GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 23, 2022

Sheila Pruzinsky
Rose Senior Living - Clinton Township
44003 Partridge Creek Blv
Clinton Township, MI 48038

RE: License #: AH500337370
Investigation #: 2022A1019057
Rose Senior Living - Clinton Township

Dear Mrs. Pruzinsky:

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 (517) 284-9730.

Sincerely,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500337370
Investigation #:	2022A1019057
Complaint Receipt Date:	06/21/2022
Investigation Initiation Date:	06/22/2022
Report Due Date:	08/21/2022
Licensee Name:	Rose Senior Living - Clinton Township
Licensee Address:	PO Box 2011 38525 Woodward Avenue Bloomfield Hills, MI 48303-2011
Licensee Telephone #:	(651) 766-4371
Administrator and Authorized Representative:	Sheila Pruzinsky
Name of Facility:	Rose Senior Living - Clinton Township
Facility Address:	44003 Partridge Creek Blv Clinton Township, MI 48038
Facility Telephone #:	(586) 840-0840
Original Issuance Date:	10/01/2014
License Status:	REGULAR
Effective Date:	03/30/2022
Expiration Date:	03/29/2023
Capacity:	127
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility refused to allow Resident A to return after being hospitalized.	Yes
Additional Findings	No

III. METHODOLOGY

06/21/2022	Special Investigation Intake 2022A1019057
06/22/2022	Special Investigation Initiated - Telephone Called complainant to conduct interview, left voicemail requesting return phone call.
06/27/2022	Contact - Telephone call made Second call placed to complainant to conduct interview- message left requesting return phone call.
06/27/2022	Inspection Completed On-site
06/29/2022	Inspection Completed BCAL Sub. Compliance
06/29/2022	Contact- Document Received Additional documentation received from Employee B
06/29/2022	APS referral
06/29/2022	Comment SIR submitted to area manager for review.

ALLEGATION:

The facility refused to allow Resident A to return after being hospitalized.

INVESTIGATION:

On 6/21/22, the department received a complaint that read:

Complainant states she is dealing with a dumping situation where her loved one was in the facility for over 7 ½ years and recently had to go to the hospital. The complainant states when the hospital released the resident, the facility wouldn't accept her back and the residents family was not given any time to make arrangements for alternative placement.

On 6/27/22, I conducted an onsite inspection. I interviewed administrator and authorized representative Sheila Pruzinsky at the facility. Ms. Pruzinsky stated that Resident A was a longtime resident at the facility who had recently shown a decline in care. Ms. Pruzinksy stated that Resident A resides in memory care, was non verbal, required staff assistance with all activities of daily living and at times required three staff to assist with transferring. Ms. Pruzinksy stated that on 5/15/22, Resident A was being fed dinner by a staff member and had begun choking. Ms. Pruzinsky stated that EMS was contacted, and the resident was sent to the hospital.

Ms. Pruzinksy stated that conversations were had with Resident A's family prior to her hospitalization about her increased care needs but that the hospitalization only provided more support that the resident may no longer be appropriate to reside at the facility. Ms. Pruzinksy stated that while at the hospital, she and other facility staff attempted to discuss this with Resident A's family, however they refused to engage in those conversations and eventually stopped taking phone calls from facility staff entirely. Ms. Pruzinksy stated that she did not provide a discharge notice to Resident A or her family because she feels that she was not given the opportunity to.

While onsite, I interviewed Employee A. Employee A confirmed that she and Ms. Pruzinksy and Employee B had all had conversations with the resident's family with concerns over her increased care needs prior to her getting admitted to the hospital. Employee A stated that the family was upset and refused to speak to them while the resident was hospitalized. Employee A stated that she was hung up on when attempting to discuss her concerns. Employee A also stated that when Resident A's family came up to move her belongings out, she went to offer assistance and they slammed the door in her face.

Ms. Pruzinksy stated that while hospitalized, Employee B had the conversations pertaining to discharge with hospital staff along with Resident A's family, so she should be able to provide more detail. Employee B was not present during my onsite, but in follow up correspondence stated, in part:

[Resident A] was sent to hospital sun 5-15 aspiration pneumonia
I received a call from SW on Friday May 20th approx. 3:30 4pm stating they were discharging [Resident A] now
I explained to SW that we may not be able to back. We would need to re-assess can not [sic] send back today
SW called [Relative A] before I had a chance to call her and the SW told her we can't take her back

By the time I called [Relative A] that day she had already talked to the SW and was angry.
After discussing [Resident A's] condition with Shelia ED and [Employee A] it was decided to not bring her back
I then called [Relative A] and informed her of the decision.

Facility progress notes were reviewed. On 5/8/22, facility staff documented:

It was discussed on the phone during the care conference, [Resident A] is weight bearing less and getting heavier. If PT does not help [Resident A] getting stronger and help restore some weight bearing during transfers, a hoyer lift may be needed to safely transfer her. If that happened where a hoyer lift is necessary, a discussion will occur again to discuss further options.

On 5/15/22, facility staff documented "Resident was pocketing her food during feeding and coughing when drinking water, resident lethargic, not verbal not able to answer any of my question [sic]. POA notified and resident sent out to HFM [Henry Ford Macomb]."

Resident A's admission contract was reviewed. Regarding discharge or transfer of the resident by the community, the contract read "The community reserves the right to terminate this Agreement pursuant to the Transfer and Discharge Policy outlined in Appendix C." Appendix C of Resident A's admission contract outlined a policy that is consistent with home for the aged rules regarding resident discharges, for both a 30-day discharge and a less than 30-day discharge. Facility staff attested that a written discharge notice was never provided to Resident A or her family. Ms. Pruzinsky stated that she ended Resident A's contract on 5/21/22 after her belongings were all moved out and her keys were turned in.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(15) A home may discharge a resident before the 30-day notice if the home has determined and documented that either, or both, of the following exist: **(a) Substantial risk to the resident due to the inability of the home to meet the resident's needs or due to the inability of the home to assure the safety and well-being of the resident, other residents, visitors, or staff of the home.** **(b) A substantial risk or an occurrence of the destruction of property.** **(16) A home that proposes to discharge a resident for any of the reasons listed in subrule (15) of this rule shall take all of the following steps before discharging the resident:**

	(a) The home shall notify the resident, the resident's authorized representative, if any, and the agency responsible for the resident's placement, if any, not less than 24 hours before discharge. The notice shall be verbal and issued in writing. The notice of discharge shall include all of the following information: **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the home, if any.** **(iii) The location to which the resident will be discharged.** **(iv) The right of the resident to file a complaint with the department.** **(b) The department and adult protective services shall be notified not less than 24 hours before discharge in the event of either of the following:** **(i) A resident does not have an authorized representative or an agency responsible for the resident's placement.** **(ii) The resident does not have a subsequent placement.** **(c) The notice to the department and adult protective services shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the home, if any.** **(iii) The location to which the resident will be discharged, if known.** **(d) If the department finds that the resident was improperly discharged, then the resident may return to the first available bed in the home that can meet the resident's needs as identified in the resident's service plan.** **(e) The resident shall not be discharged until a subsequent setting that meets the resident's immediate needs is located.**
ANALYSIS:	Written notice was not provided as this rule requires and Resident A was not afforded the opportunity to come back to the facility from the hospital.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 8/23/22, I shared the findings of this report with authorized representative Sheila Pruzinsky.

IV. RECOMMENDATION

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

08/23/2022

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Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

08/23/2022

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