GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 12, 2024

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

RE: License #: AH500337370
Investigation #: 2024A0784031
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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500337370
Investigation #:	2024A0784031
Complaint Receipt Date:	02/12/2024
Investigation Initiation Date:	02/12/2024
Report Due Date:	04/12/2024
Licensee Name:	Rose Senior Living - Clinton Township
Licensee Address:	38525 Woodward Avenue PO Box 2011 Bloomfield Hills, MI 48303-2011
Licensee Telephone #:	(651) 766-4371
Administrator/Authorized Representative:	Sheila Pruzinsky
Name of Facility:	Rose Senior Living - Clinton Township
Facility Address:	44003 Partridge Creek Blv 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:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Inadequate supervision of Resident A	Yes
Additional Findings	No

III. METHODOLOGY

02/12/2024	Special Investigation Intake 2024A0784031
02/12/2024	Special Investigation Initiated - On Site
02/12/2024	Inspection Completed On-site
02/12/2024	Exit Conference Conducted with administrator/authorized representative Mary Pruzinsky

ALLEGATION:

Inadequate supervision of Resident A

INVESTIGATION:

On 2/12/2024, the department received this complaint from adult protective services (APS).

According to the complaint, on the morning of 2/07/2024, at approximately 9am, Resident A was discovered on her floor from a presumed fall and after having laid on her floor for an extended period of time. Resident A was taken to the hospital and found to have a concussion and several broken ribs while also requiring staples to her head. Third shift staff had last checked on Resident A at 5:30am while first shift staff failed to check on Resident A until 9am. It is presumed Resident A fell around 7am as she has a camera in her room which was knocked offline at that time.

On 2/12/2024, I interviewed administrator/authorized representative Mary Pruzinsky at the facility. Ms. Pruzinsky confirmed Resident A had a fall on the morning of 2/07/2024. Ms. Pruzinsky stated the information she received from the hospital did not indicate Resident A had a concussion but did confirm she had to have staples due to a gash in her head from falling and broken ribs. Ms. Pruzinsky stated

Resident A had been living at the facility since 2/01/2024. Ms. Pruzinsky stated Resident A was unable to ambulate on her own and was known to have poor safety awareness in that she would try to get up on her own without staff assistance. Ms. Pruzinsky stated that due to Resident A's fall risk and poor safety awareness, staff were aware that when working first shift, which starts at 6:30am, Resident A needed to be one of the first residents checked on in the morning and up by at least 8am and assisted into her chair. Ms. Pruzinsky stated that after the fall, Associate 1, who was responsible to Resident A on the morning of 2/07/2024, reported to the director of memory care, Brittany Golson, she had checked on Resident A at around 7am and that Resident A was sleeping. Ms. Pruzinsky stated Ms. Golson reviewed camera footage, several times, from 10:30pm on 2/06/2024 until the morning of 2/07/2024 and that at Associate 1 did not go into Resident A's room until after 9am. Ms. Pruzinsky stated she also instructed human resource director Melissa Thomas to check the video footage and that Ms. Thomas confirmed Associate 1 came into work at 6:30am and did not check on Resident A until 9:04am. Ms. Pruzinsky stated that exact time Resident A fell is unknown as she had not been checked on since 5:30am. Ms. Pruzinsky stated it was presumed possible that Resident fell around 7am as she has a camera in her room which "went offline" around that time as reported by Resident A's authorized representative. Ms. Pruzinsky stated that this would be very possible since where Resident A fell was in the area where the camera was. Ms. Pruzinsky stated that when interviewed about the situation, Associate 1 continued to report she checked on Resident A around 7am despite video evidence proving otherwise. Ms. Pruzinsky stated that due to evidence showing Associate 1 did not perform her duties as she had stated she did, and the denial of that fact, it was determined that Associate 1 would be terminated.

I reviewed Resident A's service plan, provided by Ms. Pruzinsky, which read consistently with her statements regarding Resident A's fall risk and propensity to attempt to ambulate on her own.

I reviewed typed statements, provided by Ms Pruzinsky, signed by Ms. Golson and Ms. Thomas respectively, which read consistently with statements provided by Ms. Pruzinsky.

I reviewed a separation notice, provided by Ms. Pruzinsky, dated 2/08/2024, and addressed to Associate 1.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.

ANALYSIS:	The complaint alleged that after Resident A fell, sustaining injuries, it was discovered that associate 1 had not checked on Resident A as she was supposed to. The investigation revealed Associate 1 was supposed to check on Resident A soon after her shift started on 6:30 am 2/07/2024 and have her up by 8am but did not check on her until after 9am. Based on the findings, Resident A was not provided adequate supervision by Associate 1.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Aaron L Clum 3/11/2024

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Aaron Clum Date
Licensing Staff

Approved By:

Andrea L Moore 03/12/2024

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