GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 22, 2021

Julie Norman
Farmington Hills Inn
30350 W. Twelve Mile Road
Farmington Hills, MI 48334

RE: License #: AH630236784
Investigation #: 2021A1027038
Farmington Hills Inn

Dear Ms. Norman:

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 by the licensee authorized representative and dated.

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.
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,
Jessica Rogers

Jessica Rogers, Licensing Staff
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 #:	AH630236784
Investigation #:	2021A1027038
Complaint Receipt Date:	06/25/2021
Investigation Initiation Date:	06/25/2021
Report Due Date:	08/25/2021
Licensee Name:	Alycekay Co.
Licensee Address:	30350 W 12 Mile Rd. Farmington Hills, MI 48334
Licensee Telephone #:	(248) 851-9640
Administrator/ Authorized Representative:	Julie Norman
Name of Facility:	Farmington Hills Inn
Facility Address:	30350 W. Twelve Mile Road Farmington Hills, MI 48334
Facility Telephone #:	(248) 851-9640
Original Issuance Date:	12/29/2000
License Status:	REGULAR
Effective Date:	10/10/2020
Expiration Date:	10/09/2021
Capacity:	137
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A had multiple falls and lacked protection.	Yes
Additional Findings	No

III. METHODOLOGY

06/25/2021	Special Investigation Intake 2021A1027038
06/25/2021	Special Investigation Initiated - Letter Email sent to J. Norman requesting documentation pertinent to investigation
06/25/2021	Contact - Document Received Received requested documentation from administrator J. Norman
07/13/2021	Contact - Document Sent Email sent to J. Norman to schedule telephone interview
07/13/2021	Contact - Telephone call made Voicemail left with complainant
07/16/2021	Contact - Document Sent Email sent to J. Norman to schedule telephone interview
07/20/2021	Contact - Telephone call received Telephone interview conducted with administrator and authorized representative J. Norman and facility nurse Erin Clark
07/20/2021	Contact - Telephone call made Left voicemail with resident caregiver and medication technician Debra Denson
07/20/2021	Contact - Telephone call received Telephone interview conducted with resident caregiver and medication technician Debra Denson
07/20/2021	Contact - Document Received Requested documentation received from J. Norman
07/23/2021	Exit Conference

	Conducted with facility authorized representative J. Norman

ALLEGATION:

Resident A had multiple falls and lacked protection.

INVESTIGATION:

On 6/25/21, the department received a complaint alleging the facility did not protect Resident A. The complaint alleged prior to admission to the facility on 6/4, facility nurse Erin was informed Resident A was a high fall risk. The complaint alleged the facility did not protect Resident A because she had two falls with injuries after admission to the facility on 6/6. The complaint alleged Resident A's first fall required her to be evaluated and treated at the hospital in which she returned to the facility the same day. The complaint alleged Resident A's second fall resulted in admission to hospital then subsequently transitioning to a rehabilitation facility.

On 7/20/21, I conducted a telephone interview with administrator and authorized representative Julie Norman along with facility nurse Erin Clark. Ms. Clark stated she assessed Resident A prior to admission to the facility by Zoom due to the COVID-19 pandemic. Ms. Clark stated family had expressed their concerns to her regarding Resident A transitioning to the facility. Ms. Clark stated she felt Resident A could be managed the facility but that she informed Resident A's family that there would be a transition period due to her dementia. Ms. Norman stated Resident A was supposed to transition to their sister facility once their memory care opened, so they were planning for her to stay a short time frame. Ms. Norman stated family stated Resident A could transfer without assistance and were not aware that she was that high of fall risk until they received notes from her physician. Ms. Norman stated Resident A's first fall occurred while staff were conducting their safety checks on the midnight shift when Resident A was observed on her apartment floor and appeared she attempted to use the bathroom. Ms. Norman stated Resident A's second fall occurred in the facility hallway in which she was sent to the hospital for evaluation and returned to the facility. Ms. Norman stated Resident A's third fall occurred when Resident A attempted to get out of her bed in which she was sent to the hospital and did not return to the facility. Ms. Norman stated the two caregivers caring for Resident A when the falls occurred were medication technician Debra Denson and facility caregiver Tracey Robertson, who is no longer employed with the facility.

On 7/20/21, I conducted a telephone interview with medication technician Debra Denson. Ms. Denson's statements were consistent with Ms. Norman and Ms. Clark. Ms. Denson stated Resident A was very unsteady on her feet. Ms. Denson stated Resident A was supposed to use a walker with ambulation but would forget to use it due to her dementia. Ms. Denson stated two falls occurred on her shift in which she

followed the facility's fall protocol by assessing the resident, obtaining vital signs, completed incident reports and calling the ambulance.

I reviewed Resident A's service plan. The plan read "Resident (A) needs one person assistance to transfer. Resident uses walker to ambulate. Physical assistance to go long distance or vacate the building." The plan read "Resident (A) has history of multiple falls. Resident can self-manage ambulation in room. Needs assistance to accompany resident when ambulating outside of own room." The plan read under safety concerns "fall risk." The plan read under general comments "Resident paces halls and is a fall risk."

I reviewed Resident A's progress notes. The first note on 6/6/21 at 4:26 am read during staff rounds Resident A was observed on the floor in her room with her brief pulled down attempting to use the bathroom, along with an open left arm abrasion. The second note on 6/6 (no time) read Resident A was observed on the floor in the hallway and it was unknow what happened. The note also read resident had large knot on her right hip and was sent to the hospital. The third note on 6/6 (no time) read Resident A got out of bed and fell to the floor face down, resulting in a knot on the right side of her head above her eye, then was sent to the hospital.

I reviewed the facility's transfer forms for Resident A which read consistent with statements from the complaint.

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.
For Reference: R 325.1901	**Definitions**
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision

ANALYSIS:	Interviews with facility staff along with review of facility documentation revealed Resident A was a high fall risk. Resident A had three falls on 6/6/21. The plan as developed lacked sufficient detail and methods for staff to implement and thus did not protect her from injury. For instance, Resident A clearly needed stand by assistance within her room as well as other areas of the facility as evidenced by her pattern of falls. However, staff followed a protection plan that outlined periodic monitoring verses line of site supervision. This plan was insufficient to prevent injury.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 7/23/21, I shared the findings of this report with authorized representative Julie Norman. Ms. Norman verbalized understanding of the findings.

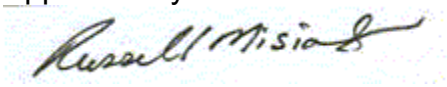
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

7/23/21

Jessica Rogers Date
Licensing Staff

Approved By:



7/23/21

Russell B. Misiak Date
Area Manager