GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 9, 2022

Stephanie Lisenko
Brentwood at Niles
1147 South Third Street
Niles, MI 49120

RE: License #: AH110376315
Investigation #: 2022A1028038
Brentwood at Niles

Dear Ms. Lisenko:

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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,
Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
Cell (616) 204-4300

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

I. IDENTIFYING INFORMATION

License #:	AH110376315
Investigation #:	2022A1028038
Complaint Receipt Date:	04/01/2022
Investigation Initiation Date:	04/04/2022
Report Due Date:	08/09/2022
Licensee Name:	GAHC3 Niles MI ALF TRS Sub, LLC
Licensee Address:	Suite 300 1819 Von Karman Avenue Irvine, CA 92612
Licensee Telephone #:	(971) 204-7200
Authorized Representative/Administrator:	Stephanie Lisenko
Name of Facility:	Brentwood at Niles
Facility Address:	1147 South Third Street Niles, MI 49120
Facility Telephone #:	(269) 684-9470
Original Issuance Date:	06/04/2015
License Status:	REGULAR
Effective Date:	02/13/2022
Expiration Date:	02/12/2023
Capacity:	80
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility did not appropriately discharge resident from the facility.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/22/2022	Contact – Email received Received email from facility executive director Alicia Sieplinga.
03/23/2022	Contact – Email received Received email from Employee A
04/01/2022	Special Investigation Intake 2022A1028038
04/04/2022	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
04/04/2022	APS Referral APS referral emailed to Centralized Intake
04/04/2022	Contact – Telephone Call Made Interviewed the complainant by telephone
04/20/2022	Contact – Telephone Call Made Interviewed Resident A's authorized representative
06/09/2022	Exit Interview

ALLEGATION:

The facility did not appropriately discharge resident from the facility.

INVESTIGATION:

On 3/14/2022, Resident A was sent to the hospital due to demonstrating increased behaviors at the facility.

On 3/22/2022, I received an email from executive director, Alicia Sieplinga, which read:

Hello Julie,

We are requesting an emergency discharge for resident [Resident A] in Memory Care. For the month of March alone, the resident was sent out on March 1, March 6, March 9, March 10 and recently on March 14 where we did a petition with Lakeland Hospital for [Resident A] not to be returned to the community due to [sic] violent behaviors.

The residents' behaviors range from hitting, kicking, slapping, pulling hair, scratching, cussing, threatening staff/family members/other residents, threatening to kill people, throwing hot coffee and coffee cups at other residents/staff and family members. Destroying the unit by throwing things off tables and off shelves and attempting to break and break out of our exit doors while aggressively exit seeking.

Myself, my Generations Director, and my Director of Nursing do not feel it is safe or viable for this resident to return to the community.

Please let me know if there is anything else you may need from me to help move this forward.

Thank you,
Alicia Sieplinga
Executive Director
Brentwood at Niles

On 3/22/2022, I responded to Ms. Sieplinga's email informing her the facility needs to issue a formal discharge in writing and provided verbally as well to Resident A and [their] authorized representative. I also provided Ms. Sieplinga the Homes for the Aged (HFA) rules for appropriate discharge for Resident A and informed Ms. Sieplinga that upon discharge from the hospital Resident A has the right to return to the facility until an appropriate placement is located for Resident A. I requested the facility discharge paperwork be completed immediately and provided to me for review by Wednesday, 3/23/2022 due to the facility's stated urgency of the situation.

On 3/23/2022, I received an email from Employee A, which read:

Julie,
Every time I have called APS to speak to [sic] about emergency placement I have to leave a voice mail and get no return call. Do you have any other suggestions for me to call?

This is about our resident that we cannot take back.

[Employee A]

On 3/23/2022, I responded to Employee A's email providing the APS phone number and reiterated that if Resident A cannot secure a placement prior to discharge from the hospital, then Resident A will need to return to the facility even if emergency discharge is in place and be placed with 1:1 care for Resident A's safety and the safety of other residents and facility staff.

I received no response further communication from Employee A.

On 3/28/2022, I received a discharge notice for Resident A via email from Ms. Sieplinga requesting to let her "*know if there is anything that needs updated or changed".*

I responded to Ms. Sieplinga stating there were several corrections that needed to be completed prior to issuing the discharge to Resident A and the authorized representative, as the discharge was not in accordance with HFS licensing rules and statues. I provided revisions to the discharge, and also provided the HFA discharge rules again in my response.

I received no further communication from Ms. Sieplinga.

On 4/1/2022, the Bureau received the allegations from the online complaint system.

On 4/4/2022, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 4/4/2022, I interviewed the complainant by telephone. The complainant reported Resident A was sent to the hospital on 3/14/22 and was appropriate for discharge from the hospital on 3/16/22, but the facility refused to accept the resident back into the facility. The facility never issued a discharge notice for Resident A and did not notify Resident A's authorized representative appropriately that Resident A was not going to be accepted back into the facility. The complainant reported the facility "essentially left [Resident A] at the hospital for 18 days despite being repeatedly informed of the HFA discharge rules and potential violation". The complainant reported "administration never provided Resident A or the authorized representative a verbal or written discharge and did not assist in helping to secure [Resident A] a new placement either." The complainant reported Resident A's authorized representative was able to secure placement at another facility and Resident A would be entering the new placement on 4/4/2022.

On 4/20/2022, I interviewed Resident A's authorized representative by telephone. The authorized representative reported the facility sent Resident A to the hospital due to demonstrating increased behaviors. The authorized representative reported

the facility did not offer appropriate alternatives for care or redirection when Resident A demonstrated behaviors and instead “their go to was to just send [Resident A] to the hospital”. The authorized representative reported Resident A was appropriate for discharge from the hospital on 3/16/2022, but the facility refused to admit Resident A back into the facility. The facility also never assisted the authorized representative with locating a more appropriate placement for Resident A. The authorized representative reported with help from hospital staff Resident A secured a more appropriate placement on 4/4/2022. The authorized representative reported the facility also never provided a verbal or written discharge for Resident A to [them] or to Resident A and [they] “never signed any exit or eviction papers for [Resident A]”, even though [they] inquired about it when removing Resident A’s items from the facility on 4/4/2022.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(16) A home that proposes to discharge a resident for any of the reasons listed in subrule (15) of this rule shall take all of the following steps before discharging the resident: **(a) The home shall notify the resident, the resident's authorized representative, if any, and the agency responsible for the resident's placement, if any, not less than 24 hours before discharge. The notice shall be verbal and issued in writing. The notice of discharge shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the home, if any.** **(iii) The location to which the resident will be discharged.** **(iv) The right of the resident to file a complaint with the department.** **(b) The department and adult protective services shall be notified not less than 24 hours before discharge in the event of either of the following:** **(ii) The resident does not have a subsequent placement.** **(c) The notice to the department and adult protective services shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the home, if any.** **(iii) The location to which the resident will be discharged, if known.**

	(d) If the department finds that the resident was improperly discharged, then the resident may return to the first available bed in the home that can meet the resident's needs as identified in the resident's service plan. **(e) The resident shall not be discharged until a subsequent setting that meets the resident's immediate needs is located.**
ANALYSIS:	On 3/14/2022, Resident A was sent to the hospital for demonstrating increased behaviors but was appropriate for discharge from the hospital on 3/16/022. However, the facility refused to accept Resident A back into the facility despite Ms. Sieplinga and Employee A being informed by the department and the complainant that Resident A must be admitted back to the facility in accordance with the HFA discharge rules and statues. Despite facility staff initially reaching out to the department for help with Resident A's discharge, the facility failed to follow discharge rules and never issued an appropriate discharge in accordance with the rules to Resident A or the authorized representative. Therefore, the facility is in violation of the rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

Additional Findings

On 4/20/2022, I reviewed the department facility file which revealed only one incident report dated 8/13/2021 concerning Resident A demonstrating increased behaviors. There are no other incident reports on file with the department from the facility concerning Resident A or about Resident A being sent to the hospital due to demonstrating behaviors.

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:	The facility reported only one incident dated 8/13/2021 concerning Resident A's behaviors. Per facility executive director, Alicia Sieplinga and Employee A, Resident A was not admitted back to into the facility due to demonstrating significant behaviors. However, no documentation was submitted to the department concerning Resident A's recent alleged outbursts, aggression and/or behaviors. Due to lack of documentation submittal, it also cannot be determined if facility staff provided redirection or alternatives in accordance with the service plan. It also cannot be determined if Resident A's physician and/or Resident A's authorized representative were notified of the alleged incidents as well.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an approved corrective action plan, I recommend this license remain unchanged.

Julie Viviano

4/28/2022

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Julie Viviano Date
Licensing Staff

Approved By:

Andrea L. Moore

06/07/2022

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