GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

Toya Sparks
American House Roseville
17267 Common Road
Roseville, MI 48066

December 04, 2023

RE: License #: AH500397563
Investigation #: 2024A1011004
American House Roseville

Dear Toya Sparks:

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 licensee's 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 (877) 458-2757.

Sincerely,

Andrea Krausmann, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(586) 256-1632

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500397563
Investigation #:	2024A1011004
Complaint Receipt Date:	11/03/2023
Investigation Initiation Date:	11/06/2023
Report Due Date:	01/03/2024
Licensee Name:	AH Roseville MC Subtenant LLC
Licensee Address:	C/O ReNew Reit One SeaGate Ste 1500 Toledo, OH 43604
Licensee Telephone #:	(248) 203-1800
Authorized Representative/ Administrator:	Toya Sparks
Name of Facility:	American House Roseville
Facility Address:	17267 Common Road Roseville, MI 48066
Facility Telephone #:	(586) 933-1593
Original Issuance Date:	08/03/2020
License Status:	REGULAR
Effective Date:	02/03/2023
Expiration Date:	02/02/2024
Capacity:	50
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was not treated with dignity including protection and safety.	Yes
Additional Findings	No

III. METHODOLOGY

11/03/2023	Special Investigation Intake 2024A1011004
11/06/2023	Special Investigation Initiated - Telephone Left voicemail for APS worker requesting call back for interview.
11/06/2023	Inspection Completed On-site Interviews conducted, observations made, records reviewed.
11/06/2023	Contact – Document Received Toya Sparks emailed two photographs of Resident A's left forearm.
11/06/2023	Contact - Face to Face Met with detective at the Roseville Police Dept.
11/06/2023	Contact - Telephone call made Left voice mail for Staff #4 requesting call back.
11/06/2023	Contact - Telephone call received Staff #4 returned my call. Interview conducted.
11/06/2023	Contact - Telephone call made Interviewed Staff #1.
11/07/2023	Contact - Telephone call made Interviewed Staff #5
11/07/2023	Contact - Telephone call made Interviewed Staff #2.
11/07/2023	Contact - Telephone call made Called Staff #5 with follow-up question.
11/07/2023	Contact - Telephone call made

	Called and left 2nd voicemail for APS worker requesting call back.
11/07/2023	Contact – Telephone call received Spoke with APS worker.
11/07/2023	Contact - Telephone call made Follow-up call to Hospice Nurse.
11/07/2023	Contact – Telephone call received Detective called with follow up information.
12/04/2023	Exit Conference – Conducted with licensee authorized representative Toya Sparks via telephone.

ALLEGATION: Resident A was not treated with dignity including protection and safety.

INVESTIGATION: On 11/06/2023, I received the allegations forwarded from adult protective services. The complainant was not identified. According to the allegations, o**n** 9/26/2023 Resident A was observed with having dried blood on his sweatshirt. Resident A was repeating, "He got rough with me". It is unknown who "He" is. I attempted to reach the APS worker before conducting my investigation but received no call-back until afterward.

On 11/06/2023, I interviewed licensee authorized representative/administrator, Toya Sparks, at the facility. Ms. Sparks said of morning shift 9/26/2023, supervisor Staff #1 reported having observed Resident A with a skin tear on his forearm, as well as bruising that appeared to be a large handprint on his forearm, both injuries of unknown origin. A bandage was over the wound, and Staff #1 did not know who placed it there.

Ms. Sparks said Resident A had a diagnosis of dementia and he could not specifically say what happened, only that a man got rough with him. Resident A has since passed away on hospice on 10/24/2023. Ms. Sparks said staff are expected to document all incidents of falls, injuries or change of condition on incident reports and on the resident's daily log in the EMAR system. The supervisor is to notify the Resident's authorized representative and physician. Ms. Sparks said when Staff #1 observed the injury, there was no documentation in Resident A's record nor incident report, as to how and when his injury occurred, which is contrary to the facility's policy and training.

Ms. Sparks said of Staff #1, who was the supervisor on day shift 9/26/2023, after having observed the bandaged injury, Staff #1 notified Ms. Sparks, Resident A's hospice nurse and Resident A's authorized representative, and Staff #1 wrote up an incident report. Ms. Sparks said did she personally did not conduct an investigation into the cause of the injury, because she is overseeing two facilities. Ms. Sparks said

she conversed with Staff #1, and then Ms. Sparks instructed her assistant and the facility's trainer staff to investigate and to obtain written statements from the facility's only two male caregivers, Staff #2 and Staff #3, both work midnight shifts.

Ms. Sparks said the assistant and trainer did not obtain written statements from the male staff, as directed but verbally reported that of the two, only Staff #2 worked in the north building with Resident A. Staff #2 worked on midnight shift 9/24/2023 but not on 9/25/2023. According to Ms. Sparks, Staff #2 reportedly said he saw no skin tear on Resident A's arm, but said Resident A was up and walking quite a bit the evening of 9/24/2023, and possibly he fell and was injured. There was no explanation for the bandage.

Ms. Sparks said Staff #3 did not work on 9/24/2023, and did not work with Resident A on 9/25/2023, because Staff #3 is assigned to work in the south building, on midnight shift. Resident A resides in the north building across the parking lot.

When asked if there were any prior incidents with either of these male staff, Ms. Sparks said in February 2023 Resident B reported being afraid of Staff #2 but Resident B did not provide a specific reason. Ms. Sparks said her investigation at that time only revealed an agency staff member working in the home having observed Staff #2 ask Resident B to leave the dining room and go to bed, so he could clean the dining room during midnight shift. Ms. Sparks explained that although she could not substantiate any specific incident to cause Resident B to be in fear of Staff #2, Ms. Sparks transferred Staff #2 from the south building to only work in the north building from that point forward. Ms. Sparks said she responded to Resident B's comments of fear because did not want any residents being fearful of staff.

On 11/06/2023, I interviewed Resident A's hospice nurse at the facility, and on 11/07/2023, I conducted a follow-up call with the hospice nurse for clarification. During these interviews, the hospice nurse said she provided weekly care to Resident A and previously saw him on 9/21/2023. At that time, there was no injury to his arm. At her next visit with Resident A on 9/26/2023, she came to the facility for a recertification and Staff #1 informed her of the unexplained injury and bandage on Resident A's forearm. The hospice nurse explained how she removed the bandage and observed an open wound with a bruise to the forearm that she described as a large handprint. The hospice nurse said when Resident A was asked what happened to cause the injury, Resident A replied, "The man got rough with me" two or three times. The hospice nurse explained Resident A had a dementia diagnosis but given his ability to still carry a conversation, the hospice nurse said, "I felt he was telling the truth".

The hospice nurse said Resident A utilized a wheeled walker for independent ambulation at the time of the injured forearm. He was incontinent of bowel and bladder and staff would change his briefs when he was in bed. The hospice nurse said Resident A had dementia but absolutely no aggression or combativeness

during care. The hospice nurse affirmed that hospice aides provided showers to Resident A but said there were no male hospice aides doing care with Resident A.

On 11/06/2023, I interviewed Ms. Sparks' assistant and trainer separately at the facility. Both the assistant and trainer denied having conducted an investigation into the situation. The assistant said she knew Resident A had a skin tear by an incident report that she received from Staff #1 on 9/26/2023. The assistant said she then transcribed the incident report information into the *Yardi* computer system. The assistant explained that is her job, and also to cut and paste any information from the *daily log* into the resident's *daily report*, also known as *progress notes*. There were no progress notes in Resident A's record between 9/5/2023 and 9/26/2023 until Staff #1's observation was documented. On 9/26/2023 at 11:07am it is documented, "During AM care Med tech notice (sic) [Resident A] arm was wrapped and bleeding. [Resident A] has 3 skin tears on his left arm from his wrist to his elbow. Hospice was notified and they came out to see [Resident A]."

Separately, the trainer said she had nothing to do with investigating the injury to Resident A.

Initially, since Staff #1 observed the bandaged injury on 9/26/2023, it was assumed that the incident that caused this skin tear and bruising injury occurred on the morning of 9/26/2023, or during midnight shift 10 pm to 6 am on 9/25/2023. However, during the course of this investigation on 11/06/2023, Ms. Sparks interrupted to say Staff #4 just reported to her that Staff #4 observed the injury the morning previous to Staff #1's observation. Staff #4 reportedly told Ms. Sparks that she observed and photographed Resident A's injury the morning of 9/25/2023, and that Staff #4 applied the bandage that Staff #1 observed the following day. Staff #4 then sent photographs of the injury to Ms. Sparks.

Consequently, it is now reasonable to assume the incident that caused injury to Resident A's arm occurred on or previous to Staff #4's 9/25/2023 morning observation, as having occurred either that morning or during the previous midnight shift of 9/24/2023, when Staff #2, was the only male staff scheduled to work in the north building where Resident A resided. Reviewing the staff schedule, Ms. Sparks said Staff #5 was the supervisor of midnight shift and she would have gone back and forth between north building and south building to administer medications. Ms. Sparks said if any incident with Resident A occurred, Staff #2 is expected to report it to supervisor Staff #5.

On 11/06/2023, Ms. Sparks forwarded two photographs to me. The photographs are of an elderly individual's left forearm. One photo reveals the top of the forearm. Approximately 1/3 of the forearm, just above the wrist, appears blackened with bruising. A large patch of this bruised skin is torn and pushed aside revealing the bloody arm underneath the skin. The top of the individual's wrist is also bruised with what appears to be a long scrape of black scabbing and some blood. A bloodied napkin is next to the arm. The other photo is presumably the underside of this same

forearm. It appears to be continuation of the large black and also a burgundy-colored bruising along 1/3 of the forearm, with the patch of skin tear revealing the bloody underside of skin.

On 11/06/2023, the facility's trainer presented documents to confirm that both Staff #2 (who worked with Resident A on 9/24/2023) and Staff #4 (who bandaged the injury on 9/25/2023) completed training on reporting and documenting incidents. The trainer said both staff are expected to document on *incident reports* and in the resident's *daily log* whenever there is a fall or any incident that causes injury. There was no such documentation about Resident A on an incident report or the daily log, by either Staff #2 or Staff #4 for that time period of 9/24/2023 until Staff #1 documented on 9/26/2023.

On 11/06/2023, I interviewed Staff #4 by telephone. Staff #4 said it was 8:50 am on Monday 9/25/2023, while she was serving breakfast, that Resident A walked into the dining room. Staff #4 said she observed Resident A's arm was bleeding, so she stopped serving breakfast, cleaned the wound, applied A & D ointment and wrapped it with a bandage. Staff #4 said Resident A told her that "It was a white man that attacked him". Staff #4 said she photographed the wound to remind herself to write an incident report, and added, "But I was tired and forgot to report it. It slipped my mind." Staff #4 also said she was "going to show Toya [Sparks] and [Ms. Sparks' assistant] but there was so much going on that day, and I was tired". Staff #4 said she showed the photograph to Staff #1, the next day that she worked with Staff #1, when she heard Staff #1 was asking about the injury. According to the staff schedule, the next time Staff #1 and Staff #4 worked together was on Wednesday 9/27/2023.

On 11/06/2023, I interviewed Staff #1 by telephone. Staff #1 explained she last saw Resident A on Sunday 9/24/2023, and he had no injury. Staff #1 next reported for work on Tuesday 9/26/2023, and while "doing rounds" she saw blood on Resident A's sleeve and that he had removed a bandage and threw it in the waste can, revealing a bruise and skin tear to his forearm. Staff #1 said Resident A told her, "I don't know what happened. I got into it with a man". Staff #1 said she asked the other staff on day shift and the 9/25/2023 midnight staff, if anyone knew how the injury occurred and said, "Everyone said 'no'." Staff #1 explained that sometime later Staff #2 told her, "I don't know what happened" and Staff #4 told her that she applied the bandage. Staff #1 said Staff #4 never showed her a photograph of the wound. Staff #1 said she documented the unexplained injury on an incident report at the time she observed it, she notified Toya Sparks, and notified hospice.

On 11/07/2023, I interviewed Staff #2 by telephone. Staff #2 affirmed having worked 9/24/2023 with Resident A on midnight shift and having found out about his arm injury sometime later but could not remember when. Staff #2 said Resident A had a fall "about that time" that may have caused his injury, as he has seen this happen to other residents. Staff #2 said when Resident A fell, Staff #2 had to help Resident A get up. Staff #2 explained that he helped Resident A up by reaching under his

shoulder blades from behind and lifting him up. Staff #2 denied having seen any skin tears or bruising at the time of the fall, and denied having applied a bandage, saying that Resident A often wore long sleeves and cardigans. Staff #2 said he did not document the fall. Staff #2 said he reported the fall to his supervisor but could not recall specifically which supervisor. Staff #2 said the supervisor would have been responsible to write up the incident report.

On 11/07/2023, I interviewed supervisor Staff #5 by telephone. Staff #5 no longer works in the home but was scheduled on shift with Staff #2 the midnight shift of 9/24/2023, and was still working at that time. Staff #5 denied being told of any issues with Resident A's care or of him having fallen. Staff #5 denied any knowledge of Resident A having sustained injury to his arm. Staff #5 said she did not work with Staff #2 in the north building during midnight shift of 9/24/2023. Staff #5 explained that as supervisor, she remained in the south building except to administer medications in the north building only when medications were due. Staff #5 denied Staff #2 ever reported to her that Resident A fell.

Review of the staff schedule for midnight shift on 9/24/2023 from10pm to 6am revealed Staff #2 was the lone Resident Assistant assigned to work in north building, providing care to the residents in that building, including Resident A. Staff #5 was the appointed Med Tech scheduled to work midnight shift on 9/24/2023, identified as "HS" meaning house supervisor, according to Ms. Sparks. Ms. Sparks explained that the house supervisor is to float between both north and south buildings to administer medications during the shift.

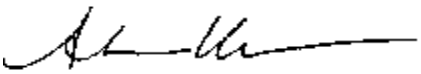
APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	Resident A sustained an injury to his left arm that included significant bruising, torn skin and bleeding, that occurred on or prior to the 9/25/2023 8:50 am observation and bandaging by Staff #4. No employee documented in writing or verbally reported any incident that caused the injury. Staff #2 said Resident A fell and required Staff #2 to pick him up, but Staff #2 did not document the incident. Staff #2 said he reported the fall to Staff #5, and Staff #5 would be expected to complete an incident report. Staff #5 denied Staff #2 told her of Resident A having a fall. On 9/25/2023, Staff #4 observed, photographed, and bandaged Resident A's arm injury of unknown origin. Staff #4 did not document the observation and treatment in writing, nor did she

	notify anyone of the injury until days later when Staff #1 was asking about it. Therefore, Resident A was not treated with dignity including protection and safety when Staff #2 was aware of his fall, and Staff #4 observed and treated his injuries, but neither staff followed facility training to document in writing nor took action of immediate notification to others.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/04/2023, I conducted an exit conference with the licensee's authorized representative Toya Sparks by telephone.

IV. RECOMMENDATION

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



11/13/2023

Andrea Krausmann Date
Licensing Staff

Approved By:

11/29/2023

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