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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 10, 2021

Jacquelyn Stokes-Williams
AH Roseville MC Subtenant LLC
6755 Telegraph Rd., Suite 330
Bloomfield Hills, MI 48301

RE: License #: AH500397563
Investigation #: 2022A1019014
American House Roseville

Dear Ms. Stokes-Williams:

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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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 authorized representative and a date.

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,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500397563
Investigation #:	2022A1019014
Complaint Receipt Date:	11/22/2021
Investigation Initiation Date:	11/22/2021
Report Due Date:	01/22/2022
Licensee Name:	AH Roseville MC Subtenant LLC
Licensee Address:	OneSeaGate Ste 1500 C/O ReNew Reit Toledo, OH 43604
Licensee Telephone #:	(248) 203-1800
Administrator and Authorized Representative:	Jacquelyn Stokes-Williams
Name of Facility:	American House Roseville
Facility Address:	17267 Common Road Roseville, MI 48066
Facility Telephone #:	(586) 933-1593
Original Issuance Date:	08/03/2020
License Status:	REGULAR
Effective Date:	02/03/2021
Expiration Date:	02/02/2022
Capacity:	50
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was abused and neglected.	No
Staff stole Resident A's property.	No
Staffed refused to shower Resident A.	No
Additional Findings	Yes

III. METHODOLOGY

11/22/2021	Special Investigation Intake 2022A1019014
11/22/2021	Special Investigation Initiated - Letter Emailed AR for census and 2021 resident discharge list.
11/24/2021	Contact - Telephone call made Called complainant to conduct interview, voicemail left requesting return phone call.
11/30/2021	Contact - Telephone call made Called complainant, interview conducted.
12/01/2021	Contact - Telephone call made Called Relative A, interview conducted
12/01/2021	Inspection Completed On-site
12/01/2021	Inspection Completed BCAL Sub. Compliance
12/10/2021	Exit Conference

ALLEGATION:

Resident A was abused and neglected.

INVESTIGATION:

On 11/22/21, the department received a complaint regarding Resident A. The complaint read that Resident A was “abused and neglected”. There was no additional detail provided regarding the nature of the abuse and neglect or when it allegedly occurred. The complaint was unclear if Resident A was a resident at the facility or another location when the allegations took place.

On 11/22/21, I contacted the facility administrator and authorized representative Jacquelyn Stokes-William via email to request a resident census and a list of all discharges for 2021 in an attempt to confirm Resident A was at the facility. Resident A was listed as residing at the facility from 4/26/21-5/5/21 and the reason for move was documented as “Moving in with Family Member - Care Needs”.

On 11/30/21, I conducted a telephone interview with the complainant. The complainant stated that the information was told to her third hand by someone who reported hearing the information directly from Resident A. The complainant did not speak with Resident A directly, did not witness any of the allegations and denied having any additional information aside from what was listed in the complaint, but felt it was her duty to report the allegations.

On 12/1/21, I conducted an onsite inspection. I interviewed Ms. Stokes-Williams and wellness administrator Toya Sparks at the facility. Ms. Stokes-Williams and Ms. Sparks recalled that on 5/3/21, Relative A1 questioned staff about toileting Resident A and her medication administration. Ms. Stokes-Williams and Ms. Sparks stated that according to Relative A1, Resident A told him that staff allowed her to self-administer her insulin but Relative A1 was “not sure how much of it was true”. Ms. Stokes-Williams and Ms. Sparks stated that staff were interviewed and denied ever allowing Resident A to self-administer medications. Ms. Stokes-Williams and Ms. Sparks were able to pinpoint a bathroom incident around the time Relative A1 voiced his concerns. At that time, an internal investigation was conducted and Ms. Stokes-Williams and Ms. Sparks stated they were unable to determine that any wrongdoing had occurred. Ms. Stokes-Williams and Ms. Sparks stated that they submitted and incident report to licensing staff Andrea Krausmann following the incident. Ms. Stokes-Williams and Ms. Sparks stated that Relative A2 alleged abuse again after the facility’s business office manager reached out to collect on Resident A’s outstanding balance

Ms. Stokes-Williams and Ms. Sparks provided a copy of the incident report onsite. The incident report dated 5/24/21 read, in part “[Relative A1] stated ‘she was abused by a nurse named Wanda’. He also stated that, ‘if we do not waive the bill, he will be

reporting this to the state.' [Relative A1] did not specify any specific abuse/information re: specific abuse."

A licensing file review was completed and it was confirmed that the incident report was submitted to the department timely. Ms. Krausmann and area manager Russ Misiak assessed the report and its corrective measures as sufficiently compliant.

A written statement from staff Wanda Jones was obtained. Ms. Jones attested:

> *On the day in question I Wanda Jones did assist [Resident A] to the rest room. She insisted that I leave her in the restroom because she wanted to believe that we were not assisting her as needed. I did tell her I was stepping out for her privacy and the door was closed for the other pts privacy also. I let Vankisha know of the problem and she agreed to assist [Resident A] further.*

Resident A's service plan was reviewed. Regarding toileting, the plan read "Resident is independent with toileting. Staff to be aware that the resident is independent with toileting."

On 12/1/21, I conducted a telephone interview with Relative A2. Relative A2 stated that there was an incident in which Resident A said she was "locked in a bathroom with the lights off" which she believes is what the complaint is referencing. Relative A2 stated that she did follow up with facility staff regarding Resident A's concerns. Relative A2 stated that staff informed her that Resident A was having a bought of diarrhea, which was common for her given her Crohn's disease diagnosis. Relative A2 stated that staff told her they closed the bathroom door after getting her situated on the toilet for privacy reasons because she had a roommate. Relative A2 stated that staff explained that the bathroom lights are on a sensor and will turn off if movement isn't detected within a certain timeframe. Relative A2 stated that she does not feel that Resident A was locked in the bathroom or that staff mistreated her but could understand why she would have felt that way. Relative A2 also stated that Resident A has an Alzheimer's diagnosis and her memory is not always reliable.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(1) A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization, which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public

	place in the health facility or agency and shall be provided to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.
For Reference MCL 333.20201	**(2) (l) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician, by a physician's assistant with whom the physician has a practice agreement, or by an advanced practice registered nurse, for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician, physician's assistant, or advanced practice registered nurse who authorized the restraint. In case of a chemical restraint, the physician, or the advanced practice registered nurse who authorized the restraint, shall be consulted within 24 hours after the commencement of the chemical restraint.**
ANALYSIS:	There is insufficient evidence to establish abuse or neglect of Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff stole Resident A's property.

INVESTIGATION:

The complaint read "Unknown staff stole [Resident A's] medications, medical devices, and dentures." The complainant could not specify which medications or types of medical devices that were allegedly taken by staff and did not have any additional detail regarding the theft allegations.

Ms. Stokes-Williams and Ms. Sparks do not recall being contacted by Resident A or her family to inquire about any items that may not have been returned to her when she was discharged. Ms. Stokes-Williams and Ms. Sparks stated that to their knowledge, all of Resident A's belongings were taken out of the facility by the family

and deny that staff would have a need for any of her devices or supplies. Ms. Stokes-Williams and Ms. Sparks stated they would have looked into the matter if items had been reported to them as stolen and were previously unaware of the allegations.

Regarding medications, Ms. Stokes-Williams and Ms. Sparks stated that they do not have any documentation to show that the medication was released to Resident A's family but Ms. Sparks stated that she personally handed over Resident A's medications to Relative A1 upon Resident A's discharge. Ms. Sparks stated that the medication was a combination of medications the family brought in from home and some medications that the facility's contracted pharmacy filled. Ms. Sparks stated that all of Resident A's medication were placed in one bag and turned over together.

On 12/1/21, I interviewed wellness coordinator Michelle Spiruda at the facility. Ms. Spiruda attested that all medications were provided to the family upon move out.

Relative A2 stated that Relative A1 received her medications from the facility when she was discharged.

Regarding medical devices, Ms. Stokes-Williams and Ms. Sparks stated that Resident A had insulin supplies and was on oxygen but attested that all of Resident A's belongings were removed from the facility. Ms. Sparks stated that the facility had no reason to withhold the abovementioned supplies, as they were not provided by the facility to begin with.

Regarding dentures, Ms. Sparks and Ms. Spiruda both stated that Resident A was wearing her dentures when Relative A1 moved her out. Care staff VanKisha Fritts, Tatiyana Giles and Lashunda Watson all attested that Resident A was independent with tasks pertaining to her dentures. Ms. Stokes-Williams affirmed that residents who are independent with denture care are responsible for cleaning and storing their dentures in their apartment.

Relative A2 stated that Resident A did leave the facility with dentures, but they were not the same pair she moved in with. Relative A2 believes that the dentures were inadvertently switched with another resident but did not notify the facility of this.

In light of what Relative A2 attested to, Ms. Stokes-Williams responded:

> *I am not sure how this could happen (unless the resident in question switched the dentures with another resident while in a common area, which is unlikely as the staff are present for observation) and in review there is no indication that this occurred as the resident in question refused to leave her apartment for the full duration of her stay.*
>
> *The resident in questions roommate also had dentures (half set only), and they shared a restroom where both sets of dentures were stored. We verified that her*

roommate's set is correct as the resident in question had a full set, and only a half set belonging to the roommate is in the unit currently.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
For Reference R 325.1901	**Definitions.**
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	Due to passage of time, lack of detail in the complaint and no inquiry or follow up from Resident A's family about the "stolen" items, there is insufficient evidence to suggest that staff intentionally took Resident A's belongings.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff refused to shower Resident A.

INVESTIGATION:

The complaint read that staff refused to give Resident A a shower. Resident A was at the facility from 4/26/21-5/5/21. Per her care plan, Resident A's assigned shower days were Tuesday and Friday and read "Staff to provide set up assistance."

The facility was unable to produce any documentation to confirm that Resident A's bathing tasks were completed, however Ms. Stokes-Williams stated:

> *The staff that worked with the resident state that, the resident refused to allow them to assist with her showers. The staff state that they were able to set up her supplies and allow her to shower herself. The Staff stated that she would become very belligerent when someone offered/attempted to assist with her shower.*

Relative A2 stated that staff "gave her a couple baths" and that it was possible Resident A was not cooperative. Relative A2 stated, "Her doctor said people with Alzheimer's don't like water."

APPLICABLE RULE	
R 325.1933	**Personal care of residents.**
	(2) A home shall afford a resident the opportunity and instructions when necessary for daily bathing, oral and personal hygiene, daily shaving, and hand washing before meals. A home shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Facility staff and Relative A2 reported that Resident A bathed and there is no evidence to suggest that staff refused to afford Resident A the opportunity to bathe as the complaint suggests.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Facility staff report that Resident A was independent with denture related tasks, including cleaning and storing them. Resident A's pre-admission assessment and service plan were reviewed. The pre-admission assessment identifies that Resident A does not need assistance with mouth care (including denture removal and care). The service plan lacks information pertaining to denture care and does not mention that Resident A wears dentures, or the fact that she is independent in caring for them.

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.
For Reference R 325.1901	**Definitions.**
	(21) "Service plan" means a written statement prepared by the home in cooperation with a resident and/or the resident's authorized representative or agency responsible for a resident's placement, if any, and that identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical, social, and behavioral needs and well-being and the methods of providing the care and services while taking into account the preferences and competency of the resident.
ANALYSIS:	Resident A's service plan wasn't developed to include oral care task designation or acknowledgement of her dentures. Without having this information on the service plan, staff have no instruction on the provision of care pertaining to this subject matter.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/10/21, I shared the findings of this report with authorized representative Jacquelyn Stokes-Williams. Ms. Williams verbalized understanding of the citation and did not have any additional questions at the time of the exit conference.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no changes to the status of the license at this time.

12/10/21

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

12/10/21

Russell B. Misiak Date
Area Manager