GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 8, 2023

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

RE: License #: AH470387116
Investigation #: 2023A0784029
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 responsible party and a date.

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 #:	AH470387116
Investigation #:	2023A0784029
Complaint Receipt Date:	01/27/2023
Investigation Initiation Date:	01/30/2023
Report Due Date:	03/28/2023
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:	09/27/2022
Expiration Date:	09/26/2023
Capacity:	93
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Inadequate supervision	No
Residents not treated with dignity	No
Spoiled and expired food stored in the kitchen	Yes
Additional Findings	No

III. METHODOLOGY

01/27/2023	Special Investigation Intake 2023A0784029
01/30/2023	Special Investigation Initiated - On Site
01/30/2023	Inspection Completed On-site
01/30/2023	Exit Conference Conducted with administrator Michael Farrell

ALLEGATION:

Inadequate supervision

INVESTIGATION:

On 1/27/2023, the department received this complaint. Due to the anonymous nature of the complaint, additional information could not be obtained.

According to the complaint, on 1/18/2023, a resident was discovered to be unconscious, and emergency medical services (EMS) had to be called. This was discovered by first shift staff and should have been noticed by third shift staff. No resident or staff names were provided regarding this complaint.

On 1/30/2023 I interviewed administrator Michael Farrell and nurse supervisor Thomas De'Silva at the facility. Mr. Farrell stated that on the morning of 1/18/2023, Resident A was heard by staff, who were conducting rounds at the time, yelling for help after having just fallen. Mr. Farrell stated Mr. De'Silva had more details regarding the incident. At this point, Mr. De'Silva joined the interview. Mr. De'Silva stated that on the morning of 1/18/2023, at approximately 6:45am, Associate 1, first shift care giver, contacted him by telephone to report that she and Associate 2,

third shift care giver, were conducting morning rounds and heard Resident A calling for help at approximately 6:30am. Mr. De'Silva stated Associate 1 reported Resident A had apparently fell from his bed and hit his hear on his nightstand causing some bleeding. Mr. De'Silva stated Associate 1 reported Resident A had indicated he had no headache or dizziness. Mr. De'Silva stated Associate 1 then contacted Resident A's power of attorney (POA) and emergency medical services (EMS) to have him evaluated as a precautionary measure since he had hit the nightstand in his head area. Mr. De'Silva stated that at no time was Resident A "unconscious". Mr. De'Silva stated the situation was unforeseeable as Resident A was not known to fall out of bed and had not had previous incidents of that nature since moving to the facility in May of 2022. Mr. De'Silva stated staff are required to conduct rounds to check on residents every two hours as a standard practice, unless the circumstances of a resident require more frequent checks. Mr. De'Silva stated staff track these rounds by entering their initials within the facilities computer tracking system on an activities of daily living (ADL) log. Mr. De'Silva stated Resident A is not a person who was identified as needed to be checked on more frequently. Mr. De'Silva stated, again, that while Resident A required staff assistance for transfers, as he could not do so on his own, he was not known to attempt to transfer on his own or roll out of bed. Mr. De'Silva stated that due to the time of Resident A's incident, it is not true that third shift staff would or should have found Resident A before first shift staff came in. Mr. De'Silva stated that first shift staff sometimes come in at 6:30am "as [Associate 1] did on the morning of 1/18/2023" and help third shift staff, who's shift is from 11pm to 7am, complete rounds. Mr. De'Silva stated it is also the case that Resident A generally sleeps later in the morning and did not have a history of getting up at the time of the incident.

On 1/30/2023, I interviewed Associate 1, who is a caretaker and a medication technician (med tech) at the facility. Associate 1 provided statements consistent with those of Mr. De'Silva regarding the events of 1/18/2023, the supervision expectations for Resident A at that time and staffing expectations for conducting rounds to check on residents.

I reviewed *Charting Notes* for Resident A, provided by Mr. Farrell, dated from 5/23/2023 until 1/26/2023, the last date of notes entered for Resident A prior to the date of onsite. The notes read consistently with statements provided by Mr. De'Silva regarding Resident A having no notable history at the facility that would require more frequent well checks or would have indicated such an event, such as the 1/18/2023 incident, would have been foreseeable.

I reviewed Resident A's *ADL Log* for January 2023, provided by Mr. Farrell, which read consistently with statements provided by Mr. De'Silva indicating staff had conducted rounds consistently as required by facility expectation.

I reviewed Resident A's service plan, provided by Mr. Farrell, which read consistently with statements provided by Mr. De'Silva.

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.**
ANALYSIS:	The complaint alleged Resident A had fallen in his room and was unconscious, on the morning of 1/18/2023, and was discovered by first shift staff during rounds but should have been found by third shift staff. While the investigation revealed Resident A did fall resulting in a laceration to his ear, there is insufficient evidence to support inadequate supervision under the circumstances.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents not treated with dignity

INVESTIGATION:

According to the compliant, staff are forcing residents to take medications and are left in soiled briefs for extended periods of time. No resident or staff names, times or date references were provided regarding this complaint.

When interviewed, Mr. Farrell and Mr. De'Silva stated they were unaware of any residents being forced by staff to take medications, or of any residents being left in soiled briefs for extended periods of time. Mr. De'Silva stated staff are aware of resident rights and that residents can refuse medications if they want to. Mr. De'Silva stated that, as a part of regular founds, staff are also expected to assist residents with brief changes and toileting as needed. Mr. De'Silva stated residents who specifically require checks for toileting and brief changes, have this scheduled and is tracked specifically on the residents *ADL log*.

When interviewed, associate 1 stated she has never "forced" a resident to take medications and is unaware of any staff who do so. Associate 1 stated "there is no benefit to me to force anyone to do such a thing". Associate 1 stated she was trained to make at least three attempts to pass medication to a resident and that if they refuse to take it, she will note this in the resident's medication administration record (MAR). Associate 1 stated she currently administers medication to one resident, Resident B, who does refuse her medications. Associate 1 stated she has a good relationship with Resident B and Resident B will often take when she administers to

her, but sometimes will refuse with other staff. Associate 1 stated she is not aware of staff neglecting to toilet residents or change their briefs. Associate 1 stated she provides care when not passing medications and feels she is able to meet this need consistently for residents.

I reviewed Resident B's MAR for January 2023, provided by Mr. Farrell. The MAR read consistently with statements provided by Associate 1 noting that on at least four administration times, two on 1/02/2023 and two on 1/02/2023, Resident B refused to take two of her medications from staff other than Associate 1.

I reviewed January *ADL Logs* for Residents C, D and E, provided by Mr. Farrell and who's names I chose randomly from the resident census. The logs read consistently with statements provided by Mr. De'Silva indicating tracking and consistency by staff in providing toileting assistance.

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:	The complaint alleged staff forced residents to take medications and did not provide adequate toileting assistance to residents. The investigation revealed insufficient evidence to support the allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Spoiled and expired food is stored in the kitchen

INVESTIGATION:

According to the complaint, the facility is keeping spoiled and expired food in the kitchen refrigerator.

When interviewed, Mr. Farrell stated he has not been made aware of any issues related to expired food being stored in the kitchen.

During the onsite, I inspected the kitchen food storage within the dry food, refrigerator, and freezer areas. All items observed within the dry food storage area were within the appropriate, non-expired, date range. Several food items within the refrigerator were discovered to be either past the labels due date, or expiration date, not dated and/or not sealed adequately. For example, I observed two pans with what appeared to some type of chicken which did have a plastic cover, however, they did

not have any date as to when it was opened and placed in the refrigerator. I observed what appeared to be a type of loaf in a metal pan which was loosely covered with plastic and had a storage date of 12/23/2022, 38 days from the date of inspection. I observed several packages of cheese and pans of sauce which were opened or loosely covered with no date indicating when these items were opened or stored. I observed raw chicken inside a plastic bag, and not completely sealed, sitting in an open box with no date of storage. I observed raw bacon inside an unsealed bag, inside an unclosed box, with no storage date. I observed several food items within the freezer to be unsealed or completely open with no storage dates including a box of mixed vegetables, bags of strawberries and a bag of ravioli.

APPLICABLE RULE	
R 325.1976	**Kitchen and dietary.**
	(6) Food and drink used in the home shall be clean and wholesome and shall be manufactured, handled, stored, prepared, transported, and served so as to be safe for human consumption.
ANALYSIS:	The complaint alleged spoiled and expired food was being stored in the kitchen. The investigation revealed several food items stored in the kitchen refrigerator and freezer which were expired, unlabeled and/or not sealed adequately. Based on the findings the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Aaron L Clum 3/03/2023

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Aaron Clum Date
Licensing Staff

Approved By:

Andrea L Moore 03/08/2023

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