigation Intake 2024A0584001.
10/06/2023	Special Investigation Initiated – Telephone interview with the complainant.
10/19/2023	Inspection Completed On-site. Face to face interviews with Resident A, Kelli St. James, Jenna Beaird, and Rebecca Lucht, and administrator Christine Marosi.
11/02/2023	Contact - Telephone interview with Jessica Kerry, direct care staff.
11/07/2023	Contact - Telephone interview with Kristen Wouda, direct care staff.
11/28/2023	Exit conference with Catherine Reese, licensee designee.

ALLEGATION:

On 8/7/2023, Staff did not properly lock a shower chair seat which caused Resident A to slip off and to the floor.

INVESTIGATION:

On 10/4/2023, the Bureau of Community and Health Systems received the above allegation via the online complaint system.

On 10/06/2023, I conducted a telephone interview with Complainant who confirmed the allegation.

On 10/19/2023, I conducted an unannounced investigation onsite, and interviewed direct care staff members Kelli St. James, Jenna Beaird, and Rebecca Lucht, who all stated they were not aware of the allegation.

I interviewed administrator Christine Marosi. Ms. Marosi provided me with Resident A's *Assessment Plan for AFC Residents (assessment plan)* and the *AFC Division Incident/Accident Report* (IR) regarding Resident A slipping off the bath chair.

Documentation under "Bathing" on Resident A's assessment plan, updated on 10/19/2023, indicated "*Shower – Standby Assist*: *Intervention: Care managers to provide standby assistance with resident's showering/bathing needs for the duration of the task".*

Documentation on the IR, written by direct care staff member Jessica Kerry, regarding Resident A slipping off the bath chair, read:

"On 8-7-2023, [Resident A] was located in the spa room, after getting her shower mp (sic) observed her drying herself off. [Resident A] then started to get some momentum to get out of the shower chair and as she sat forward, the shower chair came unlatched and slid backwards. This resulted in [Resident A] falling straight to the ground. Range of motion checked, and full set of vitals were taken all within normal range. No injury and resident [A] stated no pain. Family and on call notified, fall huddle faxed to VAAA."

"Corrective Measures Taken. Educated staff on Spa bath, making sure shower chair is complete latched before resident tries to get up. Having two people assist to get out of shower chair".

I conducted an interview with Resident A. Resident A stated that she feels safe at the facility and has not had any injuries while at the facility. Resident A stated she does not have any concerns about the bath spa and prefers to bathe using the spa. Resident A had no information regarding the allegation.

On 11/2/2023, I conducted a telephone interview with direct care staff Kristen Wouda. Ms. Wouda stated she was completing case notes on 8/7/2023 when she heard her coworker Jessica Kerry call from the spa room. According to Ms. Wouda, Ms. Kerry needed assistance getting Resident A up off the floor. Ms. Wouda stated that she observed Resident A sitting on the floor and Ms. Kerry asking Resident A about any pains or injuries. Ms. Wouda stated she and Ms. Kerry helped Resident A to a standing position and continued to assess for any other signs of injury where none were found. Ms. Wouda stated she did not observe the chair prior to the incident, however confirmed she has been trained to understand how to properly use the spa equipment.

On 11/7/2023, I conducted a telephone interview with Ms. Kerry, who stated that on 8/7/2023 when Resident A was done with the bath and while sitting on the bath chair, rocked back and forth to cause the chair to become unclipped from the base. According to Ms. Kerry, at the same time, Resident A attempted to stand up. Ms. Kerry heard the chair come unclipped, saw Resident A begin to slip off the seat. Ms. Kerry stated she could only guide Resident A to sit on her bottom on the floor until

Ms. Wouda could assist Ms. Kerry in getting Resident A to a standing position. Ms. Kerry stated the spa chair was connected correctly and the chair became unclipped due to the rocking motion from Resident A. Ms. Kerry stated she has been previously trained on the use of the spa chair and confirmed it was properly secured before the incident occurred.

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 with Resident A and several facility staff members, it has been established that on 08/07/2023, Resident A slipped off a bath chair and onto the floor. However, there is not enough evidence to substantiate the allegation that Resident A fell because facility staff members failed to lock the bath chair.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 10/19/2023, I requested and reviewed the Resident Register, which indicated 11 residents reside at the facility.

I requested and reviewed the direct care staff schedule for the month of August 2023 and established each shift only had one direct care staff member responsible for the care and supervision of all 11 residents.

I requested and reviewed every resident's assessment plan.

Resident A's assessment plan documents she is not able to communicate needs, requires "total staff assistance" with eating, with toileting due to incontinence, with bathing, dressing, personal hygiene, and transferring via a Hoyer lift to Geri chair due to complete immobility.

Resident B's assessment plan documents she is not able to communicate needs "yes" needs staff assistance with eating, complete toileting due to incontinence, bathing, dressing, personal hygiene, transferring from wheelchair however assessments were incomplete with no explanation provided under each section.

Resident C's assessment plan documents she needs staff assistance with eating, with toileting due to incontinence, with bathing, dressing, personal hygiene and transferring due to dependency on wheelchair for ambulation.

Resident D's assessment plan documents he/she is unable to communicate needs, requires "total staff assistance" with eating, with toileting due to incontinence, bathing, dressing, personal hygiene, and transferring from wheelchair.

I requested and reviewed the facility's practice fire drill records. Documentation on the fire drill records indicated staff members evacuated all of the residents to the outside of the facility in 8 minutes. However, administrator Christine Marosi stated that for practice fire drills conducted during the facility's sleeping shift, a staff member from a separate but attached adult foster care facility, owned and operated by the licensee, assisted in the evacuation of residents to the outside of the facility.

During my interview with Ms. St. James, Ms. Beaird, and Ms. Lucht, they all confirmed one direct care staff member is scheduled to work on all three shifts. According to Ms. St. James, Ms. Beaird, and Ms. Lucht, an additional staff member, who is assigned the "medication passer", works at both the facility and the attached but separate facility, on all three shifts, and floats back and forth.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based upon my investigation, which consisted of interviews with direct care staff members, and the review of facility documentation pertinent to this investigation, it has been established one direct care staff member is scheduled to provide personal care and supervision to 11 residents on first, second, and third shift. The licensee also schedules an additional direct care staff member on all three shifts, who acts as a "medication passer", and "floats" between the facility and the separate but attached facility, also owned and operated by the licensee. This floating staff member cannot be counted in the facility's staffing ratio, as they cannot be in two places at the same time. Upon assessing the personal care and supervision needs indicated in each residents' assessment plan, it has been

	established one direct care staff member to 11 residents on all three shifts is not sufficient.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/28/2023, I conducted an exit conference via email with licensee designee Catherine Reese and shared the findings of this investigation.

IV. RECOMMENDATION

Upon receiving an acceptable corrective action plan, I recommend no changes in the status of this license.

11/30/2023

Candace Coburn — Date
Licensing Consultant

Approved By:

12/04/2023

Michele Streeter — Date
Area Manager