GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 15, 2023

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

RE: License #:	AL250331306
Investigation #:	2023A0872020
	Degas House Inn

Dear Ms. Sevegney:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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

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 #:	AL250331306
Investigation #:	2023A0872020
Complaint Receipt Date:	01/12/2023
Investigation Initiation Date:	01/13/2023
Report Due Date:	03/13/2023
Licensee Name:	Symphony of Linden Health Care Center, LLC
Licensee Address:	7257 N. Lincoln Lincolnwood, IL 60712
Licensee Telephone #:	(810) 735-9400
Administrator:	Melissa Sevegney
Licensee Designee:	Melissa Sevegney
Name of Facility:	Degas House Inn
Facility Address:	202 S Bridge Street Linden, MI 48451
Facility Telephone #:	(810) 735-9400
Original Issuance Date:	05/01/2014
License Status:	1ST PROVISIONAL
Effective Date:	11/28/2022
Expiration Date:	05/27/2023
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
On 12/17/22, Relative C1 attempted to contact Resident C via telephone on numerous occasions over the course of several hours. She was unable to reach anyone at the facility via telephone until 12/18/22.	Yes
On 12/17/22, at approximately 8:20pm, Resident C was on the phone with Relative C1. As they were hanging up, Resident C fell. Staff did not find Resident C until the next morning (12/18/22) at which time she was transported to the hospital. Resident C sustained several injuries as a result of this fall.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/12/2023	Special Investigation Intake 2023A0872020
01/13/2023	Special Investigation Initiated - Letter I exchanged emails with the licensee designee, Kimberly Gee
01/17/2023	Contact - Telephone call made I interviewed Relative C1 via telephone
01/17/2023	APS Referral I made an APS complaint via email
01/19/2023	Inspection Completed On-site Unannounced
01/19/2023	Contact - Document Received I received documentation from Relative C1
02/02/2023	Inspection Completed On-site Unannounced
02/08/2023	Contact - Document Sent I emailed the licensee designee, Melissa Sevegney, requesting information related to this complaint
02/16/2023	Inspection Completed On-site Unannounced

02/17/2023	Contact - Document Received I received AFC documentation related to this complaint
02/21/2023	Contact - Telephone call made I interviewed Relative C2
02/21/2023	Contact - Telephone call made I interviewed Relative C3
02/21/2023	Contact - Document Sent I emailed Ms. Sevegney requesting additional information about this complaint
02/22/2023	Contact - Telephone call made I interviewed staff Bridgett Durance
02/22/2023	Contact - Telephone call made I interviewed the general manager, Kwadwo Owusu-Ansah about this complaint
02/23/2023	Contact - Document Received I received an email from Ms. Sevegney
02/23/2023	Contact - Telephone call made I interviewed staff Tequila Simons-Shields
02/23/2023	Contact - Telephone call made I spoke to Ms. Sevegney
03/01/2023	Contact – Document received I received an email from Relative C1
03/03/2023	Contact – Telephone call made I interviewed staff Nataevion Williams
03/07/2023	Exit Conference I conducted an exit conference with the licensee designee, Melissa Sevegney
03/07/2023	Inspection Completed—BCAL Sub. Non-Compliance

ALLEGATION: On 12/17/22, Relative C1 attempted to contact Resident C via telephone on numerous occasions over the course of several hours. She was unable to reach anyone at the facility via telephone until 12/18/22.

INVESTIGATION: On 01/17/23, I interviewed Relative C1 via telephone. Relative C1 said that on 12/17/22 at approximately 8:20pm, she was talking to Resident C on her cell phone. As they were hanging up, Relative C1 heard Resident C fall. Relative C1 said that she tried calling Resident C back on her cell phone, but she did not answer. Relative C1 said that she continually called the front desk of the facility for several hours, but nobody answered the phone.

Relative C1 said that to her knowledge, at 8pm each night, the phones are transferred to another portion of the facility. She said that she began trying to call the facility at approximately 8:20pm on 12/17/22 and was not able to talk to anybody at the facility until the morning of 12/18/22 at which time staff called to tell her Resident C was being transferred to the hospital due to a fall. Relative C1 said that there have been several other occasions when she has been unable to reach Resident C or staff at this facility via telephone.

On 02/22/23, I interviewed the general manager, Kwadwo Owusu-Ansah about this complaint. Mr. Owusu-Ansah said that from 8am-8pm, the phones of all the Inns ring into the main office and the receptionist responds to all calls. At 8pm, the phones automatically transfer over to the nursing home side of the facility. From 8pm-8am, the nurses who are working on the nursing home side of the facility are responsible for answering the phones. He said that sometimes, the nurses are taking care of patients and they are unable to answer the phones when someone calls. I asked him if anyone is able to leave a message when they call the nursing home side, and he said no. He said that the phone will continually ring until the caller hangs up or a nurse answers the phone.

Mr. Owusu-Ansah said that all residents have landline telephones in their rooms. If a resident wants to call someone, they press “9” to get an outside line and then their call goes directly to whoever they want to call. If someone wants to call and speak to one of the residents, the caller must reach someone by calling the main phone number and that individual then must transfer the caller to the resident’s room.

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: **(e) The right of reasonable access to a telephone for private communications. Similar access shall be granted for long distance collect calls and calls which otherwise are paid for by the resident. A licensee may charge a resident**

	for long distance and toll telephone calls. When pay telephones are provided in group homes, a reasonable amount of change shall be available in the group home to enable residents to make change for calling purposes.
ANALYSIS:	On 12/17/22, beginning at approximately 8:20pm, Relative C1 called the facility on numerous occasions into the morning hours of 12/18/22. Nobody at the facility answered her call and she was unable to talk to staff regarding Resident C until the morning of 12/18/22. Relative C1 said that there have been several other occasions when she has been unable to reach Resident C or staff at this facility via telephone. On 02/22/23, I interviewed the general manager, Kwadwo Owusu-Ansah via telephone. Mr. Owusu-Ansah said that from 8am-8pm, the phones of all the Inns ring into the main office and the receptionist responds to all calls. At 8pm, the phones automatically transfer over to the nursing home side of the facility. From 8pm-8am, the nurses who are working on the nursing home side of the facility are responsible for answering the phones. He said that sometimes, the nurses are taking care of patients and they are unable to answer the phones when someone calls. I asked him if anyone is able to leave a message when they call the nursing home side, and he said no. He said that the phone will continually ring until the caller hangs up or a nurse answers the phone. Mr. Owusu-Ansah said that if someone wants to call and speak to one of the residents, the caller must reach someone by calling the main phone number and that individual then must transfer the caller to the resident's room. Numerous calls by Relative C1 to the facility were not answered nor transferred to the resident. Therefore, the resident was not provided with reasonable access to a telephone for incoming calls. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: On 12/17/22 at approximately 8:20pm, Resident C was on the phone with Relative C1. As they were hanging up, Resident C fell. Staff did not find Resident C until the next morning (12/18/22) at which time she was transported to the hospital. Resident C sustained several injuries as a result of this fall.

INVESTIGATION: On 01/17/23, I interviewed Relative C1 via telephone. Relative C1 said that on 12/17/22 at approximately 8:20pm, she was talking to Resident C on her cell phone. As they were hanging up, Relative C1 heard Resident C fall. On the morning of 12/18/22, staff contacted Relative C1 and told her that Resident C was being transported to the hospital due to injuries she sustained to her face during a fall.

Relative C1 said that when she saw Resident C the next day (12/18/22), she had a wound on her head that had obviously bled. She also had injuries around her eyes and on her nose. Relative C1 said that when Resident C fell, she shattered her cell phone and smashed her eyeglasses.

On 01/19/23, I conducted an unannounced onsite inspection of Degas House Inn and Homer House Inn. Since Resident C no longer has a room in Degas House Inn, I inspected her new bedroom in Homer House Inn. I found her room to be clean, although cluttered, since she just moved in. Resident C was in another portion of the facility, receiving physical therapy so I was unable to meet with her.

On 01/19/23, I obtained a copy of an Incident/Accident (IR) Report dated 12/19/22 regarding Resident C. The IR was completed at 7:15am by the health and wellness director, Stephanie Gunn, on behalf of staff Bridgett Durance. According to the IR, "(Staff) Bridgett (Durance) went into the resident's room to get her up for the day. She observed the resident on the floor. She had hit her face and forehead. The staff assisted the resident to her chair." Resident A was sent to the hospital for treatment. The corrective measures taken were, "The resident will have frequent checks by the staff for safety."

On 02/02/23, I conducted another unannounced onsite inspection of Homer House Inn. I interviewed the director of guest services, Melissa Reich, Resident C and Relative C1. I asked Ms. Reich how often staff are required to check on the residents and she said every two hours or more often if necessary.

I interviewed Relative C1 and Resident C in Resident C's bedroom. I observed Resident C to be clean and dressed appropriately. Relative C1 told me that she is concerned that staff is not meeting Resident C's needs. She said that she is very concerned about Resident C's fall on 12/17/22 since she laid injured, in her room for hours until staff found her the next morning. According to Relative C1, when Resident C was admitted to Symphony Inns, she was told that staff would check on her every two hours or more often if necessary.

I asked Resident C about the fall, and she said that she does not remember much. She did say, "It was a bad fall" but she does not remember what day it happened and does not remember if it was daytime or nighttime. I asked her if she laid on the floor for a long time before staff discovered her and she said that she does not think so, but she does not know. Resident C said that she remembers being in pain, but she does not know if she lost consciousness and does not remember what time or the name of the staff who

found her. She told me that her head “didn’t feel right” and she remembers going to the hospital and knows that her glasses and her cell phone broke from the fall.

On 02/16/23, I conducted another unannounced onsite inspection of Degas/Homer House Inn. I interacted with Resident C who was walking in the hallway with her walker. I observed her to be clean and dressed appropriately. Staff was accompanying her to physical therapy.

On 02/21/23, I reviewed AFC paperwork related to this complaint. According to Resident C’s Health Care Appraisal, she is diagnosed with dementia, hard of hearing, rhabdomyolysis, osteoarthritis, falls, hyperlipidemia, and unsteadiness. She uses a walker for mobility.

On 02/21/23, I reviewed her Assessment Plan dated 04/02/22 which states that she needs supervision with bathing, personal hygiene, and dressing. She uses a walker for mobility. She wears pull-ups due to partial incontinence of her bladder. Her assessment plan indicates that she does not have a history of falls, but she is taking medications that may affect falls. According to the previous licensee designee, Kimberly Gee, the current licensee, Melissa Sevegney and the previous health and wellness director, Stephanie Gunn, staff are supposed to check on the residents every two hours or more often if necessary.

On 02/21/23, I reviewed staff progress notes related to Resident C from 12/15/22 through 01/12/23. On 12/17/22, the last notation was at 4:01pm from staff Bridgett Durance stating that she applied a medicated topical ointment to Resident C’s feet. There were no notations for 12/18/22.

On 12/19/22, staff Stephanie Gunn noted, “Writer spoke with resident regarding fall yesterday. The resident has bruising to forehead, nose and around both eyes. When the resident was asked what happened, the resident responded ‘I don’t know of anything happening. Every day is about the same.’ The writer asked the resident how the bruises occurred on their face. The resident stated they had no idea they had bruises to their face and could not recall any fall or incident. The resident was sent to the ER on 12/18/22 for eval and treatment. The resident was returned to the facility the same day. No new orders. The staff will continue to monitor the resident frequently. The resident was also seen by PT today for eval. The resident will begin therapy for altered gait.” Staff Stephanie Gunn no longer works for this facility.

On 02/22/23, I interviewed staff Bridgett Durance via telephone. Ms. Durance said that she has worked for Symphony Inns for approximately three years, and she typically works 1st shift. She said that she used to work in Degas House Inn with Resident C. I reviewed the allegations with Ms. Durance. She told me that she typically gets to work at 6am and begins doing wakeup checks at 7am. Although she does not remember the date of the incident, she did tell me that in December 2022, when she went into Resident C’s room, she found her on the floor. Ms. Durance said that Resident C was

lying by her bed. Ms. Durance helped her up, called the then-director, Stephanie Gunn who then called 911 to have Resident C sent to the hospital.

Ms. Durance said that she does not remember a lot about the incident but does remember that Resident C's nose was bleeding and said, "her nose looked broken." Ms. Durance said that she asked Resident C what happened, and she said, "I fell." I asked Ms. Durance if she remembers if the blood on Resident C's face was fresh or dried and she said she does not remember. She said that she believes that Resident C had been laying there "a while" because whenever she has fallen in the past, she has been able to get herself back up. Ms. Durance said that she does not remember anything else about the incident. I asked Ms. Durance how often staff is supposed to check on the residents and she said every two hours or more often if necessary.

On 02/23/23, I interviewed staff Tequila Simons-Shields via telephone. Ms. Simons-Shields said that she is a 3rd shift supervisor. She said that she has worked at Symphony Inns for approximately six months, and she typically works 3rd shift. I asked Ms. Simons-Shields how often staff is supposed to check on the residents. She said that staff is required to check on the residents every two hours or more often if necessary.

I completed an investigation, SIR #2022A0872019 dated 03/03/22. I substantiated violation to R 400.15303(2) and concluded that staff often left one of the residents in a soiled brief. In addition, staff did not bath her on a regular basis, and they did not assist her with meals. The licensee designee, Kimberly Gee submitted a corrective action plan dated 03/09/22 stating that education was provided to the evening supervisor "to ensure proper personal care provided as specified in each resident assessment plan."

I completed an investigation, SIR #2022A0872058 dated 11/09/22. I substantiated violation to R 400.15303(2) and concluded that on one occasion, Resident A pressed her call light for staff assistance and staff did not respond for five hours during which Resident A was left sitting in a wet brief. Family spent 8-12 hours a day caring for Residents A and B cleaning, doing laundry, and helping Resident B with meals. On one occasion, Resident B had an odor. When staff undressed him, they found he had stuffed three socks soiled with fecal matter in his brief. Family had to change Resident A and B's briefs because staff was unavailable. Staff Melissa White and Trinidy Tomlin told me that there were occasions that staff was unable to respond to Resident A and B's needs in a timely manner. The licensee designee, Kimberly Gee submitted a corrective action plan dated 11/21/22 stating "Licensee and Director will review schedule and assignment sheets to ensure proper levels of staff provided." On 11/28/22, this facility's license status was changed to provisional.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	On 12/17/22 at approximately 8:20pm, Relative C1 was talking to Resident C on the phone. As they were hanging up, Relative C1 heard Resident A fall. Staff contacted Relative C1 on the morning of 12/18/22 and told her that Resident C was being transported to the hospital due to injuries on her face received during a fall. Relative C1 saw Resident C on 12/18/22 and saw several injuries to her forehead, nose, and around both eyes. Resident C suffers from dementia as well as other diagnoses. Resident C told me that she remembers having "a bad fall" but does not remember any details about the fall. Resident C is diagnosed with dementia, hard of hearing, rhabdomyolysis, osteoarthritis, falls, hyperlipidemia, and unsteadiness. She requires personal care, protection, and supervision according to her Assessment Plan. On 02/21/23, I reviewed staff progress notes related to Resident C. The last notation was made by staff Bridgett Durance on 12/17/22 at 4:01pm stating that she applied a medicated ointment to Resident C's feet. There were no notations regarding Resident C on 12/18/22. On 02/22/23, I interviewed staff Bridgett Durance. She told me that she typically gets to work at 6am and begins doing wakeup checks at 7am. Although she does not remember the date of the incident, she did tell me that in December 2022, when she went into Resident C's room, she found her on the floor, with injuries to her face. Ms. Durance said that Resident C was lying by her bed and "her nose looked broken." She said that she believes that Resident C had been laying there "a while" because whenever she has fallen in the past, she has been able to get herself back up. According to Relative C1, former licensee designee, Kimberly Gee, current licensee designee, Melissa Sevegney, former health and wellness director, Stephanie Gunn, the director of guest services, Melissa Reich, staff Tequila Simons-Shields and staff Bridgett Durance, staff are required to check on the residents every two hours or more often if necessary.

	According to the Incident/Accident Report dated 12/19/22 at 7:15am, staff Bridgett Durance found Resident C on the floor in her room. Resident A had injuries to her face, so she was transported to the hospital. She was treated for her injuries and released. Resident C fell during the evening of 12/17/22 and she was not found by staff until the morning of 12/18/22. Degas House Inn policy states that residents will be checked every two hours or more often if necessary. According to Resident C's assessment plan, she requires personal care, protection, and supervision. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Ref. SIR #2022A0872019 dated 03/03/22 and CAP dated 03/09/22.** **Ref. SIR #2022A0872058 dated 11/09/22 and CAP dated 11/21/22.**

ADDITIONAL FINDINGS:

INVESTIGATION: On 01/17/23, I interviewed Relative C1 via telephone. Relative C1 said that on 12/17/22 at approximately 8:20pm, she was talking to Resident C on her cell phone. As they were hanging up, Relative C1 heard Resident C fall. Relative C1 said that she continually called the front desk of the facility for several hours, but nobody answered the phone, and she was unable to check on Resident C's well-being. On the morning of 12/18/22, staff contacted Relative C1 and told her that Resident C was being transported to the hospital due to injuries she sustained to her face during a fall. Relative C1 said that staff did not check on Resident C's well-being from prior to 8:20pm on 12/17/22 until the morning of 12/18/22.

On 02/22/23, I interviewed the general manager, Kwadwo Owusu-Ansah about this complaint. He said that the facility phones are transferred to the nursing home side of the facility from 8pm-8am. Mr. Owusu-Ansah said that nursing home staff are not required to provide care to the residents of Degas House Inn during the hours of 8pm-8am but they are responsible for answering the phones.

According to Resident C's Health Care Appraisal, she is diagnosed with dementia, hard of hearing, rhabdomyolysis, osteoarthritis, falls, hyperlipidemia, and unsteadiness.

According to Resident C's Assessment Plan dated 04/02/22, she requires supervision with bathing, personal hygiene and dressing and she uses a walker for mobility. She also wears pull-ups due to partial incontinence of her bladder.

According to the former licensee designee, Kimberly Gee, current licensee designee, Melissa Sevegney, former health and wellness director, Stephanie Gunn, the director of guest services, Melissa Reich, staff Tequila Simons-Shields and staff Bridgett Durance, staff are required to check on the residents every two hours or more often if necessary.

According to the current licensee designee, Melissa Sevegney, the previous licensee designee did not require staff assignment sheets. Therefore, there is no record of which staff or how many worked in each of the five Inns during the months of November and December 2022.

Relative C1 said that when Resident C was admitted to this facility, she was told that there would be sufficient staff to provide care and supervision to Resident C and that staff would check on her every two hours or more often if necessary.

On 03/03/23, I interviewed staff Nataevion Williams via telephone. Mr. Williams said that he typically works 1st shift, and it is his understanding that staff are required to constantly check on the residents and to recheck them during any "down time" they may have.

I completed an investigation, SIR #2022A0872019 dated 03/03/22. I substantiated a violation to R 400.15206(2) and concluded that there was insufficient staff to meet the needs of the residents. At the time of the investigation, there were several residents that required a 2-person assist however the facility did not have at least 2 full time staff per shift to provide personal care, protection, and supervision to the residents. The licensee designee, Kimberly Gee submitted a corrective action plan dated 03/09/22 stating that, "The Licensee/Administrator educated eve supervisor on 2 staff requirements for Degas due to Resident(s) assessment plan. Degas House Schedule will be reviewed daily to ensure compliance. This review will be captured on an audit tool, turned in weekly to Licensee for additional oversight for the next 3 months."

I completed an investigation, SIR #2022A08750 dated 10/10/22. I substantiated a violation to R 400.15206(2) and concluded that there was insufficient staff to provide for the needs of the residents. At the time of that investigation, staff were responsible for the following: passing medications, providing patient care, distributing meals to the residents, cleaning up after meals, doing laundry, showering residents, and doing light housekeeping. The licensee designee, Kimberly Gee submitted a corrective action plan dated 10/21/22 stating that the assistant living director would identify the acuity of each house and staff accordingly. In addition, the administrator was to educate the director and assistant living director regarding sufficient staffing.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services

	specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	On 12/17/22 at approximately 8:20pm, Resident C fell. She was not discovered by staff until 12/18/22 at approximately 7:15am. According to Relative C1, former licensee designee, Kimberly Gee, current licensee designee, Melissa Sevegney, former health and wellness director, Stephanie Gunn, the director of guest services, Melissa Reich, staff Tequila Simons-Shields and staff Bridgett Durance, staff are required to check on the residents every two hours or more often if necessary. According to the current licensee designee, Melissa Sevegney, the previous licensee designee did not require staff assignment sheets. Therefore, there is no record of which staff worked in each of the five Inns during the months of November and December 2022. According to staff Nataevion Williams, staff is supposed to "constantly" check on the residents and to recheck them during any down time. On 12/17/22, Relative C1 was unable to reach Resident A by telephone for approximately 11 hours. According to the general manager, Kwadwo Owusu-Ansah Degas House Inn staff are not required to answer the phones between the hours of 8pm-8am. Nursing home staff in another part of the building is responsible for answering the phones but if they are busy with patients, they do not answer. There were no staff progress notes on 12/18/22 indicating that staff checked on Resident C. On 12/17/22 into the morning of 12/18/22, there are no staff notes indicating that staff checked on Resident C. In addition, there was insufficient staff to answer the phones from 8:20pm on 12/17/22 into the morning hours of 12/18/22. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Ref. SIR #2022A0872019 dated 03/03/22 and CAP dated 03/09/22.** **Ref. SIR #2022A0872050 dated 10/10/22 and CAP dated 10/21/22.**

INVESTIGATION: On 02/23/23, I spoke to the current licensee designee, Melissa Sevegney via telephone. Ms. Sevegney said that she does not know for sure who worked 3rd shift in Degas House Inn on 12/17/22. According to Ms. Sevegney, the previous licensee designee did not require assignment sheets for the months of November and December 2022. Symphony Inns has a total of five AFC facilities at this location, each with a total capacity of 20 residents. The staff schedule does not specify which staff worked according to the specific Inn. Ms. Sevegney said that she is working on ensuring that each facility has its own staff schedule so staff names and shifts worked will be clear. Ms. Sevegney said that the closest she can get to knowing who worked on which days at which Inn is to contact the human resources department and find out the names of staff that clocked in and out on that date. Even with this information, Ms. Sevegney said that she will not know which staff worked in which Inn unless she contacts each of them and asks them if they remember which Inn they were working on a specific date in November/December 2022.

APPLICABLE RULE	
R 400.15208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.** **(b) Job titles.** **(c) Hours or shifts worked.** **(d) Date of schedule.** **(e) Any scheduling changes.**
ANALYSIS:	According to the current licensee designee, Melissa Sevegney, the previous licensee designee did not require staff assignment sheets. Therefore, there is no record of the names of staff, hours or shifts worked, date of schedule, and any scheduling changes for the months of November and December 2022. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: Degas House Inn is one of five 20-bed Adult Foster Care facilities owned by Symphony Inns located at 202 S. Bridge St., Linden, MI.

On 01/19/23, I received an email from Relative C1. She stated that on 01/18/23, Relative C2 received a telephone call from the facility, notifying them that Resident C would be moved from Degas House Inn to Homer House Inn. Relative C1 said that Resident C and her family were only given one hours' notice of this move. She said that

when she got to the facility, she found Resident C “traumatized and very upset” in her new room. Relative C1 said that Resident C is 93-years old and was very confused about this move, especially since there was no family there to comfort her during the move.

On 02/21/23, I emailed the licensee designee, Melissa Sevegney. I asked her to email me information about the notice Symphony Inns provided to Resident C and her family regarding her move from Degas House Inn to Homer House Inn.

On 02/21/23, I interviewed Relative C2 via telephone. Relative C2 said that on January 18, 2023, she received a voicemail message from Symphony Inns telling her that Resident C was being moved from Degas House Inn to Homer House Inn in a couple of hours. Relative C2 said that she called the facility back and spoke to staff (she does not recall who she spoke to.) Relative C2 said that she was told that Resident C was moving to another one of the Inns to a similar room. She said that she was not given the option of which Inn or which room Resident C was going to be moved to and she was not given written notification of this move.

On 02/21/23, I interviewed Relative C3 via telephone. Relative C3 said that she was not notified by Symphony Inns that Resident C would be moving from Degas House Inn to Homer House Inn. Relative C3 said that she was not provided verbal or written notice of this move.

On 02/22/23, I received additional documentation from Ms. Sevegney regarding this complaint. I reviewed a progress note dated 01/18/23 at 4pm completed by clinical services consultant, Joann Maddux regarding Resident C. According to the progress note, “Discussed consolidation of Degas Inn and the need to move residents’ room with resident/responsible party. Appropriate 30-day notice was discussed with the option of voluntarily moving to another Inn earlier. Resident/responsible party chose to proceed with move effective immediately, resident was relocated to a comparable room and oriented to new Inn.”

On 02/22/23, I reviewed a letter dated 01/18/23 addressed to the family of Resident C. According to this letter, “Per our discussion on January 18, 2023, this letter is to confirm that you have agreed and been provided a ’30-day’ notice (effective 1/18/23) about your loved ones’ change of inns and new suite that is comparable to their current one. Per your verbal approval, the move to the new suite happened effective immediately. Please sign below to provide confirmation of this notice.” The letter is signed by the former licensee designee, Kimberly Gee. The letter is not signed by any of Resident C’s family.

APPLICABLE RULE	
R 400.15302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(6) A licensee shall not change the residency of a resident from one home to another without the written approval of the resident or the resident's designated representative and responsible agency.
ANALYSIS:	On 01/18/23, Relative C2 received a voice mail message from Symphony Inns telling her that Resident C would be relocated from Degas House Inn to Homer House Inn within the next couple of hours. Relative C2 said that she called the facility back and spoke to staff (she does not recall who she spoke to.) Relative C2 said that she was told that Resident C was moving to another one of the Inns to a similar room. She said that she was not given the option of which Inn or which room Resident C was going to be moved to and she was not given written notification of this move. Relative C1 and Relative C3 said that they were not provided with verbal or written notice that Resident C would be moved from Degas House Inn to Homer House Inn. Relative C1 said that on 01/18/22 when she met with Resident C in her new room in Homer House Inn, she found her “traumatized and very upset”. Relative C1 said that Resident C is 93-years old and was very confused about this move, especially since there was no family there to comfort her during the move. I reviewed a letter dated 01/18/23 addressed to the family of Resident C. According to this letter, “Per our discussion on January 18, 2023, this letter is to confirm that you have agreed and been provided a ’30-day’ notice (effective 1/18/23) about your loved ones’ change of inns and new suite that is comparable to their current one. Per your verbal approval, the move to the new suite happened effective immediately. Please sign below to provide confirmation of this notice.” The letter is signed by the former licensee designee, Kimberly Gee. The letter is not signed by any of Resident C’s family. Degas House Inn did not receive written approval from Resident C or Resident C’s family before moving her to a different facility.

	I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 01/19/23, I obtained a copy of an Incident/Accident (IR) Report dated 12/19/22 regarding Resident C. The IR was completed at 7:15am by the health and wellness director, Stephanie Gunn, on behalf of staff Bridgett Durance. According to the IR, "(Staff) Bridgett (Durance) went into the resident's room to get her up for the day. She observed the resident on the floor. She had hit her face and forehead. The staff assisted the resident to her chair." Resident C was sent to the hospital for treatment. The corrective measures taken were, "The resident will have frequent checks by the staff for safety."

On 02/22/23, I interviewed staff Bridgett Durance via telephone. She confirmed that she found Resident C on the floor on 12/18/22 and Resident C was sent to the hospital. Ms. Durance confirmed that she did not complete an IR regarding this incident.

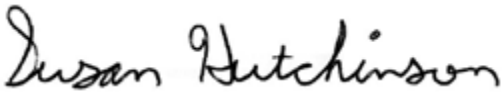
APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division with 48 hours of any of the following: **(b) Any accident or illness that requires hospitalization.**
ANALYSIS:	On 01/19/23, I obtained a copy of an Incident/Accident Report (IR) dated 12/19/22. I did not receive the IR within 48 hours of the incident as required. Furthermore, the staff who found the resident on the floor, Bridgett Durance did not complete the IR. The IR was completed by the health and wellness director, Stephanie Gunn. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 03/07/23, I conducted an exit conference with the licensee designee, Melissa Sevegney. I discussed the results of my investigation and told her which rule violations I am substantiating. I told her that I am recommending revocation of this license. Ms.

Sevegney said that she does not agree with my recommendation and stated that since taking over as licensee designee on 02/01/23, she has been making significant changes and improvements to this facility's operation. Ms. Sevegney said that she feels confident that these changes and improvements will prevent future negative actions against this facility.

IV. RECOMMENDATION

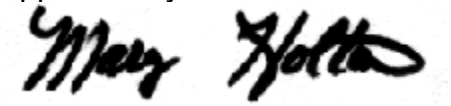
I recommend revocation of the license.



March 7, 2023

Susan Hutchinson Licensing Consultant	Date

Approved By:



March 7, 2023

Mary E. Holton Area Manager	Date