GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 10, 2024

Rhonda Anagnostopoulos
Swank Home Assisted Living, Inc
9412 Miller Rd
Swartz Creek, MI 48473

RE: License #:	AL250072158
Investigation #:	2024A1039023
	Swank Home Assisted Living

Dear Rhonda Anagnostopoulos:

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 responsible party 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) 643-7960.

Sincerely,

Martin Gonzales, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL250072158
Investigation #:	2024A1039023
Complaint Receipt Date:	02/15/2024
Investigation Initiation Date:	02/16/2024
Report Due Date:	04/15/2024
Licensee Name:	Swank Home Assisted Living, Inc
Licensee Address:	9412 Miller Rd Swartz Creek, MI 48473
Licensee Telephone #:	(181) 034-8204
Administrator:	Rhonda Anagnostopoulos
Licensee Designee:	Rhonda Anagnostopoulos
Name of Facility:	Swank Home Assisted Living
Facility Address:	9412 Miller Rd Swartz Creek, MI 48473
Facility Telephone #:	(810) 635-3183
Original Issuance Date:	11/14/1996
License Status:	REGULAR
Effective Date:	10/23/2023
Expiration Date:	10/22/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
• Resident was left unattended, and she fell. The manager posted a video of the fall on social media.	Yes
• Resident was left laying on the floor during an entire shift and was not strong enough to get herself off the ground. • Administrator kept a violent resident in the home even after the resident attacked residents and staff. • Staff gave medication without checking to see if resident could have them.	No No No

III. METHODOLOGY

02/15/2024	Special Investigation Intake 2024A1039023
02/16/2024	APS Referral I completed aps referral via email.
02/16/2024	Special Investigation Initiated - Letter Initiated via aps referral.
02/16/2024	Contact - Document Sent Email with Genesee County APS worker Mackenzie Scott-Carney.
02/28/2024	Contact - Document Sent Email with Genesee County APS worker Mackenzie Scott-Carney.
03/28/2024	Inspection Completed On-site completed onsite investigation and spoke to home manager and multiple residents.
03/28/2024	Contact - Telephone call made Attempted phone contact with Direct Care Staff Amanda Drotzur. No Answer.
03/28/2024	Contact - Face to Face Interview with Resident A's guardian.
04/04/2024	Contact - Telephone call made

	Attempted phone contact with Direct Care Staff Amanda Drotzur. No Answer.
04/04/2024	Contact - Telephone call made Phone interview with McLaren Hospice Nurse Julie Campbell.
04/04/2024	Contact - Telephone call made Phone interview with Resident C's guardian.
04/04/2024	Contact - Telephone call made Phone interview with McLaren Hospice Nurse Sarah Young.
04/08/2024	Contact - Telephone call made Phone interview with Direct Care Staff Tiffany Callis.
04/09/2024	Exit Conference Completed with Licensee Designee.
04/09/2024	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

- **Resident was left unattended, and she fell. The manager posted a video of the fall on social media.**
- **Resident was left laying on the floor during an entire shift and was not strong enough to get herself off the ground.**
- **Administrator kept violent resident in the home even after the resident attacked residents and staff.**
- **Staff gave medication without checking to see if resident could have them.**

INVESTIGATION:

On 02/15/2024, the Bureau of Community and Health Systems (BCSH) received the above allegation, via the BCHS online complaint system. It is alleged that a manager left an unsteady resident unattended, and they fell. The incident was caught on camera and the Manager Pam posted a video of the incident on social media. Staff Amanda was giving out medications without check to see if residents could take the medication. A staff member let a resident lay on the floor her entire shift. The resident was not strong enough to get herself up off the ground. Administrator Kori kept a violent resident in the home after he attached other residents and staff members.

On 02/28/2024, an email was received from Genesee County Adult Protective Services (APS) worker Shwanda Lee stating that she completed her investigation and was substantiating on the case.

On 03/28/2024, an unannounced onsite investigation was completed at Swank Assisted Living concerning the allegations. The following people were interviewed: Administrator Kori Hendricks, House Manager Pam Erickson, Resident A, Resident B and Guardian A1.

On 03/28/2024, I completed an onsite interview with Administrator Hendricks concerning the allegations. Administrator Hendricks stated that she was aware of the allegations and had already been dealing with a few issues. Administrator Hendricks stated that she was aware of the incident regarding Resident A falling in a hallway and a video being uploaded to social media. Administrator Hendricks stated that Resident A did fall to the ground, but a staff member helped her to the ground. Resident A was being walked to the dining room from her room and she stopped and told the staff member that she wanted to sit down and when the staff member turned around to grab the wheelchair, Resident A began to fall but the staff member was right there with her and slowly guided Resident A and herself down to the ground together. Administrator Hendricks stated that the staff did a fall protocol and check all of Resident A's vitals and there were no injuries. At that point Resident A was helped back into her chair. An incident report was completed for the fall and the family was notified. Administrator Hendricks was able to provide a copy of the incident report. It was completed on 12/29/2023, by Home Manager Pamela Erickson.

Administrator Hendricks stated that Home Manger (HM) Erickson was the staff member that was involved in the incident and that she was also the staff member who posted the video of them falling on social media. Administrator Hendricks stated that resident was blurred in the video and that she instructed HM Erickson to take down the video immediately. Administrator Hendricks stated that the family was immediately made aware of the video, and they developed a social media policy to ensure that this did not happen again. Administrator Hendricks stated that there was internal discipline for HM Erickson. Administrator Hendricks stated that the family accepted their apology and wanted Resident A to remain in their facility for care.

Administrator Hendricks stated that she is aware of allegations of a Staff Amanda Drotzur giving medications to a resident without checking to see if the resident could receive those medications. Administrator Hendricks stated that the allegation is not true, and that the description of the incident is inaccurate. Administrator Hendricks stated that the resident in question is on hospice and has a nurse from McLaren Hospital. Resident B was prescribed a PRN (as needed) for Alprazolam but there was an issue with the order, so Staff Amanda Drotzur called the McLaren Hospice Nurse Julie Campbell for a verbal order to ensure that it was approved before the medication was administered. There were no further issues with the prescription. Administrator Hendricks stated that the PRN for Alprazolam was changed to scheduled medication but that it was not accurate on the medication list and that is the reason they called to

ensure that they were not giving medication incorrectly to Resident B. Administrator Hendricks provided the physician's order for Resident B.

I reviewed Resident B's Medical Administration Record (MARS) for February 2024 and was able to verify the medication was a PRN and then changed to a scheduled dose.

Administrator Hendricks stated that she is aware of the allegations that staff let a resident lay on the floor their entire shift and the resident was not strong enough to get off the ground herself. Administrator Hendricks stated that that the allegation is not true. Administrator Hendricks stated Resident C was a hospice resident that passed away on 02/15/2024. Administrator Hendrics stated that the description of the incident is not accurate. Administrator Hendricks stated that Resident C would continuously climb out of her bed and get on the floor. Administrator Hendricks stated that Resident C did not spend an entire shift on the floor. Administrator Hendricks stated that Resident C would tell staff that she wanted to be on the floor because she was very religious, and she wanted to pray. The staff made an area for Resident C to sit on the floor while she prayed. Administrator Hendricks stated that the McLaren Hospice Nurse and family were contacted concerning the situation and were ok with the plan as long as Resident C was safe and comfortable. Administrator Hendricks state that there was no incident report completed for this situation.

Administrator Hendricks stated that she is aware of the allegations that she kept a violent resident in the home after he attached other residents and staff members. Administrator Hendricks stated that the allegation was not true. Administrator Hendricks stated that the allegation is concerning Resident D. Administrator Hendricks stated that they do have an emergency discharge policy in place but Resident D did not meet the requirements of that policy until 01/30/2024 when he assaulted a staff member. Administrator Hendricks stated that Resident D moved into the home on 07/25/2023 and showed no signs of aggressive behaviors initially but then began to show signs of being easily agitated and verbal aggression. Administrator Hendricks stated that Resident D was limited verbally and was diagnosed with Lewy Body Dementia. Administrator Hendricks stated that prior to Resident D being discharged that the staff had contacted the family, and they would come and sit with Resident D and try to calm him down. Administrator Hendricks stated that the staff were ultimately unable to manage Resident D's behaviors as they were getting worse and had to discharge him. Administrator Hendricks provided me with the contact information for Resident D's Power of Attorney. Administrator Hendricks provided the incident report dated 01/30/2024, detailing the incident of physical aggression towards a staff member. Administrator Hendricks provided the assessment plan, face sheet and emergency discharge letter for Resident D. Administrator Hendricks did not have any further information regarding the allegations.

On 03/28/2024, I completed an onsite interview with Home Manger (HM) Pam Erickson concerning the allegations. HM Erickson stated that she was aware of the allegations as she had already spoken to the administrator regarding them. HM Erickson stated that she was the staff member involved with the incident where Resident A fell to the

ground and a video was posted online. HM Erickson stated that the incident happened on 12/29/2023. HM Erickson stated that she was helping Resident A walk to breakfast and Resident A stated that she didn't want to walk and wanted her wheelchair. HM Erickson stated that they had just left the room so the wheelchair was inside of the door and she turned around to grab the chair and when she turned around Resident A began to fall. HM Erickson stated that she was right there behind Resident A so she tried to keep her up but she was already falling so she guided her fall down to the ground. HM Erickson stated that she called for another staff member to help Resident A and herself up off the ground. Resident A was helped into the wheelchair and all of her vitals were checked to ensure that she was ok. There were no injuries to Resident A as a result of the fall. HM Erickson completed an incident report detailing the incident. HM Erickson stated that she was reviewing the incident on the facility cameras and thought that the incident was funny due to the way that Resident A and herself fell to the ground. HM Erickson stated that she posted a copy of the video to her TikTok account but that she blurred out the resident so that she could not be identified. HM Erickson stated that she took the video down around 5 hours later. HM Erickson stated that she took the video down on her own before anyone asked her to do it. HM Erickson stated that she spoke to Administrator Hendricks regarding the situation and was disciplined. HM Erickson stated that she then called the Power of Attorney for the family to explain the situation and apologize to the family for posting the video. HM Erickson stated that the family accepted her apology and were very understanding of the situation.

HM Erickson stated that she was aware of the allegation that a staff giving medication to a resident without knowing if they could receive the medication. HM Erickson stated that there are no issues with staff giving the wrong medication to any resident. HM Erickson stated that the issue involved Resident B was because the medication was originally prescribed as a PRN (as needed) and it was changed to a scheduled dose but that the pharmacy had not clearly put in in the orders so they had to call the McLaren hospice nurse to ensure that it was changed to a scheduled dose. Once it was confirmed that the medication was a scheduled dose the medication was administered by the staff member. HM Erickson stated that they received new orders from the pharmacy and the correct dosage and scheduled times are on it and there have been no further issues.

HM Erickson stated that she is aware of the allegation that a resident was left on the floor during an entire shift and the resident was not strong enough to get up on their own. HM Erickson stated that this is not accurate and that there was a resident who would get on the floor of their room, but it was never for an entire shift and that the resident's family and hospice nurse were aware of the situation. HM Erickson stated that Resident C did spend time on the floor, but it was never for a staff members full shift. HM Erickson stated that Resident C had suffered from cancer and had strokes which affected her way of thinking. HM Erickson stated that staff would find Resident C on the floor, and she would say that she was very religious and was down there praying. HM Erickson stated that the family and hospice nurse were contacted because Resident C was spending more and more time on the floor. HM Erickson stated that the family and hospice nurse were okay with Resident C being on the floor as long as it was

comfortable and safe for her. HM Erickson stated that they put pillow, blankets and falling mats on the floor to ensure Resident C's safety. HM Erickson stated that Resident C has an alarm on her bed and bed rail as well, but that Resident C always found a way to get on the floor. HM Erickson stated that Resident C suffered no injuries and that the staff made sure that Resident C was comfortable and safe. HM Erickson stated that Resident C passed away on 02/15/2024.
HM Erickson stated that she is aware of the allegations that the administrator kept a resident in the home after they attacked staff and residents. HM Erickson stated that the allegation is not true. HM Erickson stated that they have policies in place to deal with residents that have behavioral issues that that may become too much for staff to handle. HM Erickson stated that the person in question is Resident D. HM Erickson stated that Resident D was limited verbally but would yell at other residents and become easily agitated and display physical aggression towards objects but not people. HM Erickson stated that they did not want to discharge Resident D but that his aggressive behaviors escalated, and he began to become physically aggressive with staff members. HM Erickson stated that the on 01/30/2024, Resident D had a physical altercation with a staff member and that was the final incident before Swank Management notified Resident D's power of attorney that they were completing an emergency discharge for Resident D. HM Erickson stated that Resident D's behaviors became too much for the staff to manage and he was a threat to the safety of the other residents and staff members.

On 03/28/2024, I attempted to contact Direct Care Worker (DCW) Amanda Drotzur via telephone in regard to the allegations concerning Swank Assisted Living. There was no answer, and I left a message with my contact information. I contacted HM Erickson to see if there was another contact number for DCW Drotzur and she informed me that DCW Drotzur quit working at Swank Assisted Living and that she might not respond to my calls. I attempted to contact DCW multiple other times with no success.

On 04/08/2024, I interviewed via telephone Direct Care Worker (DCW) Tiffany Callis regarding the allegations. DCW Callis stated that she was aware of Resident A falling in the hallway and the staff member putting the video on TikTok. DCW Callis stated that it was HM Erickson who was involved in the incident, but she was not sure what happened as far as discipline for HM Erickson. HM Callis stated that a new social media policy was developed by management and that they all had to review the policy and sign the policy. HM Callis stated that she doesn't know anything else about the incident since it did not involve her, and she doesn't take pictures of the residents anyways.

DCW Callis stated that she did not have any information regarding the allegations involving Resident B. DCW Callis stated that she has not heard any issues with staff giving the wrong medication to residents. DCW Callis stated that she does not believe this is an issue at Swank Assisted Living.

DCW Callis stated that she did not know too much about Resident C as she was on medical leave when Resident C was admitted to Swank Assisted Living. DCW Callis

stated that she was aware that Resident C would get out of her bed and sit on the floor. DCW Callis stated that Resident B had and alarm and handrails on her bed. DCW Callis stated that Resident C had a fall matt, pillows, and blankets on the floor to ensure Resident B's safety while she sat on the floor. DCW Callis stated that she knows that management contacted the family and hospice nurse to make sure it was ok to let Resident C sit on the floor. DCW Callis stated that Resident C would sit on the floor a lot but that she was never there for long periods of time.

DCW Callis stated that she is aware of the allegations that the administrator kept a resident in the home after they attacked staff and residents. DCW Callis stated that she believes that the allegation is concerning Resident D as he was recently discharged from the facility. DCW Callis stated that Resident D was admitted and then became more and more physically aggressive. DCW Callis stated that Resident D was aggressive with objects and not people but then he became physically aggressive with a resident aide and was discharged after that. DCW Callis stated that on 01/30/2024, Resident D was being verbally aggressive with some residents and when a resident aide tried to redirect Resident D, he then grabbed the resident aide and tried to pull them down to the ground. DCW Callis stated that resident's family was notified and that an incident report was completed detailing the incident. DCW Callis stated that Resident D was sent to McLaren Hospital and that he did not return after that.

On 03/28/2024, I completed an onsite interview with Resident A regarding the allegations. Resident A did not have noticeable health concerns, she appeared neat and clean and was able to communicate with no issues. Resident A stated that she was aware of the video that was posted online but that she was not mad about it. Resident A stated that they took it down and apologized to her and her family about it. Resident A stated that she has no complaints about the workers or facility, and she like it there. Resident A stated that she does not try to walk anymore and uses a wheelchair when she is out of her bed.

On 03/28/2024, I completed an onsite interview with Resident A's guardian, Guardian A1, concerning the allegations. Guardian A1 was interviewed onsite as he was there to visit Resident A. Guardian A1 stated that the administrator called him and told him about the video that was posted of Resident A and apologized for what happened. Guardian A1 stated that he thought it was inappropriate for the staff to post that video, but everyone makes mistakes and he believes that the facility was sorry for what they did and they disciplined the staff member who posted the video. Guardian A1 stated that Resident A received good care at the facility, and he did not think about moving her out of the facility at all. Guardian A1 stated that he believes that the incident is water under the bridge and just wants to move on from it.

On 03/28/2024, I completed an onsite interview with Resident B regarding the allegations. Resident B did not have noticeable health concerns, she appeared neat and clean and was able to communicate with no issues. Resident B stated that she was not aware of any incident regarding her medications. Resident B stated that the staff give her the correct medication as she is very aware of what she takes every day.

Resident B stated that the staff have never given her the wrong medication as far as she is aware, and she stated that she believes she would be able to tell if she received the wrong medication. Resident B stated that she likes the staff, and they take the time to go over what medication she is taking when they give her medication. Resident B stated that she has a hospice nurse that also makes sure that she has the correct medication, so it is not a concern to her at all.

On 04/04/2024, I completed a phone interview with Resident B's McLaren Hospice Nurse Julie Campell regarding the allegations concerning Resident B. Nurse Campbell stated that she is aware of the allegations and that she believes the entire situation was just a mix up from the pharmacy. Nurse Campbell stated that Resident B was prescribed a PRN (as needed) for Alprazolam but that she changed it to a scheduled medication and the pharmacy did not correct it on the order. Nurse Campbell stated that DCW Drotzur called her and asked her for a verbal order as the PRN had not been changed to a scheduled medication on the order. Nurse Campbell approved her to administer the medication and the order has since been corrected with the pharmacy. Nurse Campbell stated that Swank Assisted Living does a great job with their medication, she stated that they always have names, birthdays, and pictures of the residents by the medication to ensure that they are giving the correct medication to the residents. Nurse Campbell stated that Swank Assisted Living is outstanding with their care of the residents and that she has no complaints at all and that the staff are well trained, and the residents always tell her how much they love the staff at Swank Assisted Living.

On 04/04/2024, I completed a phone interview with Resident C's guardian, Guardian C1, regarding the allegations concerning Resident C. Guardian C1 stated that she was not aware of the allegations but that she was aware that Resident C had spent time on the floor of her room at Swank Assisted Living. Guardian C1 stated that she received calls from Swank Assisted Living staff regarding Resident C being on the floor. Guardian C1 stated that the staff explained what Resident C was telling them about her religious beliefs and wanting to be on the floor. Guardian C1 stated that the staff explained to her that they would be putting a fall matt, blankets and pillows on the floor to ensure that Resident C would be comfortable and safe when she sat on the floor. Guardian C1 stated that she approved of the plan for Resident C. Guardian C1 stated that the staff would always call her and give her updates on Resident C. Guardian C1 stated that she believes that the reason Resident C was on the floor was that she was probably confused and unclear on things going on around her and that she was suffering from cancer and had multiple strokes and she believes that this affected her way of thinking. Guardian C1 stated that she spoke with Resident C's Hospice Nurse Sarah Young to make sure that were no issues with Resident C sitting on the floor. Guardian C1 stated that there were no issues with the plan that the Swank Assisted Living staff devised for Resident C. Guardian C1 stated that she had no issues with the care that Resident C received while she was in the care of Swank Assisted Living, she stated that they were always on top of things and always kept her updated with any thing that went on with Resident C.

On 04/04/2024, I completed a phone interview with Resident C's McLaren Hospice Nurse Sarah Young regarding the allegations concerning Resident C. Nurse Young stated that she was not aware of any allegations but that she was aware that Resident C had spent time on the floor of her room at Swank Assisted Living. Nurse Young stated that the Swank Assisted Living staff had contacted her and Guardian C1 to ensure that there were no safety issues or concerns with making an area on the floor for Resident C to sit. Nurse Young stated that she never witnessed Resident C sitting on the floor but that there were never any reported injuries from Resident C sitting on the floor. Nurse Young stated that the Swank Assisted Living staff cared for their patients and kept her up to date on any changes in health concerning Resident C.

Resident C passed away on 02/15/2024 from cancer.

On 04/04/2024, I completed a phone interview with Resident D's guardian, Guardian D1, regarding the allegations concerning Resident D. Guardian D1 stated that he was not aware of any allegations but that he is aware that Resident D was given an emergency discharge after he had a physical altercation with a Swank Assisted Living staff member. Guardian D1 stated that he had been in contact with the Swank Assisted Living staff prior to Resident D being discharged on 01/30/2024. Guardian D1 stated that he had been working with the staff on different solutions to help with Resident D's behaviors as they had been escalating since he was admitted to Swank Assisted Living on 07/25/2023. Guardian D1 stated that he was not concerned about the care that Resident D was getting while he was at Swank Assisted Living, but he did state that he had some concern about the emergency discharge process. Guardian D1 stated that Resident D stayed at McLaren Hospital to have his medication reevaluated and he is now placed in another adult foster home.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(1) A resident shall be assured privacy and protection from moral, social, and financial exploitation.
ANALYSIS:	It was alleged that: • Resident was left unattended, and she fell. The manager posted a video of the fall on social media. I completed an investigation and interviewed Adult Protective Services worker, Swank Assisted Living Staff and the Resident's guardian and determined that there was evidence to conclude that R 400.15305 (1) was violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	It was alleged: • Resident was left laying on the floor during an entire shift and was not strong enough to get herself off the ground. • Staff gave medication without checking to see if resident could have them. • Administrator kept violent resident in the home even after the resident attacked residents and staff. I completed an investigation and interviewed Adult Protective Services worker, Swank Assisted Living Staff, Resident's guardian, and McLaren Hospice Nurses and determined that there was no evidence to conclude that R 400.15305 (3) was not violated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	It was alleged: • Staff gave medication without checking to see if resident could have them. I completed an investigation and interviewed Adult Protective Services worker, Swank Assisted Living Staff, Resident's guardian, and McLaren Hospice Nurses and determined that there was no evidence to conclude that R 400.15312 (2) was not violated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 04/09/2024, I completed an exit Interview with Licensee Designee Rhonda Anagnostopoulos. Rhonda Anagnostopoulos was informed of the findings of this investigation.

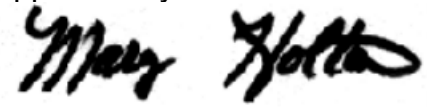
IV. RECOMMENDATION

I recommend no change to the current licensing status pending the receipt of an appropriate corrective action plan.

04/10/2024

Martin Gonzales Licensing Consultant	Date

Approved By:



04/10/2024

Mary E. Holton Area Manager	Date