GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 30, 2022

Justin Niemi
American House Rochester Hills
3565 S. Adams Rd
Rochester Hills, MI 48309

RE: License #: AH630397557
Investigation #: 2023A0784005
American House Rochester Hills

Dear Mr. Niemi:

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 responsible party 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.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630397557
Investigation #:	2023A0784005
Complaint Receipt Date:	10/17/2022
Investigation Initiation Date:	10/17/2022
Report Due Date:	12/16/2022
Licensee Name:	AH Rochester MC Subtenant LLC
Licensee Address:	One Towne Square Ste 1600 Southfield, MI 48076
Licensee Telephone #:	(248) 203-1800
Administrator/ Authorized Representative:	Justin Niemi
Name of Facility:	American House Rochester Hills
Facility Address:	3565 S. Adams Rd Rochester Hills, MI 48309
Facility Telephone #:	(248) 734-4488
Original Issuance Date:	01/16/2020
License Status:	REGULAR
Effective Date:	07/16/2022
Expiration Date:	07/15/2023
Capacity:	50
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was physically Abused	No
Additional Findings	Yes

III. METHODOLOGY

10/17/2022	Special Investigation Intake 2023A0784005
10/17/2022	Special Investigation Initiated - Telephone Interview with Complainant
10/17/2022	APS Referral
10/18/2022	Inspection Completed On-site
11/30/2022	Exit Conference – Telephone Message left with authorized representative Justin Niemi regarding the determination of the investigation.

ALLEGATION:

Resident A was physically Abused

INVESTIGATION:

On 10/17/2022, the department received this online complaint. A referral was made to adult protective services (APS).

According to the complaint, on 9/21/2022, at approximately 3pm, Associate 1 was witnessed being physically abusive with Resident A in the television area of the East wing of the building. Resident A attempted to get out of her GERI chair several times and Associate 1 screamed across the room "Sit Down [Resident A]!!" Associate 1 appeared angry and frustrated with Resident A. The third time Resident A exited her chair, Witness 1 observed Associate 1 grab Resident A by the upper left arm lifting her off the ground and pushing her with her shoulder and roughly placed her in the chair. The wellness director, Ashley Pardon was notified immediately at that time. When entering back into the room after being notified, Ms. Pardon and Witness 1 observed Associate 1 holding Resident A around her left wrists and “roughly shove

her over the side of the chair". Witness 1 saw Resident A again on 9/26/2022 and observed her to have circular finger bruises and bruises on her upper left arm.

On 10/17/2022, I interviewed Witness 1 by telephone. Witness 1 stated that when Ms. Pardon observed Associate 1 grabbing Resident A from behind by the wrists and was questioned about it, Ms. Pardon reportedly said she did not think there was a problem with what Associate 1 was doing. Witness 1 stated that on 9/26/2022, the observations made on 9/21/2022 were reported to administrator/authorized representative Justin Niemi. Witness 1 stated Mr. Niemi indicated he would investigate the matter. Witness 1 stated the regional nurse and human resources director were also made aware of the situation. Witness 1 stated it was common for Associate 1 to "yell and scream" at Resident A across the room to sit down in her chair. Witness 1 stated Mr. Niemi reported he had investigated the matter and believe the bruises on Resident A were a result of a fall she had several days earlier. Witness 1 stated the referenced fall happened prior to the situation on 9/21/2022 and believed the bruises noted on 9/26/2022 were not consistent with a fall. Witness 1 stated Resident A is on hospice, but was unsure if hospice staff were aware of the alleged abuse or the bruises on Resident A.

On 10/18/2022, I observed Resident A sitting in her Geri Chair watching tv in a common area of the memory care (MC). Resident A appeared calm and comfortable. An interview was attempted; however Resident A was unable to provide meaningful answers to questions asked due to reduced cognition related to her diagnosis of Alzheimer's disease.

On 10/18/2022, I interviewed assistant wellness director Lashawnda Williams at the facility. Ms. Williams stated she was aware of the allegations regarding alleged abuse to Resident A but was not present during the time of the alleged abuse and was not privy to all the details of the situation related to the circumstances.

On 10/18/2022, I interviewed Associate 1 at the facility. Associate 1 denied ever being aggressive with Resident A or harming her in any way. Associate 1 stated Resident A is a high fall risk and has low safety awareness who will sometimes attempt to get up out of her chair and walk on her own. Associate 1 stated that on 9/21/2022, she noticed Resident A, from across the room while helping another resident, was attempted to stand up from her chair. Associate 1 denied yelling at Resident A but stated she did use a "strong tone" and said Resident A's name as this usually works to get Resident A's attention so she will sit and wait for staff to assist her. Associate 1 stated Resident A did not sit down so she quickly moved over to Resident A to assist her as Resident A had stood up and, while attempted to sit back down, was losing her footing. Associate 1 stated she had approached Resident A from the front and was facing her during this interaction. Associate 1 stated she placed her left arm under Resident A's left arm to stabilize her and wrapped her right arm around Resident A's back and held on to the back of Resident A's pants in order to help her sit down. Associate 1 stated that after that happened, she did not have to assist Resident A again and could not speak to the allegation that she was observed

a second time holding on to Resident A's wrist. Associate 1 stated Resident A did have bruising on her arm from a previous fall, but that she had not grabbed her arm so the bruising could not have come from her. Associate 1 stated she never touched Resident A's right arm during this interaction and denied leaving any bruises on her.

On 10/18/2022, I interviewed administrator/authorized representative Justin Niemi at the facility. Mr. Niemi stated he was made aware of the incident with Associate 1 and Resident A on 9/21/2022. Mr. Niemi stated Associate 2 initially reported, on 9/21/2022, that she felt Associate 1 was "a little rough" with Resident A but did not report "in any way" that Associate 1 had harmed Resident A physically or abused her". Mr. Niemi stated he did indicate he would investigate the matter but did not immediately investigate due to the nature in which it was reported. Mr. Niemi stated that Associate 2 was off work after 9/21/2022 until 9/26/2022 and had not reached out regarding the matter during that time. Mr. Niemi stated it was not until 9/26/2022, when Associate 2 came back for her next scheduled workday, that she reported she had thought more about the situation and felt Associate 1 had abused Resident A. Mr. Niemi stated he thought this was strange since Associate 2 had his contact number and could have followed up with him any time prior to 9/26/2022 if she felt the matter was abusive in nature. Mr. Niemi stated that once the allegation was intensified, he did begin the process of investigating right away having reported the matter to the regional hr director, Kimberly Jones, for investigation. Mr. Niemi stated he did observe Resident A for any new bruising, on 9/26/2022, and did not see any bruising on Resident A's arms that appeared new to fresh to him. Mr. Niemi stated he did not check for marks or bruises on 9/21/2022 because Associate 2 had not reported any physical abuse or physical harm had been done to Resident A. Mr. Niemi stated Resident had fallen several times, prior to 9/21/2022, and had already had some bruising to her arms. Mr. Niemi stated Associate 2 never reported a secondary issue alleging Associate 1 pulled on or grabbed Resident A's wrists. Mr. Niemi stated Ms. Jones did investigate and based on what she found; it was his understanding that abuse could not be substantiated. Mr. Niemi stated Associate 1 has been a good employee and he has not had any related issues with her. Mr. Niemi stated Associates 1 and 2 never really "saw eye to eye" which he stated may have had something to do with how the situation was viewed. Mr. Niemi stated Associate 2 has since decided to no longer work with the facility.

On 10/18/2022, I interviewed hr director Kimberly Jones at the facility. Ms. Jones confirmed she received reporting from Mr. Niemi regarding the allegations of abuse to Resident A on 9/21/2022. Ms. Jones stated she spoke with Associates 1 and 2 as well as wellness director Ashley Pardon as she stated Associate 2 had indicated she reported the incident immediately to Ms. Pardon and that Ms. Pardon had allegedly also witnessed physical mistreatment by Associate 1. Ms. Jones stated Associates 1 denied being physically aggressive with Resident A in anyway and stated she did quickly move to Resident A to help her sit down. Ms. Jones stated Associate 2 reported feeling Associate 1 was aggressive with Resident A to the point of being abusive. Ms. Jones stated she also requested a physical assessment of Resident A

by Resident A's hospice nurse and the facilities regional nurse related to alleged new bruising Associate 2 reported seeing on Resident A. Ms. Jones stated both the hospice and regional nurse reported that from their observations, the bruising on Resident A's arms was most likely related to a previous fall. Ms. Jones stated that Ms. Pardon denied seeing any inappropriate physical handling of Resident A by Associate 1. Ms. Jones stated Ms. Pardon did report that Associate 2 came to her after the alleged incident, however, she stated Ms. Pardon reported that when she came out of the office Resident A was already in her chair and that she did not observe Associate 1 handling Resident A in any manner that was rough or abusive. Ms. Jones stated the investigation did not reveal sufficient evidence to conclude Associate 1 was abusive to Resident A. Ms. Jones stated she did, however, recommend additional staff training due to the nature of the allegations to ensure staff had extra training for the safety of residents.

I reviewed training documents titled Safety & Transfers and Abuse & Neglect, provided by Mr. Niemi, which he stated were the in-service trainings provided to staff based upon Ms. Jones recommendation. The trainings were dated 10/13/2022 and included staff signatures indicating their participation.

I reviewed a hospice *Client Coordination Note Report*, dated 9/18/2022, for Resident A provided by Mr. Niemi. Under a section titled *SKIN*, the report read, in part, "SEPTEMBER SKIN PALE COOL DRY INTACT, GENERALIZED BRUISING, INCREASED BRUISING TO ARMS AND LEGS DUE TO FALLS, REINFORCE USE OF BARRIER CREAMS FOR DEPENDENT AREAS".

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(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 or a physician's assistant to whom the physician has delegated the performance of medical care services 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 or physician's assistant. In case of a chemical restraint, a physician shall be**

	consulted within 24 hours after the commencement of the chemical restraint.
ANALYSIS:	The complaint alleged that on 9/21/2022 Resident A was subjected to abuse by Associate 1. The investigation revealed insufficient evidence to support a finding of abuse.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

When interviewed, Witness 1 stated Resident A can "bear her own weight" and could ambulate around her chair on her own, but would struggle to stand if left for too long. Witness 1 stated staff would lean Resident A's Geri Chair back so she could not get out of her chair to keep her from falling.

During the onsite, I observed Resident A's Geri chair to be slightly leaned back while she was sitting in it.

When interviewed, Ms. Williams stated Resident A has fallen on several occasions. Ms. Williams stated Resident A is a person who is a high fall risk and has low safety awareness in that she will attempt to stand up even though she is physically unable to support herself to walk as she has an unsteady gate. Ms. Williams stated Resident A does not seem to remember that she unable to walk on her own. Ms. Williams stated Resident A can support her own weight for a short amount of time and can stand in one place with support, but that it is likely she will fall most of the time if not supported. Ms. Williams stated she was aware the Resident A's Geri chair was slightly tipped back. Ms. Williams stated the chair is leaned back, in part, to keep her from getting up from the chair since she has shown a propensity to try and get up without staff assistance on several occasions.

When interviewed, Associate 1 provided statements consistent with those of Ms. Williams regarding Resident A's fall risk and safety awareness and leaning Resident A's chair back in order to keep her from getting up in order to mitigate the possibility of Resident A having additional falls.

When interviewed, Mr. Niemi stated he was not aware of any staff leaning Resident A's chair back in order to keep her from getting up. Mr. Niemi stated he was aware that Resident A is a high fall risk with a low safety awareness, but that staff are not supposed to be leaning her chair back for the purpose of keeping her from getting out and only supposed to lean the chair back for Resident A's personal preference. Mr. Niemi stated staff are not instructed to lean any resident back in a chair with

such capabilities and are only service planned for this if a resident re quests such measures for comfort.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(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 or a physician's assistant to whom the physician has delegated the performance of medical care services 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 or physician's assistant. In case of a chemical restraint, a physician shall be consulted within 24 hours after the commencement of the chemical restraint.**

ANALYSIS:	Resident A is a person who has been identified as a high fall risk with low safety awareness and one who will frequently attempt to get up on her own, without staff assistance, even though she is unable to support herself for transfers or ambulation. Witness 1 reported Resident A has a Geri chair which staff lean back for the purposes of keeping her from getting up due to her propensity to fall. While the administrator, Mr. Niemi, denied Resident A's Geri chair is being used for this purpose, the assistance wellness director, Ms. Williams, and Associate 1 both reported that Resident A's chair is leaned back for this purpose. Additionally, during the onsite, I observed Resident A's chair to be leaned back while she was sitting in it. Due to staff adjusting Resident A's chair, in part, for the purposes of keeping her from getting up out of it while Resident A has the ability, and apparent preference, to get out of the chair at times, it seems reasonable to view this use as a form of restraint.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon received of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

11/28/2022

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Aaron Clum Date
Licensing Staff

Approved By:

11/28/2022

_____

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