GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 20, 2023

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

RE: License #: AL250331295
Investigation #: 2023A0779012
Homer House Inn

Dear Ms. 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,

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL250331295
Investigation #:	2023A0779012
Complaint Receipt Date:	12/09/2022
Investigation Initiation Date:	12/09/2022
Report Due Date:	02/07/2023
Licensee Name:	Symphony of Linden Health Care Center, LLC
Licensee Address:	7257 N. Lincoln Lincolnwood, IL 60712
Licensee Telephone #:	(810) 735-9400
Administrator:	Kimberly Gee
Licensee Designee:	Kimberly Gee
Name of Facility:	Homer House Inn
Facility Address:	202 S Bridge Street Linden, MI 48451
Facility Telephone #:	(810) 735-9400
Original Issuance Date:	05/01/2014
License **Status:**	REGULAR
Effective Date:	11/03/2022
Expiration Date:	11/02/2024
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A reported that a man had taken her out of her room when she was in bed during the night and pulled on her brief.	No

III. METHODOLOGY

12/09/2022	Special Investigation Intake 2023A0779012
12/09/2022	APS Referral Complaint was referred to AFC licensing by APS centralized intake.
12/09/2022	Special Investigation Initiated - Telephone Spoke to Resident A's power of attorney.
12/12/2022	Inspection Completed On-site
01/03/2023	Contact - Telephone call made Spoke to Linden Police officer, Brian Drinkwine.
01/05/2023	Contact - Telephone call made Interview conducted with staff person, Shamonique Bowen.
01/05/2023	Contact - Telephone call made Spoke to general manager, Kwadwo Owusu-Ansah.
01/05/2023	Contact - Telephone call made Interview conducted with staff person, Matthew Weston.
01/11/2023	Contact - Telephone call made Spoke to Resident A's POA.
01/11/2023	Contact - Telephone call made Spoke to staff person, Mel Sevegney.
01/12/2023	Contact - Telephone call made Interview conducted with assisted living director, Stephanie Gunn.
01/13/2023	Contact - Telephone call received Spoke to staff person, Shamonique Bowen.

01/18/2023	Contact - Telephone call made Spoke with Mel Sevegney
01/18/2023	Contact - Telephone call made Interview conducted with staff person, Sierra Weatherspoon.
01/19/2023	Exit Conference Held with licensee designee, Kimberly Gee.

ALLEGATION:

Resident A reported that a man had taken her out of her room when she was in bed during the night and pulled on her brief.

INVESTIGATION:

On 12/9/22, a phone conversation took place with Resident A's power of attorney (POA), who confirmed that she was aware of the allegations. She stated that she had seen Resident A on Monday 12/5/22 and that Resident A did not say anything related to a man entering her room. She stated that she saw Resident A again on Thursday 12/8/22 and this is when Resident A made these allegations to her, so she believes that the alleged incident took place between 12/5/22 and 12/8/22. POA reported that Resident A told her that a male came into her room at night, messed with her brief, and that she knew he was not supposed to be doing that. POA reported that Resident A said that she yelled and someone came, but that she still felt safe there. POA stated that even though Resident A has dementia, she is confident that if this incident would have reached the level of an assault, Resident A would have been able to express that. POA stated that the police were contacted and that they are looking through video from the facility.

On 12/12/22, an unannounced on-site inspection was conducted and Resident A was interviewed. During the interview process, Resident A could best be described as being pleasantly confused. Resident A went on for several minutes as she attempted to describe what she thought happened when a male had entered her room. Resident A stated that the man wanted to do "some kind of business", maybe wash her hair, then he wanted to change her brief. Resident A then said that the man wanted her to go out of her room to clean her bottom, then said he wanted to do a "test" and "take things out of her butt". Resident A reported that she told him "no", that she yelled, and they both started running. Resident A could not say if the man was a staff person or another resident or when the incident happened. She stated that she thought he was someone who came in and got lost, because he seemed confused. Resident A confirmed that she still feels safe at this facility.

On 12/12/22, general manager, Kwadwo Owusu-Ansah, stated that POA reported these allegations to him on 12/8/22 and that he interviewed Resident A with POA that same

day. Mr. Owusu-Ansah stated that Resident A was not coherent with her story, but did say that a man was touching her brief. He stated that a police officer came to the facility and they watched hours of video that their camera recorded between 12/5/22 and 12/8/22. He reported that the recordings showed that there was only one occurrence where a black male staff person had briefly entered Resident A's room on 12/6/22. Mr. Owusu-Ansah stated that on 12/6/22, Resident A could be seen leaving her room by herself and then approximately five minutes, Resident A was escorted back to her room by a male staff person. He stated that the staff person was only in Resident A's room for a very short time and that the door was left open the entire time. He stated that there was no other time where any male could be seen entering Resident A's room during the time period in question.

On 12/12/22, director of guest services, Melissa Reich, stated that she had also watched several days and multiple hours of video that was recorded during the days in question. She stated that the only time a male staff person entered Resident A's room was at 6:30 pm on 12/6/22. Ms. Reich reported that the video shows that Resident A was escorted from the hallway back into her room. She stated that the male staff was only in Resident A's room for approximately one minute and that the door to the room was left open the entire time. Ms. Reich stated that Resident A is in and out of her room all day and night wandering the hallways. She stated that since these allegations were made, only female staff are allowed inside Resident A's room moving forward.

On 1/3/23, a phone conversation took place with Linden police officer, Brian Drinkwine, who confirmed that he was investigating the same allegations. He stated that he had interviewed Resident A, but that she could not answer any questions of competency. Officer Drinkwine stated that Resident A seemed very confused, that her story was very hard to follow and made little sense. He reported that Resident A could not say who the alleged man was or when the alleged incident happened. He stated that Resident A was not found to be a credible witness and that there are no known witnesses to the alleged incident. Officer Drinkwine confirmed that he watched the facility's video recordings for 12/5/22 through 12/8/22 and that there was nothing on the recordings to suggest that any male spent any significant time alone with Resident A. He stated that he spoke to multiple staff of this facility and that no one reported knowing anything about any assault involving Resident A. Officer Drinkwine reported that POA later changed her story to say that the assault happened on 12/2/22. He stated that he went back out to the facility to check the video recordings for 12/2/22, but that the video system had already automatically erased the video for that day. Officer Drinkwine stated that the only male staff person to work on 12/2/22 was Matthew Weston and that he denied ever being involved in any type of inappropriate behavior with Resident A. Officer Drinkwine stated that Mr. Weston claims that he had no reason to even enter Resident A's room on 12/2/22. He stated that the facility has no record of any disciplinary action against Mr. Weston and that Mr. Weston has no known criminal history. Officer Drinkwine stated that there was no evidence found to suggest that a crime was committed and that he was closing his case with no charges being pressed.
On 1/5/23, a phone interview was conducted with staff person, Shamonique Bowen, who confirmed that she was aware of the allegations. She stated that on 12/7/22, she

was the first staff person that Resident A mentioned these allegations too. She stated that Resident A told her story for several minutes, but that not much about her story made much sense. Ms. Bowen reported that the general facts of Resident A's story was that a man went into her room and touched her butt/brief, like maybe he was trying to change her or clean her up. Ms. Bowen stated that Resident A did not know who the man was but did describe him as being "white". She stated that she reported what Resident A had told her to her supervisor, Stephanie Gunn on 12/7/22.

On 1/5/23, Mr. Owusu-Ansah, stated that POA changed the date of when the alleged incident took place to 12/2/22, but that he did not know where POA was getting her information from or coming up with that specific date. He reported that the only male staff that worked on 12/2/22 was Matthew Weston and that Mr. Weston is denying the allegations. Mr. Owusu-Ansah confirms that the facility's video recordings automatically delete after 10 days and that by the time the date of 12/2/22 was brought to their attention, the video was no longer available.

On 1/5/23, a phone interview was conducted with staff person, Matthew Weston, who confirmed that he worked at this facility on 12/2/22 and that he is denying the allegations. He stated that he did not spend any time inside Resident A's room, did not take Resident A out of her room for any reason and did not spend any time alone with her during that shift. Mr. Weston reported that Resident A has general confusion most of the time and is frequently wandering around the halls of the facility. Mr. Weston stated that Resident A is fairly independent and is able to do all her self-care, so there would be no need for him to do any personal care, bathing, or toileting for Resident A. He stated that he does not remember anything out of the ordinary involving Resident A during that shift and that Resident A did not display any known fear or anxiety. On 1/11/23, Mr. Weston reported that he does not remember having to work by himself at any time during his shift on 12/2/22.

On 1/11/23, a second conversation took place with POA. She stated that the facility wrote an incident report (IR) after Ms. Bowen and other staff were present when Resident A originally disclosed the allegations, but no one from the facility contacted her to report it. POA reported that during a visit to the facility, Resident A showed her in the dining room where the man took here and told her that the man heard something and ran. POA stated that she believes that Mr. Weston was the only staff working for a short period of time on 12/2/22, because another staff came in late, so he might have had time to be alone with Resident A. POA stated that she is not certain that an assault happened, but that she believes that someone went into Resident A's room and made her feel unsafe regarding something to do with her brief. POA feels that the facility has not been forth coming with information surrounding these allegations. She stated that she feels that Resident A is still safe at this facility.

On 1/11/23, executive admin assistant to the licensee designee, Mel Sevegney, stated that she was aware of the allegations. She stated that when these allegations were made, general manager, Mr. Owusu-Ansah, and new assisted living director, Stephanie Gunn, completed an internal investigation. She stated that they did not find any

evidence that any type of assault or inappropriate behavior toward Resident A had taken place. Ms. Sevegney stated that Resident A's dementia appears to be worsening and that they would like to move her to their dementia unit, but POA seems hesitant to make such a move.

On 1/12/23, a phone interview was conducted with assisted living director, Stephanie Gunn. She stated that she first learned of these allegations at the end of her day on 12/7/22, when Ms. Bowen reported to her what Resident A originally said to her. She stated that she wrote an IR from the information obtained from Ms. Bowen. Ms. Gunn reported that she did not contact POA right away because she wanted to conduct an investigation into the matter and gather more facts before alarming POA. Ms. Gunn stated that their internal investigation did not turn up any evidence suggesting that a male had entered and/or spent any time in Resident A's room or took Resident A out of her room during the night. She stated that a staff person shared the date of 12/2/22 with POA as a possible date that staff person Matt Weston would have had access to Resident A, but that staff did this with no knowledge or proof that anything inappropriate actually happened on that date. Ms. Gunn stated that Resident A is quite independent and there would be no need for any staff to spend significant time in Resident A's room or to check her brief without her asking for help. Ms. Gunn reported that she is not aware that Mr. Weston had to work alone for any length of time on 12/2/22.

Resident A's *Assessment Plan for AFC Residents* was reviewed. The plan confirms that Resident A has dementia and wears adult briefs. It documents that Resident A is independent with all her activities of daily living and only requires prompting and/or stand-by supervision for bathing and hygiene.

The facility provided copies of two separate IR's related to what Resident A disclosed to staff on 12/7/22. One of those IR's was written by Ms. Gunn and says that Resident A disclosed to staff that an employee touched her bottom. It documents that Resident A stated that "the guy was touching my butt like the girls do when they clean you up". The staff believed that Resident A was referring to the assistance from caregivers during personal care. The IR also states that Resident A stated the man did not remove any of her clothing. The IR states that an internal investigation was completed and the police were contacted. The corrective measures listed on the IR was to have only female staff assigned to care for Resident A.

The second IR was completed by staff person, Aroura Scheffler, and documents what allegations she witnessed Resident A disclose on 12/7/22. Ms. Scheffler documented that Resident A said that a white man came into her room and said they were giving her a shower, but that Resident A said she was independent and that ladies give her showers. The IR documents that Resident A claims to have told the man not to go into her butt, that she screamed and then ran. Ms. Scheffler documented that management was told of the allegations and that management and POA then spoke to Resident A.

On 1/13/23, five short audio recordings were received from staff person, Ms. Bowen. The audio was recordings of parts of Resident A's disclosure of allegations to Ms.

Bowen on 12/7/22 and parts were low and could be difficult to hear. In the recordings, Resident A made statements such as, “It didn’t scare me that he was going to clean me, but always women who took my butt”, “I always liked him but I do not see him very often and I always thought of him as a nice person”, and “I did not want him in my butt”. Resident A stated that she got mad and told him no. She stated that the man did not take anything off her, that there was nobody around, and that he was scared and just left. At one point Resident A stated that he ran and she ran. Resident A said that she wanted to apologize to him for her getting mad and she repeatedly refers to the man as being a nice person.

On 1/18/23, Ms. Sevegney stated that the staff schedule shows that there were three staff who worked the night of 12/2/22. She stated that she reviewed the clock-in times of all three staff and it shows that no staff person, including Mr. Weston, worked alone on 12/2/22.

On 1/18/23, a phone interview was conducted with previous employee, Sierra Weatherspoon, who confirmed that she was aware of these allegations and that she worked at the facility the night of 12/2/22. She stated that at no time did Mr. Weston work alone. Ms. Weatherspoon stated that she does not remember anything unusual taking place with Resident A during that shift.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Resident A has told her story about a man coming in her room and touching her brief and/or wanting to do something to her butt. Each time she told the story to multiple staff, a police officer and licensing consultant, the story was quite confusing and did not make much sense. It is difficult to determine what happened or if anything actually happened and/or if this is a result of her dementia. Many versions of Resident A’s story

	appear to describe this alleged male possibly trying to provide or help her with normal personal care. There were no known witnesses to the alleged incident and Resident A suffered no injuries. Video recordings of the facility for the days that the alleged incident was originally suspected of happening show that there were no occurrences where any males had spent time alone with Resident A. When a second possible date for the alleged incident came up, it was determined that the only male staff working on 12/2/22 was Matthew Weston. Mr. Weston has denied the allegations and again, there were no known witnesses on 12/2/22. There was insufficient evidence found to prove that facility staff have failed to provide adequate protection and safety to Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 1/11/23, Resident A's POA stated that staff person, Ms. Bowen, made an audio recording of Resident A disclosing allegations. She confirmed that the facility has not been given permission to audio record Resident A.

On 1/12/23, assisted living director, Ms. Gunn, stated that she was aware of Ms. Bowen making audio recordings of Resident A. She stated that Ms. Bowen provided her with several short recordings that she made.

On 1/13/23, staff person, Ms. Bowen, confirmed that she made five short audio recordings of parts of Resident A's disclosure of allegations to her on 12/7/22. She stated that she made the recordings because Resident A's story was quite confusing and she did not want to miss any details of what she was saying.

On 1/18/22, Ms. Sevegney stated that she had reviewed Resident A's admission paperwork. She stated that she found no documents providing the facility with permission to audio record Resident A.

APPLICABLE RULE	
R 400.15304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or

	the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.**
ANALYSIS:	On 12/7/22, staff person, Shamonique Bowen, made several short audio recordings of Resident A. It was confirmed that this facility has no written document providing them with permission to audio record Resident A. By making these audio recordings, Resident A's right and need for privacy was violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 1/19/23, an exit conference was held with licensee designee, Kimberly Gee. She was informed of the outcome of this investigation and that a written corrective action plan is required.

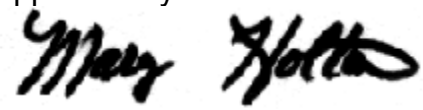
IV. RECOMMENDATION

Upon receipt of an approved written corrective action plan, it is recommended that the status of this home's license remain unchanged.

1/20/2023

Christopher Holvey — Date
Licensing Consultant

Approved By:



1/20/2023

Mary E. Holton — Date
Area Manager