GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 27, 2021

Rhonda Hendrickson
University Living
One Town Center Rd, Suite 310
Boca Raton, FL 33486

RE: License #: AH810401699
Investigation #: 2021A1019038
University Living

Dear Ms. Hendrickson:

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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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.

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 (248) 975-5053.

Sincerely,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH810401699
Investigation #:	2021A1019038
Complaint Receipt Date:	06/17/2021
Investigation Initiation Date:	06/18/2021
Report Due Date:	08/17/2021
Licensee Name:	Ann Arbor Senior Housing OPCO, LLC
Licensee Address:	Ste 310 One Town Center Rd Boca Raton, FL 33486
Administrator:	Josie Gentry
Authorized Representative:	Rhonda Hendrickson
Name of Facility:	University Living
Facility Address:	2865 S. Main Street Ann Arbor, MI 48103
Facility Telephone #:	(734) 665-2819
Original Issuance Date:	05/26/2021
License Status:	TEMPORARY
Effective Date:	05/26/2021
Expiration Date:	11/25/2021
Capacity:	90
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A is being abused by facility staff.	No
Additional Findings	Yes

III. METHODOLOGY

06/17/2021	Special Investigation Intake 2021A1019038
06/17/2021	Comment Complaint was forwarded to LARA from APS.
06/18/2021	Special Investigation Initiated - Letter Emailed APS worker for additional information.
06/22/2021	Contact - Telephone call received Call received from APS worker S. Smith
07/21/2021	Inspection Completed On-site
07/21/2021	Inspection Completed BCAL Sub. Compliance

ALLEGATION:

Resident A is being abused by facility staff.

INVESTIGATION:

On 6/17/21, the department received a complaint alleging abuse of Resident A. The complaint stated that on 6/15/21, bruising was observed on Resident A's hands and arms and that Resident A verbalized that he was attacked. The complaint alleged that there were other occurrences of Resident A making similar allegations against staff, and at one time provided the name "Zach" as a perpetrator. Due to the anonymous nature of the complaint, additional information cannot be obtained.
On 6/22/21, a telephone interview was had with Adult Protective Services worker Sam Smith. Ms. Smith reported that she went to the facility to observe and interview

Resident A promptly after being notified of the allegations on 6/15/21. Ms. Smith reported that she did not observe any bruising on Resident A's hands or arms. Ms. Smith stated that Resident A referenced that staff have attacked him but could not provide details of the events. Ms. Smith stated that she felt Resident A was an unreliable historian and had cognitive impairments that made his allegations unlikely.

On 7/21/21, I conducted an onsite inspection. I interviewed administrator Josey Gentry and director of nursing Shauntel Garland at the facility. Ms. Gentry and Ms. Garland stated that Resident A has resided at the facility for roughly eight years and moved into the memory care unit four years ago. Ms. Gentry and Ms. Garland stated that Resident A has dementia and suffers from hallucinations. Ms. Gentry and Ms. Garland stated that he is often combative and aggressive with care and is very particular on which staff he allows to assist him. Ms. Gentry and Ms. Garland stated that Resident A does not like any male staff to assist him and that they do their best to accommodate that preference. Ms. Gentry and Ms. Garland acknowledged that Resident A had made allegations against staff that they have determined to be unfounded. Ms. Gentry stated that Resident A has a legal guardian and denies that the guardian has ever approached her with concerns over potential physical abuse of Resident A; the guardian was most recently at the facility a few weeks ago. Ms. Gentry confirmed there is a staff member at the facility named Zach and stated that he does not work directly with Resident A but does occasionally work in the memory care unit.

While onsite, I interviewed care staff Zachary Barnes. Mr. Barnes stated that Resident A is extremely physically combative and described him having frequent hallucinations. Mr. Barnes stated that it is well known that Resident A does not like having male caregivers and stated that he has never been alone with Resident A when providing care to him. Mr. Barnes stated "It's been months since I've gone into his room." Mr. Barnes denied ever physically harming Resident A and stated he has never witnessed any other staff harm Resident A.

While onsite, I interviewed care staff Danielle Drummer who was working in the memory care unit with Resident A. Ms. Drummer stated that Resident A is combative with care, has bouts of confusion and is very particular which staff he wants to assist him. Ms. Drummer stated that Resident A had made allegations of physical abuse against several staff. Ms. Drummer stated "I don't want to discredit how he feels but he will tell me he was attacked during the night and then will name the person who did it and they haven't worked here in months. I think he really thinks these things happen, but I don't think it's possible." Ms. Drummer denied ever physically harming Resident A and stated she has never witnessed any other staff harm Resident A.

While onsite, I interviewed medication technician Leslie Reed who was working in the memory care unit with Resident A. Ms. Reed stated that Resident A is difficult to provide care for and that he refuses care with certain staff. Ms. Reed stated that she has heard Resident A had make allegations of abuse towards other staff members

but never provided detail in his allegations. Ms. Reed stated that she has no reason to suspect that any staff member has abused Resident A and stated that Resident A has memory issues than can impact his recall. Ms. Reed denied ever physically harming Resident A and stated she has never witnessed any other staff harm Resident A.

While onsite, I interviewed Resident A. Resident A was able to answer basic questions appropriately. Resident A made statements that he is frequently attacked by staff and stated “They always do it, they do it whenever they want and no one stops them”. Resident A identified staff members “Zach” and “Alex” as some of the perpetrators and stated that the attacks mostly happen at night. Resident A stated that people have come into his room through the window and have thrown him on the ground. Resident A stated that he has reported these issues “to the office” but cannot recall when or who he notified of his concerns.

Facility schedules were reviewed. Employee “Zach” worked in memory care twice for the timeframe reviewed, both during day shift and was reportedly not alone with Resident A. I was unable to locate an employee named “Alex” on the schedule as referenced by Resident A.

Guardianship documentation was reviewed which identified Resident A as disabled and “totally without understanding or capacity to make or communicate decisions regarding his/her person”.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(1) A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization, which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.
For Reference: MCL 20201	**(2) (l) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician for a specified and**

	limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician. In case of a chemical restraint, a physician shall be consulted within 24 hours after the commencement of the chemical restraint.
ANALYSIS:	Resident A has a diagnosis of dementia and has been deemed by a judge to be incapable of decision making. Interviews with multiple staff reveal that Resident A is combative, aggressive, suffers from hallucinations and has accused numerous staff of attacking and physically assaulting him. At this time, there is insufficient evidence to determine that the allegations are true.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Resident A's service plan dated 4/18/20 thoroughly outlined specific care instructions when working with Resident A. The document from 4/18/20 goes into great detail about each activity of daily living and how to provide care to Resident A. The document clearly outlines that female staff are preferred, and even necessary for certain tasks, describes combative behavior, frequent refusals of care and reads that at times he is difficult to redirect. The service plan also reads that Resident A has told staff and visitors that he is beaten up by staff and goes on to describe specific methods of redirection and guidance for staff when providing care to Resident A.

Resident A's most recent service plan dated 6/13/21 lacks the above detail that was included in his previous service plan and does not provide staff with adequate guidance on Resident A's care needs. Ms. Gentry and Ms. Garland stated that the information provided in the 4/18/20 service plan still holds true for Resident A and both acknowledged that the current care plan is not fully reflective of the care that Resident A needs or receives.

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.**
	(21) "Service plan" means a written statement prepared by the home in cooperation with a resident and/or the resident's authorized representative or agency responsible for a resident's placement, if any, and that identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical, social, and behavioral needs and well-being and the methods of providing the care and services while taking into account the preferences and competency of the resident.
ANALYSIS:	Resident A's most recent service plan lacked pertinent information specifying Resident A's preferences and behaviors.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 7/27/21, I shared the findings of this report with authorized representative Rhonda Hendrickson via email.

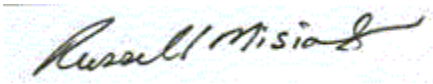
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no changes to the status of the license at this time.

7/26/21

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:



7/26/21

Russell B. Misiak Date
Area Manager