GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 10, 2023

Kimberly Gee
Symphony of Linden Health Care Center, LLC
30150 Telegraph Rd
Suite 167
Bingham Farms, MI 48025

| | |
|---|---|
| RE: License #: | AL250281706 |
| Investigation #: | 2023A0872010 |
| | Monet House Inn |

Dear Mrs. Gee:

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. 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,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AL250281706 |
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| **Investigation #:** | 2023A0872010 |
| | |
| **Complaint Receipt Date:** | 11/23/2022 |
| | |
| **Investigation Initiation Date:** | 11/28/2022 |
| | |
| **Report Due Date:** | 01/22/2023 |
| | |
| **Licensee Name:** | Symphony of Linden Health Care Center, LLC |
| | |
| **Licensee Address:** | 7257 N. Lincoln<br>Lincolnwood, IL 60712 |
| | |
| **Licensee Telephone #:** | (810) 735-9400 |
| | |
| **Administrator:** | Kimberly Gee |
| | |
| **Licensee Designee:** | Kimberly Gee |
| | |
| **Name of Facility:** | Monet House Inn |
| | |
| **Facility Address:** | 202 S. Bridge Street<br>Linden, MI 48451 |
| | |
| **Facility Telephone #:** | (810) 735-9400 |
| | |
| **Original Issuance Date:** | 06/25/2008 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 08/08/2021 |
| | |
| **Expiration Date:** | 08/07/2023 |
| | |
| **Capacity:** | 20 |
| | |
| **Program Type:** | AGED<br>ALZHEIMERS |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| On 11/11/22, Resident A was found by staff unresponsive on the toilet. The staff removed her from the toilet, to lay her in her bed as she remained unresponsive. Staff did not call 911 for one and a half hours. | Yes |

## III. METHODOLOGY

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|---|---|
| 11/23/2022 | Special Investigation Intake<br>2023A0872010 |
| 11/28/2022 | Special Investigation Initiated - Letter<br>I exchanged emails with Monet House Inn former director, Amanda Walworth |
| 11/28/2022 | APS Referral<br>I made an APS complaint via email |
| 11/30/2022 | Inspection Completed On-site<br>Unannounced |
| 12/08/2022 | Contact - Document Received<br>I received AFC documentation about this complaint |
| 01/09/2023 | Contact - Telephone call made<br>I interviewed Relative A1 |
| 01/10/2023 | Contact - Telephone call made<br>I interviewed staff Matt Weston |
| 01/10/2023 | Contact - Telephone call made<br>I interviewed staff Janelle Robinson |
| 01/10/2023 | Contact - Telephone call made<br>I interviewed staff Dia Leon |
| 01/10/2023 | Exit Conference<br>I conducted an exit conference with the licensee designee, Kim Gee |
| 01/10/2023 | Inspection Completed-BCAL Sub. Compliance |

**ALLEGATION: On 11/11/22, Resident A was found by staff unresponsive on the toilet. The staff removed her from the toilet, to lay her in her bed as she remained unresponsive. Staff did not call 911 for one and a half hours.**

**INVESTIGATION:** I reviewed an Incident/Accident Report (IR) dated 11/16/22 regarding Resident A. According to this IR, "Resident was demonstrating lethargic behaviors. BP taken, which was high, and unresponsiveness noted. Called director, assistant director, on call and EMS." According to additional documentation, "Staff member called Director of AL at around 12:30am. When discussing situation resident was having high BP, lethargic and tremors. Per GA resident was in an out being able to talk and was unsure if she was just tired or if something else was going on. Director had GA call on call to discuss and to call me back to let me know what the situation was. Per GA at 12:45am on call and left a message. When GA told Director that BP was above 200/100 Director told GA to call EMS. EMS came and got resident at that time. On call returned phone call around 3am but resident was already out to hospital."

On 11/30/22, I conducted an unannounced onsite inspection of Monet House Inn Adult Foster Care facility. I met with Resident A in her bedroom and attempted to interview her but due to her dementia, she was not able to participate in the interview. I observed Resident A to be clean and dressed appropriately for the day and the weather. She was sitting on her bed in her room and although she interacted with me, she was not able to answer any of my questions.

On 12/08/22, I received AFC documentation related to this complaint. Resident A was admitted to Monet House Inn on 11/08/21. According to her Assessment Plan dated 4/07/22, she does not have any assistive devices and she is able to ambulate on her own. She wears pull-ups and has difficultly communicating due to dementia.

I reviewed an Internal Investigation Analysis completed by the Assisted Living Director, Stephanie Gunn. According to this report, on 11/11/22, Resident A was sent out to the hospital by staff. Staff observed Resident A not responding normally so they contacted the then-assisted-living-director, Amanda Walworth. Ms. Walworth told staff to contact the on-call doctor. Staff called the on-call doctor and while waiting for a response, they continued checking on Resident A, "who was breathing but not responding to the staff's verbal or physical stimuli." Staff said that this is not uncommon behavior from Resident A. The report stated, "After some time, the staff made the executive decision to send the resident out to the ER for eval and treatment. The family was made aware, and the resident returned within 24 hours with no new treatment or orders." According to the analysis section of the report, "Since this date, the staff member has been educated on the proper procedure on how to send out a resident to the hospital. Discussions with an on-call doctor regarding communication expectations."

According to Resident A's Health Care Appraisal, she is on numerous medications including Aricept for dementia, but it does not state her diagnoses. However, I reviewed staff progress notes which state she is diagnosed with generalized anxiety disorder, unspecified dementia, anxiety, and hypertension.

I reviewed several progress notes completed by PA-C Kristen Dziadula. Resident A was seen by PA-C Dziadula on several occasions in October and November 2022.

On 10/18/22, Resident A was seen due to a “mental status change.” PA-C Dziadula noted that Resident A has advanced dementia and she ordered lab work. No other recommendations were noted.

On 10/21/22, Resident A was seen again due to a “mental status change.” She told PA-C Dziadula that she “does not feel well.” PA-C Dziadula noted that the labs were still pending from her urine and blood work. Since Resident A appeared “nontoxic and is currently afebrile” PA-C Dziadula did not have any further recommendations.

On 10/27/22, Resident A was seen to “hypertension urgency.” At the time of her exam, her blood pressure was elevated but she was not in distress. PA-C Dziadula did not change her medication but did order staff to monitor her vital signs daily.
On 11/04/22, Resident A was seen regarding a sore throat. PA-C Dziadula ordered a Chloraseptic spray, and she would be reassessed in one week. Resident A appeared “a bit paranoid today and anxious.”

On 11/17/22, Resident A was seen by PA-C Dziadula due to elevated blood pressure. “Resident (A) has been seen in the hospital several times secondary to elevated blood pressure reading.” PA-C Dziadula noted that Resident A was not in any distress during this examination, but she did have an elevated blood pressure reading. Therefore, PA-C Dziadula increased her blood pressure medication and asked that she be reassessed in one week. She also noted that Resident A has coronary artery disease.

On 11/30/22, Resident A was seen by PA-C Dziadula due to weakness and some confusion. Psychiatric services were ordered due to a diagnosed mood disorder.

On 01/09/23, I interviewed Guardian A1 via telephone. She said that on 11/11/22, she received a phone call from Monet House Inn staff telling her that Resident A was found in her bathroom, on the floor. Guardian A1 was told that staff helped her up, got her into bed, checked her blood pressure and determined she did not need further medical attention. Approximately one hour later, staff called Guardian A1 and told her that Resident A was nonresponsive, so she was being transported to the hospital.

Guardian A1 said that the emergency room doctor contacted her and told her that they did not find any reason for Resident A’s condition. She said that the ER doctor told her that they examined Resident A, and she seemed fine, so they are not admitting her, and they are releasing her back to Monet House Inn.

According to Guardian A1, Resident A suffers from dementia and high blood pressure. She is prone to falls and confusion. She has “good days and bad days.” Some days, Resident A is not very responsive to others and other days, she is able to engage and

interact. Guardian A1 said that overall, she has been comfortable with the care that Resident A receives at Monet House Inn.

On 01/10/23, I interviewed staff Matt Weston, via telephone. Mr. Weston said he does not remember much about the incident involving Resident A on 11/11/22. He said that he does remember finding Resident A on the floor in her bathroom, sitting in front of the toilet. He said that she was “staring at the wall, like she was waiting for something.” Mr. Weston said that he helped Resident A get up, and he put her in her recliner. According to Mr. Weston, Resident A was talking to him, but she was acting “strange.” He said that later that evening, he went to check on her and it was difficult to wake her up, so he and his coworker called 911. Mr. Weston told me that he does not remember who was working with him on that date and he does not recall if one of them took Resident A’s blood pressure when they first found her in the bathroom.

On 01/10/23, I interviewed staff Janelle Robinson via telephone. Ms. Robinson confirmed that she was working 3rd shift on 11/11/22. She said that on that date, Resident A was found in her bathroom, on the floor by her coworker, Dia Leon. Ms. Robinson said that they got Resident A up and put her in a recliner in the front room to “keep an eye on her.” According to Ms. Robinson, she checked Resident A’s blood pressure, and it was high. In addition, Resident A appeared shaky. Ms. Robinson said that she called the on-call doctor, the assistant living director, and the assistant to the assistant living director and nobody answered her call. Ms. Robinson told me that she and Ms. Leon continued to monitor Resident A, whose condition did not improve. Ms. Robinson said, “We didn’t know what to do because nobody would call us back.” Ms. Robinson stated that after approximately 1.5 hours, she had still not received a return phone call from management or the on-call doctor, so she and Ms. Leon called 911 to have Resident A transported to the hospital.

On 01/10/23, I interviewed staff Dia Leon via telephone. Ms. Leon confirmed that she worked 3rd shift with Janelle Robinson on 11/11/22. According to Ms. Leon, she was doing rounds and found Resident A on the floor in her bathroom. Ms. Leon said that Resident A “wasn’t acting like herself, almost like she was drunk” so she helped her up and she and Ms. Robinson put her in a recliner in the front room so they could monitor her. Ms. Leon told me that Ms. Robinson took Resident A’s vitals and Ms. Leon attempted to contact the on-call doctor, the manager, and the assistant manager. According to Ms. Leon, Resident A’s condition was not alarming at first because she is often confused and disoriented but after continuing to monitor her, her condition did not improve. Ms. Leon said that since the on-call doctor, manager, and assistant manager did not get back to her, “I made the executive decision to send her out.” According to Ms. Leon, she contacted 911 and Resident A was transported to the hospital.

On 01/14/21, I completed an investigation alleging that on 10/27/20, a resident fell. Staff assessed her for injuries, took her vitals, and performed a range of motion tests. The resident did not receive any external medical attention. On 10/29/20, the resident appeared to be in extreme pain so she was taken to the hospital at which time she was diagnosed with several rib fractures and a punctured lung which doctors determined

may have been from her fall on 10/27/20. I substantiated R 400.15310(4). The licensee designee submitted a corrective action plan (CAP) dated 01/29/21. According to the CAP, the resident no longer resides at the facility, the staff involved is no longer employed by the facility, and staff were given training “on responding to falls and seeking medical attention.”

| **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:** | On 11/11/22, staff found Resident A on the floor in her bathroom. Staff took her blood pressure which was high. In addition, Resident A’s behavior was unusual, and it did not improve as time went on.<br><br>Staff Janelle Robinson and Dia Leon said that they attempted to contact the on-call doctor, the manager, and the assistant manager but they did not receive a call back. Ms. Robinson and Ms. Leon said that since Resident A’s condition did not improve, they called 911 approximately 1.5 hours after initially finding her on the floor in her bathroom. Resident A was transported to the hospital at that time.<br><br>I conclude that upon finding Resident A in an altered state with high blood pressure, staff did not seek medical attention for her immediately which is a direct violation of this rule. |
| **CONCLUSION:** | **REPEAT VIOLATION ESTABLISHED:**<br>**Ref. SIR #2020A0872008 dated 01/14/21.** |

On 01/10/23, I conducted an exit conference with the licensee designee, Kim Gee. I told her which rule violation I am substantiating and asked her to complete and submit a corrective action plan upon the receipt of my investigation report.

## IV. RECOMMENDATION

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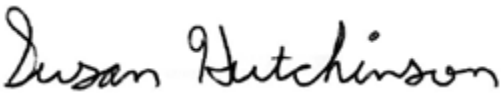
| Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status. |



January 10, 2023

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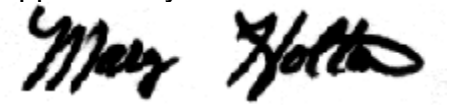
| Susan Hutchinson<br>Licensing Consultant | Date |

Approved By:



January 10, 2023

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| Mary E. Holton<br>Area Manager | Date |