GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 19, 2025

Michael Ross
Christian Care Assisted Living
1530 McLaughlin Avenue
Muskegon, MI 49442-4191

RE: License #: AH610236765
Investigation #: 2025A1010023
Christian Care Assisted Living

Dear Licensee:

Attached is the Special Investigation Report for the above-mentioned 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 authorized representative 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) 241-1970.

Sincerely,
Lauren Wohlfert

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa NW Unit 13 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS**
**BUREAU OF COMMUNITY AND HEALTH SYSTEMS**
**SPECIAL INVESTIGATION REPORT**

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AH610236765 |
| | |
| **Investigation #:** | 2025A1010023 |
| | |
| **Complaint Receipt Date:** | 01/07/2025 |
| | |
| **Investigation Initiation Date:** | 01/07/2025 |
| | |
| **Report Due Date:** | 03/06/2025 |
| | |
| **Licensee Name:** | Christian Care Inc. |
| | |
| **Licensee Address:** | 1530 McLaughlin Ave.<br>Muskegon, MI 49442 |
| | |
| **Licensee Telephone #:** | (231) 722-7165 |
| | |
| **Authorized Representative/ Administrator:** | Michael Ross |
| | |
| **Name of Facility:** | Christian Care Assisted Living |
| | |
| **Facility Address:** | 1530 McLaughlin Avenue<br>Muskegon, MI 49442-4191 |
| | |
| **Facility Telephone #:** | (231) 777-3494 |
| | |
| **Original Issuance Date:** | 01/01/2000 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 08/01/2024 |
| | |
| **Expiration Date:** | 07/31/2025 |
| | |
| **Capacity:** | 105 |
| | |
| **Program Type:** | AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| During third shift on 1/2/25 into 1/3/25, staff did not put Resident C's Cpap on her and did not properly transfer her. Resident C had injuries as a result and was observed in her own feces during the morning hours on 1/3/25. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 01/07/2025 | Special Investigation Intake<br>2025A1010023 |
| 01/07/2025 | Special Investigation Initiated - Letter<br>Emailed assigned Muskegon Co APS worker Brett Kortman |
| 01/09/2025 | Contact - Telephone call made<br>Left voicemail for Muskegon Co APS worker |
| 01/10/2025 | Contact - Telephone call received<br>Interviewed Muskegon Co. APS worker |
| 01/13/2025 | Inspection Completed On-site |
| 01/13/2025 | Contact - Document Received<br>Received incident report and resident service plan |
| 02/19/2025 | Exit Conference |

**ALLEGATION:**

**During third shift on 1/2/25 into 1/3/25, staff did not put Resident C's Cpap on her and did not properly transfer her. Resident C had injuries as a result and was observed in her own feces during the morning hours on 1/3/25.**

**INVESTIGATION:**

On 1/7/25, the Bureau received the complaint from Adult Protective Services (APS). The complaint read, "Overnight the evening on 1/2/2025-1/3/2025, Christian Care Assisted Living resident [Resident C] was without her required cpap all night leading to an unresponsive episode. Christian Care Assisted Living staff attempted to transfer patient out of her bed without proper supervision and safety technique. As a result, [Resident C] was lowered to the floor. Christian Care Assisted Living staff then transferred [Resident C] from the floor back to bed using a sheet. During the

improper transfers, [Resident C] sustained 3 new wounds. In addition, she was found covered in her own feces in the morning on 1/3/2025."

On 1/7/25, I emailed assigned Muskegon County APS worker Brett Kortman.

On 1/10/25, I interviewed Mr. Kortman by telephone. Mr. Kortman reported Resident C was moved out of the facility because of this incident. Mr. Kortman stated the facility fired three third shift staff persons who did not put Resident C's cpap on her overnight and improperly transferred her causing injuries to her arm and leg. Mr. Kortman said he is notifying law enforcement of this incident.

On 1/31/25, I interviewed the facility's wellness director at the facility. The wellness director reported that on the morning of 1/3/25, Staff Person 1 (SP1) informed SP2 that she observed skin tears on Resident C and Resident C had labored breathing and was weak and non-responsive. The wellness director reported SP1 contacted hospice staff as Resident C was receiving hospice services. The wellness director said Resident C's hospice nurse did arrive at the facility approximately between 8:00 – 9:00 am. The wellness director stated Resident C was not sent to the hospital, however hospice staff did write a new order for morphine for Resident C. The wellness director reported Resident C moved out of the facility on 1/8/25.

The wellness director reported an internal investigation was completed regarding the incident. The wellness director stated that because of the incident, three of the third shift staff persons involved in the incident were terminated. The wellness director reported SP3, SP4, and SP5 responded and assisted Resident C in her room when she had an incontinence incident during third shift on 1/3/25. The wellness director stated SP3 and SP5 were interviewed regarding the incident.

The wellness director provided me with copies of SP3 and SP5's written interviews regarding the incident for my review. SP3's interview read, "RCA [SP4] was in the middle of med pass she was in the middle of having a B/M they assisted her to the toilet and she stated they must of caused the skin tears. When taking her to the bathroom she was having a B/M on the floor she left out the room she asked the RCA's of they needed help and was told they had it. She stated she did not know what happened. 8:50 AM [SP4] had to leave a message stated she had never gotten her up before and she stated she saw the skin tears and stated it was bleeding she cleaned it up she wouldn't stand up, she had a b/m everywhere, resident put call light on and soaked through bed stated she was weaker, feet kept slipping from under her, her leg could have hit the wheelchair, she stated she would have gotten these from the transfers, she stated the med tech was in the room when it happened. Stated she thought it was just a scratch and it was almost 6:00AM."

SP5's interview read, "Went in room to change her and was not sure if she was a 1/2 assist assisted in w/c to the bathroom, to the toilet refused to stand could not do by themselves with 2 person got help from med tech when asked about changing in bed or skin tears she replied she could not do that and the skin tear on skin could

have come from wheelchair in the transfer. She stated she was little and so was the other RCA that was assisting her, and this was not her floor."

The wellness director provided me with a copy of Resident C's *Alleged Resident Abuse Investigation Form* dated 1/3/25 for my review. The *Resident Injured* section of the form read Resident C was injured and the *If yes, describe* section of the form read, "multiple skin tears Right forearm, left lower leg, and gash between right toe, skin tears under both breasts." The *Did injuries require medical attention If yes, describe* section of the form read, "Hospice came in to evaluate resident and apply dressing to areas and Nystatin powder under breasts." The *Other immediate action taken* section of the form read, "New order was placed for Morphine every 6 hours and every 1 as needed for pain and S.O.B." The *Name of Person(s) accused of alleged abuse* section named SP3, SP4, and SP5.

The *Summary by person(s) reporting alleged incident* section of the report read, "when first shift started their rounds around 6:45 A.M. resident was observed in her bed soiled in Feces with a clean brief on her. A new skin tear on her right forearm and lower left leg. Also, her pinky toe on left foot was bleeding. RCA informed me that her 0'2 was not on as well. Resident was extremely lethargic. As well as not bearing any weight her 0'2 was 86. Clinical was notified and Hospice was called No reports of any new injuries relayed to first shift from third shift." The form read, "Resident was unable to verbally give a statement as to what happened.

The *Summary of investigator's findings* section of the report read, "In conclusion of this investigation it is determined that there were findings of abuse and the 3 parties involved will be terminated effective immediately." The *Corrective actions taken* section of the form read, "All responsible parties involved were suspended for 3 days pending investigation. Terminated effective 1/6/24 [sic]."

The wellness director provided me with copies of SP3, SP4, and SP5's *NOTICE OF EMPLOYEE REPRIMAND* documents dated 1/6/24 [sic] for my review. The notices reads SP3, SP4, and SP5 were terminated for "Alleged abuse/neglect" for "Failure to follow policies or procedures in the Company Handbook, additional written Company policies and procedures, and any federal, state or local law or regulation. Physical, verbal, or mental abuse or neglect of residents, visitors, families or co-workers. Failure to report an incident to supervisor or their designee within 24-hours (resident incident, work related injury or any other incident requiring immediate reporting to supervisor)."

The wellness director provided me with a copy of Resident C's service plan for my review. The *Health Monitoring* section of the plan read, "Care Coordination with Home Care Agency Hospice service through Gentiva. [Witness 1] N.P. for wound care for left forearm call for any questions or concerns. Monitor and/or assist with CPAP/BIPAP maintain cleanliness and changing tubing monthly filling machine water levels as needed. Oxygen Therapy: Check 02 levels per physician's order. Resident has services through Gentiva Hospice for any questions or concerns. Vitals

Monitoring: Full set of vitals monthly, per facility protocol." The *BATHROOM ASSISTANCE* section of the plan read, "Encourage resident to participate as much as possible to promote independence. The resident needs assistance from 1 staff member for toilet use. The resident uses adaptive assistive equipment: toilet seat riser to assist in toilet use."

On 1/13/25, I interviewed SP1 at the facility. SP1 reported that when she arrived for first shift on 1/3/25, SP6 approached her after SP6 was in Resident C's room. SP1 explained SP6 informed her she observed Resident C was "weak, lethargic, and unable to get up." SP1 said SP6 informed her Resident C's oxygen tubing was not "hooked up," therefore Resident C was not getting oxygen.

SP1 said SP6 asked her to assist her with Resident C in Resident C's room. SP1 reported as she approached Resident C's room, she could smell feces coming from inside, which was unusual for Resident C. SP1 reported Resident C normally uses her pendant to summon staff for assistance to use the bathroom when she must have a bowel movement. SP1 stated she observed Resident C in bed and she was not responding. SP1 reported she took Resident C's oxygen, and it was in the "low 70s" because of not having her oxygen on. SP1 said she did not know how long Resident C went without her required oxygen.

SP1 reported she and SP6 attempted to get Resident C up and out of bed so they could change her soiled brief and bedding. SP1 stated Resident C was too weak when they attempted to stand her up, as a result, SP1 and SP6 had to lower her to the floor. SP1 said while Resident C was on the floor, she observed new skin tears on her right arm, under her left knee, and her left pinky toe had a skin tear that was bleeding. SP1 explained these injuries occurred during third shift because they were not present when SP1 observed her during her shift on 1/2/25.

SP1 stated she and SP6 were able to get Resident C off the floor and back into her bed with the assistance of additional staff. SP1 reported she contacted hospice staff who arrived at approximately 8:30 am on 1/3/25 to assess Resident C and dress her wounds. SP1 said hospice staff ordered additional morphine for comfort measures for Resident C and it was administered as prescribed. SP1 reported she reported her observations and concerns regarding the condition Resident C was in to SP2.

On 1/13/25, I interviewed SP2 at the facility. SP2's statements were consistent with SP1 and the documents regarding the incident on 1/3/25 that I reviewed.

On 1/13/25, I interviewed SP7 at the facility. SP7's statements were consistent with SP1, SP2, and the documents regarding the incident on 1/3/25 that I reviewed.

On 1/13/25, I was unable to interview Resident C as she no longer resides at the facility.

| APPLICABLE RULE | |
|---|---|
| **R 325.1931** | **Employees; general provisions.** |
| | **(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.** |
| **ANALYSIS:** | The interviews with the wellness director, SP1, SP2, SP7, along with review of the internal investigation documents regarding Resident C's incident on 1/3/25, revealed Resident C was injured during third shift while being transferred in the bathroom by SP3, SP4, and SP5. Resident C also did not have her oxygen on when first shift staff arrived, as a result Resident C's oxygen level was in the low 70s when SP1 took her vitals. Resident C did not receive care consistent with her service plan, therefore the facility was not in compliance with this rule. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

I shared the findings of this report with the facility's licensee authorized representative on 2/19/2025.

## IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remains unchanged.

02/13/2025

Lauren Wohlfert Date
Licensing Staff

Approved By:

02/19/2025

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section