GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 2, 2023

Sheila Pruzinsky
Rose Senior Living - Clinton Township
44003 Partridge Creek Blvd.
Clinton Township, MI 48038

RE: License #: AH500337370
Investigation #: 2023A1019012
Rose Senior Living - Clinton Township

Dear Mrs. Pruzinsky:

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 #:	AH500337370
Investigation #:	2023A1019012
Complaint Receipt Date:	01/11/2023
Investigation Initiation Date:	01/11/2023
Report Due Date:	03/10/2023
Licensee Name:	Rose Senior Living - Clinton Township
Licensee Address:	PO Box 2011 38525 Woodward Avenue Bloomfield Hills, MI 48303-2011
Licensee Telephone #:	(651) 766-4371
Administrator and Authorized Representative:	Sheila Pruzinsky
Name of Facility:	Rose Senior Living - Clinton Township
Facility Address:	44003 Partridge Creek Blv Clinton Township, MI 48038
Facility Telephone #:	(586) 840-0840
Original Issuance Date:	10/01/2014
License Status:	REGULAR
Effective Date:	03/30/2022
Expiration Date:	03/29/2023
Capacity:	127
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Inappropriate staff conduct towards Resident A.	Yes
Additional Findings	No

III. METHODOLOGY

01/11/2023	Special Investigation Intake 2023A1019012
01/11/2023	Special Investigation Initiated - Telephone Phone interview conducted with complainant.
01/16/2023	Contact- Document Received Copy of surveillance video provided by complainant.
01/19/2023	Inspection Completed On-site
01/19/2023	Inspection Completed-BCAL Sub. Compliance
01/19/2023	Exit Conference Conducted with AR while onsite.
01/19/2023	Contact - Document Sent Emailed Clinton Township police detective for additional information.
01/19/2023	Contact - Document Received Case report provided by Clinton Township police detective.
01/20/2023	APS Referral Notified APS of the allegations via email referral template.

ALLEGATION:

Inappropriate staff conduct towards Resident A.

INVESTIGATION:

On 1/11/23, the department received a complaint alleging that on 10/4/22, Resident A was seen being physically assaulted by two care staff. The complaint read that Resident A has a visible security camera in her room and that family witnessed the event take place.

On 1/11/23, I had a phone interview with the complainant. The information provided during the interview was consistent with the written complaint. The complainant added that there is a criminal investigation being conducted by the Clinton Township police department.

On 1/19/23, I conducted an onsite inspection. I interviewed administrator and authorized representative Sheila Pruzinksy at the facility. Ms. Pruzinksy reported that Resident A has resided at the facility since it first opened its doors in 2014 and that she is a memory care resident. Ms. Pruzinksy reported that Resident A has a camera in her room that staff are aware of. Ms. Pruzinsky stated that Resident A's family called the police on the evening of 10/5/22 after observing the encounter on the camera and that police arrived at the facility shortly thereafter. Ms. Pruzinsky stated that she was not present when the police arrived and stated that she has not been permitted to view the video footage however was told by law enforcement that staff can be heard on the video speaking in a disrespectful manner to Resident A and at one point, a slap can be heard followed by the resident crying out. Ms. Pruzinsky stated that Detective one reported Employee 1 to be the aggressor and has a warrant out for her arrest. Ms. Pruzinsky reported that Employee 2 does not have any charges pending but that the case has been forwarded to the Macomb County prosecutor's office for review. Ms. Pruzinsky stated that both employees have been placed on administrative leave until the investigation is closed but reported that Employee 2 has submitted a letter of resignation.

Ms. Pruzinsky stated that as part of their internal investigation, statements were obtained from Employee 1 and 2. Ms. Pruzinksy stated that both staff denied that an inappropriate physical encounter with Resident A took place. Employee 1's statement read:

> *Monday night 10/3/22 the nurse on shift said 140 daughter called stating her mother been calling out and falling out the bed for 30 mins and no one was in the room. We went in 140 room I stood there when I first walked in to see was she in bed just talking or was she falling out the bed. 140 was not falling out the bed she was sitting up on the side of the bed. [Employee 2] got her wheelchair out the bathroom. I got her night pants put them back on we put her in the chair we left out 140 room*.

Employee 2's statement read:

> *Tuesday morning 12am I receive da test for the nurse to go check on 140. I didn't get the message right away, but I guess [Employee 1] did so she got there before I did and went into 140 apartment. When I got the message I got up to go into 140 apartment. [Employee 1] was standing there so I went in there and she grabbed the wheelchair out the bathroom and proceeded to help transfer 140 in the wheelchair. She's unable to bare weight so it take two of us to transfer her into the wheelchair as we did. As in the video you can probably her [sic] saying "hurry up" so I said [Resident A] say please and thank you.*

On 10/6/23, Ms. Pruzinksy notified licensing staff Brender Howard of the incident. Ms. Pruzinksy reported, in part:

> *On Wednesday night October 5, 2022, at 10:00pm, [Employee 3] received a call from [Employee 4] that there were 3 police officers in the building with the family of [Resident A]; wanting to speak to her regarding an incident the family said was on their video surveillance camera with sound that occurred on Tuesday, October 4, 2022 at 12:14am. the police wrote a report an the reference number is 22-41584. There were two caregivers in the video, identified as the two scheduled to work in MC on midnights that night. [Employee 5] came in to release name, address and phone numbers and driver license numbers of these two staff. The police said they did not have the video as it was turned over to the detective bureau of Clinton Township. We have not viewed the video but the family claims that when mom was saying help me help, (which is baseline behavior for her for an unmet need, she also said hurry up hurry up). Police reported that on the video one staff said you better say please and thank you. The police went on to say it showed a moving arm and the sound of a slap, at which time the resident was heart crying. This community leadership has not viewed the video and were told we cannot see it as it is evidence.*

The complainant provided the department with a copy of the video footage. Two care staff can be seen in Resident A's apartment and Resident A can be heard asking for staff to put her in her wheelchair. At one point Resident A states "Please don't hurt me, don't hurt me honey". Before transferring her into her wheelchair, staff were assisting Resident A in putting her pants on. At this time, one staff member said "Did you say please and thank you?" before helping her. Immediately after, a staff member is seen assisting Resident A with putting her pants on and Resident A states "Hey don't do it hard because that hurts". After getting her pants on, both staff assist in transferring Resident A to her wheelchair. At one point, there is a loud "smack" or "slapping" sound followed by the resident groaning and squealing. During the encounter, both staff had their backs to the camera. Once Resident A is in her wheelchair, one staff member grabs the residents shoes and puts them in her lap stating "Hold your shoes. You better hold them before they fall. I aint picking them

up.” Resident A is then wheeled out of the room.

Follow up correspondence was had with Detective 1. He reported that there is an active warrant for Employee 1’s arrest with a charge of vulnerable adult abuse -third degree against and also provided a copy of his case report. The case report described the video footage as follows:

> *Upon reviewing the Cctv video I observed a time stamp in the lower right corner, 10/04/2022 00:12 hours. I observed employee, [Employee 1] (sus) enter [Resident A’s] room. [Resident A] can be heard saying, “ma’am are you here, I gotta get out of here, she does not want me here”. [Employee 1] is observed standing at the end of [Resident A’s] bed aggressively starring [sic] at her while [Resident A] appears confused and suffering from memory issues. [Employee A] does not utter a single word to calm [Resident A]. I observed a second employee, [Employee 2] enter [Resident A] room and retrieve a wheelchair from the bathroom area. [Employee 2] moves the wheelchair to [Resident A] bedside to move her out of her room. [Resident A] is heard saying, “can you put me in there, god bless you everyday day, and completed the sign of the cross”. [Employee 1] retrieves a pair of pants and [Resident A] is heard saying, “do it in a hurry, I am going to die”. [Employee 2] replies, “say please and thank you”. [Resident A] responds by saying, “thank you”. [Employee 1] and [Employee 2] are observed putting [Resident A] pants on. [Resident A] is heard saying, “don’t do it hard because it hurts”. [Employee 2] and [Employee 1] aggressively pull [Resident A] out of her bed by her right and left arm and [Employee 1] is witnessed and heard slapping [Resident A] on the back of her leg. [Resident A] cries out, “Ouch, what are you doing”. [Resident A] asks [Employee 1] if she would put her shoes on. [Employee 1] aggressively tosses [Resident A’s] slippers onto her lap and says, “you better hold them, I am not picking them up if they fall”.*

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 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. In case of a chemical restraint, a physician shall be consulted within 24 hours after the commencement of the chemical restraint.**
ANALYSIS:	Employees 1 and 2 treated Resident A in a manner that is inconsistent with the provision of care outlined in this statute.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

01/23/2023

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Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

02/02/2023

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