GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 22, 2023

Mark Walker
The Pines of Clarkston
7550 Dixie Hwy
Clarkston, MI 48346

RE: License #: AH630382729
Investigation #: 2023A1019021

Dear Mr. Walker:

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 #:	AH630382729
Investigation #:	2023A1019021
Complaint Receipt Date:	02/10/2023
Investigation Initiation Date:	02/10/2023
Report Due Date:	04/12/2023
Licensee Name:	Premier Operating Clarkston AL, LLC
Licensee Address:	245 Park Ave, 39th FLoor New York, NY 10167
Licensee Telephone #:	(212) 739-0794
Administrator:	Ruby Mogensen
Authorized Representative:	Mark Walker
Name of Facility:	The Pines of Clarkston
Facility Address:	7550 Dixie Hwy Clarkston, MI 48346
Facility Telephone #:	(248) 922-7000
Original Issuance Date:	03/28/2017
License Status:	REGULAR
Effective Date:	09/26/2022
Expiration Date:	09/25/2023
Capacity:	30
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
A change in the appointed administrator has not been reported to the department.	No
Incidents are not being reported to the department.	Yes
Additional Findings	No

III. METHODOLOGY

02/10/2023	Special Investigation Intake 2023A1019021
02/10/2023	Special Investigation Initiated - Letter Emailed AR for additional information.
02/10/2023	Contact - Document Received Email received from facility AR containing requested information.
02/15/2023	Inspection Completed On-site
02/15/2023	Inspection Completed-BCAL Full Compliance

ALLEGATION:

A change in the appointed administrator has not been reported to the department.

INVESTIGATION:

On 2/10/23, the department received a complaint alleging that Employee 1 has been the administrator of the facility since January, but this was not reported to LARA. Due to the anonymous nature of the complaint, I was unable to obtain any additional information.

On 2/10/23, I contacted Mark Walker (authorized representative) to inquire about this matter. Mr. Walker reported that the Ruby Mogensen (current administrator on file) is still the facility's administrator and is currently training Employee 1 who will become the administrator once her onboarding is complete.

On 2/15/23, I conducted an onsite inspection. Ms. Mogensen and Employee 1 were both present at the facility. Ms. Mogensen and Employee 1's statements were consistent with that of Mr. Walker, confirming that Employee 1 is in training.

APPLICABLE RULE	
R 325.1913	**Licenses and permits; general provisions.**
	(2) The applicant or the authorized representative shall give written notice to the department within 5 business days of any changes in information as submitted in the application pursuant to which a license, provisional license, or temporary nonrenewable permit has been issued.
ANALYSIS:	Employee 1 is currently in training to become the administrator, however Ms. Mogensen remains the appointed administrator at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Incidents are not being reported to the department.

INVESTIGATION:

The complaint alleged that Employee 1 didn't submit an incident report for a resident who passed away and also didn't report a hospitalization of a resident. The complaint did not provide the names of the residents or dates of the incidents. Due to the anonymous nature of the complaint, I was unable to obtain any additional information.

Ms. Mogensen and Employee 1 reported that Resident A passed away on 2/2/23 and reported that his death was an expected, hospice death. Employee 1 reported that an incident report was completed for their internal records but was not submitted to LARA. I reviewed a copy of that incident report, combined with staff attestations I did not feel that it met criteria to be reported to the department. I requested additional documentation pertaining to resident incidents for the previous two months. Ms. Mogensen and Employee 1 provided a four total incident reports for that time period. Two of the four incidents I felt met criteria to be reported. Both incidents involved Resident B and occurred on 1/17/23 and 2/8/23. On both dates, Resident B hit his head during a fall and was taken to the hospital. I confirmed that the 2/8/23 incident had been submitted to LARA but the 1/17/23 incident had not. In addition to not reporting to LARA, staff failed to document that the resident's

physician and authorized representative were notified. The corrective/preventive measures listed on the report were “sent to the hospital” which is more appropriate for the “action taken by staff” section of the report. The corrective/preventive measures do not address fall prevention methods to prevent future reoccurrences.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(1) The home shall complete a report of all reportable incidents, accidents, and elopements. The incident/accident report shall contain all of the following information: **(a) The name of the person or persons involved in the incident/accident.** **(b) The date, hour, location, and a narrative description of the facts about the incident/accident which indicates its cause, if known.** **(c) The effect of the incident/accident on the person who was involved, the extent of the injuries, if known, and if medical treatment was sought from a qualified health care professional.** **(d) Written documentation of the individuals notified of the incident/accident, along with the time and date.** **(e) The corrective measures taken to prevent future incidents/accidents from occurring.** **(2) The original incident/accident report shall be maintained in the home for not less than 2 years.** **(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.** **(4) If an elopement occurs, then the home shall make a reasonable attempt to locate the resident and contact the resident's authorized representative, if any. If the resident is not located, the home shall do both of the following:** **(a) Contact the local police authority.** **(b) Notify the department within 24 hours of the elopement.**

ANALYSIS:	The facility failed to report Resident B's hospitalization to the department and the incident report itself lacked pertinent and required information.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [for reference, see special investigation report (SIR) 2021A1027029 and 2020A1019044]**

IV. RECOMMENDATION

I recommend no changes to the status of the license at this time.

02/17/2023

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Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

02/22/2023

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