GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 22, 2024

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

RE: License #: AL780360984
Investigation #: 2024A0584019
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 #:	2024A0584019
Complaint Receipt Date:	02/26/2024
Investigation Initiation Date:	02/27/2024
Report Due Date:	04/26/2024
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 2/22/2024, breakfast food served did not match the menu items.	Yes
Resident A has injuries from unknown origin.	No
Additional Findings	Yes

III. METHODOLOGY

02/26/2024	Special Investigation Intake - 2024A0584019.
02/27/2024	Special Investigation Initiated – Telephone to complainant.
02/27/2024	APS Referral - Sent via email to Central Intake.
03/21/2024	Contact - Face to Face interview with Resident A, Relative A 1, direct care staff Jessica Kerry, Becky Lucht, and Resident Care Coordinator Breanna Young.
04/01/2024	Contact - Email sent to Christine Marosi, Administrator.
04/09/2024	Contact – Face to face interview with facility kitchen manager Angela Campbell at the facility.
4/16/2024	Exit conference with licensee designee Catherine Reese.

ALLEGATION:

- **On 2/22/2024, breakfast food served did not match the menu items.**
- **Resident A has injuries from unknown origin.**

INVESTIGATION:

On 2/26/2024, the Bureau of Community and Health Systems (BCHS) received the above allegations via the BCHS online complaint system.

On 3/21/2024, I conducted an unannounced investigation at the facility and interviewed Resident A, Relative A 1**,** and direct care staff members Jessica Kerry, Becky Lucht, and Breanna Young.

Resident A was unwilling or unable to answer my questions. I observed his exposed skin and body parts and did not see any injuries. Resident A did not appear to be experiencing any pain.

Relative A 1 stated she had no complaints with the care provided at the facility. Relative A 1 provided no information regarding the allegation Resident A has injuries.

Both Ms. Kerry and Ms. Lucht verified they worked the morning shift on 2/22/2024. Ms. Kerry stated breakfast consisted of yogurt, donuts, water, juice, coffee and tea. Ms. Lucht stated she did not recall the exact food served on that morning. Both Ms. Kerry and Ms. Lucht stated they had no knowledge of Resident A having any injuries.

Ms. Young stated Resident A has a pattern of wandering. As a result, on 1/17/2024, she increased Resident A safety checks from 30 minute intervals to 15 minute intervals. According to Ms. Young, on 2/28/2024, this was reduced to every hour. Ms. Young stated she had no knowledge of Resident A having any injuries.

I requested and reviewed Resident A's facility file, which included four recent *AFC Incident/Accident Report*s (IRs). Information on each IR is as summarized:

- 1/2/2024 - Resident A found on the floor in the 100 hall near a table. Resident A expressed left hip pain and sent to the hospital for evaluation. There were no other injuries noted. Corrective measures stated that resident wanders, redirect and assist to a chair. POA notified, Hospice notified.

- 1/15/2024 – Resident A observed on the floor in another resident's room and possibly hit his head. Vitals taken and all within normal range. POA notified and did not wish to have facility send him to hospital. Corrective measures stated to do frequent checks, monitor closely for wandering and to redirect from other resident rooms.

- 1/28/2024 – Resident A observed on his hands and knees in another resident's room. Resident A was checked 10 minutes prior and sitting in chair in the 100 hall. All vitals done and in normal range, normal range of motion, no pain. A skin tear was noticed near left elbow. Corrective measures state to monitor resident when wandering into other resident's rooms or other hallway Hospice, on call, and family notified.

- 2/13/2024 – Resident A observed on the ground on side of his bed. After evaluation, three new skin tears found on left elbow. Family, Hospice, and on call notified.

I reviewed a Physicians order form completed by Amara Hospice on 2/19/2024 documenting that Resident A tends to kneel down on the floor and has a history of falls.

On 4/9/2024, I conducted a face to face interview with kitchen manager Angela Campbell. Ms. Campbell stated she was working the morning of 2/22/2024. According to Ms. Campbell, both service staff scheduled to work in the facility called absent to work that morning, leaving nobody to serve the breakfast menu as written. Ms. Campbell stated that as a result, the residents received yogurt, donuts, and beverages. Ms. Campbell admitted to neglecting to update the menu with the substitutions for that meal.

I reviewed the 2/22/2024 breakfast menu item listed as served:

Pancakes
Eggs of choice
Sausage Patty
Maple Syrup
Margarine
Assorted Beverages

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.
ANALYSIS:	Based on interviews with direct care staff, and kitchen manager Angela Campbell, as well as review of the facility menu, there is enough evidence to substantiate the allegation that on 2/22/2024, breakfast food served did not match the menu items.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 on interviews with direct care staff, and Relative A 1, an observation of Resident A, as well as review of facility files, there is not enough evidence to substantiate the allegation Resident A has injuries from unknown origin.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 3/21/2024, I reviewed Resident A's *Assessment Plan for AFC Residents (assessment plan),* dated 8/17/2023. Documentation on Resident A's assessment plan did not include routine safety checks.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
DEFINITIONS:	**"Assessment plan" means a written statement that is prepared in cooperation with a responsible agency or individual that 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:	It has been established Resident A's current assessment plan was not updated to reflect his current care needs.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 4/16/2024, I conducted an exit conference with license designed Catherine Reese and informed her of the findings of this investigation.

IV. RECOMMENDATION

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

4/16/2024

Candace Coburn — Date
Licensing Consultant

Approved By:

4/22/2024

Michele Streeter — Date
Area Manager