GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 28, 2023

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

RE: License #:	AL250281713
Investigation #:	2023A0872019
	Leighton 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 #:	AL250281713
Investigation #:	2023A0872019
Complaint Receipt Date:	01/12/2023
Investigation Initiation Date:	01/13/2023
Report Due Date:	03/13/2023
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:	Leighton House Inn
Facility Address:	202 S. Bridge Street Linden, MI 48451
Facility Telephone #:	(810) 735-9400
Original Issuance Date:	06/25/2008
License Status:	REGULAR
Effective Date:	08/08/2021
Expiration Date:	08/07/2023
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident E is not being cared for properly. Staff will not check on her for up to four hours at a time.	No
On 12/18/22, Resident D went to the hospital. When she was discharged and sent back to the facility via non-emergency ambulance, nobody at the facility would open the door or answer the phone. Resident D was taken back to the hospital. Staff eventually called the hospital to say that their phones were not working.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/12/2023	Special Investigation Intake 2023A0872019
01/13/2023	Special Investigation Initiated - Letter I exchanged emails with the licensee designee, Kimberly Gee
01/17/2023	APS Referral I made an APS complaint via email
01/19/2023	Inspection Completed On-site Unannounced
02/01/2023	Contact - Document Received I received a new complaint regarding Resident E
02/02/2023	Inspection Completed On-site Unannounced
02/08/2023	Contact - Document Sent I emailed the licensee designee, Melissa Sevegney requesting information about this complaint
02/22/2023	Contact - Telephone call made I interviewed the general manager, Kwadwo Owusu-Ansah about this complaint
02/23/2023	Contact - Telephone call made I interviewed Relative D1

02/23/2023	Contact - Telephone call made I interviewed Relative D2
02/23/2023	Contact - Telephone call made I interviewed Relative D3
02/23/2023	Contact - Telephone call made I interviewed Relative E1
02/24/2023	Inspection Completed-BCAL Sub. Compliance
02/24/2023	Exit Conference I conducted an exit conference with the licensee designee, Melissa Sevegney

ALLEGATION: Resident E is not being cared for properly. Staff will not check on her for up to four hours at a time.

INVESTIGATION: On 01/31/23, I interviewed Resident E's friend, Friend E1 via telephone. Friend E1 said that she does not feel that Resident E is being cared for properly. She said that on 01/24/23 and 01/31/23, she visited with Resident E for over four hours and staff did not check on her the entire time she was there on either occasion. She said that when she saw Resident E on 01/24/23 and she found a washcloth covered with feces in Resident E's bathroom. When she was there today (01/31/23), the same washcloth was still in Resident E's bathroom.

According to Friend E1, she has talked to staff on numerous occasions about providing better care to Resident E, but the care has not improved. Friend E1 said that she has also talked with Resident E's family about her lack of care, but Resident E's family feels Resident E is being well taken care of and they "don't do anything about it." According to Friend E1, Resident E's family is now trying to make it so Resident E cannot have contact with her anymore.

On 02/02/23, while at Leighton House Inn, I interviewed the director of guest services, Melissa Reich. Ms. Reich confirmed that Resident E's family is trying to limit contact between Resident E and Friend E1. Ms. Reich said that Friend E1 comes up to the facility multiple times a week and she harasses staff and management. Ms. Reich told me that Friend E1 yells at staff which makes staff, residents, and resident family members uncomfortable.

On 02/02/23, I interviewed Resident E who was in her bedroom, resting in bed. Resident E appeared to be clean as was her hair and clothes. I examined her bedroom and her bathroom and found both to be clean and tidy, with no malodorous odor. I did not see any soiled washcloths or other items with feces on them in Resident E's bathroom or bedroom. Resident E told me that she is not able to get out of bed, so staff

gives her bed baths. She said that staff takes good care of her, and she does not have any concerns. Resident E told me that staff checks on her “quite often” and if she needs something, she presses her call light.

Resident E confirmed that Friend E1 does not like the care she receives at Leighton House Inn. Resident E told me that her family does not approve of Friend E1 even though “she means well.” According to Resident E, staff checks on her and changes her brief every two hours or more often if necessary. She said that when Friend E1 is visiting her, staff does not come in her room as often because Friend E1 “wants to take care of me.” Resident E stated that Friend E1 “is very good about seeing to my every need” and Friend E1 thinks that staff should do the same.

On 02/22/23, I reviewed Adult Foster Care documentation related to Resident E. Resident E was admitted to Symphony Inns on 10/05/19. She is diagnosed with psychosis, hypertension, altered mental status, thrombocytopenia sepsis, weakness, cellulitis, difficulty in walking, parenteral nutrition, major depressive disorder, Parkinson’s disease, essential hypertension, peripheral vascular disease, deep vein thrombosis, urinary tract infection, and chronic pain. The physician’s assistant who examined her for her health care appraisal on 8/24/22 also noted that Resident E has “good hygiene” and has chronic edema and kyphosis.

On 02/23/23, I interviewed Relative E1 via telephone. Relative E1 said that he does not have any concerns about the care that Resident E receives at this facility. He said to his knowledge, staff takes good care of Resident E. Relative E1 said that Friend E1 is not a good influence on Resident E. He said that Resident E lived with Friend E1 and due to the neglectful surroundings and the fact that Friend E1 took money from Resident E, he moved Resident E into an AFC Home. He said that he has contacted the police and since Relative E1 is Resident E’s POA, and Resident E suffers from dementia, the police told Friend E1 that she can no longer have contact with Resident E.

On 02/23/23, I interviewed Relative D3 via telephone. Relative D3 said that she is an EMT with MedStar ambulance service. On 02/14/23, she and her partner transported Resident D back to Leighton House Inn after being hospitalized. When they got her back to her room, Relative D3 pulled Resident D’s covers off her bed and went to assist her in bed. As she pulled the covers off, she noticed dried feces on the sheets and comforter. Relative D3 said that she took the soiled sheets off Resident D’s bed, notified staff who then brought her clean sheets to put on Resident D’s bed. Relative D3 said this is the only concern she has about Resident D’s care.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	Friend E1 said that Resident E is not being taken care of properly. Resident E and Relative E1 said that they do not have any concerns about the care that Resident E is receiving from staff. Relative D3 said that on 2/14/23, she found dried feces on Resident D's sheets and comforter. She said that she notified staff, and they brought her clean sheets to put on Resident D's bed. I conclude that there is insufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: On 12/18/22, Resident D went to the hospital. When she was discharged and sent back to the facility via non-emergency ambulance, nobody at the facility would open the door or answer the phone. Resident D was taken back to the hospital. Staff eventually called the hospital to say that their phones were not working.

INVESTIGATION: On 01/19/23, I conducted an unannounced onsite inspection of Leighton House Inn. I met with Resident D who was taking a nap, in her bedroom. I asked Resident D several questions, but she would not answer me. At one point, she threw the covers off her body, sat up, and stared at me but again she would not answer any of my questions. From what I could see, Resident D appeared to be clean and dressed appropriately. Her bedroom and bathroom also appeared to be clean.

On 02/02/23, I conducted an unannounced onsite inspection of Leighton House Inn. Resident D was unavailable, so I was not able to attempt to interview her again.

On 02/22/22, I reviewed AFC paperwork related to Resident D. Resident D was originally admitted to Symphony Inns on 09/21/21. She can ambulate without assistive devices. At the time of her assessment, Resident D did have a history of 1-2 falls within the past six months, but she does not require enhanced supervision or assistance from staff.

Resident D is diagnosed with a magnesium deficiency, major depressive disorder, generalized anxiety disorder, essential hypertension, cerebral infarction, chest pain, and vascular dementia. On 02/08/23, she was also diagnosed with a urinary tract infection, unspecified.

On 02/22/23, I interviewed the general manager, Kwadwo Owusu-Ansah about this complaint. Mr. Owusu-Ansah said he is aware that on 12/18/22, the hospital social worker was unable to reach anyone at the facility regarding Resident D. According to Mr. Owusu-Ansah, he spoke to the social worker that night and she told him that the non-emergency paramedics tried knocking on one of the outside doors for several minutes and then tried calling the facility on multiple occasions and they were unable to reach anyone. Mr. Owusu-Ansah said that when he got to work the morning of 12/19/22, he spoke to the nursing home staff who said that they did not know they missed a call from anyone.

Mr. Owusu-Ansah said that from 8am-8pm, the phones of all the Inns ring into the main office and the receptionist responds to all calls. At 8pm, the phones automatically transfer over to the nursing home side of the facility. From 8pm-8am, the nurses who are working on the nursing home side of the facility are responsible for answering the phones. He said that sometimes, the nurses are taking care of patients and they are unable to answer the phones when someone calls. I asked him if anyone can leave a message when they call the nursing home side, and he said no. He said that the phone will continually ring until the caller hangs up or a nurse answers the phone.

Mr. Owusu-Ansah said that all residents have landline telephones in their rooms. If a resident wants to call someone, they press “9” to get an outside line and then their call goes directly to whoever they want to call. If someone wants to call and speak to one of the residents, the individual must reach someone by calling the main phone number and that individual then must transfer the caller to the resident’s room.

On 02/23/23, I interviewed Relative D1 via telephone. He said that he is aware of the incident that took place on 12/18/22. According to Relative D1, ambulance and hospital staff tried contacting the facility on several occasions and they were unable to reach anyone. Relative D1 said that he also tried contacting staff at the facility, and he was unable to reach anyone.

On 02/24/23, I conducted an exit conference with the licensee designee, Melissa Sevegney. I discussed the results 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. Ms. Sevegney said that she is already in the process of working on a solution to the phone issue.

APPLICABLE RULE	
R 400.15304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or

	the resident's designated representative, a copy of all of the following resident rights: **(e) The right of reasonable access to a telephone for private communications. Similar access shall be granted for long distance collect calls and calls which otherwise are paid for by the resident. A licensee may charge a resident for long distance and toll telephone calls. When pay telephones are provided in group homes, a reasonable amount of change shall be available in the group home to enable residents to make change for calling purposes.**
ANALYSIS:	On 12/18/22, Resident D went to the hospital. When she was discharged and sent back to the facility via non-emergency ambulance, nobody at the facility would open the door or answer the phone. Resident D was taken back to the hospital. Staff eventually called the hospital to say that their phones were not working. The general manager, Kwadwo Owusu-Ansah said he is aware that on 12/18/22, the hospital social worker was unable to reach anyone at the facility regarding Resident D. According to Mr. Owusu-Ansah, he spoke to the social worker that night and she told him that the non-emergency paramedics tried knocking on one of the outside doors for several minutes and then tried calling the facility on multiple occasions and they were unable to reach anyone. Mr. Owusu-Ansah said that when he got to work the morning of 12/19/22, he spoke to the nursing home staff who said that they did not know they missed a call from anyone. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: While at the facility on 02/02/23, I obtained an Incident/Accident (IR) Report dated 12/17/22 at 6:15pm completed by staff Audraya Forrest regarding Resident D. According to the IR, “The resident was harassing another guest and when the resident was asked to leave room 515, she raised her hand to hit the staff. The staff went into the med room and then the resident put her hands around the staff member’s neck. The resident then raised her fist to hit another staff member.” The action taken by staff was, “The staff attempted to redirect and deescalate the situation. The attempt was unsuccessful. The resident was sent to the hospital for psych eval and treatment.” The corrective measures taken were, “The resident is to have a medication eval.” This incident took place on 12/17/22 but I did not receive a copy of the IR until 02/02/23.

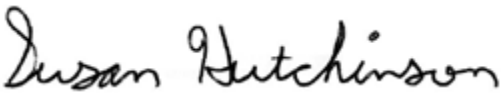
I completed an investigation, SIR #2022A0872052 dated 10/20/22. I concluded that Resident A fell on three occasions, and she was sent to the hospital on all occasions. The licensee designee did not send me an Incident/Accident Report regarding any of these hospitalizations. The licensee designee, Kimberly Gee submitted a Corrective Action Plan (CAP) dated 10/26/22, stating that the director assistive living and the assistant to the assisted living director will be educated on incident reporting and quarterly random checks will be made to ensure compliance.

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1)(c) Incidents that involve any of the following: **(i) Displays of serious hostility.** **(ii) Hospitalization.** **(iii) Attempts at self-inflicted harm or harm to others.** **(iv) Instances of destruction to property.**
ANALYSIS:	While at the facility on 02/02/23, I obtained an Incident/Accident (IR) Report dated 12/17/22 at 6:15pm completed by staff Audraya Forrest regarding Resident D. This incident took place on 12/17/22 but I did not receive a copy of the IR until 02/02/23. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Ref SIR #2022A0872052 dated 10/20/22.**

On 02/24/23, I conducted an exit conference with the licensee designee, Melissa Sevegney. I discussed the results 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. Ms. Sevegney said that she is already in the process of working on a solution to the phone issue.

IV. RECOMMENDATION

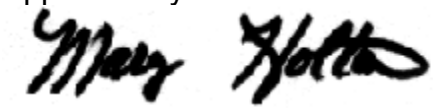
Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.



February 27, 2023

Susan Hutchinson Licensing Consultant	Date

Approved By:



February 28,2023

Mary E. Holton Area Manager	Date