GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 2, 2023

Caitlin Hartman
Fleischman Residence
6710 West Maple Road
West Bloomfield, MI 48322

RE: License #: AH630236785
Investigation #: 2024A1019009
Fleischman Residence

Dear Licensee:

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 #:	AH630236785
Investigation #:	2024A1019009
Complaint Receipt Date:	10/26/2023
Investigation Initiation Date:	10/27/2023
Report Due Date:	12/25/2023
Licensee Name:	Jewish Home and Aging Services
Licensee Address:	6710 W Maple Rd. West Bloomfield, MI 48322
Licensee Telephone #:	(248) 661-2999
Administrator and Authorized Representative:	Caitlin Hartman
Name of Facility:	Fleischman Residence
Facility Address:	6710 West Maple Road West Bloomfield, MI 48322
Facility Telephone #:	(248) 661-2999
Original Issuance Date:	09/01/1999
License Status:	REGULAR
Effective Date:	07/02/2023
Expiration Date:	07/01/2024
Capacity:	116
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was treated inappropriately by staff.	Yes
Additional Findings	No

III. METHODOLOGY

10/26/2023	Special Investigation Intake 2024A1019009
10/26/2023	Comment Complaint was forwarded to LARA from APS. APS denied the referral and is not investigating.
10/27/2023	Special Investigation Initiated - Letter Admin/AR notified LARA of the allegations on 10/9/23. On 10/27/23, LARA requested supporting documentation regarding the incident from Admin/AR.
10/27/2023	Contact - Document Received Requested documentation provided by admin/AR.
10/27/2023	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Resident A was treated inappropriately by staff.

INVESTIGATION:

On 10/26/23, the department received a complaint alleging that Resident A was hit and pushed by Employee 1 on 10/7/23. The complaint read that this was a witnessed event.

On 10/9/23, administrator and authorized representative Caitlin Hartman notified the department of the allegations. Per Ms. Hartman, she also notified Adult Protective Services and the West Bloomfield police. In follow up correspondence, Ms. Hartman

provided an incident report and supporting documentation of her internal investigation of the event. The incident report authored by Ms. Hartman read:

> *At approximately 1000, resident was observed by community employees striking [Employee 1] on the arm several times. Resident resides in Fleischman- Memory Care Unit. Resident is not alert to person, place, time or situation with isolated behaviors r/t dementia dx. [Employee 1], was observed by community employees striking resident on hand in response to resident. Employee further stated "Do not hit me", while she hit resident on hand. Additionally, employee was observed pushing resident back down on chair when she attempted to get up.*

Employee 2 was a witness to the event. Employee 2 attested "*On October 7th, 2023 I [Employee 2] saw [Employee 1] hit [Resident A] on the hand who lives on third floor. It was early in the morning and [Resident A] had hit her on the arm, in return she hit [Resident A] back and told her don't hit her*."

Ms. Hartman provided a summary of Employee 1's interview that read:

> *[Employee 1] was asked about the incident that occurred with [Resident A]. employee was asked if she hit resident in response to her hitting her. Employee stated no. employee stated initially she did not remember if she did or not d/t everything happening "so fast". [Employee 1] was asked to definite hitting and what hitting means to her. Employee further stated that she did not hit her but that when resident hit her on her arm, she pushed her back down by the shoulders back into the chair and tapped her on the hand several times stating "you cannot do that [Resident A]". employee was educated on the definition of abuse, that any tapping, striking, hitting in response of behavior initiated by a resident is considered abuse. Employee was further educated on restraining resident and pushing resident down in a response to keep her in place is a restraint. Employee expressed remorse and stated she would not do it again. Employee was suspended pending investigation.*

Progress note documentation was reviewed. The notes read that Resident A had no recollection of the incident and did not show any signs or symptoms of pain immediately after the event or in subsequent assessments over the following week.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(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:	Employee 1 was directly observed hitting Resident A's hand and pushing her down into a chair. This unnecessary and wrongful application of force is inconsistent with the provision of care outlined in this statute.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon approval of an acceptable corrective action plan, I recommend no changes to the status of the license at this time.

10/27/2023

_____

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

11/02/2023

_____

Andrea Moore Date
Area Manager