GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 8, 2023

Julie Norman
Farmington Hills Inn
30350 W. Twelve Mile Road
Farmington Hills, MI 48334

RE: License #: AH630236784
Investigation #: 2023A1027058
Farmington Hills Inn

Dear Ms. Norman:

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 authorized representative 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) 241-1970.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630236784
Investigation #:	2023A1027058
Complaint Receipt Date:	04/11/2023
Investigation Initiation Date:	04/11/2023
Report Due Date:	06/11/2023
Licensee Name:	Alycekay Co.
Licensee Address:	30350 W 12 Mile Rd. Farmington Hills, MI 48334
Licensee Telephone #:	(248) 851-9640
Authorized Representative/ Administrator:	Julie Norman
Name of Facility:	Farmington Hills Inn
Facility Address:	30350 W. Twelve Mile Road Farmington Hills, MI 48334
Facility Telephone #:	(248) 851-9640
Original Issuance Date:	12/29/2000
License Status:	REGULAR
Effective Date:	10/10/2022
Expiration Date:	10/09/2023
Capacity:	137
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was neglected and lacked care. Employees utilized personal cell phones. An unknown resident eloped from the facility.	Yes
Resident A's authorized representative did not receive a discharge notification letter.	No
Additional Findings	No

III. METHODOLOGY

04/11/2023	Special Investigation Intake 2023A102705
04/11/2023	Special Investigation Initiated - Letter Email sent to complainant requested additional information
04/11/2023	Contact - Document Received Email received from complainant with additional information requested
05/04/2023	Inspection Completed On-site
05/04/2023	Contact - Document Received Email received from Ms. Norman will additional documentation
05/05/2023	Contact - Document Received Email received from Ms. Norman will additional documentation
05/08/2023	Contact - Document Sent Email sent to Ms. Norman requesting additional documentation
05/12/2023	Contact - Document Received Email received from Ms. Norman will additional documentation
05/26/2023	Exit Conference Conducted by voicemail, then by email with authorized representative Ms. Norman

ALLEGATION:

Resident A was neglected and lacked care. Employees utilized personal cell phones. An unknown resident eloped from the facility.

INVESTIGATION:

On 4/11/2023, the Department received a complaint through the online complaint system which read Resident A was in the later stages of dementia but was fine prior to moving into the facility, then quickly declined. The complaint read Resident A moved into the facility on 1/10/2023. The complaint read by the third weekend after moving in, Resident A was sitting in a wheelchair with her arm out of her shirt and staff were on their cell phones. The complaint read Resident A lacked bathing. The complaint read Resident A's spouse would visit daily before lunch in which sometimes he would arrive, and she would be in bed. The complaint read it was uncertain if Resident A received meals. The complaint read Resident A had fallen out of bed and had an injury on her temple, as well as fell out of bed on 3/14/2023. The complaint read Resident A had wounds on her heels due to being in bed too long. The complaint read Resident A was prescribed Tylenol #3 in which she could not handle something that strong and thought the facility medicated her to keep quiet so staff could be on their cell phones. The complaint read on 3/11/2023 documentation located at the nurse's station was observed which read a resident had "escaped" on 3/10/2023 around 4:00 PM and was brought back to the facility by the police.

On 5/4/2023, I conducted an on-site inspection at the facility. I interviewed administrator and authorized representative Julie Norman who stated she assessed Resident A for admission to the facility on 12/27/2022. Ms. Norman stated Resident A ambulated without equipment and had dementia in which initially her needs could be met upon that assessment. Ms. Norman stated Resident A admitted to the facility on 1/10/2023. Ms. Norman stated shortly after admission, Resident A would not bear weight on both of her legs during transfers. Ms. Norman stated Resident A had knee surgery, but her spouse stated it was six months prior to admission, so she was uncertain of what caused her change. Ms. Norman stated it seemed Resident A "became fearful" of falling in which she had fallen at home and had a fall at the facility in March 2023. Ms. Norman stated Resident A required two to three staff assistance for transferring. Ms. Norman stated when Resident A had home care services in which physical therapy worked with her at the facility. Ms. Norman stated after home care services, the facility obtained an order for hospice services. Ms. Norman stated the facility was unable to accommodate Resident A's increased level of assistance. Ms. Norman stated she provided Resident A's spouse with a 30-day discharge notification letter on 3/8/2023. Ms. Norman stated Resident A's family found a facility who could meet her needs and she discharged on 3/14/2023. Ms. Norman stated the facility did not maintain physician visit notes or hospice agency notes, but she could request them if needed. Ms. Norman stated Resident A's file lacked chart notes, except for a note regarding a visit from the podiatrist. Ms.

Norman stated the facility maintained a shower schedule for all residents; however, all residents received showers minimally once weekly and as needed. Additionally, Ms. Norman stated staff were to only utilize their cell phones in private areas to take calls and messages.

While on-site, I observed the Reflections (memory care) unit. I observed approximately 14 residents who appeared groomed and dressed in clean clothing. I observed four staff within the unit in which each staff person appeared to be providing resident care. For example, one staff person was talking with residents, one staff person was administering medications, one staff person was assisting a resident in their room and the other one staff person was painting residents' nails.

While on-site, I interviewed Employee #1 whose statements were consistent with Ms. Norman. Employee #1 stated Resident A would yell for her spouse at night. Employee #1 stated Resident A would lay on her back if staff attempted to rotate her throughout the night. Employee #1 stated if staff were observed on their cell phones in resident care areas, then they would be required to go home, which had not occurred recently.

While on-site, I interviewed Employee #2 whose statements were consistent with previous staff interviews. Employee #2 stated some mornings Resident A declined to get out of bed, however with encouragement from her spouse and staff, she would get into her wheelchair. Employee #2 stated Resident A refused showers at times, in which she would offer again and sometimes would agree.

While on-site, I interviewed Employee #3 whose statements were consistent with previous staff interviews. Employee #3 stated staff would sometimes request her assistance when transferring Resident A. Employee #3 stated Resident A had falls out of bed. Employee #3 stated Resident A would sleep in her chair while she conducted activities in the Reflections unit, however she would encourage her to participate.

While on-site, I interviewed Employee #4 whose statements were consistent with previous staff interviews. Employee #4 stated she completed the resident's shower schedule in which Resident A's showers were on Mondays, however they were on Mondays and Wednesday once she signed onto hospice services. Employee #4 stated Resident A's hospice aide had requested additional staff assistance with bathing.

On 5/12/2023, per email correspondence with Ms. Norman, an incident report was sent to the Department for Resident B's elopement. Additionally, the correspondence read Resident B had a 1:1 agency aide with her when she exited the facility in which her wander guard was on, staff were alerted, and they were aware she left the facility. The email read Resident B's private duty aide was with her when she exited the facility until her daughter arrived at the facility.

I reviewed Resident B’s incident report dated 3/10/2023 at 4:45 PM read consistent with the complaint and email correspondence from Ms. Norman. The report read in part Resident B’s daughter took her to the psychiatry unit at the hospital.

I reviewed Resident A’s face sheet which read consistent with statements from Ms. Norman. The face sheet read in part Resident A’s diagnoses were dementia, hypothyroid, GERD [Gastroesophageal reflux disease], incontinence and anxiety.

I reviewed Resident A’s initial assessment dated 12/27/2022 which read she was independent with ambulation and utilized a walker. The assessment read Resident A had a fall last September. The assessment read she was independent with eating meals. The assessment read she required extensive assistance with bathing in which she may require encouragement to bathe, direction, as well as hands-on assistance. The assessment read she required assistance with toileting, dressing and grooming. The assessment read her behavior and mood was appropriate. The assessment read a physical therapy order would be sent to start services.

I reviewed Resident A’s service plan updated on 3/9/2023 which read she was dependent for ambulation, was non weight bearing requiring three-person assist and no longer able to ambulate. The plan read Resident A was independent for fall prevention and had no recent falls. The plan read Resident A required limited assist with meals and had a fair appetite. The plan read Resident A required assistance with bathing, dressing, grooming, in which staff were to encourage her to participate. The plan read Resident A will occasionally resist care. The plan read Resident A was dependent for toileting. The plan read Resident A was dependent for cognition and mood in which she was confused to self, day, and time and was easily re-directed. The plan read Resident A was independent with behavior which was appropriate at that time. The plan read there were no safety concerns.

I reviewed Resident A’s licensed healthcare provider notes.

> Note dated 1/31/3023 read in part Resident A had a left knee surgery in September 2022 and was walking with a walker. The note read her dementia was worsening and she was transferred to the facility’s memory care. The note read in part Resident A continued to have pain in her left knee. The note read in part Tylenol was scheduled and Tylenol #3 was added for severe pain or discomfort. The note read in part to continue physical therapy, as well as maintain safety and fall precautions. The note read in part her medications and current plan of care were reviewed with her spouse. The note read in part a psychiatry consult was declined by her family.
>
> Note dated 2/7/2023 read in part Resident A’s laboratory work was completed on 2/4/2023 and the results were reviewed. The note read in part Resident A’s knee pain was slightly improved with scheduled Tylenol and Tylenol #3 as needed. The note read in part psychiatry was consulted for behavioral issues. The note read in part to continue physical therapy along with ultrasound therapy for knee

pain, per Resident A's orthopedic surgeon. The note read in part her medications, as well as current plan of care was discussed and reviewed with her spouse.

Note dated 2/23/2023 read in part staff reported on 2/15/2023, Resident A was a three person assist, and having issues transferring from the wheelchair to her bed. The note read in part, staff reported on 2/17/2023, her left foot had an open area to be evaluated. The note read in part there were no signs or symptoms of infection noted to left heel pressure ulcer. The note read in part a visiting nurse was consulted, Bactroban was prescribed twice daily. The note read in part Resident A was currently receiving physical therapy for her debility with worsening gait. The note read in part the licensed healthcare provider discussed and reviewed the changes with Resident A's spouse, who was agreeable.

Note dated 3/8/2023 read in part the visit was for follow up regarding redness of her eyes, left heel wound and right face wound. The note read in part; Resident A sustained a fall two days prior in which led to injuring her right facial area. The note read in part orders were provided for allergic conjunctivitis. The note read in part her left heel wound orders were changed and external ointment was prescribed for her right face abrasion. The note read in part changes were discussed and reviewed with Resident A's daughter and spouse, who agreed.

I reviewed Resident A's physician orders which read consistent the licensed healthcare professional notes reviewed. Order dated 1/31/2023 read in part to for America's Choice home care to obtain laboratory work. Order dated 1/31/2023 read Acetaminophen-Codeine #3 [Tylenol #3] 300-30 mg take one tablet orally every 12 hours as needed for moderate to severe pain. Order dated 2/7/2023 read in part to consult psychiatry to evaluate and treat for behavior disturbances. Order dated 2/24/2023 read Mupirocin 2%, cleanse left heel wound with wound spray, pat dry, apply mupirocin and cover with bordered gauze 2 times per day for 14 days.

I reviewed Resident A's Heart to Heart Hospice orders. Order dated 3/2/2023 read in part to admit to Heart to Heart hospice and read she had senile degeneration of the brain. Order dated 3/9/2023 read in part wound care instructions for her left heel wound.

I reviewed an incident report dated 3/14/2023 which read in part Resident A was observed on the floor. The report read in part the licensed healthcare professional was in the facility and notified, her spouse and daughter, was well as hospice agency were notified. The report read in part an emergency x-ray was ordered and staff were to continue to monitor her safety until her discharge from the facility.

I reviewed the facility's meal census' dated from 2/5/2023 to 3/5/2023 which read consistent with the facility's resident census for that time.

I reviewed the facility's cell phone policy which read in part cell phones must be in vibrate mode and used only during break or lunch periods. The policy read in part cell phone usage was not permitted in work areas.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	Rule 21. (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.**
For Reference: **R 325.1901**	**Definitions.** **Rule 1. As used in these rules:**
	(t) "Service plan" means a written statement prepared by the home in cooperation with a resident, the resident's authorized representative, or the agency responsible for a resident's placement, if any, that identifies the specific care and maintenance, services, and resident activities appropriate for the individual resident's physical, social, and behavioral needs and well-being, and the methods of providing the care and services while taking into account the preferences and competency of the resident.
For Reference: **333.20201**	**Policy describing rights and responsibilities of patients or residents; adoption; posting; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions**
	(**c) A patient or resident is entitled to confidential treatment of personal and medical records, and may refuse their release to a person outside the health facility or agency except as required because of a transfer to another health care facility, as required by law or third party payment contract, or as permitted or required under the health insurance portability and accountability act of 1996, Public Law 104-191, or regulations**

	promulgated under that act, 45 CFR parts 160 and 164.
ANALYSIS:	Review of Resident A's facility records revealed upon admission she ambulated independently with an assistive device, then required increased need for more than one staff person assistance due to the inability to bear weight on her legs. Staff attestations regarding Resident A's care were consistent with review of the facility records. Review of Resident A's licensed healthcare professional notes revealed psychiatry was consulted for Resident A for behaviors. Review of the licensed healthcare professional notes revealed Resident A had a fall resulting in a facial abrasion on 3/6/2023; however Resident A's service plan updated on 3/9/2023 read she had no recent falls, behaviors, or safety concerns. Review of the licensed healthcare professional notes and orders revealed Resident A was prescribed Tylenol #3 as needed for severe pain, related to her complaints of left knee pain. Staff attestations and observations revealed the facility maintained a resident shower schedule. Staff attestations were consistent with the facility's cell phone policy. Review of Resident B's incident report revealed she sought exit from the facility while under observation of private duty caregiver and staff were alerted. In conclusion, although some allegations lacked evidence to be substantiated, the above analysis revealed the facility lacked an organized program to ensure Resident A's service plan was updated to reflect her falls, behaviors, and safety. Additionally, the allegations pertaining to Resident B were consistent with the facility's incident report, thus the facility lacked an organized program to ensure resident confidentiality was maintained.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A's authorized representative did not receive a discharge notification letter.

INVESTIGATION:

On 4/11/2023, the Department received a complaint through the online complaint system which read in late February or early March 2023, the facility notified Resident A's family she had 30 days to discharge. The complaint read a discharge letter was never received.

On 5/4/2023, I conducted an on-site inspection at the facility. I interviewed Ms. Norman who stated Resident A had ambulated without equipment upon admission then shortly after moving into the facility declined in which she was would not bear weight on her legs. Ms. Norman stated they attempted many interventions including home care services, specifically therapy, a psychiatry consult, and then hospice services to conduct evaluations and treatment for Resident A's decline. Ms. Norman stated after all interventions were implemented, she discussed with Resident A's spouse that Resident A had maintained her decline in which required more staff assistance than what the facility could accommodate. Ms. Norman stated shortly after the discussion, she mailed Resident A's spouse a discharge notification letter. Ms. Norman stated she confirmed with Resident A's spouse that he had received the letter by mail.

While on-site, I interviewed Employees #1, #2, #3 and #4 who stated Resident A would not bear weight on her legs in which it required multiple staff to conduct transfers from her bed to the chair.

I reviewed Resident A's face sheet which read in part her spouse was her responsible party for her bill and notifications.

I reviewed Resident A's initial admission assessment dated 12/27/2022 and service plan updated on 3/9/2023 which read consistent with statements from Ms. Norman and staff interviews.

I reviewed Resident A's admission contract dated 1/10/2023 and signed by her spouse which read in part if a resident exceeded the scope of care, such as by being bed-bound or unable to participate in Activities of Daily Living, the family was expected to seek alternative placement immediately. The contract read in part the discharge criteria was unable to feed self or bear weight.

I reviewed Resident A's licensed healthcare professional note dated 2/23/2023 which read in part staff reported on 2/15/2023, Resident A was a three person assist, and having issues transferring from the wheelchair to her bed.

I reviewed Resident A's discharge notification letter dated 3/8/2023 addressed to her spouse which read in part a 30-day notice was provided due to her increased level of care. The letter read in part Resident A was no longer weight bearing and was more than two-person transfer. The letter read in part the facility was unable to care for her properly and safely. The letter read in part to find placement for her no later than 4/6/2023. The letter read it was sent on 3/8/2023.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(3) The following additional requirements for the policy described in subsection (2) apply to licensees under parts 213 and 217: **(e) A home for the aged resident may be transferred or discharged only for medical reasons, for his or her welfare or that of other residents, or for nonpayment of his or her stay, except as provided by title XVIII or title XIX. A nursing home patient may be transferred or discharged only as provided in sections 21773 to 21777. A nursing home patient or home for the aged resident is entitled to be given reasonable advance notice to ensure orderly transfer or discharge. Those actions shall be documented in the medical record.**
For Reference: **R 325.1922**	**Admission and retention of residents.**
	(13) A home shall provide a resident and his or her authorized representative, if any, and the agency responsible for the resident's placement, if any, with a 30-day written notice before discharge from the home. The written notice shall consist of all of the following: **(a) The reasons for discharge.** **(b) The effective date of the discharge.** **(c) A statement notifying the resident of the right to file a complaint with the department. The provisions of this subrule do not preclude a home from providing other legal notice as required by law.**

ANALYSIS:	Review of facility documentation and staff attestations revealed Resident A had required increased staff assistance with her activities of daily living. Review of Resident A's admission contract read consistent with the reason for discharge and the discharge notification letter mailed to her spouse. Based on this information, this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

I recommend the status of this license remain unchanged.

05/15/2023

Jessica Rogers Date
Licensing Staff

Approved By:

05/26/2023

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