GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 15, 2022

Megan Rheingans
Brighton Manor LLC
7560 River Road
Flushing, MI 48433

RE: License #:	AH470387116
Investigation #:	2022A1021062
	Brighton Manor

Dear Ms. Rheingans:

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.
- 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) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH470387116
Investigation #:	2022A1021062
Complaint Receipt Date:	09/16/2022
Investigation Initiation Date:	09/16/2022
Report Due Date:	11/16/2022
Licensee Name:	Brighton Manor LLC
Licensee Address:	7560 River Road Flushing, MI 48433
Licensee Telephone #:	(989) 971-9610
Administrator:	Michael Farrell
Authorized Representative:	Megan Rheingans
Name of Facility:	Brighton Manor
Facility Address:	1320 Rickett Road Brighton, MI 48116
Facility Telephone #:	(810) 247-8442
Original Issuance Date:	03/27/2019
License Status:	REGULAR
Effective Date:	09/27/2021
Expiration Date:	09/26/2022
Capacity:	93
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A treated disrespectfully.	No
Call lights are not answered.	Yes
Additional Findings	Yes

III. METHODOLOGY

09/16/2022	Special Investigation Intake 2022A1021062
09/16/2022	Special Investigation Initiated - Letter Referral sent to APS
09/21/2022	Inspection Completed On-site
09/22/2022	Contact-telephone call made Interviewed SP2
09/23/2022	Contact-telephone call made Interviewed SP3
10/11/2022	Contact-Document received Received staff training
11/15/2022	Exit Conference Exit conference with authorized representative Megan Rheingans

ALLEGATION:

Resident A treated disrespectfully.

INVESTIGATION:

On 9/16/22, the licensing department received a complaint with allegations on 9/9/22, Resident A called for assistance and a caregiver was rough with Resident A. The complainant alleged that the caregiver grabbed Resident A and caused a bruise. The complainant alleged the caregiver took Resident A's pendent off her neck and left Resident A in the bathroom.

On 9/16/22, the allegations in this report were sent to Adult Protective Services (APS).

On 9/21/22, I interviewed the complainant by telephone. The complainant reported Resident A is limited in her ability to speak due to a stroke but can answer yes/no questions. The complainant reported family visited Resident A on the evening of 9/9/22, and observed bruises on Resident A. The complainant reported Resident A was able to articulate that it was a caregiver she had never seen before, it happened after breakfast, and the caregiver was rough with her. The complainant reported Resident A reported that the caregiver transferred her into the bathroom, took her pendent, and left her in the bathroom. The complainant reported that Resident A had to yell for help.

On 9/21/22, I interviewed Resident A at the facility. Resident A was limited in her ability to speak due to a stroke but was able to report that the bruises happened after breakfast but before lunch. Resident A reported the caregiver hit her wrists. Resident A reported the caregiver took her pendent. Resident A reported this made her feel sad. Resident A reported this has never occurred before. Resident A reported she feels safe at the facility.

At the facility I observed Resident A's arms and wrists. There was a small bruise in the healing stages on her left wrist.

On 9/21/22, I interviewed administrator Michael Farrell at the facility. Mr. Farrell reported Resident A's family brought concerns of abuse to his attention last week. Mr. Farrell reported with the daughter's assistance Resident A was able to report that a caregiver grabbed her wrists and was rough with her. Mr. Farrell reported he spoke with staff person 1 (SP1) and SP1 reported no wrongdoing. SP1 reported Resident A is transferred using hands under Resident A's armpits not her wrists. Mr. Farrell reported he has no concerns with caregivers that provided care on 9/9/22 and the caregivers have no discipline history in their files. Mr. Farrell reported he has no idea where the bruises came from.

On 9/21/22, I interviewed SP2 at the facility. SP2 reported she did observe very small bruises on Resident A, but they did not look like fingerprints. SP2 reported Resident A will scream out if someone is treating her incorrectly. SP2 reported caregivers "hook" Resident A under her armpits to transfer her. SP2 reported Resident A will only page when she needs to go to the bathroom. SP2 reported Resident A does not require much assistance and is receptive to receiving care from caregivers. SP2 reported she did work on 9/9 on first shift and there were no new caregivers on shift that day. SP2 reported she has no concerns with any of her coworkers of how they interact with residents.

On 9/22/22, I interviewed SP3 by telephone. SP3 reported she worked on 9/9 on first shift. SP3 reported Resident A is transferred by lifting her under her armpits. SP3 reported if Resident A feels she is being hurt or injured she will scream out for

assistance. SP3 reported even though Resident A can does not vocalize much, she can make her needs known.

On 9/23/22, I interviewed SP4 by telephone. SP4 reported she worked on 9/9/22 on first shift. SP4 reported Resident A can pivot herself to assist with transfers. SP4 reported Resident A is transferred by "hooking" her under the arms. SP4 reported no knowledge of bruises on Resident A's arm.

I reviewed 9/9/22 call light response time for Resident A. The document revealed Resident A pushed her call pendent on 10:11, 10:30, and 10:44.

I reviewed Resident A's service plan. The service plan read,

> *"Resident has right side weakness. Transfer resident using under right arm and resident's pants."*

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:	Interviews with caregivers and review of documents revealed lack of evidence to support the allegation Resident C was treated disrespectfully.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Call lights are not answered.

INVESTIGATION:

The complainant alleged Resident A had an acute urinary tract infection (UTI) on 9/1, 9/7, and 9/19. The complainant alleged Resident A is not toileted often enough which leads to recurrent UTI's. The complainant alleged it takes staff members increased time to respond to call lights which results in Resident A holding urine.

Mr. Farrell reported a few weeks ago there were multiple residents with UTI's. Mr. Farrell reported the facility reviewed proper hygiene with caregivers and encouraged residents to drink water. Mr. Farrell reported call lights are to be answered within 10 minutes.

SP2 reported a few weeks ago there were multiple residents with UTI's. SP2 reported caregivers encouraged residents to drink water. SP2 reported the facility could not find any reasoning with the increased in UTI's.

SP4 reported there was an increased in UTI's within the facility. SP4 reported the facility could not find reasoning with the increased UTI's but caregivers were to encourage residents to drink water.

I reviewed Resident A's service plan. The service plan read,

> *"Provide and encourage fluids to resident during meals. Resident is now continent of bladder, staff to check and cue/assist resident to use the bathroom every 4hrs."*

I reviewed call light response time for Resident A for 9/1-9/21. The average response time was 17 minutes.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
For Reference: R 325.1901	**Definitions.**
	(4) "Assistance" means help provided by a home or an agent or employee of a home to a resident who requires help with activities of daily living.
ANALYSIS:	Review of call light response times for Resident C revealed on average Resident C must wait 17 minutes for staff assistance. This practice results Resident C not receiving the assistance she requires such as assistance in toileting.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of employee training record for SP3 and SP4 staff persons completed quizzes on topics related to caregiving, such as reporting requirements, resident rights, and personal care. The quizzes were not marked for competency.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(7) The home's administrator or its designees are responsible for evaluating employee competencies.
ANALYSIS:	The method of determining employee competencies must assure that the employee is fully able to demonstrate his or her learning obtained from the training program. Evidence of competency was not maintained in the employee record.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/15/22, I conducted an exit conference with authorized representative Megan Rheingans by telephone. Ms. Rheingans had no questions regarding the findings in this report.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

Kimberly Horst 10/11/2022

Kimberly Horst Date
Licensing Staff

Approved By:

Andrea L. Moore 11/15/2022

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