GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 4, 2023

Julie Norman
Farmington Hills Inn
30350 W. Twelve Mile Road
Farmington Hills, MI 48334

RE: License #: AH630236784
Investigation #: 2023A0585025
Farmington Hills Inn

Dear Ms. Norman:

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) 284-9730.

Sincerely,

Brender L. Howard

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street, P.O. Box 30664
Lansing, MI 48909
(313) 268-1788

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630236784
Investigation #:	2023A0585025
Complaint Receipt Date:	01/20/2023
Investigation Initiation Date:	01/24/2023
Report Due Date:	03/19/2023
Licensee Name:	Alycekay Co.
Licensee Address:	30350 W 12 Mile Rd. Farmington Hills, MI 48334
Licensee Telephone #:	(248) 851-9640
Administrator/Authorized Representative:	Julie Norman
Name of Facility:	Farmington Hills Inn
Facility Address:	30350 W. Twelve Mile Road Farmington Hills, MI 48334
Facility Telephone #:	(248) 851-9640
Original Issuance Date:	12/29/2000
License Status:	REGULAR
Effective Date:	10/10/2022
Expiration Date:	10/09/2023
Capacity:	137
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff was abusive to Resident A.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/20/2023	Special Investigation Intake 2023A0585025
01/24/2023	Special Investigation Initiated - Telephone Called listed witness for additional information.
01/24/2023	APS Referral Referrals were sent to us by Adult Protective Services (APS).
02/08/2023	Inspection Completed On-site Completed with observation, interview and record review.

ALLEGATION:

Staff was abusive to Resident A.

INVESTIGATION:

On 1/22/2023, the department received a complainant from Adult Protective Service (APS) via the BCHS Online Complaint website. The complaint alleges that on 1/11/2023, Employee #1 was pulling Resident A's arm and made her undress to take a shower while making comments that she stinks and her breath stinks. The complaint alleges that Employee #1 took Resident A's cell phone away. The complaint alleges that the facility moved Resident A and another resident instead of doing something about Employee #1 being aggressive and mean to the residents.

On 2/8/2023, an onsite was completed at the facility. The administrator Julie Norman was not there. I interviewed admission coordinator/assistant administrator Marshall Bain at the facility. Ms. Bain stated that she has not received any complaints about Employee #1 being aggressive with any residents. She stated that

Employee #1 has been an employee for a long time, and she had all her training, including residents' rights and abuse.

During the onsite, I interviewed Employee #1. Employee #1 stated that Resident A was moved to another hallway because she wanted to move. Employee #1 stated that she has never been aggressive with any of the residents. She stated that Resident A hollers all the time, and she had feces all over everywhere and she had to clean her up. Employee #1 stated that Resident A did not want her to take care of her. Employee #1 stated that Resident A would sleep in her clothes and would often take things off the wall.

On 2/8/2023, I interviewed Employee #2 at the facility. Employee #2 stated that Resident A was moved because of Employee #1. She stated that she heard Resident A screaming and she was on the toilet with no clothes on. Employee #2 stated that Employee #1 would not let Resident A eat. She stated that Employee #1 pushed and pulled on Resident A.

On 2/28/2023, I interviewed Employee #3 by telephone. Employee #3 stated that on 1/11/2023, Employee #1 forcefully gave Resident A her shower. Employee #3 stated that Employee #1 was yelling at Resident A and grabbing on her. She stated that Employee #1 has been physically aggressive with other residents. She said the facility never addressed the issues but move the residents when they complained.

During the onsite, I interviewed Resident A. Resident A stated that Employee #1 put her in the hallway and told her she was uncooperative. Resident A stated that she did everything that Employee #1 told her to do but she was still mean to her. Resident A stated that Employee #1 didn't like her and gave her a cold shower. Resident A stated that Employee #1 took her phone. Resident A stated that the office got it back for her. She said they found it under the bed and guess that is where Employee #1 threw it. Resident A stated that Employee #1 told her that she will never go home. Resident A stated that Employee #1 have threaten to put her in dementia.

During the onsite, I interviewed Resident B. Resident B stated that there are staff that harbor hatred in her heart. Resident B would not talk any further as to the specific of what staff she was talking about. She stated that she moved to a different hallway, and everything is better now. She stated that since she moved to another hallway, the staff does not holler at her, and they are very nice.

On 2/10/2023, I interviewed administrator Julie Norman by telephone. Ms. Norman stated that there was nothing physical between Employee #1 and Resident A. She stated that Resident A said that Employee #1 took her phone, but they found her phone under the bed. Ms. Norman stated that Employee #1 gave Resident A her shower but couldn't prove that she showered her in cold water. She stated that Resident A ran out of her room naked. Ms. Norman stated that Resident A wanted a

private room and was moved to another room. She stated that Resident A was not moved because of the staff.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(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 or a physician's assistant to whom the physician has delegated the performance of medical care services 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 or physician's assistant. In case of a chemical restraint, a physician shall be consulted within 24 hours after the commencement of the chemical restraint.**
ANALYSIS:	The complaint alleged that staff was abusive to Resident A. Based on interview with staff and interviews with Resident A and Resident B, Employee #1 on several instant displayed abusive behavior toward Resident #1. This claim was substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS

Resident A said that Employee #1 is not supposed to come near her and said the other Employee #1 brought her roommate back from dinner and she came into the

room where she was. Resident A stated that she gets scared when she is around Employee #1 because of how she treated her.

During the onsite, when visiting Resident A in her room, Employee #1 knocked on the door. Resident A stated that Employee #1 was not supposed to come near her, and she shouldn't be at her door. Resident A repeated again that Employee #1 just does not like her.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	Employee #1 continues to go into Resident A room when she has stated that she is afraid of her. Therefore, the facility did protect Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remains unchanged.

Brender L. Howard 04/05/2023

Brender Howard Date
Licensing Staff

Approved By:

Andrea L. Moore 04/05/2023

Andrea L. Moore, Manager Date

Long-Term-Care State Licensing Section