GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

Sheila Pruzinsky
Rose Senior Living - Clinton Township
44003 Partridge Creek Blvd.
Clinton Township, MI 48038

January 17, 2024

RE: License #: AH500337370
Investigation #: 2024A1022009
Rose Senior Living - Clinton Township

Dear Sheila Pruzinsky:

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.

Please review the enclosed documentation for accuracy and contact me with any questions.

Sincerely,

Barbara P. Zabitz, R.D.N., M.Ed.
Health Care Surveyor
Health Facility Licensing, Permits, and Support Division
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Mobile Phone: 313-296-5731
Email: zabitzb@michigan.gov

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500337370
Investigation #:	2024A1022009
Complaint Receipt Date:	11/02/2023
Investigation Initiation Date:	11/03/2023
Report Due Date:	12/02/2023
Licensee Name:	Rose Senior Living - Clinton Township
Licensee Address:	38525 Woodward Avenue Bloomfield Hills, MI 48303-2011
Licensee Telephone #:	(651) 766-4371
Administrator/Authorized Rep	Sheila Pruzinsky
Name of Facility:	Rose Senior Living - Clinton Township
Facility Address:	44003 Partridge Creek Blvd. Clinton Township, MI 48038
Facility Telephone #:	(586) 840-0840
Original Issuance Date:	10/01/2014
License **Status:**	REGULAR
Effective Date:	03/30/2023
Expiration Date:	03/29/2024
Capacity:	127
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Two facility employees mistreated Resident A after he was involved in an altercation with Resident B.	No
Additional Findings	Yes

III. METHODOLOGY

11/02/2023	Special Investigation Intake 2024A1022009
11/03/2023	Special Investigation Initiated - Telephone Message left for the referral source.
12/08/2023	Inspection Completed On-site
01/17/2024	Exit Conference

ALLEGATION:

Two facility employees mistreated Resident A after he was involved in an altercation with Resident B.

INVESTIGATION:

On 11/02/2023, the Bureau of Community and Health Systems (BCHS) received a referral from Adult Protective Services (APS) that read, “[Name of Resident A] lives in the Rose Senior Living home… On 10/31/2023, law enforcement was called to Rose Senior Living due to concerns that [name of the Resident A] was displaying aggressive behavior. When law enforcement and EMS (emergency medical services) arrived, two Rose Senior Living Staff Members, [name of employee #1] and [name of employee #2] were seen being aggressive with [name of Resident A], overpowering him and shoving him onto the stretcher. [Name of Resident A] exhibited no aggressive behavior at that time. [Name of the ROC] does not feel safe in the home… [Name of Resident A] did not have any visible injuries today but was taken to Henry Ford Macomb Hospital. [Name of employee #1] and [name of employee #2] both displayed impatience, poor attitudes, were extremely prone to physical contact, impolite and seemed to be undertrained to work with the elderly and those with cognitive impairments…” The APS referral source (RS) was an employee of a local ambulance service. The referral was marked, “Denied,” signifying that APS had determined they would not be investigating the allegations.

On 11/02/2023, a phone call was placed to the contact phone number provided by APS RS #1, but I was unsuccessful in reaching him.

On 11/09/2023, BCHS received a second APS referral concerning the same resident, but from a slightly different perspective. The second referral read, “… [Name of the ROC] lives in the memory care side of Rose Senior Living. On 10/31/2023, 911 was called because [name of Resident A] became agitated by another resident. [Name of Resident A] pushed the resident (Resident B) and the resident became injured after they fell back and hit their head. [Name of Resident A] was not injured during this altercation. Staff at Rose Senior Living manhandled [name of Resident A] to get him onto the stretcher when EMS arrived. The staff grabbed Jack by his shirt or outer garment and tried to yank him on the stretcher aggressively; this did not cause any marks, bruises, or injuries to [name of Resident A]. Staff were redirected to stop and [name of Resident A] got himself on the stretcher… [Name of Resident A] is currently at Henry Ford Hospital in Macomb and he will be seen by a psychiatrist to address a mental status change. [Name of Resident A] attempted to say what happened at Rose Senior Living but he started to talk about his childhood state. [Name of Resident A] did say that "they did something to him" but his conversation was hard to follow.” The second APS referral source was a hospital employee. APS declined to investigate this second referral as they did with the first.

On 12/08/2023, at the time of the onsite visit, I interviewed the administrator/authorized representative (AR). According to the AR, on 10/31/2023, at about 6:10 pm, in the memory care (MC) unit, Resident A either pushed Resident B or knocked her off balance and Resident B fell to the floor. At the time, Resident A was being uncharacteristically aggressive. It was later determined that Resident A had developed a urinary tract infection (UTI) which may have prompted the aggressive behavior. According to the incident report and supporting documentation, there were four employees attending on the MC unit on 10/31/2023: Employee #1, employee #2 and employee #3, all caregivers as well as employee #4, the medication technician who was serving as the shift supervisor.

When the AR was asked why there was law enforcement presence when EMS came to the building, she stated that it was because Resident A was being sent out to the hospital for behavior and not for an illness or injuries. The local authorities considered an emergency room visit for mental status change as an involuntary mental health hospitalization. She went on to say that their city contracted with a local ambulance company whose employees were known to make negative remarks about the facility whenever they were called to transport a resident to the emergency room. The AR stated that she believed there were ambulance company employees who regularly called APS, lodging complaints again the facility. The AR further stated that the complaints would reach the ears of the workers in the emergency room, and that had prompted the hospital to make additional calls to APS.

At the time of the onsite visit, of the employees present in the MC unit at the time of the altercation between Resident A and Resident B, only employee #3 was in the building and available for interview. Employee #1 and employee #4 were available by phone at a later time. Employee #2 had been terminated from employment due to attendance issues and because she used inappropriate language in the presence of residents and was not available for interview.

When I interviewed employee #3, she stated that she had not been present for the altercation between Resident A and Resident B, but she had been called to help separate them and to provide care for Resident B, who was bleeding from a laceration. Employee #3 recalled that it was employee #2 and another caregiver who took Resident A into another room to try and calm him down. Employee #3 was able to identify only employee #2 and not the other caregiver. Employee #3 recalled that at the time, Resident A was agitated, rowdy and mumbling expletives to himself. Employee #3 went on to say that she was focused on providing care to Resident B and did not know what had occurred when EMS came to transport Resident A to the hospital.

When I interviewed employee #4 by phone, employee #4 stated that she did not witness any part of the altercation, but was told that Resident A pushed Resident B, causing Resident B to fall. Employee #4 acknowledged that as she was the shift supervisor, it was her responsibility to call EMS. According to employee #4, after Resident B left the building, Resident A continued to be aggressive. Employee #4

recalled that it was employee #2 and employee #3 who were trying to provide care to Resident A. Employee #4 went on to say that Resident A had smeared feces all over his bathroom and flooded his entire apartment with water, apparently by turning on a facet. At this point, employee #4 stated she place a phone call to the Director of Health Service, who instructed employee #4 to send Resident A out to the hospital for a mental status change. According to employee #4, EMS arrived to transport Resident A to the hospital emergency room, but Resident A did not have shoes on his feet. She recalled that Resident A resisted the EMS personnel who attempted to obtain his vital signs and that employee #2 and employee #3 attempted to assist EMS, but the emergency medical technician instructed them to “step away” from Resident A and allow the EMS personnel to handle the situation. When employee #4 was asked about the behavior of employees #2 and #3, she stated that they were very appropriate with Resident A, trying only to facilitate EMS’s process.

When I interviewed employee #1 by phone, employee #1 stated that she was not assigned to the MC unit on 10/31/2023 but had been called to help the caregivers on that unit when Resident A was found in his room, with water on the floor. According to employee #1, employee #2 went into Resident A’s room to try and coax him to come out of the room. Resident A’s shoes, socks and the bottoms of his pants were soaking wet, and employee #2 wanted to get him out of the wet apparel. Employee #1 went on to say that Resident A was very combative at that point and stated that it was her recollection that Resident A chased employee #4 down the hall. Employee #1 stated that when the EMS staff arrived and attempted to talk to Resident A, he continued with very combative behavior. She stated that she and employee #2 tried to get Resident A to sit down on the transport gurney by holding him under his arms on both sides and guiding him towards the gurney. According to employee #1, Resident A became “frustrated,” maybe because he did not understand what was happening to him and blurted out, “what the hell are you (employees) doing?” Employee #1 stated that at that time she and employee #2 backed off. Employee #1 denied that either she or employee #2 were rough, or unprofessional in any way with Resident A. According to employee #1, they were guiding Resident A in the way which they were trained to do.

Review of the two incident reports generated for both Resident A and Resident B revealed that Resident A was seen having a verbal argument with Resident B, but then grabbed Resident B by her wrist. This motion caused Resident B to fall backwards hitting her head on the wall behind her, resulting in a laceration to the back of her head. Resident B was taken to the local emergency room for treatment. Resident A was not injured, but his incident report indicated he was also taken to the local emergency room for evaluation of increased aggression.

Review of the service plan for Resident A revealed he had poor judgement, displayed anxiety, was known to exhibit disruptive, aggressive, or socially inappropriate behavior, and had long term memory impairment. Review of the service plan for Resident B revealed that she also had poor judgement, was frequently disoriented, and had moderately impaired long term memory issues.

The AR was not able to provide any documentation detailing Resident A's behaviors as described by employee #1, employee #3 and employee #4.

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.**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(l) A patient or resident is entitled to be free from mental and physical abuse**
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.**
For Reference: R325.1901	**Definitions.**
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	There was no evidence that employee #1 and employee #2 mistreated Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Although Resident A was sent to the local emergency room due to aggressive behavior, there were no charting notes or entries to Resident A's "Daily Log" notes to document observations made by care staff members, as described by employee #1, employee #3 and employee #4. While the incident report dated 10/31/2023 indicated Resident A displayed "increased aggression," there was no documentation to describe what those aggressive behaviors were.

APPLICABLE RULE	
MCL 333.20175	**Maintaining record for each patient; wrongfully altering or destroying records; noncompliance; fine; licensing and certification records as public records; confidentiality; disclosure; report or notice of disciplinary action; information provided in report; nature and use of certain records, data, and knowledge.**
	(1) A health facility or agency shall keep and maintain a record for each patient, including a full and complete record of tests and examinations performed, observations made, treatments provided, and in the case of a hospital, the purpose of hospitalization.
ANALYSIS:	The facility did not document the care staff's observations of Resident A's behavior in his health record.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the authorized representative (AR) on 01/17/2024. When asked if there were any comments or concerns with the investigation, the AR stated that there were none.

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend no change to the status of the license.

01/17/2024

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Barbara Zabitz Date
Licensing Staff

Approved By:

01/11/2024

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