RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

August 22, 2017

Janet Mazzetti
Lake Orion Assisted Living, LLC
PO Box 564
Oxford, MI 48371

RE: License #: AM630378604
Investigation #: **2017A0989068**
Orion Manor

Dear Ms. Mazzetti:

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 (248) 975-5053.

Sincerely,

Theresa Cipponeri, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 285-8590

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM630378604
Investigation #:	2017A0989068
Complaint Receipt Date:	05/08/2017
Investigation Initiation Date:	05/09/2017
Report Due Date:	07/07/2017
Licensee Name:	Lake Orion Assisted Living, LLC
Licensee Address:	1814 S Lapeer Lake Orion, MI 48360
Licensee Telephone #:	(248) 814-6714
Administrator:	Loraine Lee
Licensee Designee:	Janet Mazzetti
Name of Facility:	Orion Manor
Facility Address:	1814 S. Lapeer Road Lake Orion, MI 48360
Facility Telephone #:	(248) 814-6713
Original Issuance Date:	06/09/2016
License Status:	REGULAR
Effective Date:	12/09/2016
Expiration Date:	12/08/2018
Capacity:	12
Program Type:	AGED; ALZHEIMERS PHYSICALLY HANDICAPPED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was given a 24 hours discharge notice for no reason.	No
Staff refused to provide Resident A's guardians with Resident A's records.	No
Resident A fell and hit her head when staff did not act quickly to stop her from exiting the facility. Staff did not seek medical attention for Resident A.	Yes
Facility staff did not immediately provide the guardian with a copy of the incident report regarding Resident A's head injury.	No

III. METHODOLOGY

05/08/2017	Special Investigation Intake 2017A0989068
05/09/2017	Special Investigation Initiated – Telephone Left voicemail message for Complainant.
5/9/2017	Contact-Telephone call from Spoke to Complainant.
05/17/2017	Contact - Face to Face Conducted an unannounced onsite inspection. Interviewed the Manager, Candace Collins, staff, Grace Carano, staff, Keri Rizzo, and Licensee, Janet Mazzetti.
07/13/2017	Contact - Telephone call made Spoke to Complainant.
07/13/2017	Contact - Telephone call made Left voicemail message for Licensee.
07/14/2017	Contact-Telephone call received From Ms. Mazzetti.
07/14/2017	Exit Conference Held with Ms. Mazzetti.
08/16/2017	Exit Conference I left a message for Ms. Mazzetti.

08/18/2017	Exit conference Held with Ms. Mazzetti.

ALLEGATION:

Resident A was given a 24 hours discharge notice for no reason.

INVESTIGATION:

On 5/9/2017, I spoke to Complainant. The Complainant stated that staff at the facility presented her with an emergency discharge notice without warning and stated that Resident A had to be out of the facility within 24 hours. Complainant stated that the facility "kicked her mother out" and she did not know why. Complainant added that Resident A has vascular dementia and sundowners, and the facility was aware of this but they accepted her anyway then kicked her out.

On 5/17/2017, I conducted an unannounced onsite inspection. I interviewed the Manager, Candace Collins, staff, Grace Carano, staff, Keri Rizzo, and Licensee, Janet Mazzetti. Staff stated that from the very first day that Resident A came to the facility there were problems regarding her behavior. Staff stated that Resident A constantly wandered all over the facility and repeatedly made attempts to get out. Staff constantly had to verbally re-direct her away from the doors to prevent her from getting out. Every time the door opened, Resident A would try to walk out, and staff had to constantly keep an eye on Resident A. Staff stated that the guardians completed an assessment plan with staff and they did indicate anywhere in the assessment plan that Resident A had these types of behavioral issues, nor did they verbally express these issues to staff before Resident A was admitted to the facility.

Ms. Mazzetti stated that a meeting was held with Resident A's guardians on 4/12/2017 to discuss the problems. During the meeting, the guardians disclosed that Resident A was violent when she was living with them prior to coming to this facility. An incident occurred where Resident A pushed one of the guardians so hard that they had to contact 911 for assistance. Staff stated that the family withheld the true nature of Resident A's behaviors and did not fully inform them of these incidents until the discharge meeting was held. Staff felt that they could not tend to Resident A's needs, as their facility is not equipped to handle her elopement tendencies.

Ms. Mazzetti issued an emergency discharge notice to the guardians on 4/13/2017 and gave them 24 notice to remove Resident A.

I received a copy of the discharge notice, which stated specific language as to why Resident A was being given an emergency discharge. "Substantial risk to the resident due to the inability of the home to meet the resident's needs or assure the safety and well-being of other residents at the home".

I received a copy of Resident A's assessment plan, signed and dated by one of the guardians. The assessment plan did not list any concerns or statements indicating Resident A's wandering, elopements tendencies, or need for 1:1 supervision. Staff stated that had they known about Resident A's higher level of needs then they would not have considered admitting Resident A into the facility.

I received a copy of Resident A's health appraisal, which listed her only diagnosis as "advanced dementia".

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(4) A licensee may discharge a resident before the 30-day notice when the licensee has determined and documented that any of the following exists: **(a) Substantial risk to the resident due to the inability of the home to meet the resident's needs or assure the safety and well-being of other residents of the home.**
ANALYSIS:	According to the Complainant, staff kicked Resident A out of the facility without warning and Complainant did not know why. According to interviews with Ms. Collins, Ms. Carano, Ms. Rizzo, and Ms. Mazzetti, prior to admission, the guardians were not forthcoming with the level of supervision and care that Resident A would require. The assessment plan did not indicate any statements regarding Resident A's wandering behaviors or elopement tendencies. Staff held a meeting with the guardians informing them that they cannot handle Resident A's needs, and an emergency discharge notice was issued to the guardians the next day.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff refused to provide Resident A's guardians with Resident A's records.

INVESTIGATION:

On 7/13/2017, I contacted the Complainant to clarify what specific records she requested from the facility. The Complainant stated that she wanted all the notes the

staff took. I stated that I needed her to specify that further, and the Complainant stated that she knows that staff takes notes on Resident A, so she wanted all the notes. Complainant clarified that she wanted the staff notes relating specifically relating to Resident A's fall and injury. I stated that the facility is not required to keep staff notes, however, they are required to write incident reports when there are injuries which is what the facility did in this case. The Complainant then stated that she really wasn't sure what staff records she wanted, but alluded that she wanted Resident A's medication logs. She stated that she did request Resident A's medication logs from the facility, however, they refused to give them to her and stated that it was against their policy.

On 7/13/2017, I left a voicemail message for Ms. Mazzetti requesting that she return my call regarding this issue.

On 7/14/2017, I spoke to Ms. Mazzetti, who stated that the Complainant never requested any of Resident A's medical records at all at any time. Ms. Mazzetti then stated that the Complainant even came back to collect the refund money that was owed to her for Resident A, and she never mentioned anything about getting copies of any of Resident A's medical records. Ms. Mazzetti stated that if the Complainant wants copies of Resident A's medication records then she will provide them to her should she request them.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(8) At the time of discharge, a licensee shall provide copies of resident records to the resident and his or her designated representative when requested, and as determined appropriate, by the resident or his or her designated representative. A fee that is charged for copies of resident records shall not be more than the cost to the licensee of making the copies available.
ANALYSIS:	According to the Complainant, she requested Resident A's records from the facility, but they refused to give them to her. The Complainant later clarified that she wanted to see Resident A's medication logs. Ms. Mazzetti stated that at no time did the Complainant request any of Resident A's records, however, she will provide those logs to the Complainant.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A fell and hit her head when staff did not act quickly to stop her from exiting the facility. Staff did not seek medical attention for Resident A.

INVESTIGATION:

On 5/9/2017, I spoke to the Complainant. The Complainant stated that there are two sets of doors leading out of the facility, and Resident A managed to get past both the doors to the outside. She added that there is a 15 second alarm that goes off signaling that a Resident has gotten outside the building. Staff heard the alarm but did not react. Once Resident A got out of the facility she slipped and hit her head, causing it to bleed. Complainant stated that she and the guardian went to the facility and saw that Resident A's head was bleeding badly. Staff told them that they did not feel that she required medical attention, but informed the Complainant that she and the guardian could contact EMS and have Resident A taken to the hospital if they thought she should be medically examined. The Complainant felt that the staff should have been the ones to call EMS. Complainant added that if staff had been paying attention to Resident A, then this never would have happened.

On 5/11/2017, the Complainant texted several pictures of Resident A's injuries to me. I observed that there was some type of contusion on Resident A's head near the scalp. Resident A's hair is very light, and the red blood was very vibrant in her hair. It was obvious that there was some sort of injury, but it was difficult to tell how bad it was from the pictures. The cut was bloody so I couldn't ascertain where the specific cut was and where the blood was coming from. In addition, the Complainant texted me saying that Ms. Collins called her to tell her about the injury and sent her a picture of the gash. The Complainant stated that she asked Ms. Collins to call 911 but when the Complainant arrived at the facility, staff stated that Resident A was really OK and would watch her closely. The Complainant stated that no one ended up calling 911, but Ms. Collins told her that if the Complainant fell differently about the situation then she could call 911 and obtain medical attention for Resident A should she wish to do so.

On 5/17/207, I conducted an unannounced onsite inspection. I interviewed the Manager, Candace Collins, staff, Grace Carano, staff, Keri Rizzo, and Licensee, Janet Mazzetti. Staff stated that Resident A would always hover around the exit doors and when people opened the doors she would try to elope. Staff stated that they did the best they could, but they are not set up to watch Resident 1:1, nor was that information put in her assessment plan. Staff stated that there are plenty of staff on shift, however it was difficult to keep up with Resident A because they had not been warned of her behaviors beforehand. After the first door is opened, an alarm sounds and here is a 15 second delay. After the 15 seconds is up, the second door can be opened. Ms. Carano and Ms. Rizzo stated that they were on shift when this occurred, and when they heard the alarm go off they ran to the door. Once they got there, Resident A had gotten outside and was lying on the ground. They asked her if she was OK and she stated that she was. Ms.

Carano and Ms. Rizzo brought her inside and stated that Resident A was walking OK. Upon further examination, Ms. Carano and Ms. Rizzo saw some sort of cut on Resident A's head. They stated that it was not a gash but described it as a cut, only deeper. Blood was visibly seen in Resident A'a hair, however, Resident A's hair is very light so they just thought that the light hair accentuated the red blood. Ms. Carano and Ms. Rizzo stated that that asked the staff physical therapist to examine Resident A, and the physical therapist's opinion was that Resident A was fine and did not require medical treatment. Staff contacted the guardians and stated that they did not think this was a medical emergency nor did they feel that Resident A required medical treatment. The guardians came to the facility and stayed a few hours trying to decide if they should take Resident A for medical treatment. Staff told the guardians that if they felt that Resident A should be medically examined then they were free to take her, however, the guardians decided to not take Resident A for medical treatment.

I received a copy of the resident register and observed that there were six residents in the facility as of 4/6/2017, when this incident occurred. I received a copy of the staff schedule and observed that the staff shifts sometimes overlapped, however, on average there were two staff members on shift during the day, and two staff on shift in the afternoon. The shift hours were typically 7:00 a.m.-3:00 p.m., 7:30 a.m.-3:00 p.m., 2:00-9:00 p.m., and 3:00-11:00 p.m.

On 7/14/2017, I interviewed Ms. Mazzetti by telephone. According to Ms. Mazzetti, the guardians came up to the facility on the day of this incident. After examining Resident A's injuries, they did not feel that the Resident A required medical attention. Ms. Mazzetti stated that she staff went along with the Complainant's decision to not take Resident A for treatment. Ms. Mazzetti stated that it is her understanding that if a guardian is available and makes the decision to decline medical treatment then that is the final decision. Ms. Mazzetti added that there are residents at the facility who do not have involved or active guardians, and if those residents needs medical treatment then staff does seek medical treatment should it be deemed appropriate if the guardians do not wish to be involved.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	On 4/6/2017, Resident A sustained an injury to her head when she slipped and fell. According to Ms. Carano, Ms. Collins, and Ms. Rizzo, after examining the injury they did not feel that it was necessary to obtain medical attention. However, they contacted Resident A's guardian and texted a picture of the injury. Resident A's guardian went to the facility and examined the injury. Staff informed the guardian that they were not going to

	contact EMS, however, the guardians were free to take Resident A for medical treatment should they deem it necessary. According to the Complainant, the staff should have contacted the EMS and taken Resident A for medical treatment. Staff informed the guardians that they would continue to monitor Resident A closely, and the guardians ultimately chose not to take Resident A for medical treatment. Resident A sustained an injury to her head which caused injury and bleeding. According to licensing rules, staff should have obtained medical attention for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Facility staff did not immediately provide the guardian with a copy of the incident report regarding Resident A's head injury.

INVESTIGATION:

On 5/17/2017, I conducted an unannounced onsite inspection. I interviewed the Manager, Candace Collins, staff, Grace Carano, staff, Keri Rizzo, and Licensee, Janet Mazzetti. Staff stated that they contacted Resident A's guardians that same day to inform them of Resident A's head injury. Neither staff nor the guardians chose to contact EMS for medical treatment and staff stated they would continue to monitor Resident A closely.

I observed a copy of the incident report which indicated that the guardian had been called on 4/6/2017 at 1:30 p.m. and was informed about this incident.

On 7/13/2017, I spoke to the Complainant. The Complainant confirmed that the guardians were contacted regarding this incident, however, the facility refused to provide a copy of the incident report to the guardians until the day of Resident A's discharge. The Complainant stated that the facility was supposed to provide her with a copy of the incident report as soon as the incident happened, and she did received a copy of the incident report until later.

On 7/14/2017, I spoke to Ms, Mazzetti, who stated that she provided the Complainant with a copy of the incident report at the time of discharge.

On 7/14/2017, I held an exit conference with Ms. Mazzetti. I stated that I did not find any licensing violations and she will receive a copy of this special investigation in the mail. Ms. Mazzetti agreed to contact me should see have any questions.

On 8/16/2017, I attempted to contact Ms. Mazzetti and speak to her in regards to a licensing violation that was found upon further review regarding this investigation. I was informed that Ms. Mazzetti was out of town but would call me back when she returned.

On 8/18/2017, I held an exit conference with Ms. Mazzetti. I discussed the 310 (4) rule violation and explained that the facility has the final say in regards to obtaining medical attention for the residents in their care, despite the guardian's opinion. Ms. Mazzetti stated that the guardians agreed to the idea of not taking Resident A for medical attention, so it was her understanding that staff would just continue to monitor Resident A, as the guardians were not insisting that Resident A obtain medical attention. Ms. Mazzetti stated that she understood, and agreed to complete a correction action plan for the violation.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(a) The death of a resident.** **(b) Any accident or illness that requires hospitalization.** **(c) Incidents that involve any of the following:** **(i) Displays of serious hostility.** **(ii) Hospitalization.** **(iii) Attempts at self-inflicted harm or harm to others.** **(iv) Instances of destruction to property.** **(d) Incidents that involve the arrest or conviction of a resident as required pursuant to the provisions of section 1403 of Act No. 322 of the Public Acts of 1988.**

ANALYSIS:	According to interviews with the Complainant and staff at the facility, staff did call Resident A's guardians to verbally inform them of Resident's A head injury. Resident A was not hospitalized, nor was she taken for medical treatment. The Complainant requested a copy of the incident report, but stated that staff refused to provide her with a copy of it until the day Resident A was discharged approximately a week later. Ms. Mazzetti confirmed that she did provide the Complainant with a copy of the incident report at the time of Resident A's discharge. According to the licensing rules, staff is not required to provide the guardians with a copy of the incident report except in the situations listed above.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

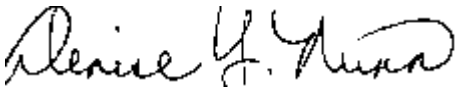
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change to the status of this license.

8/16/2017

Theresa Cipponeri — Date
Licensing Consultant

Approved By:



08/17/2017

Denise Y. Nunn — Date
Area Manager