GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 5, 2024

Shannon East
Madison American Lakeshore TRS, LLC
One Towne Square Suite 1600
Southfield, MI 48076

RE: License #: AH500409733
Investigation #: 2024A0784070
American House Lakeshore

Dear Shannon East:

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 #:	AH500409733
Investigation #:	2024A0784070
Complaint Receipt Date:	06/27/2024
Investigation Initiation Date:	06/28/2024
Report Due Date:	08/26/2024
Licensee Name:	Madison American Lakeshore TRS, LLC
Licensee Address:	One Towne Square Suite 1600 Southfield, MI 48076
Licensee Telephone #:	(248) 203-1800
Administrator/Authorized Representative:	Shannon East
Name of Facility:	American House Lakeshore
Facility Address:	28801 Jefferson Ave St Clair Shores, MI 48081
Facility Telephone #:	(586) 218-6228
Original Issuance Date:	11/19/2021
License Status:	REGULAR
Effective Date:	05/19/2024
Expiration Date:	07/31/2024
Capacity:	27
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Inadequate care and supervision of residents	Yes
Additional Findings	No

III. METHODOLOGY

06/27/2024	Special Investigation Intake 2024A0784070
06/28/2024	Special Investigation Initiated - On Site
06/28/2024	Inspection Completed On-site
06/28/2024	Exit Conference Conducted with administrator/authorized representative Shannon East

ALLEGATION:

Inadequate care and supervision of residents

INVESTIGATION:

On 6/27/2024, the department received this complaint from adult protective services (APS).

According to the complaint, one resident fell on her face because a caregiver was asleep on the couch. One resident was left in her urine and staff did not clean it up. No staff names, dates, times or specific incidents were provided in the complaint. Resident A and Resident B were noted in the complaint as the residents involved, however the allegations did not specify which resident the allegations were in reference to.

On 6/28/2024, I interviewed administrator/authorized representative Shannon East at the facility. Ms. East stated she was aware of the allegations as a staff member brought the concerns to her. Ms. East stated that Resident A recently had a fall in the early morning of 6/16/2024. Ms. East stated a staff member alleged that the fall happened because the third shift staff on duty at the time was sleeping. Ms. East stated she reviewed the facility video, upon receiving the complaint, and that no staff

were found to be sleeping on the shift. Ms. East stated Resident A requires assistance from staff getting to the restroom and that it is likely she attempted to get up and go to the bathroom on her own. Ms. East stated Resident A does not commonly get up at night. Ms. East stated staff are instructed to conduct “hourly rounds” to check on residents during the nighttime. During the onsite, I observed Resident A eating breakfast in the dining area. Resident A appeared comfortable and well groomed. I observed Resident A to have bruising to the left side of her face by her cheek and eye. Ms. East stated she had also received a complaint regarding Resident B. Ms. East stated that the complaint was received on 6/20/2024 and it was reported that during third shift on the morning of 6/20/2024, Associate 1 had changed Resident B’s brief after finding her standing in urine in her room during room checks and did not clean the urine off the floor. Ms. East stated Associate 1 was asked about this and admitted to not cleaning up the urine believing it was housekeeping's job to clean up such messes. Ms. East stated Associate 1 was re-educated on the fact that any staff available to clean up in a resident's room is supposed to do so if they are aware of the need to do so.

I reviewed the facility incident report regarding Resident A’s fall on the morning of 6/16/2024, provided by Ms. East. Within a section titled *Description*, the report read, in part, “on 6/16/2024, upon the med tech entering the apartment to administer the residents scheduled breathing treatment, the resident was observed face down on the floormat. Upon rolling the resident to her right side, the resident was observed with a small cut above her left eye with purple discoloration to the eye, and cheek”. Within a section titled *Statement from person involved in incident*, the report read, in part, “Upon the ED and SWD investigating, the caregiver responsible for the resident did not complete rounds on the resident the entirety of the shift. It is unknown what time the resident fell from bed and how long she was on the floor”.

I reviewed Resident A’s service plan, provided by Ms. East. Within a section titled Psychosocial Category, the plan read, in part “[Resident A] requires frequent nighttime rounding to ensure her safety and support of incontinence episodes. She is a fall risk and has a history of falls from bed. She requires routine toileting due to increased incontinence during the night. She will make attempts to toilet herself at night, which increases her risk of falls”.

I reviewed a written statement from Associate 1, dated 6/21/2024, which read, in part, “when checking on [Resident A] on midnight shift I assumed housekeeping would clean the urine from the floor”.

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 a lack of adequate care due to a resident being left in urine in her room and a lack of adequate supervision when a resident was discovered having fallen on her face due to a staff member allegedly sleeping during the shift. While the complaint did not provide specific information to identify the residents, when interviewed, the administrator, Ms. East, indicated two recent incidents involving Residents A and B which matched the description of the complaint. The investigation revealed Associate 1 did leave urine on Resident B's floor after changing Resident B's brief. While Associate 1 admitted to the circumstances stating she believed it was housekeeping's job to clean it up, this appears to have been a misunderstanding of job duties and Associate 1 was re-educated on this matter. As it pertains to Resident A, Ms. East reported that an investigation into this complaint did not support that staff had been sleeping on the shift. Ms. East did report that Resident A had a fall and sustained bruising to her face. Review of facility incident reporting revealed that upon investigation, Ms. East discovered staff had not checked on Resident A for the duration of the shift on the night in question and that it could not be determined as to how long Resident A had been on her floor after having fallen thought Ms. East stated staff are required to conduct hourly checks on residents during the night. Review of Resident A's service plan indicated Resident A specifically requires frequent nighttime checks due to being a high fall risk person who has a propensity to attempt to get up and toilet herself at night, which conflicted with Ms. Easts statement that Resident A does not commonly get up at night. Based on the evidence, the allegation of a lack of adequate supervision for Resident A is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

8/05/2024

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Aaron Clum Date
Licensing Staff

Approved By:

08/05/2024

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