GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 14, 2021

Tatjana Savich
Novak Assisted Care Corporation
68453 Stoecker Lane
Richmond, MI 48062

RE: License #: AL500082088
Investigation #: 2022A0604002
Leisure Manor Residence For Srs

Dear Ms. Savich:

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.

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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,

Kristine Cilluffo, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 285-1703

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL500082088
Investigation #:	2022A0604002
Complaint Receipt Date:	10/15/2021
Investigation Initiation Date:	10/18/2021
Report Due Date:	12/14/2021
Licensee Name:	Novak Assisted Care Corporation
Licensee Address:	68453 Stoecker Lane Richmond, MI 48062
Licensee Telephone #:	(586) 727-0700
Administrator:	Tatjana Savich
Licensee Designee:	Tatjana Savich
Name of Facility:	Leisure Manor Residence For Srs
Facility Address:	68453 Stoecker Lane Richmond, MI 48062
Facility Telephone #:	(586) 727-0700
Original Issuance Date:	01/14/2000
License Status:	REGULAR
Effective Date:	08/27/2020
Expiration Date:	08/26/2022
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A has injuries that are inconsistent with falls. Incident report indicates that Resident A's family was contacted regarding fall when they were not.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/15/2021	Special Investigation Intake 2022A0604002
10/15/2021	APS Referral Referral received from Adult Protective Services (APS) denied and sent to licensing.
10/18/2021	Special Investigation Initiated - On Site Completed unannounced onsite investigation. Interviewed Home Manager, Tracey Rygwelski and Alex Savich. Received copies of Resident A's assessment plan, medical records, hospital discharge report, EMS report and Leisure Manor's assistive device form.
11/05/2021	Contact - Telephone call made TC to Relative 1
11/05/2021	Contact - Document Sent Email to Relative 1
11/08/2021	Contact - Document Received Received pictures by email of injury from Relative 1.
11/09/2021	Contact - Document Sent Email to Relative 1
12/03/2021	Contact - Document Received Email from Relative 1. Sent return email.
12/13/2021	Contact - Document Sent Email to Tracey Rygwelski and Tatjana Savich.

12/13/2021	Exit Conference Completed exit conference by email with Tatjana Savich

ALLEGATION:

Resident A has injuries that are inconsistent with falls. Incident report states that Resident A's family was contacted regarding fall when they were not.

INVESTIGATION:

I received a complaint regarding Leisure Manor Residence for Seniors on 10/15/2021. It was alleged that on 10/07/2021, Resident A was taken to Leisure Manor for respite care. On 10/12/2021, Resident A attempted to get up on her own and fell to the ground. Resident A also fell on 10/10/2021 while at the facility. Resident A received bruising on her hip, neck, chin and arms from falling. Resident A was picked up from the facility on 10/14/2021. Resident A was observed with a softball size bruise or abrasion on her hip. A request for the incident reports was made. In the incident report it was documented on 10/10/2021, that staff at the home made a call to notify Resident A's caregivers of the original fall. That call never took place. The owner of the nursing home stated that there was no call placed to Resident A's caregivers when Resident A fell first. There is concern that the injuries that Resident A has now do not add up to her falling out of bed twice. There are not any concerns of physical abuse at this time, more so that Resident A fell more than twice while being moved or attempting to use the bathroom.

I completed an unannounced onsite investigation on 10/18/2021. I interviewed Home Manager, Tracey Rygwelski and Co-Owner Alex Savich. I received copies of Resident A's assessment plan, medical records, hospital discharge report, EMS report and Leisure Manor's assistive device form.

On 10/18/2021, I interviewed Home Manger, Tracey Rygwelski. She stated that Resident A was placed at the facility on 10/07/2021 for respite care while Resident A's family went to Florida. Resident A was supposed to stay until 10/17/2021, however, was picked up early on 10/14/2021. Resident A was previously placed at Leisure Manor for respite care when the family went to Florida from 07/01/2021-07/14/2021. Ms. Rygwelski stated that Resident A makes noises but is non-verbal. She came to the facility with a wheelchair. Resident A spent most of her time in the recliner in her bedroom and had to be fed. Resident A used a Geri chair when she stayed for respite in July 2021. Ms. Rygwelski stated Resident A fell on 10/10/2021. Staff went in her room and found her on floor. EMS was called for a lift assist. Staff, Andrea Vansen, found her on the floor and completed incident report. EMS arrived and helped Resident A back into bed. Resident A did not have any injuries and appeared to be fine. A copy of the run report from EMS was received and no injuries were noted in report. Ms. Rygwelski stated that Resident A fell again on 10/11/2021 around 7:00 am. Staff went into Resident A's bedroom to do a medication pass and found Resident A on the floor next to her bed. Staff helped her get up and no injuries were noted.

Ms. Rygwelski stated that she fed Resident A lunch on 10/11/2021 while Resident A was in her recliner. Resident A had a pureed diet. Ms. Rygwelski stated that she did not see any bruising on Resident A's chin or neck when she fed Resident A. She stated that bruising on Resident A was not seen until that evening. She received a message about bruising on Resident A's face and swelling/pink area on hip. Ms. Rygwelski advised staff that she would check Resident A in the morning. Ms. Rygwelski saw Resident A on 10/12/2021 and noticed bruising. Resident A had swelling and a pink area on left hip that looked like a rug burn. There was a thin layer of skin scraped off. Relative 1 was notified that Resident A had bruising to face and hip was swollen and warm to the touch. Ms. Rygwelski asked visiting doctor, who was at facility to see another resident, to check Resident A. The doctor indicated that Resident A needed to be sent out for an assessment. Relative 1 was contacted and agreed. Relative 1 also attempted to contact Resident A's doctor. EMS was contacted and Resident A was sent to McLaren Hospital in Port Huron, MI. Relative 1 called at 3:53 pm that afternoon and said that Resident A did not have any fractures and was only bruised. Relative 1 decided to have Resident A sent back to Leisure Manor and wanted Resident A to use a hospital bed. Resident A arrived back at facility at 9:13 pm. Relative 1 was sent a text message notifying him that Resident A had returned. Relative 1 notified facility that day, they would be returning home early. Resident A did not have any additional falls or injuries after she returned from the hospital.

On 10/18/2021, I interviewed Co-Owner, Alex Savich, at the facility. He stated that he communicated with Relative 1 regarding the incident. Mr. Savich stated that it is true that Staff, Tiffany Gibson, did not notify Relative 1 of Resident A's fall as indicated on incident report dated 10/10/2021. Mr. Savich stated that he pulled phone records and confirmed the call was never made. Ms. Gibson said that she thought she called him, however, must have forgotten. Mr. Savich shared this miscommunication with Relative 1 and admitted the call was never made. On 10/14/2021, Relative 1 expressed concern to Ms. Rygwelski and stated that he wanted to speak with Mr. Savich. Mr. Savich stated that he talked to Relative 1 on 10/15/2021 after getting information. Relative 1 thought Resident A's bruises were inconsistent but did not allege abuse. He thought maybe she had a fall in the shower; however, Resident A did not have any showers during respite placement, only sponge baths.

On 11/05/2021, I interviewed Relative 1 by phone. He stated that Resident A was placed at Leisure Manor while he went to Florida for a family emergency. He was told that Resident A fell twice. She had her first fall on 10/10/2021, however, he was not notified until 10/12/2021. He stated that he would have come back earlier if notified. Resident A had bruising on her neck, chin, eye and left hip. When Resident A was picked up, the whole front of her throat was bruised and was black, yellow, and blue. Resident was checked at the home and there was a soft ball size sore on her left hip that was swollen. The hip was bruised and there was a red circle and skin that had been pulled off. Relative 1 stated that he spoke to owner and received copies of incident reports. The owner verified that he was not contacted as noted on incident report. Relative 1 stated that he is not trying to say Resident A was abused, however, does not

believe the injuries were a result of falling out of bed. Relative 1 stated that Resident A is in the same position every morning and does not move during sleep. Relative 1 sleeps in a hospital bed with rails. Relative 1 stated that the facility provided a hospital bed when she was placed there for respite care in July, however, did not provide one during most recent stay.

On 10/18/2021, I received a copy of Resident A's assessment plan dated 06/04/2021. The plan was completed during Resident A's first respite placement at the facility. Under physical limitations the plan states that Resident A needs help walking with staff. No walker. The plan indicates that Resident A does not use any assistive devices.

On 10/18/2021, I received Leisure Manor's Permission to Use Assistive Devices for Safety form for Resident A dated 06/28/2021. The form is signed by Resident A's guardian. There is no physician signature on form. The form states, I (Relative 2) understand that a hospital bed, Geri chair, shower chair, toilet raiser and bed cane is being placed in the room of (Resident A) as prescribed by Dr. Pou for safety reasons to prevent him/her from injuring themselves". I understand that will be used duration of stay for his/her protection. I understand that this is being added to her/his care plan effective immediately". Home Manger, Tracey Rygwelski stated that Resident A was not using a hospital bed during her placement in October 2021 and did not have physician authorizations for assistive devices listed on form.

On 10/18/2021, I received a copy of Resident A's discharge papers from McLaren Port Huron Hospital dated 10/12/2021. The record indicates that Resident A was seen for a contusion of left hip and traumatic ecchymosis of chin.

On 10/18/2021, I received a copy of Resident A's patient health summary dated 06/01/2021. The summary lists wheelchair under Resident A's assistive devices. The facility also provided a medical report from Visiting Physicians Association dated 11/11/2020. This report also lists wheelchair under Resident A's assistive devices. The facility did not have a completed health care appraisal form for Resident A.

On 10/18/2021, I received a report from Richmond Lenox EMS Ambulance Authority dated 10/10/2021. The report states, "A1 was dispatched via 911 for lift assist with no injuries. Arrived to find patient supine with knees bent, laying beside her bed. Staff states the patient was not injured and patient is verbally and cognitively impaired. Patient was sat up and then "fireman carried" back into her bed. No further need for EMS assistance, patient information obtained, no signatures necessary, A1 clear with public assist".

On 11/08/2021, I received pictures of Resident A's injuries from Relative 1. Resident A had a large purple and yellow bruise on her chin and front of neck. The pictures also show a red sore and skinned area on hip. Relative 1 indicated on 11/09/2021 that the hospital did not have any input as to what happened to Resident A.

I received an incident reported dated 10/10/2021 completed by staff Andrea Vansen. The report indicates that staff went to check on (Resident A) and found them laying on the floor. Resident had fallen out of bed. Staff checked her out from head to toe and no visible injury found. Staff also called for a lift assist from 911. The report indicates that Relative 1 was notified at 9:06 am on 10/10/2021 via Tiffany's call. Called (Relative 1).

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:	There is not enough information to determine that Resident A's injuries were not consistent with falls. Resident A was taken to McLaren Macomb on 10/12/2021 and the hospital did not provide input or dispute cause of injuries. Resident A was found on bedroom floor by staff.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	Resident A was placed at Leisure Manor Residence for Seniors in July 2021 and October 2021 for respite care. The facility did not have a health care appraisal completed for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15306	**Use of assistive devices.**
	(2) An assistive device shall be specified in a resident's written assessment plan and agreed upon by the resident or the resident's designated representative and the licensee.
ANALYSIS:	The licensee completed a Permission to Use Assistive Devices for Safety form for Resident A dated 06/28/2021. The form is signed by Relative 2. There is no physician's signature on the form. The form indicates, I (Relative 2) understand that a hospital bed, Geri chair, shower chair, toilet raiser and bed cane is being placed in the room of (Resident A) as prescribed by Dr. Pou for safety reasons to prevent him/her from injuring themselves". Resident A's patient health summary dated 06/01/2021 lists wheelchair under Resident A's assistive devices. Report from Visiting Physicians Association dated 11/11/2020 also lists wheelchair under Resident A's assistive devices. Resident A's assessment plan dated 06/04/2021 lists no assistive devices and states "no walker". Relative 1 stated that Resident A used a hospital bed during her first placement but not second placement in the home. According to the Home Manager, Tracey Rygwelski, Resident A was not using a hospital bed during her placement in October 2021 and did not have physician's authorization for assistive devices listed on form.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15306	**Use of assistive devices.**
	(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization.
ANALYSIS:	The licensee completed a Permission to Use Assistive Devices for Safety form for Resident A dated 06/28/2021. The form is signed by Relative 2. There is no physician's signature on the form authorizing use of assistive devices. The form indicates, I (Relative 2) understand that a hospital bed, Geri chair, shower

	chair, toilet raiser and bed cane is being placed in the room of (Resident A) as prescribed by Dr. Pou for safety reasons to prevent him/her from injuring themselves".
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15310	**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:	Resident A fell at facility on 10/10/2021 and 10/11/2021. Resident A was found to have bruising to her face and swelling of hip on the evening of 10/11/2021. Resident was not sent to the hospital until the afternoon of 10/12/2021.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(6) An accident record or incident report shall be prepared for each accident or incident that involves a resident, staff member or visitor. "Incident" means a seizure or a highly unusual behavior episode, including a period of absence without prior notice. An accident record or incident report shall include all the following information: **(d) The name of individuals who were notified and the time of notification.**
ANALYSIS:	Incident report dated 10/10/2021 completed by staff Andrea Vansen states that staff went to check on (Resident A) and found them laying on their floor. Resident had fallen out of bed. Staff checked her out from head to toe and no visible injury found. Staff also called for a lift assist from 911. The report states that Relative 1 was notified at 9:06 am on 10/10/2021 via Tiffany's call. Called (Relative 1). Co-owner, Alex Savich, stated that he checked phone records and confirmed that Relative 1 was never contacted as noted on incident report.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 10/18/2021, I completed an unannounced onsite investigation at Leisure Manor Residence for Seniors. I requested training and fingerprinting clearance for co-owner, Alex Savich, as he was reported to be involved in Resident A's placement at the facility. Fingerprinting clearance could not be located for Mr. Savich.

On 12/13/2021, I completed an exit conference with Licensee Designee, Tatjana Savich by email. I informed her of the violations cited and that a corrective action plan would be requested. I also informed her that a copy of the special investigation report would be mailed once approved.

APPLICABLE RULE	
MCL 400.713	**License required; application; forms; investigation; on-site evaluation; issuance or renewal of license; disclosures; maximum number of persons; stating type of specialized program; issuance of license to specific person at specific location; transferability of license; sale of facility; notice; items of noncompliance; refusal by department to issue or renew license; conditions; unlicensed facility; violation as misdemeanor; penalty; receipt of completed application; issuance of license within certain time period; inspections; report; criminal history and records check; storage of fingerprints in automated fingerprint identification system database; convictions; "completed application" defined.**
	(3) Before issuing or renewing a license, the department shall investigate the activities and standards of care of the applicant and shall make an on-site evaluation of the facility. On-site inspections conducted in response to the application may be conducted without prior notice to the applicant. On-site inspections conducted for renewing a license may be conducted within 12 months before the expiration date of the current license without impact on the license renewal date or the license fee. Subject to subsections (9), (10), and (11), the department shall issue or renew a license if satisfied as to all of the following: **(c) The good moral character of the applicant, or owners, partners, or directors of the facility, if other than an individual. Each of these persons shall be not less than 18 years of age.** **(e) The good moral character of the licensee or licensee designee, owner, partner, director, and person responsible**

	for the daily operation of the facility. The applicant is responsible for assessing the good moral character of the employees of the facility. The person responsible for the daily operation of the facility shall be not less than 18 years of age.
ANALYSIS:	Fingerprinting clearance was not provided for co-owner, Alex Savich.
CONCLUSION:	**VIOLATION ESTABLISHED**

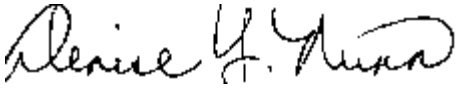
IV. RECOMMENDATION

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

12/13/2021

Kristine Cilluffo — Date
Licensing Consultant

Approved By:



12/14/2021

Denise Y. Nunn — Date
Area Manager