GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 13, 2023

David Karapetian
Manoogian Manor
15775 Middlebelt Road
Livonia, MI 48154

RE: License #: AH820236836
Investigation #: 2023A1019064
Manoogian Manor

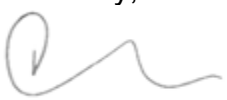
Dear Licensee:

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 #:	AH820236836
Investigation #:	2023A1019064
Complaint Receipt Date:	08/14/2023
Investigation Initiation Date:	08/14/2023
Report Due Date:	10/13/2023
Licensee Name:	Michigan Home for the Armenian Aged Inc.
Licensee Address:	15775 Middlebelt Rd. Livonia, MI 48154
Licensee Telephone #:	(734) 522-5780
Administrator and Authorized Representative:	David Karapetian
Name of Facility:	Manoogian Manor
Facility Address:	15775 Middlebelt Road Livonia, MI 48154
Facility Telephone #:	(734) 522-5780
Original Issuance Date:	06/01/1999
License Status:	REGULAR
Effective Date:	06/07/2023
Expiration Date:	06/06/2024
Capacity:	76
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was improperly discharged.	Yes
Additional Findings	No

III. METHODOLOGY

08/14/2023	Special Investigation Intake 2023A1019064
08/14/2023	Special Investigation Initiated - Letter Emailed admin/AR for additional information and documentation.
08/14/2023	APS Referral
08/14/2023	Inspection Completed BCAL Sub. Compliance

ALLEGATION:

Resident A was improperly discharged.

INVESTIGATION:

On 8/14/23, the department received a complaint alleging a wrongful discharge of Resident A. The complaint read that Resident A was discharged without a place to go and did not feel that a sufficient reason for discharge was provided.

Follow up correspondence was conducted with administrator and authorized representative David Karapetian. Mr. Karapetian provided two discharge notices that were submitted to Relative A which were submitted to the department. The first notice authored by Mr. Karapetian and dated 7/24/23 and read, in part:

> *I've been repeatedly advised of the impacts of your mother's incontinence and the consequences of her inability to control herself have extended far beyond our ability to consistently maintain the standard of cleanliness and sanitation that we apply to all of our residents' rooms. Indeed, today the odor from her room was at a level well past what we can expect any of our aids to tolerate.*

For nearly one month you mother has been on an alternative diet prescribed by her doctor in hopes of changing her body's ability to control itself. Sadly, her system has not responded in any helpful way.

We've done our best to maintain your mother's room to our standard of sanitary cleanliness; yet try as we have, we cannot keep up with this extreme situation, which could impact the health of our other residents and staff.

We've done all we can do.

Regrettably, we must not advise you to make arrangements to immediately move your mother from Manoogian Manor to other quarters of your choice. We'll expect to hear from you in the near days ahead of new of her move.

This notification did not provide a date that Resident A must be out of the facility.

The second notice authored by Mr. Karapetian and dated 7/29/23 read, in part:

I was informed on Thursday that during the day on Wednesday, one of our housekeeping staffers reported the following incident: while she was cleaning your mother's room a member of our laundry staff came to return your mother's laundered clothing. When she opened a dresser drawer to place the clean laundry inside, both employees were alarmed to see raw feces in the drawer. See attached photo. We did our best to safely clean up this most unsettling example of your mother's inability to control herself.

Our frequent cleaning your mother's room of her uncontrolled urinary and other discharges poses health risks to our employees. Also, her discharges emit odors that are distinct in the nearby corridor. This condition directly impacts our staff working anywhere near your mother's room, as well as our ability to invite visitors and prospective residents to tour that particular section of our building.

In short, the condition I've described has become a major issue facing our operations. This latest revelation goes beyond anything we could have contemplated before now.

[Relative A], under these circumstances Manoogian Manor cannot continue exposing our employees, our guests, and others who visit the Manor. We've done all that we can and have no expectation that things will get better. As I shared earlier, we've done our best to maintain your mother's room to our standards of sanitary cleanliness; yet try as we do, we cannot keep up with this extreme behavioral situation, which we must control from impacting the health of our other residents and staff.

Very regrettably, we must now advise you to make arrangements to <u>immediately</u> move your mother from Manoogian Manor to other quarters of

your choice. We are rescinding the August 9 vacating date that I offered last week and now insist that you remove your mother from the Manor not later than July 31. Your timely action will enable you to avoid imposition of the August rent obligation… We'll expect to hear from you in the next 48 hours with your plan for your mother's move and, again, we very deeply regret having to take these measures.

Administrator and authorized representative David Karapetian described exceptional measures taken by staff to prevent the discharge from occurring, however those were not included in this notification as alternatives to discharge that were sought by the facility. Neither discharge notice informs the reader of the resident's right to file a complaint with the department.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(16) A home that proposes to discharge a resident for any of the reasons listed in subrule (15) of this rule shall take all of the following steps before discharging the resident: **(a) The home shall notify the resident, the resident's authorized representative, if any, and the agency responsible for the resident's placement, if any, not less than 24 hours before discharge. The notice shall be verbal and issued in writing. The notice of discharge shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the home, if any.** **(iii) The location to which the resident will be discharged.** **(iv) The right of the resident to file a complaint with the department.** **(d) If the department finds that the resident was improperly discharged, then the resident may return to the first available bed in the home that can meet the resident's needs as identified in the resident's service plan.** **(e) The resident shall not be discharged until a subsequent setting that meets the resident's immediate needs is located.**

ANALYSIS:	The less than 30-day discharge notice issued to Resident A did not include all required information as outlined in this rule such as the resident's right to file a complaint with the department.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

08/16/2023

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

12/11/2023

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