GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 23, 2024

Ginger Nahikian
Niche Aging Center Hampton LLC
581 Scheurmann Rd
Bay City, MI 48708

RE: License #:	AL090409334
Investigation #:	2024A0123033
	Niche Aging Center Hampton

Dear Ginger Nahikian:

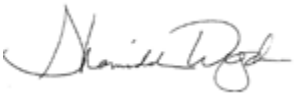
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.

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,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL090409334
Investigation #:	2024A0123033
Complaint Receipt Date:	04/12/2024
Investigation Initiation Date:	04/16/2024
Report Due Date:	06/11/2024
Licensee Name:	Niche Aging Center Hampton LLC
Licensee Address:	581 Scheurmann Rd Bay City, MI 48708
Licensee Telephone #:	(989) 737-2355
Administrator:	Ginger Nahikian
Licensee Designee:	Ginger Nahikian
Name of Facility:	Niche Aging Center Hampton
Facility Address:	581 Scheurmann Rd Bay City, MI 48708
Facility Telephone #:	(989) 737-2355
Original Issuance Date:	05/20/2022
License Status:	REGULAR
Effective Date:	11/20/2022
Expiration Date:	11/19/2024
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 04/01/24, Resident A fell at the facility and was observed bleeding from the head. Resident A was transported to the hospital by ambulance. Resident A received six forehead stitches and was discharged back to the facility. Staff Jill Majznerski reported she bumped Resident A with the bathroom door, and that Resident A lost balance falling back into the tub.	Yes

III. METHODOLOGY

04/12/2024	Special Investigation Intake 2024A0123033
04/15/2024	APS Referral Information received regarding APS referral.
04/16/2024	Special Investigation Initiated - Telephone I spoke with adult protective services investigator Bethany Hornbacher via phone.
04/25/2024	Inspection Completed On-site I conducted an unannounced on-site at the facility.
05/02/2024	Contact - Document Received Documentation received via fax.
05/03/2024	Contact - Telephone call made I spoke with Relative 1 via phone.
05/03/2024	Contact - Telephone call made I made an attempted phone call to staff Laurie Duffield.
05/03/2024	Contact - Telephone call made I interviewed staff Kari Manning via phone.
05/03/2024	Contact - Telephone call made I left a voicemail requesting a return call from staff Jill Majznerski.
05/03/2024	Contact - Telephone call made I made a follow up call to the facility. I spoke with staff Aleshia Garcia.
05/03/2024	Contact- Telephone call made I interviewed staff Kari Manning via phone.

05/07/2024	Contact- Telephone call received I interviewed staff Laurie Duffield via phone.
05/07/2024	Contact- Telephone call made I interviewed staff Jill Majznerski via phone.
05/23/2024	Exit Conference I conducted an exit conference with licensee designee Ginger Nahikian via phone.

ALLEGATION: On 04/01/24, Resident A fell at the facility and was observed bleeding from the head. Resident A was transported to the hospital by ambulance. Resident A received six forehead stitches and was discharged back to the facility. Staff Jill Majznerski reported she bumped Resident A with the bathroom door, and that Resident A lost balance falling back into the tub.

INVESTIGATION: On 04/16/2024, I spoke with adult protective services investigator Bethany Hornbacher via phone. She stated that she conducted an on-site at the facility and saw Resident A last week. Resident A remembered falling but didn't remember receiving any medical treatment. She stated that staff Jill Majznerski had went to get some items, came back, and opened Resident A's bathroom door (but did not knock). Resident A was in close proximity to the door and fell when Staff Majznerski opened the door. An incident report was completed. Resident A went to a hospital emergency room. Bethany Hornbacher stated that now staff will assist Resident A with getting dressed in the main area of the bedroom. Resident A received six stitches to the forehead. Resident A had minimal bruising visible under the eyes. Bethany Hornbacher stated that Relative 1 feels the facility is a good facility, Resident A is receiving good care, and Relative 1 is fine with Resident A remaining at the facility. She stated that Relative 1 feels staff were untruthful about what happened, but that staff did admit later to what occurred.

On 04/25/2024, I conducted an unannounced on-site visit at the facility. I interviewed home manager Shelby Hoskins. She stated that Staff Majznerski has since been transferred to another facility. Staff Hoskins stated that she was not on shift when the incident occurred. She stated that Resident A received stitches, which have since healed. She stated that she was told that Staff Majznerski was getting clothes for Resident A, then went back to open the bathroom door. Resident A's back was to the door, and staff Majznerski hit Resident A with the bathroom door. Resident A lost their balance, toppled over, and hit the tub. Staff Hoskins stated that Resident A now gets dressed in the bedroom area and not in the private bathroom. Staff Hoskins stated that there have been no other issues with Staff Majznerski, and that Staff Majznerski was very remorseful, and apologized to Relative 1. Staff Hoskins stated that Resident A may have had a concussion, but the facility did not get a copy of the discharge paperwork.

During this on-site, I received copies of requested documents. An *AFC Licensing Division- Incident/Accident Report* dated 04/01/2024, signed by staff Laurie Duffield states that at 6:15 am "*As staff was assisting resident getting dressed, resident lost balance and fell backwards, staff tried to slow residents fall down but could not hold resident's weight. Resident fell backwards into bathtub. Resident's left side of head started bleeding. Staff held pressure on wound. Called 911had ambulance come while resident was in bathtub due to bleeding. Notified management. Notified wife. Follow discharge instructions from hospital*." Staff Majznerski, Staff Manning, and Staff Duffield were listed as other persons involved/witnesses.

A copy of Resident A's *Health Care Appraisal* dated 04/19/2024 notes that Resident A has Alzheimer's/dementia and needs 24- hour supervision due to being at risk of falls. "*Uses cane*" is marked but "*suggest*" is written next to it.

A copy of Resident A's *Assessment Plan for AFC Residents* dated 04/16/2024 states that Resident A is alert to surroundings, needs no assistance with walking/mobility, and uses no assistive devices.

On 04/25/2024, I interviewed Resident A at the facility. Resident A reported not remembering what happened, but said they got hit in the head. Resident A reported getting stiches and stated that it still hurts. Resident A denied remember what room they were in when the incident occurred but remembers hitting the floor. Resident A denied having any falls since the incident and stated that it really hurts. Resident A appeared clean and appropriately dressed during this interview. The stitches appeared to have healed. Resident A appeared clean and appropriately dressed during this on-site, as well as other residents observed during this visit. No issues were noted.

On 05/03/2024, I interviewed Relative 1 via phone. Relative 1 stated that Resident A did not just fall. Resident A was in the bathroom. A staff told Relative 1 that she opened the bathroom door. Resident A then fell forward, hit the tub, and the right side of their face. Relative 1 stated that Resident A received stitches over the right eye. Relative 1 stated that the incident report says something different. Relative 1 stated that Resident A also had a red mark on their back, which Relative 1 has a photo of. Relative 1 stated that staff told adult protective services the truth about what occurred. Relative 1 stated they had a conversation with staff Laurie Duffield about signing a false incident report. Relative 1 stated that staff Jill Majznerski was the staff present during the incident. Relative 1 stated that Resident A healed remarkably well, and that Resident A has no recollection of what happened. Relative 1 stated that that hospital was concerned there may have been a brain bleed, but there wasn't. Relative 1 stated that staff not being honest about the incident, bothered them more than anything, but Staff Majznerski was remorseful. Relative 1 stated they were told the incident report was re-written. Relative 1 stated that what Staff Majznerski told Relative 1 about what happened, made more sense than what the incident report noted. When asked if Resident A falls, Relative 1 stated that Resident A is very stable (gait). After this phone call, I received photos of Resident

A’s injuries from Relative 1. The first photo shows Resident A with dark bruising above and below the right eye. The second photo shows a red mark on the upper right shoulder blade area of Resident A’s back.

On 05/03/2024, I interviewed staff Kari Manning via phone. Staff Manning stated that she works third shift. She stated that the incident with Resident A happened at the end of third shift, beginning of first shift. Staff Manning reported being present in the building when it happened, but she was in another bathroom. When she came out of the bathroom, she stated that her co-worker was running down the hallway asking for help. Staff Manning stated that she stayed to assist. Staff Manning reported that she went into Resident A’s bathroom. Resident A was in the tub. She stated that she went and got another co-worker, then made phone calls to 911 and Relative 1. Staff Manning denied witnessing the incident. Staff Manning stated that after the fact, Staff Majznerski said she tried to help Resident A, but lost grip, and Resident A fell into the tub. Staff Majznerski also said to Staff Manning that she tried to keep Resident A from falling. Staff Manning stated that she had started helping Staff Majznerski write the incident report, then another co-worker, Caitlyn Liddy, stepped in and took over writing the incident report. Staff Manning stated that she left when staff Caitlyn Liddy took over. Staff Manning stated that she heard others say that Resident A was in the bathroom behind the door when Staff Majznerski opened the door. Staff Majznerski saw Resident A falling over and tried to reach out to Resident A. Staff Manning denied seeing or hearing of Resident A falling before this incident. She stated that Resident A bumps into the walls sometimes, but always walks by themselves. She stated that staff assist Resident A with getting dressed so Resident A doesn’t fall.

On 05/03/2024, I made a follow-up call to the facility to inquire about the incident report that was written. I spoke with staff Aleshia Garcia. She stated that she was not aware of the incident report being re-written. She stated that typically a manager or the highest person on duty fills out an incident report. The incident report is staff Caitlyn Liddy writing but signed by staff Laurie Duffield. During this call, Staff Garcia called staff Shelby Hoskins. I heard Staff Hoskins say during this call that the incident report was not correct, and that it was written per word of mouth. Staff Laurie Duffield, staff Kari Manning were in the building at the time of the incident, and Staff Majznerski was in the room with Resident A when it happened.

On 05/07/2024, I interviewed staff Laurie Duffield via phone. Staff Duffield stated that Staff Majznerski was in the room with Resident A. She stated that she was in a different room at the time. She stated that her name was called, and she ran to Resident A’s room. Resident A was in the tub. She stated that she told staff to make calls to 911, management and Relative 1. Staff Duffield stated that she was told to sign the incident report, but staff Caitlyn Liddy wrote the incident report. She stated that she saw Resident A was lying in the tub on their back and was bleeding from the head. Resident A said that Staff Majznerski pushed them. Staff Majznerski denied pushing Resident A. She stated that Staff Majznerski said that Resident A was in the bathroom, Staff Majznerski opened the bathroom door, and did not know

Resident A was by the door, and Resident A lost their balance. She stated that Resident A does not have a history of falls but gets clumsy at times and may bump into the wall. She stated that Resident A walks non-stop.

On 05/17/2024, I interviewed staff Jill Majznerski via phone. Staff Majznerski worked first shift on 04/01/2024. She stated that Resident A went to the bathroom. She gathered his clothing to get Resident A dressed. Staff Majznerski stated that she opened the bathroom door slowly. Resident A was startled and fell towards the shower. Staff Majznerski stated that she tried to stop Resident A from falling. Resident A fell in the tub, and was bleeding, so she called for help on the walkie talkie for assistance from another staff. Staff Majznerski stated that she saw Resident A falling. Staff Laurie Duffield came in and held a washcloth to Resident A's head until the ambulance arrived. Staff Majznerski stated that Resident A fell toward their side, towards the shower. Staff Majznerski denied that the bathroom door made physical contact with Resident A, but Relative 1 says it did. Staff Majznerski stated that Resident A fell face first, and the temple area of their head hit the floor. Staff Majznerski stated that it was only her and Resident A present when Resident A fell. Staff Majznerski stated that the red mark on Resident A's was probably from Resident A hitting the tub. Staff Majznerski stated that staff Caitlyn Liddy re-wrote the incident report, telling Staff Majznerski there were too many mistakes on the report Staff Majznerski was writing.

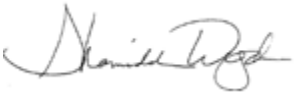
On 05/23/2024, I conducted an exit conference with licensee designee Ginger Nahikian via phone. I informed Ginger Nahikian of the findings and conclusion. Ginger Nahikian stated that she does not think that this incident could have been prevented as Resident A is easily startled. She also stated that she will address with staff about documenting incident reports accurately, including management having a conversation with the staff person directly involved, and doing skin audits of the residents.

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:	On 04/25/2024, I conducted an unannounced on-site inspection at the facility. Home manager Shelby Hoskins reported that she was told that Resident A received several stitches after staff Jill Majznerski opened Resident A's bathroom door, hit Resident A with the door, causing Resident A to lose balance. This resulted in Resident A falling and hitting the tub. I interviewed Resident A during this on-site who denied remembering what happened but stated they fell and had to get

	stitches. On 05/03/2024, I spoke with Relative 1 who reported Resident A received stitches to the right side of the face and had a red mark on their back. Relative 1 expressed concerns that the incident report written did not accurately reflect Resident A's injuries. On 05/03/2024, I interviewed staff Kari Manning who was present in the facility at the time of Resident A's fall. She stated that she did not witness the incident but made the calls to 911 and Relative 1. On 05/07/2024, I interviewed staff Laurie Duffield. She stated that staff called her into Resident A's room after the fall. She witnessed Resident A lying in the tub, bleeding from the head. She stated that Resident A told her that Staff Majznerski pushed them. She stated that Staff Majznerski told her that when Staff Majznerski opened the bathroom door, Resident A lost balance and fell. On 05/17/2024, I interviewed staff Jill Majznerski. She stated that when she opened the bathroom door slowly, it startled Resident A, and Resident A fell towards the shower. She stated that she attempted to stop Resident A from falling. There is a preponderance of evidence to substantiate a rule violation. While providing personal care, Staff Jill Majznerski opened the bathroom door, causing Resident A to lose balance, fall, and sustain an injury resulting in receiving medical treatment for stitches.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

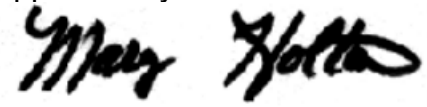
Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC large group home license (capacity 1-20).



05/23/2024

Shamidah Wyden Date
Licensing Consultant

Approved By:



05/23/2024

Mary E. Holton Date
Area Manager