GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 9, 2023

Melissa Sevegney
Symphony of Linden Health Care Center, LLC
30150 Telegraph Rd
Suite 167
Bingham Farms, MI 48025

RE: License #:	AL250331295
Investigation #:	2023A0872016
	Homer House Inn

Dear Ms. Sevegney:

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) 643-7960.

Sincerely,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL250331295
Investigation #:	2023A0872016
Complaint Receipt Date:	12/22/2022
Investigation Initiation Date:	01/03/2023
Report Due Date:	02/20/2023
Licensee Name:	Symphony of Linden Health Care Center, LLC
Licensee Address:	7257 N. Lincoln Lincolnwood, IL 60712
Licensee Telephone #:	(810) 735-9400
Administrator:	Melissa Sevegney
Licensee Designee:	Melissa Sevegney
Name of Facility:	Homer House Inn
Facility Address:	202 S Bridge Street Linden, MI 48451
Facility Telephone #:	(810) 735-9400
Original Issuance Date:	05/01/2014
License Status:	REGULAR
Effective Date:	11/03/2022
Expiration Date:	11/02/2024
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A is not receiving her medications as prescribed.	Yes
Resident A is not receiving showers as needed.	Yes
Resident A's room is not being cleaned properly.	No

III. METHODOLOGY

12/22/2022	Special Investigation Intake 2023A0872016
01/03/2023	Special Investigation Initiated - Telephone I interviewed Relative A1
01/04/2023	Inspection Completed On-site Unannounced
01/04/2023	Contact - Document Sent I emailed the Health & Wellness Director, Stephanie Gunn requesting information about this complaint
01/10/2023	Contact - Document Received I received AFC paperwork related to this complaint
01/17/2023	APS Referral I made an APS complaint via email
01/19/2023	Inspection Completed On-site Unannounced
01/27/2023	Contact - Telephone call made I interviewed Relative A2
02/07/2023	Contact - Telephone call made I interviewed Relative A3
02/07/2023	Contact - Document Received I received a copy of Resident A's death certificate from Sharp Funeral Home

02/08/2023	Contact - Telephone call made I interviewed PA-C Kristen Dziadula
02/09/2023	Contact - Telephone call made I interviewed staff Tequila Shields
02/09/2023	Exit Conference I conducted an exit conference with the licensee designee, Melissa Sevegney
02/09/2023	Inspection Completed-BCAL Sub. Compliance

ALLEGATIONS:

- **Resident A is not receiving her medications as prescribed.**
- **Resident A is not receiving showers as needed.**
- **Resident A's room is not being cleaned properly.**

INVESTIGATION: I reviewed an Incident/Accident Report (IR) dated 12/28/22 regarding Resident A. According to the IR, "The resident requested to the staff to be sent to the hospital. The resident has had diarrhea for two days. The resident refused to go to dialysis yesterday." The action taken by staff was the resident was transferred to the hospital for evaluation and treatment and staff contacted the on-call doctor to obtain a prescription for Imodium for diarrhea. The corrective measures taken were, "The resident has a PRN in their orders to help decrease the diarrhea. Encourage more fluids more frequently."

On 01/03/23, I interviewed Relative A1 via telephone. He said that Resident A has resided at Homer House Inn for approximately two months. According to Relative A1, Resident A goes to dialysis three times a week. On her dialysis days, she does not get back to the facility in time for dinner so when her dinner is served, it is cold. He also said that on dialysis days, Resident A was not getting her nighttime medications until late. She is not getting showers twice a week and her room is not being cleaned.

On 01/04/23, I conducted an unannounced onsite inspection of Homer House Inn. Resident A was sent to the hospital today due to rectal bleeding, so I was unable to interview her. I interviewed the assistant to the licensee designee, Mel Sevegney and the health and wellness director, Stephanie Gunn. According to Ms. Gunn, Resident A goes to dialysis 3x's per week, off site. On those days, Resident A was not at the facility for dinner so by the time she received it, it was not always hot. In addition, she was scheduled for a shower on dialysis days, and she was refusing because she was too tired. Ms. Gunn said that on dialysis days, when staff would go to pass her nighttime medications, they would have to wake her up to pass them because she was tired and was going to bed early. Ms. Gunn also stated that this facility has a separate housekeeping staff who is on the floor, 2x's per week, cleaning resident rooms. In between housekeeping, direct care staff keep resident's rooms clean and tidy.

Ms. Gunn and Ms. Sevegney said that they have been in contact with Resident A's family, and they have implemented some things to assist Resident A. On her dialysis days, she orders her dinner ala carte when she gets back to the facility, so it is always served hot. They have changed her shower days to be on non-dialysis days. Staff now passes her nighttime medications earlier, so they do not have to wake her up. The facility has created sign in sheets so staff can document when they complete daily tasks.

While at the facility, I examined Resident A's room and found it to be clean, with no evidence of odor. I also examined her bathroom which was also clean with no odor.

On 01/04/23, I received an IR regarding Resident A. According to the IR, Resident A notified staff that she had rectal bleeding and had passed a blood clot. Resident A requested to be sent to the hospital. Staff contacted 911 and Resident A was transported to the hospital.

On 01/10/23, I received AFC documentation related to this complaint. According to Resident A's Assessment Plan, she was admitted to Homer House Inn on 10/20/22. She requires staff assistance with bathing, dressing and personal hygiene and she uses a wheelchair for mobility. She is fully incontinent with her bladder and bowels and wears briefs. She has a history of diarrhea, has a poor appetite but does not have a history of falls.

According to Resident A's Health Care Appraisal, she is diagnosed with hypertension, heart failure unspecified, osteoarthritis, history of falling, and end stage renal disease. I reviewed an Order Summary Report and noted that on 01/14/23, Resident A's showers were changed from Tuesday and Saturday evenings to Tuesday and Saturday mornings. I also noted an order effective 01/10/12 for her room to be cleaned and her laundry to be done in the evening every Tuesday and Saturday.

I reviewed Resident A's medication administration log, her physician's prescriptions, and nursing notes for December 2022. According to this information, she missed the following medications on the following dates:

- 12/01/22 – 12/25/22: Diphenhydramine (medication not at the facility)
- 12/17/22: Metoclopramide (medication not available)
- 12/18/22: Sennosides-Docusate (medication "not in cart")
- 12/20/22: Alprazolam, Melatonin, Rena-Vite, Metoclopramide, Trazadone, and Acetaminophen (medication "not on hand")
- 12/24/22: Calcium Acetate and Sennosides-Docusate (medication out)

On 01/19/23, I conducted another unannounced onsite inspection of Homer House Inn. I met with Resident A in her room. Resident A appeared to be clean, as did her room. Resident A told me that she has been out of the hospital for a week. She said that she still goes to dialysis, but she does not want to keep going. According to Resident A, while she was at the hospital, the doctor told her she needs to be on an antidepressant.

Resident A said that she has not seen a psychiatrist since being back at Homer House Inn. She said that a social worker checks in with her every day, but she is not on any psychotropic medications. Resident A told me that she is not getting showers 2x's per week like she was told she would. She said that her room is being cleaned, "okay" but staff do not clean under her chair or under her dresser. Resident A said that staff has been administering her medications as prescribed, but they were not doing so prior to her last hospitalization. Resident A told me that she has had diarrhea for over a month and medical staff does not know why. The doctor at the hospital told her she needs to have a fiber supplement, but she has not received it as of this date.

On 01/27/23, I interviewed Relative A2 via telephone. Relative A2 said that Resident A has lived at Homer House Inn for over a month. She said that this has been Resident A's third AFC facility in the past 3 months. According to Relative A2, Resident A was sent back to the hospital today. She said that Resident A has not been receiving her medications like she is supposed to, she is not getting showers like she is supposed to, and her room is not being cleaned. According to Relative A2, on 01/25/23, Relative A3 went to visit Resident A and found her covered in diarrhea. Relative A2 said that according to Relative A3, Resident A had diarrhea on her clothes, bed, and wheelchair. Relative A3 contacted staff who then cleaned Resident A up but Relative A2 said "(Relative A3) said she was sitting like that all day."

On 01/27/23, I received an Incident/Accident Report (IR) regarding Resident A. According to the IR, "The resident requested to be sent to Genesys for further eval and treatment for congestion, cold and flu symptoms. The staff performed a COVID test, it was negative. The staff called for transport to the hospital."

I reviewed Resident A's medication administration log, her physician's prescriptions, and nursing notes for January 2023. According to these documents, Resident A missed the following medications on the following dates:

- 01/03/23: Alprazolam, Diphenhydramine, Metoprolol Succinate (medication not available)
- 01/12/23: Sennosides-Docusate Sodium, Allopurinol, Amlodipine Besylate (medication not available)
- 01/17/23: Metoprolol Succinate, Levothyroxine Sodium, Mirtazapine (medication not available)
- 01/18/23: Alprazolam (medication not available)
- 01/19/23: Mirtazapine (medication not available)
- 01/21/23: Metoclopramide (medication not on hand)
- 01/22/23 – 01/26/23: Alprazolam (Medication not available. Staff noted that they called the pharmacy, and a new script is needed)

Resident A was prescribed Cholestyramine and Imodium-AD on 1/10/23 to take for diarrhea once per day on an as needed basis. According to the medication log, she was not administered these medications in January 2023.

According to her medication records, she was first prescribed an antidepressant on 10/21/22. It appears that her doctor tried several different antidepressants during Resident A's stay at this facility. Resident A was also prescribed Sennosides-Docusate Sodium 2x's per day for stool beginning on 10/21/23. On 01/10/23, Resident A was prescribed Ensure Plus, 3x's per day with meals. According to her medication log, she often refused this supplement.

I reviewed her shower schedule for November 2022, December 2022, and January 2023. According to these records, she received a shower in November on 11/22, 11/25 and 11/29. She received a shower in December on 12/03, 12/06, 12/10, 12/13, 12/17, 12/24 and 12/27. She received a shower in January on 1/14, 1/17 and 1/24.

I reviewed staff progress notes from December 2022 and January 2023. The director of guest services, Melissa Reich met with Resident A on 12/08/22. Ms. Reich wrote, "Met with (Resident A) she was feeling well and getting ready for the day. She stated that she is feeling that the staff is treating her well and she is having a good experience."

On 12/27/22, staff noted, "The resident was complaining of diarrhea. The resident did not go to dialysis due to diarrhea. Called the on call (doctor) and obtained an order for Imodium."

On 12/28/22, staff noted, "(Resident A) requested to be sent out to hospital due to having loose stool and shakes & missing dialysis. Guest assistant called on call doctor and guest's son and daughter and left voicemails, on call doctor said send her out.

On 01/12/23, staff noted, "Received a phone call from dialysis. The resident is verbalizing they want to stop dialysis to commit suicide. The resident will be seeing psych in house today. The referral was made. The resident will also be seen by the PA that is in house as well."

On 01/21/23, staff noted, "Resident's family was concerned with 'low vital signs.' The nurse took the residents BP 106/55, HR 71, O2 on room air 95%. The resident was at rest in the recliner watching television. No S/S of distress. The nurse explained to the resident the vital signs were good. Called and spoke with the family and explained the vital signs were within normal limits."

On 01/24/23, staff noted, "Resident has been out of Alprazolam, called the pharmacy and they need a new Rx. PA notified."

On 01/27/23, staff noted, "Guest requested transfer out to Genesys Regional Medical Center to be seen further for congestion and cold and flu symptoms. GA tested for covid with neg results. GA notified family via phone call made on guest's personal cell phone at 1:12pm. No answer guest stated to leave voicemail. GA called 911 to set up transfer to (hospital.)"

On 01/31/23, staff noted, “It was reported that the resident will not be returning to the facility. They are going home on hospice care.”

I reviewed progress notes regarding Resident A completed by Physician’s Assistant-Certified (PA-C) Kristen Dziadula. On 11/01/22, Resident A was seen by PA-C Dziadula due to hip pain and new patient admission. She has a history of end stage renal disease. She denied chest pain, shortness of breath, nausea and vomiting. She said she is having some discomfort in her left hip but said this is “not new” due to her bilateral hip replacements. PA-C Dziadula reviewed her medications and ordered an x-ray.

On 11/08/22, Resident A was seen by PA-C Dziadula for a follow up due to her hip pain. Her x-ray was not abnormal and Resident A was not complaining of any pain or distress during her examination. She was prescribed Tylenol for pain.

On 01/10/23, Resident A was seen by PA-C Dziadula for a healthcare appraisal. Resident A was not complaining of any pain or distress during this examination. PA-C Dziadula stated that Resident A was not in acute distress although she did appear weak.

On 01/19/23, Resident A was seen by PA-C Dziadula due to “malaise, refusing hemodialysis, refusing care.” Resident A said she was having some diarrhea which is probably contributing to her poor appetite. She was resting comfortably and was “doing relatively well.” PA-C Dziadula noted “Patient admits to just feeling overall depressed regarding her medical circumstances.” Resident A denied any new symptoms or complaints. PA-C Dziadula changed some of her medications including increasing one of her antidepressants.

On 01/24/23, Resident A was seen by PA-C Dziadula due to “anxiety and medication management per nursing staff request.” Resident A was not in distress but appeared weak. PA-C Dziadula reviewed her medications, and no other recommendations were made.

On 01/26/23, Resident A was seen by PA-C Dziadula due to “nausea, vomiting, and diarrhea.” Resident A said that she has intermittent nausea and diarrhea. She also stated she has nasal congestion with a runny nose and a cough. PA-C Dziadula noted “The patient was previously placed on Imodium as needed which she has not received.” PA-C Dziadula changed some of Resident A’s medications and made no further recommendations.

On 01/27/23, Resident A was seen by PA-C Dziadula in regard to a “loose stool follow-up.” She was resting comfortably but appeared weak. She said that she continues to have bouts of loose stool. PA-C Dziadula ordered a stool culture and for staff to continue Imodium. No other recommendations were made.

On 02/07/23, I interviewed Relative A3 via telephone. Relative A3 confirmed that Resident A resided at Homer House Inn from October 2022 through January 2023. She said that while a resident, the care provided to Resident A was “awful.” Relative A3 told me that Resident A did not get her medications as she was supposed to, she did not get showers, and her room was not cleaned. According to Relative A3, on 1/26/23 she went to the facility to cut Resident A’s nails and shower her. Resident A refused to shower because she was too tired. Relative A3 said that she found feces on the bathroom toilet, the bathroom floor, Resident A’s wheelchair wheels, Resident A’s socks, and Resident A's comforter. Relative A3 said that she contacted one of the staff who came in and cleaned up the mess. Relative A3 said that she suspects that Resident A had an accident and tried to clean herself up but was not able to do so. Relative A3 said that she does not believe Resident A notified staff that she had an accident.

Relative A3 told me that while a resident of Homer House Inn, Resident A was frequently hospitalized due to renal failure. She had frequent diarrhea and suffered from anxiety. Relative A3 said that Resident A frequently went without her Xanax and whenever she would bring it to management’s attention, they told her that would look into it but “nothing ever got any better.” Relative A3 said that Resident A was hospitalized once again on 01/27/23. When she was released, family took her home with them under hospice care and Resident A passed away on 02/07/23.

On 02/07/23, I contacted Sharp Funeral Home in Linden and requested a copy of Resident A’s death certificate. I received a copy of her death certificate and reviewed it on 02/07/23. According to her death certificate, Resident A died on 02/05/23. She was 83-years old. Her manner of death is listed as natural, and her cause of death is listed as ESRD (End Stage Renal Disease.)

On 02/08/23, I interviewed Physician’s Assistant-Certified (PA-C) Kristen Dziadula via telephone. PA-C Dziadula confirmed that she provided medical care to Resident A while she resided at Homer House Inn. PA-C confirmed that Resident A attended dialysis several times a week and when she returned to the facility after treatments, she was often feeling poorly.

PA-C Dziadula said that every time she met with Resident A, they were in Resident A’s room. She said that she always found Resident A’s room to be clean and she never noted an odor emanating from Resident A or her room. PA-C Dziadula said that she was aware that Resident A was not receiving her Alprazolam (Xanax) as prescribed but said that she believes this was an error with the pharmacy, not because staff was deliberately not administering it to her. According to PA-C Dziadula, she did not have any concerns about Resident A’s care while residing at this facility and whenever she met with Resident A, she did not appear in distress, and she did not have any complaints other than what was documented in her notes.

On 08/23/22, I received a complaint alleging that a resident had not received her prescribed insulin for several days (SIR #2022A0872053 dated September 28, 2022.)

I substantiated violation to R 400.15302 (2). The former licensee designee, Kimberly Gee submitted a corrective action plan dated 10/26/22 stating that the assistant living director was educated on the availability of insulin pens during a new admission. She also stated that the administrator/licensee designee "will randomly audit new admits to ensure timely medication delivery."

On 02/09/23, I conducted an exit conference with the licensee designee, Melissa Sevegney via telephone. I discussed the result of my investigation and told her which rule violations I am substantiating. Ms. Sevegney agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Relative A1, A2, and A3 and Resident A said that while a resident of this facility, Resident A did not receive her medications as prescribed. I reviewed Resident A's medication logs, her physician's prescriptions, and nursing notes from December 2022 and January 2023 and noted that on several occasions, she did not receive her medications as prescribed by her doctor. On 02/08/23 I interviewed Resident A's Physician's Assistant-Certified, Kristen Dziadula. PA-C Dziadula said that she was aware that Resident A was not receiving her Alprazolam (Xanax) as prescribed but said that she believes this was an error with the pharmacy, not because staff was deliberately not administering it to her. I conclude that there is sufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR #2022A0872053 dated 09/28/22.**

APPLICABLE RULE	
R 400.15314	**Resident hygiene.**
ANALYSIS:	**(1) A licensee shall afford a resident the opportunity, and instructions, when necessary, for daily bathing and oral**

	and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
	Relative A1, A2, and A3 and Resident A said that while a resident of this facility, Resident A did not receive her showers as needed. The licensee designee, Melissa Sevegney and the health and wellness director, Stephanie Gunn said that Resident A was supposed to receive showers on dialysis days, but she would often refuse because she was too tired. Therefore, they changed her shower schedule for non-dialysis days.
ANALYSIS:	I reviewed Resident A's shower schedule and noted that she did not receive showers at least weekly in November 2022 and January 2023 as required by this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
ANALYSIS:	**(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.**
	Relative A1, A2, and A3 and Resident A said that while a resident of this facility, Resident A's room was not cleaned properly. Staff Melissa Sevegney and Stephanie Gunn said that the facility has a separate housekeeping staff who cleans resident rooms twice per week. In the meantime, direct care staff are responsible for keeping the resident rooms clean and tidy. I conducted unannounced onsite inspections on 01/04/23 and 01/19/23 and found Resident A's room and bathroom to be clean with no evidence of a malodorous odor. PA-C Kristen Dzidula said that while Resident A was a resident of this facility, she met with her on numerous occasions in her room. PA-C Dzidula said that she always found Resident A's room to be cleaned with no evidence of an odor from the room or Resident A. Relative A3 said that on one occasion, she found feces on Resident A's bathroom toilet, the bathroom floor, her wheelchair

	wheels, socks, and comforter. She said that she brought it to staff's attention, and they cleaned up the mess. She said that she believes that Resident A had an accident which she tried to clean up by herself. Relative A3 said that she does not believe Resident A notified staff that she had an accident. I conclude that there is insufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

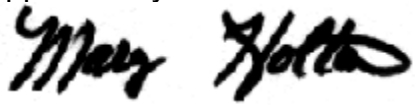
IV. RECOMMENDATION

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

February 9, 2023

Susan Hutchinson Licensing Consultant	Date

Approved By:



February 9, 2023

Mary E. Holton Area Manager	Date