GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 3, 2023

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

RE: License #:	AL250331306
Investigation #:	2023A0872026
	Degas House Inn

Dear Ms. Sevegney:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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

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 #:	AL250331306
Investigation #:	2023A0872026
Complaint Receipt Date:	02/09/2023
Investigation Initiation Date:	02/10/2023
Report Due Date:	04/10/2023
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:	Degas House Inn
Facility Address:	202 S Bridge Street Linden, MI 48451
Facility Telephone #:	(810) 735-9400
Original Issuance Date:	05/01/2014
License Status:	1ST PROVISIONAL
Effective Date:	11/28/2022
Expiration Date:	05/27/2023
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
On 01/23/23, Resident D was in Degas House Inn and there was no staff present. All the residents had been moved to other Inns on 01/20/23. Resident D was left unsupervised for hours.	No
Resident D went without some of her medications while a resident of Degas House Inn.	Yes

III. METHODOLOGY

02/09/2023	Special Investigation Intake 2023A0872026
02/09/2023	APS Referral This complaint was referred to APS but was not assigned for investigation
02/10/2023	Special Investigation Initiated - Telephone
02/16/2023	Inspection Completed On-site Unannounced
02/21/2023	Contact - Document Sent I emailed the licensee designee, Melissa Sevegney, requesting information about this complaint
02/23/2023	Contact - Telephone call made I interviewed Relative D1
02/23/2023	Contact - Telephone call made I interviewed 3rd shift supervisor, Tequila Simons-Shields
02/23/2023	Contact - Document Received I received AFC documentation from Ms. Sevegney
03/27/2023	Exit Conference I conducted an exit conference with the licensee designee, Melissa Sevegney
03/27/2023	Inspection Completed-BCAL Sub. Non-Compliance

ALLEGATION:

- **On 01/23/23, Resident D was in Degas House Inn and there was no staff present. All the residents had been moved to other Inns on 01/20/23. Resident D was left unsupervised for hours.**
- **Resident D went without some of her medications while a resident of Degas House Inn.**

INVESTIGATION: On 02/16/23, I conducted an unannounced onsite inspection of Degas House Inn. I interviewed the licensee designee, Melissa Sevegney and Resident D. Ms. Sevegney said that on 01/23/23, Resident D was moved from Degas House Inn to Leighton House Inn. According to Ms. Sevegney, Resident D was the last resident in Degas House Inn, but she was never left unattended, and staff was always available until all the residents were moved to different Inns. Ms. Sevegney also said that Resident D did not go without her medications on the morning of 01/23/23 and she was not in pain.

I met with Resident D in her bedroom as she was finishing lunch. She appeared to be clean as was her hair and clothes. Resident D confirmed that she was recently moved from Degas House Inn to Leighton House Inn. I asked her if she was ever left unattended while a resident of Degas House Inn and she said no. Resident D said that she did not know she was the last resident at Degas House Inn and said that while a resident there, she was always able to contact staff. She told me, “There was a lot of chaos while we were moving” but said that she was not neglected by staff. Resident D said that she has had to wait up to 45 minutes for staff after pressing her call button but said that staff always responds.

I asked Resident D if she ever went without her medications while residing at Degas House Inn and she said that to her knowledge, she always received her medications. I asked Resident D if she was ever left in pain or not cared for and she said whenever she is in pain, she notifies staff, and they give her medication if she is allowed to have it. Resident D said that she does not ever remember being in pain or needing help and staff not responding.

On 02/21/23, I reviewed Adult Foster Care documentation related to Resident D. Resident D was admitted to Symphony Inns on 10/05/19. She is diagnosed with psychosis, hypertension, thrombocytopenia sepsis, 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 D has “good hygiene” and has chronic edema and kyphosis.

On 02/21/23, I emailed the licensee designee, Melissa Sevegney requesting additional information about this complaint.

On 02/23/23, I interviewed Relative D1 via telephone. Relative D1 said that he has no concerns about the care Resident D receives from staff at this facility. He said that he

understands that Resident D was one of the last residents at Degas House Inn before being moved to Leighton House Inn but said that he does not believe she was unsupervised. He also said that to his knowledge, Resident D has always received her medications as prescribed, and she has never been in pain and staff has not responded.

On 02/28/23, Ms. Sevegney emailed me a list of staff names and phone numbers for who was working in all the Inns during 01/20/23 through 01/23/23. She stated that staff were scheduled and working in Degas House Inn during this time.

On 02/28/23, I received Adult Foster Care paperwork regarding Resident D. I reviewed Resident D's medication administration record for January 2023. According to this record, Resident D was not administered the following medications on the following dates per physician's instructions:

- Furosemide 20 mg 1x per day; 01/13, 01/14, 01/16, 01/17, 01/18, 01/19, 01/20, and 01/21
- Atorvastatin Calcium tablet 20 mg 1x per day; 01/16, 01/20, 01/21, 01/22 and 01/23
- Glucema 1x per day; 01/02, 01/05, 01/06, 01/07, 01/09, and 01/17
- Pramipexole Dihydrochloride 1mg 1x per day; 01/20, 01/21, 01/22 and 01/23
- Seroquel 25mg 1x per day; 01/16, 01/20, 01/21, 01/22, and 01/23
- Norco tablet 5-325 mg 3x's per day; her 9:00pm dose on 01/20, 01/21, 01/22 and 01/23

On 03/27/23, I conducted an exit conference with the licensee designee, Melissa Sevegney. I discussed the findings of my investigation and explained which rule violation I am substantiating.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
ANALYSIS:	**(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.**
	The licensee designee, Melissa Sevegney said that while a resident of Degas House Inn, Resident D was never left unattended, and staff was always available. Ms. Sevegney emailed me a list of staff names and phone numbers for who was working in all the Inns during 01/20/23 through 01/23/23. She stated that staff were scheduled and working in Degas House Inn during this time.

ANALYSIS:	Resident D said that while a resident of Degas House Inn, she was never left unattended, and staff was always available. She said that sometimes, she would have to wait 45 minutes for staff to come after pressing her call button, but staff always attended to her needs. Relative D1 said that to his knowledge, Resident D was never left unattended while a resident of Degas House Inn and staff was always available. I conclude that there is insufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 11/09/22, I completed an SIR #2023A0872058 at this facility and substantiated R 400.312(2). I concluded that staff failed to administer Resident A's medications in July, August, and September 2022. I also concluded that staff failed to administer and/or remove Resident B's 24-hour Exelon patch within one hour of the doctor's 9am order. In July 2022, staff failed to follow doctor's orders regarding Resident B's Ativan (Lorazepam) and Zyprexa (Olanzapine) on more than one occasion. The licensee designee, Kimberly Gee submitted a CAP dated 11/21/22. Ms. Gee stated, "Education and audit of medication records completed to ensure process in place to prevent missed medications." Ms. Gee also said, "Director of assisted living will continue to audit and review medication records for accuracy and timeliness of meds." I recommended that the facility be placed on a provisional license at that time.

On 03/03/22, I completed an SIR #2022A0872019 at this facility and substantiated R 400.312(2). I concluded that staff failed to administer several of Resident D's medications on several days in October 2021. The licensee designee, Kimberly Gee submitted a corrective action plan (CAP) dated 03/09/22. Mrs. Gee stated that she "provided education for all staff related to the requirement of medication administration and timely documentation." She said that the director of assisted living or the licensee, "will perform a daily review of the medication administration record to ensure compliance with this rule. This review will be captured on an audit tool, turned in weekly to licensee for additional oversight for the next three months."

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	The licensee designee, Melissa Sevegney, Resident D and Relative D1 said that to their knowledge, Resident D never went without any of her medications while a resident of Degas House Inn.

	I reviewed Resident D's medication administration record for January 2023. According to this record, Resident D was not administered the following medications on the following dates per physician's instructions: • Furosemide 20 mg 1x per day; 01/13, 01/14, 01/16, 01/17, 01/18, 01/19, 01/20, and 01/21 • Atorvastatin Calcium tablet 20 mg 1x per day; 01/16, 01/20, 01/21, 01/22 and 01/23 • Glucema 1x per day; 01/02, 01/05, 01/06, 01/07, 01/09, and 01/17 • Pramipexole Dihydrochloride 1mg 1x per day; 01/20, 01/21, 01/22 and 01/23 • Seroquel 25mg 1x per day; 01/16, 01/20, 01/21, 01/22, and 01/23 • Norco tablet 5-325 mg 3x's per day; her 9:00pm dose on 01/20, 01/21, 01/22 and 01/23 I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Ref. SIR #2022A0872058 dated 11/09/22 and CAP dated 11/21/22.** **Ref. SIR #2022A0872019 dated 03/03/22 and CAP dated 3/16/22.**

On 03/15/23, I completed an SIR #2023A0872020 at this facility and substantiated several quality-of-care violations as well as repeat violations. Since this facility was on a provisional license status at the time, I recommended revocation of the license. The Notice of Intent was served on 03/23/23 and a compliance conference is scheduled for 05/10/23.

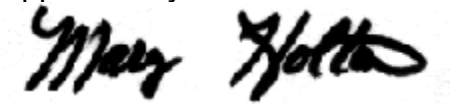
IV. RECOMMENDATION

I recommend revocation of this license.

March 28, 2023

Susan Hutchinson Licensing Consultant	Date

Approved By:



April 3, 2023

Mary E. Holton Area Manager	Date