GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 10, 2021

Daniella Soave
Brighton Manor LLC
7560 River Road
Flushing, MI 48433

RE: License #:	AH470387116
Investigation #:	2022A1021012
	Brighton Manor

Dear Mrs. Soave:

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) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH470387116
Investigation #:	2022A1021012
Complaint Receipt Date:	11/24/2021
Investigation Initiation Date:	11/29/2021
Report Due Date:	1/24/2021
Licensee Name:	Brighton Manor LLC
Licensee Address:	7560 River Road Flushing, MI 48433
Licensee Telephone #:	(989) 971-9610
Administrator:	Sarah Molner
Authorized Representative:	Daniella Soave
Name of Facility:	Brighton Manor
Facility Address:	1320 Rickett Road Brighton, MI 48116
Facility Telephone #:	(810) 247-8442
Original Issuance Date:	03/27/2019
License Status:	REGULAR
Effective Date:	09/27/2020
Expiration Date:	09/26/2021
Capacity:	93
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Facility refused to accept Resident A from the hospital.	No
Facility failed to contact Relative A1.	No
Additional Findings	Yes

III. METHODOLOGY

11/24/2021	Special Investigation Intake 2022A1021012
11/29/2021	Special Investigation Initiated - Face to Face inspection completed on site
11/29/2021	APS Referral referral sent to centralized intake
12/02/2021	Contact-Telephone call made Interviewed complainant
12/02/2021	Contact-Telephone call made Interviewed Elizabeth Kragel
12/07/2021	Contact-Telephone call made Interviewed Relative A1
12/10/2021	Exit Conference Exit conference with authorized representative Daniela Soave

ALLEGATION:

Facility refused to accept Resident A from the hospital.

INVESTIGATION:

On 11/24/21, the licensing department received a complaint with allegations the facility refused to accept Resident A from the hospital. The complainant alleged Resident A was seen in the emergency room for evaluation and was cleared for

discharge. The complainant alleged the facility then refused to accept the resident back to the facility.

On 11/29/21, the allegations in this report were sent to centralized intake at Adult Protective Services (APS).

On 11/29/21, I interviewed administrator Sarah Molner at the facility. Ms. Molner reported Resident A moved into the facility on 10/26 and has had a difficult time adjusting. Ms. Molner reported Resident A has had behavior issues including pulling fire alarms in hope of exiting the facility. Ms. Molner reported on 11/21, Resident A pulled the fire alarm and emergency medical services (EMS) responded to the alarm. Ms. Molner reported Resident A complained of chest pain and Resident A was transferred to the local hospital. Ms. Molner reported this occurred at 9:02am and Resident A returned to the facility on 11/22 at 11:15am. Ms. Molner reported the facility accepted Resident A back to the facility and did not refuse re-admission.

On 11/29/21, I interviewed caregiver Dalisa Clinton at the facility. Ms. Clinton reported on 11/21, Resident A pulled the fire alarm during first shift. Ms. Clinton reported EMS came and Resident A complained of chest pain, so he was sent to the hospital. Ms. Clinton reported she believes she spoke with the hospital later in her shift regarding Resident A. Ms. Clinton reported medical staff reported Resident A was cleared to return to the facility. Ms. Clinton reported she explained Resident A required a mental evaluation. Ms. Clinton reported the hospital was still going to discharge him and Ms. Clinton accepted this. Ms. Clinton reported she heard nothing more from the hospital and Resident A did not return that day.

On 11/29/21, I interviewed resident care manager Thomas Da-Silva at the facility. Mr. Da-Silva reported he was not working on 11/21. Mr. Da-Silva reported on 11/22, EMS brought Resident A back to the facility. Mr. Da-Silva reported sometimes the hospital will call and let them know that they are transporting the resident back to the facility and other times an ambulance will appear at the facility. Mr. Da-Silva reported no knowledge of receiving a telephone call on 11/22 reporting Resident A would be returning. Mr. Da-Silva reported if it is a short stay, or an observation stay the facility does not receive discharge paperwork. Mr. Da-Silva reported the facility did not receive discharge paperwork for the hospital visit. Mr. Da-Silva reported the facility had no issues with accepting Resident A from the hospital.

On 12/2/21, I interviewed the complainant by telephone. The complainant reported Resident A was seen in the emergency room on 11/21. The complainant reported the emergency room received report that Resident A was agitated and violent. The complainant reported Resident A was alert and orientated and refused medical care. The complainant alleged hospital staff called the facility and explained Resident A would be sent back to the facility. The complainant reported facility staff told hospital staff that if Resident A was sent back to the facility, then the facility would send him back to the hospital. The complainant reported the hospital kept him overnight for

continued medical evaluation but there was no medical need for Resident A to be in the hospital.

On 12/2/21, I interviewed caregiver Elizabeth Kragel by telephone. Ms. Kragel reported she worked 11/21 on second shift. Ms. Kragel reported Resident A was at the hospital and did not return during her shift. Ms. Kragel reported she cannot recall receiving any calls from the hospital regarding Resident A.

On 12/2/21, I interviewed caregiver Morgan Harp by telephone. Ms. Harp reported she worked 11/21 on second shift. Ms. Harp reported she heard Resident A might return that day, but he did not. Ms. Harp reported she did not hear any comments of the facility refusing re-admission.

On 12/7/21, I interviewed Relative A1 by telephone. Relative A1 reported someone in the hospital mentioned that they thought the facility would not accept Resident A back to the facility. Relative A1 reported she never heard this from the facility and the facility never refused Resident A. Relative A1 reported the hospital kept Resident A to ensure he was medically stable. Relative A1 reported Resident A will complain of medical issues to get attention.

I reviewed the chart notes for Resident A for the incident on 11/21. The chart notes read,

> *"came into work and resident had some sort of contraption tied to his door. He was trying to lock (Relative A1) out of the room per previous shift. About 25 mins later he set off the fire alarm and walked outside w/o shoes, socks, pants. Got him to come back in and when fire department came he became combative w/ them to get back. Tied calling (Relative A1) and her phone went straight to voicemail each time. So he was sent out to the hospital for a psych-eval."*

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(13) A home shall provide a resident and his or her authorized representative, if any, and the agency responsible for the resident's placement, if any, with a 30-day written notice before discharge from the home. The written notice shall consist of all of the following: **(a) The reasons for discharge.** **(b) The effective date of the discharge.** **(c) A statement notifying the resident of the right to file a complaint with the department. The provisions of this subrule do not preclude a home from providing other legal notice as required by law.**

ANALYSIS:	On 11/21/21, Resident A was transported to the local hospital for an evaluation. While there were discrepancies if Resident A was sent for medical or mental health evaluation, there is lack of evidence to support the allegation the facility refused to accept Resident A back to the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Facility failed to contact Relative A1.

INVESTIGATION:

The complainant alleged the facility did not contact Relative A1 to inform her Resident A was in the hospital.

Ms. Clinton reported Relative A1 spent the night with Resident A prior to his transfer to the hospital. Ms. Clinton reported Relative A1 left the facility and reported she was exhausted and was going home to get some rest. Ms. Clinton reported when Resident A was transferred to the hospital, she attempted multiple times to contact Relative A1, but her telephone was turned off. Ms. Clinton reported she attempted to contact for hours but was unsuccessful.

I reviewed admission documents for Resident A. The documents revealed Resident A was his own decision maker and was able to make his own decisions.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.
ANALYSIS:	Prior to Resident A transfer to the hospital, Relative A1 reported she was returning home to get rest. Staff at the facility tried to contact Relative A1 multiple times but was unsuccessful in reaching Relative A1 to inform her of Resident A’s transfer to the emergency room.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Ms. Molner reported Resident A moved into the facility on 10/26. Ms. Molner reported he has been in and out of the hospital due to behavior issues. Ms. Molner reported the facility has placed Resident A on one hour safety checks due to Resident A pulling the fire alarm. Ms. Molner reported caregivers are to encourage Resident A to participate in activities and keep him in common areas. Ms. Molner reported the facility has attempted to schedule a care conference with Resident A and Relative A1 but has been unsuccessful due to Resident A continued transfers to the hospital.

Mr. Da-Silva reported he has worked with Relative A1 on techniques to keep Resident A engaged in the facility as well as decrease Resident A pulling the fire alarm. Mr. Da-Silva reported Resident A started on new medication for behaviors but Relative A1 discontinued the medication. Mr. Da-Silva reported the facility had Resident A go down to memory care for increased supervision. Mr. Da-Silva reported the facility has requested Relative A1 to visit the facility to engage with Resident A.

Resident A service plan read,
"Resident whereabouts should be monitored by staff to prevent elopement. Resident is on 2hr safety checks."

I reviewed incident report dated 11/2 for Resident A. The narrative read,
"Resident pulled the memory care fire alarm to unlock the exit door."
The corrective measures read,
"Asked (Relative A1) to come visit to put him more at ease."

I reviewed incident report dated 11/2 for Resident A. The narrative read,
"Resident pulled the fire alarm to unlock the front door."
The corrective measures read,
"Provided distracting items."

APPLICABLE RULE	
R 325. 1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.

ANALYSIS:	Resident A has continued to exhibit elopement behaviors such as pulling the fire alarm. Review of Resident A's service plan revealed lack of detail as to how staff are to manage these behaviors. Due to this insufficiently developed plan, staff are not equipped to monitor and ensure the safety of Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Ms. Molner reported Resident A was transferred to the emergency room on 11/15, 11/21, and 11/23. Ms. Molner reported on 11/15, Resident A pulled the fire alarm and requested to be sent to the emergency room due to a sore on his arm. Ms. Molner reported on 11/21, Resident A complained of chest pain and requested to be evaluated. Ms. Molner reported on 11/23, Resident A pulled the fire alarm, was combative with staff, and was transferred to the emergency room for a psychological evaluation.

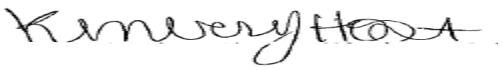
APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(1) The home shall complete a report of all reportable incidents, accidents, and elopements. The incident/accident report shall contain all of the following information: **(a) The name of the person or persons involved in the incident/accident.** **(b) The date, hour, location, and a narrative description of the facts about the incident/accident which indicates its cause, if known.** **(c) The effect of the incident/accident on the person who was involved, the extent of the injuries, if known, and if medical treatment was sought from a qualified health care professional.** **(d) Written documentation of the individuals notified of the incident/accident, along with the time and date.** **(e) The corrective measures taken to prevent future incidents/accidents from occurring.**

ANALYSIS:	Review of Resident A's record revealed no incident report was completed for the transfer to the emergency room for Resident A on 11/15, 11/21, and 11/23.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/10/21, I conducted an exit conference with authorized representative Daniela Soave by telephone.

IV. RECOMMENDATION

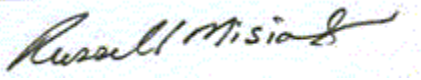
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.



12/7/21

Kimberly Horst Date
Licensing Staff

Approved By:



12/10/21

Russell B. Misiak Date
Area Manager