GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 12, 2022

Ginger Nahikian
Niche Aging Center Hampton LLC
581 Scheurmann Rd
Bay City, MI 48708

RE: License #:	AL090409334
Investigation #:	2022A0123047 Niche Aging Center Hampton

Dear Ms. Nahikian:

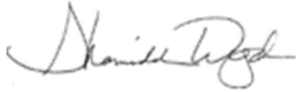
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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. 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) 643-7960.

Sincerely,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL090409334
Investigation #:	2022A0123047
Complaint Receipt Date:	07/22/2022
Investigation Initiation Date:	07/22/2022
Report Due Date:	09/20/2022
Licensee Name:	Niche Aging Center Hampton LLC
Licensee Address:	581 Scheurmann Rd Bay City, MI 48708
Licensee Telephone #:	(989) 737-2355
Administrator:	Ginger Nahikian
Licensee Designee:	Ginger Nahikian
Name of Facility:	Niche Aging Center Hampton
Facility Address:	581 Scheurmann Rd Bay City, MI 48708
Facility Telephone #:	(989) 737-2355
Original Issuance Date:	05/20/2022
License Status:	TEMPORARY
Effective Date:	05/20/2022
Expiration Date:	11/19/2022
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A currently has two fractures of the neck and bruised knees due to a recent fall. It is unknown how long after the fall that Resident A was transported to the hospital.	Yes
Resident A's purse came up missing, and she did not have any shoes on when transported to the hospital.	No
The facility provided little to no details to Resident A's family and did not provide an incident report.	Yes
Resident A was moved without having family sign any paperwork and without their permission.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/22/2022	Special Investigation Intake 2022A0123047
07/22/2022	APS Referral Information received regarding APS referral.
07/22/2022	Special Investigation Initiated - Telephone I spoke with Complainant 1 via phone.
07/27/2022	Contact - Telephone call made I spoke with licensee designee Ginger Nahikian via phone.
07/27/2022	Inspection Completed On-site I conducted an on-site visit at the facility.
07/27/2022	Contact- Document Received I received a written statement from staff Jordan Ancel via email.
08/17/2022	Contact - Document Received Documentation received via email from Complainant 1.
08/29/2022	Contact- Document Sent I sent an email requesting additional information from the facility.

08/29/2022	Contact- Document Received Requested information received via email.
08/30/2022	Contact- Telephone call made I spoke with Resident A’s former A & D Waiver case manager.
09/01/2022	Contact- Telephone call made I left a voicemail message requesting a return call from Careline, Resident A’s health care provider.
09/01/2022	Contact- Telephone call made I spoke with Relative 1 via phone.
09/01/2022	Contact- Telephone call made I made a call to Ashley Family Care Center, Resident A’s current placement.
09/01/2022	Contact- Document Sent I sent an email requesting a copy of the 06/29/2022 incident report.
09/01/2022	Contact- Document Received I received a copy of the requested incident report.
09/12/2022	Exit Conference I spoke with licensee designee Ginger Nahikian via phone.

ALLEGATION: Resident A currently has two fractures of the neck and bruised knees due to a recent fall. It is unknown how long after the fall that Resident A was transported to the hospital.

INVESTIGATION: On 07/22/2022, I spoke with Complainant 1 via phone. Complainant 1 stated that Resident A currently has an old fracture, and a new fracture, and the hospital placed Resident A in a nursing home. Complainant 1 stated that Resident A does not currently have a guardian or DPOA (Durable Power of Attorney). When asked if Resident A was a fall risk prior to this alleged incident, Complainant 1 stated that Resident A was falling, but not like lately, and that Resident A was on a lot of medications (too many downers). Complainant 1 reported being unsure when the fall happened, but thinks it occurred between June 26th and June 30th. Resident A was transported to McClaren Bay Region, and the hospital told her that her neck was broken. The facility’s staff were not with Resident A at the time Relative 1 arrived at the hospital. Resident A was admitted to the hospital on July 2, 2022. Complaint 1 stated that staff at the facility reported that Resident A was sitting in a chair in front of them, it is unknown if staff could have prevented the fall, and staff did not take Resident A to the hospital right away.

On 07/27/2022, I made a call to licensee designee Ginger Nahikian upon arriving to the parking lot of the facility. Mrs. Nahikian stated that she was not currently at the facility. She stated that Resident A’s fall occurred at another facility owned by Mrs. Nahikian on 06/29/2022 at 11:30 pm. She stated that Resident A was not sent to the hospital as Resident A was not complaining of any pain at the time of the fall. She stated that Resident A was moved back to Niche Aging Center Hampton the following day. She stated that a body assessment was completed on 06/29/2022, and Resident A was complaining that she wanted to go home. Mrs. Nahikian stated that she did not see Resident A hit her neck at all, and there was only a rug burn on her head. She stated that she does not know how, or where the fracture happened. She stated that staff Caitlyn Lyddy sent Resident A to the hospital (on 07/02/2022), and that Relative 1 wanted Resident A transported in a private vehicle because she did not want to be charged an ambulance fee. During this call, I also spoke with Jordan Ancel, Mrs. Nahikian’s assistant. Mr. Ancel stated that he informed Relative 1 the next day (after the night of the fall on 06/29/22) at 8:00 am that Resident A had a mark on her forehead and Relative 1 agreed to move Resident A back to Niche Aging Center Hampton. The following day, Resident A was in pain and screaming, and Relative 1 appeared irritated that they were considering sending Resident A into the hospital due to her behaviors. He stated that Relative 1 appeared irritated that they sent Resident A to the hospital (on 07/02/2022). He stated that in that situation, he did not think it was appropriate to listen to Relative 1 and seek permission to send Resident A to the hospital.

On 07/27/2022, I requested Mr. Ancel provide me with a written statement. I received an emailed statement from Mr. Ancel. He stated that on 06/30/2022 he called Relative 1 to inform her that he was thinking about sending Resident A to the hospital due to an unwitnessed fall with a mark on her head the night before. He stated that Relative 1 was adamant to not send Resident A in because of the cost of an ambulance. He then stated that on 07/02/2022, when staff Caitlyn Lyddy sent Resident A to the hospital, Resident A mentioned neck pain, so Staff Lyddy informed the licensee designee Mrs. Nahikian, and they kept an eye on the pain. Later in the shift, Resident A had 10/10 pain, and Staff Lyddy sent Resident A in. Mr. Ancel stated that Relative 1 was upset that the 911 call was made to transport Resident A to the hospital.

On 07/27/2022, I interviewed staff Caitlyn Lyddy at the facility. She stated that she is not sure what exactly happened regarding Resident A’s fall. She stated that the day she sent Resident A out to the hospital, it was on first shift. She stated that when she woke Resident A up that morning, Resident A kind of complained about neck pain. Resident A had breakfast and was up walking and sitting around the facility. She stated that the pain gradually got bad, so she applied some pain cream, but Resident A did not like the cream. She stated that about an hour later, Resident A was screaming in pain, so she called 911 and had Resident A sent out. She stated

that MedStar transported Resident A to McClaren Bay Region. She stated that Resident A was not transported in a private car.

An *AFC Licensing Division- Incident/Accident Report* dated 06/29/2022, states that *"Wednesday June 29th at 11:30 pm [Resident A] was experiencing high anxiety about going home & began biting, scratching, hitting staff member Jaylen. Jaylen left [Resident A] to assist another resident trying to get out of bed. When staff member came back, [Resident A] was on her knees with a mark on her head. Staff member Jaylen contacted Jordan Ancel and Ginger Nahikian to evaluate [Resident A]. [Resident A] wasn't complaining of pain and seemed unharmed. Following afternoon Resident began complaining of neck pain."*

An *AFC Licensing Division- Incident/Accident Report* dated for 07/02/2022, states that Resident A "*acknowledged to staff that she was having pain in her neck and back*." Staff called an ambulance, notified the house manager, and Relative 1. Resident A was transported to Bay Regional Medical Center. The incident report notes that Careline Health Group, A&D Waiver, Relative 1, and Mrs. Nahikian were notified.

On 08/17/2022, I received a copy of Resident A's *McLaren Bay Region History and Physical Reports.* It states that "*patient coming from nursing home for fall x3 days ago patient was sent in for neck pain, denies thinners, no LOC. No bruising or obvious deformity*." The report further states that "*patient began complaining of neck pain earlier today. At that time patient's nursing care facility contacted EMS for transportation to the hospital. According to the daughter the patient has been falling at her nursing facility. Her daughter reports that patient was recently moved to a new facility however, at the new facility she was having agitation and becoming combative, so she was then moved back to her old facility. The daughter states that she believes the patient fell at the new facility approximately 2 to 3 days ago. However, the emergency department provider did discuss with the patient's care facility, and they stated that the patient fell in a different building prior to being received at their new facility*." The documentation further states that Resident A has dementia and was unable to recall any falls. It is noted that Resident A has an "*acute fracture of lower portion of odontoid, with mild fragment separation. There is acute fracture of posterior arch of C1 on left, without significant fragment separation*."

On 08/29/2022, I received a copy of Resident A's *Assessment Plan for AFC Residents* dated 05/01/2022. The assessment plan indicates that Resident A can move independently in the community on her own but needs assistance with walking/mobility due to being unsteady at times. It does not indicate the use of an assistive device.

On 08/30/2022, I spoke with A & D Waiver case manager Tom Kubiak via phone. Mr. Kubiak stated that Resident A is no longer receiving waiver services and is in a nursing home. He stated that he thinks Resident A had a fall, and right after the fall she was not complaining of any pain when staff checked her over. Resident A was moved back to Niche Aging Center Hampton after the fall, and that is where she started to complain of pain. He stated that the thought was moving her to a smaller facility would be a good fit, but it was not, that is why she moved back to Niche Aging Center Hampton. Mr. Kubiak stated that he does not recall Resident A having any falls at Niche Aging Center Hampton when she moved back after having the fall at the smaller facility. He stated that he does not think the staff tried to cover up anything, and it sounded to him like the pain Resident A experienced did not come until later. When asked if he knew whether or not Resident A was transported in a private car to the hospital on 07/02/2022, he stated that it does not say so in his notes.

On 09/01/2022, I spoke with Relative 1 via phone. Relative 1 stated that Resident A is verbal and currently resides at Ashley Home Care Center in memory care. Resident A does not remember having a broken neck and changes her story every time. Relative 1 stated that they were told Resident A's neck will never heal, and they cannot do surgery. Relative 1 stated that there were no previous neck injuries they were aware of, but they were informed by a doctor that there was evidence of a previous fractured vertebrae.

On 09/01/2022, I spoke with Shelly Spitzley, LPN from Ashley Home Care Center where Resident A currently resides. She stated that upon admission, Resident A was pleasant but confused, and had bruising on her left elbow. She stated that Resident A was admitted to their facility from the hospital, and there did not appear to be any issues brought to their attention regarding the previous placement. When asked if in her medical opinion if it is possible for an individual to experience a delayed pain reaction to a fracture in the neck, she stated that it is possible. She stated that behavior can be displayed as agitation, if a patient does not realize they are in pain. She stated signs would include a change in their normal disposition because dementia can limit how a patient experiences pain. She stated that for Resident A specifically, it is hard to say because her prior level (of care) beforehand is unknown. She stated that Resident A does not recognize safety, and tries to do things independently, needs assistance, but she does not realize that she is a fall risk.

On 09/01/2022, I made two separate unsuccessful attempts to interview Resident A by phone. After my interview with Ms. Spitzley, I was informed that Resident A was asleep. A second attempt was made later in the day, there was no answer after being transferred to her area. A call back was attempted, and there was no answer.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	An incident report dated for 06/29/2022 states that Resident A had a fall, and the following morning began complaining of neck pain. Mr. Ancel reported in writing that he contemplated sending Resident A into the hospital on 06/30/2022 due to an unwitnessed fall on 06/29/2022 but did not. An incident report dated 07/02/2022 states that Resident A was sent to the emergency room due to excruciating neck pain. A copy of Resident A's hospital records was reviewed and confirmed that Resident A had a fractured neck. There is a preponderance of evidence to substantiate a rule violation in regard to the facility failing to get immediate care regarding Resident A's neck pain.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A's purse came up missing, and she did not have any shoes on when transported to the hospital.

INVESTIGATION: On 07/22/2022, I spoke with Complainant 1 via phone. Complainant 1 stated that Resident A's purse and six pair of shoes are missing.

On 07/27/2022, I made a call to licensee designee Ginger Nahikian upon arriving to the parking lot of the facility. Mr. Jordan Ancel was on the call as well. Mr. Ancel stated that when they took over the facility from the previous owners, there was no list of valuables provided to them, and no purse of Resident A's was found. On 09/01/2022, Mr. Ancel clarified via email that no inventory of valuable's was completed for Resident A.

On 07/27/2022, I interviewed staff Caitlyn Liddy at the facility. She stated that when Resident A went with the EMT's she was wearing either shoes or slippers because Resident had not gotten dressed yet. She stated that she did not let Resident A walk around without shoes on due to Resident A being a fall risk. She stated that Resident A did have a purse, but Resident A moved and all of Resident A's belongings have been moved as well.

On 08/30/2022, I spoke with Resident A's former A&D Waiver case manager Tom Kubiak via phone. He stated that he was not aware of Resident A having any missing personal items.

On 09/12/2022, I spoke with Relative 1 via phone. Relative 1 stated that she does not recall the current or previous owners of the facility completing an inventory of valuables for Resident A.

APPLICABLE RULE	
R400.15315	**Handling of resident funds and valuables.**
	(4) A listing of all valuables that are accepted by the licensee for safekeeping shall be maintained. The listing of valuables shall include a written description of the items, the date received by the licensee, and the date returned to the resident or his or her designated representative. This listing of valuables shall be signed at the time of receipt by the licensee and the resident or his or her designated representative. Upon return of the valuables to the resident or his or her designated representative, the listing shall be signed by the resident or his or her designated representative and the licensee.
ANALYSIS:	Complaint 1 reported that Resident A has a missing purse and shoes. Mr. Ancel reported that there was no list of valuables documented for Resident A prior to them taking over ownership of the facility, and there was no list of valuables documented for safekeeping for Resident A. Relative 1 did not recall the facility completing an inventory list for Resident A's valuables. Staff Liddy reported that Resident A was wearing a pair of shoes or slippers at the time of being transported to the hospital. Mr. Kubiak denied having knowledge of Resident A having any missing valuables. There is no preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The facility provided little to no details to Resident A's family and did not provide an incident report.

INVESTIGATION: On 07/22/2022, I spoke with Complainant 1 via phone. Complainant 1 stated that the facility has not provided Resident A's family with any incident reports. Complainant 1 stated that Resident A does not currently have a guardian or DPOA.

On 07/27/2022, I made a call to licensee designee Ginger Nahikian upon arriving to the parking lot of the facility. Mr. Jordan Ancel was on the call as well. Mr. Ancel stated that he was not sure if the incident report was okay to be sent to Relative 1.

On 08/30/2022, I spoke with Resident A's former A&D Waiver case manager Tom Kubiak who stated that Relative 1 was listed in their records as Resident A's active patient advocate.

An *AFC Licensing Division- Incident/Accident Report* dated 06/29/2022, regarding Resident A having a fall, only lists that the licensee designee Ginger Nahikian was notified.

An *AFC Licensing Division- Incident/Accident Report* dated for 07/02/2022, regarding Resident A being sent to the hospital for neck pain notes that Careline Health Group, A&D Waiver, Relative 1, and Mrs. Nahikian were notified.

On 08/29/2022, I received a copy of Resident A's Assessment Plan for AFC Residents dated 05/01/2022. There is no designated person signature on the assessment plan that would indicate who Resident A's designated person is, however, Relative 1 is noted as the individual who handles Resident A's money on page 1 of the assessment plan.

On 09/01/2022, Mr. Ancel wrote via email that they had plans for Relative 1 to come in and sign paperwork for Relative 1, but Relative 1 had no ride to the facility. He stated that they had no paperwork filled out by Relative 1.

On 09/12/2022, I spoke with Relative 1 via phone. Relative 1 stated that she asked for a copy of the incident report about four or five times. She stated that she has always acted in the capacity of a designated person for Resident A, and the facility treated her as one.

APPLICABLE RULE	
R400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated

	representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(b) Any accident or illness that requires hospitalization.**
ANALYSIS:	On 07/02/2022, the facility documented Relative 1 as the designated person who was contacted when Resident A was sent via ambulance to the hospital. Complainant 1 reported that the facility did not provide Relative 1 with a copy of the incident report. Relative 1 stated that she asked for a copy of the incident report multiple times. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A was moved without having family sign any paperwork and without their permission.

INVESTIGATION: On 07/22/2022, I spoke with Complainant 1 via phone. Complainant 1 stated that Relative 1 gave a verbal okay to move Resident A but did not sign any paperwork.

On 07/27/2022, I spoke with licensee designee Ginger Nahikian and her assistance Jordan Ancel via phone. Mr. Ancel stated that Relative 1 agreed to take Resident A back to Niche Aging Center Hampton.

On 07/27/2022, I interviewed staff Caitlyn Liddy at the facility. She stated that Resident A was moved to a smaller facility because everyone thought it would be a better fit, but she is not sure what happened exactly, but that Resident A was moved back to this facility.

On 08/30/2022, I spoke with Resident A's former A&D Waiver case manager Tom Kubiak who stated that they thought the smaller facility would be a better fit, but it was not, and Resident A was moved back to this facility.

On 09/01/2022, I emailed Mr. Ancel asking if there was anything in writing that gave the okay for Resident A to move between facilities. He stated that there was nothing in writing about Resident A's move.

On 09/12/2022, I spoke with Relative 1 via phone. Relative 1 stated that she was not told the approval was needed in writing, and that she did not want Resident A to be relocated at first because the other facility was further away. Relative 1 stated that

Resident A was moved back and forth really quickly. She stated that Mr. Kubiak did not reach out to her regarding the move.

APPLICABLE RULE	
R400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(6) A licensee shall not change the residency of a resident from one home to another without the written approval of the resident or the resident's designated representative and responsible agency.
ANALYSIS:	Complainant 1 reported that Relative 1 only gave a verbal okay to move Resident A. Relative 1 stated that she was not told the approval was needed in writing. Mr. Ancel reported that there was nothing in writing approval Resident A's move from one home to another. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 08/29/2022, I received a copy of Resident A's Assessment Plan for AFC Residents dated 05/01/2022. There is no designated person signature on the assessment plan, and there is no signature for Resident A or the responsible agency. The only signature noted is licensee designee Ginger Nahikian's.

On 09/12/2022, I spoke with Relative 1 via phone. She stated that she did not sign any paperwork for Resident A, and the facility did not reach out.

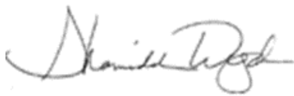
APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's assessment plan on file in

	the home.
ANALYSIS:	Resident A's assessment plan completed on 05/01/2022 and dated for 05/16/2022 did not include all applicable signatures. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 09/12/2022, I conducted an exit conference with licensee designee Ginger Nahikian via phone. I informed her of the findings and conclusions.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend continuation of this AFC large group home license (capacity 20).



09/12/2022

Shamidah Wyden Date
Licensing Consultant

Approved By:

09/12/2022

Mary E. Holton Date
Area Manager