GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 16, 2024

Marina Galu
American House Wyoming
5812 Village Dr SW
Wyoming, MI 48519

RE: License #: AH410402896
Investigation #: 2024A1021034
American House Wyoming

Dear Marina Galu:

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 authorized representative 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,
Kimberly Horst

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410402896
Investigation #:	2024A1021034
Complaint Receipt Date:	01/31/2024
Investigation Initiation Date:	02/01/2024
Report Due Date:	04/01/2024
Licensee Name:	AH Wyoming Subtenant LLC
Licensee Address:	STE 1600 One Towne Square Southfield, MI 48076
Licensee Telephone #:	(248) 827-1700
Administrator:	Tamara Monks
Authorized Representative/	Marina Galu
Name of Facility:	American House Wyoming
Facility Address:	5812 Village Dr SW Wyoming, MI 48519
Facility Telephone #:	(616) 421-2675
Original Issuance Date:	11/05/2020
License Status:	REGULAR
Effective Date:	05/05/2023
Expiration Date:	05/04/2024
Capacity:	166
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident C is not changed appropriately.	Yes
Resident C's medication is not administered.	No
Additional Findings	Yes

III. METHODOLOGY

01/31/2024	Special Investigation Intake 2024A1021034
02/01/2024	Special Investigation Initiated - Letter referral sent to APS
02/02/2024	Contact - Telephone call received received call from complainant
02/05/2024	Inspection Completed On-site
02/06/2024	Contact - Telephone call received received video footage
02/08/2024	Contact-telephone call made Interviewed SP5
02/16/2024	Exit Conference

ALLEGATION:

Resident C is not changed appropriately.

INVESTIGATION:

On 01/31/2024, the licensing department received a complaint with allegations Resident C is not changed.

On 02/01/2024, the allegations in this report were sent to centralized intake at Adult Protective Services (APS).

On 02/02/2024, I interviewed the complainant by telephone. The complainant alleged Resident C has been found with a urine soaked depend and the urine has been in Resident C's shoes.

On 02/05/2024, I interviewed staff person 1 (SP1) at the facility. SP1 reported Resident C spends majority of time in her room. SP1 reported Resident C is incontinent and wears incontinence products. SP1 reported Resident C is now on hospice services as she has had a decline in health. SP1 reported caregivers are to check on Resident C every two hours.

On 02/05/2024, I interviewed SP5 at the facility. SP5 reported she typically works first shift. SP5 reported she has observed Resident C to be soaked in urine and wearing the same clothes for multiple days. SP5 reported Resident C is incontinent and can be resistant to care. SP5 reported she has a good relationship with Resident C and can usually encourage her to get up and get changed. SP5 reported when Resident C refuses care, some caregivers just walk away instead of trying again or using other technicians to get Resident C to agree to care. SP5 reported caregivers are to check on Resident C every two hours but she could use increase checks due to incontinence issues.

On 02/05/2024, I interviewed SP4 at the facility. SP4 reported she has observed Resident C to be covered in urine. SP4 reported Resident C can be resistant to care and it can be difficult to provide care to Resident C.

On 02/05/2024, I observed Resident C at the facility. Resident C was sitting in her room. Resident C appeared to have clean clothes on and appeared well kept. I did not smell any urine on Resident C.

On 02/08/2024, I interviewed SP6 by telephone. SP6 statements were consistent with those made by SP5.

I reviewed Resident C's service plan. The service plan read,

> *"Toileting: adult briefs. Resident utilizes adult briefs for accidental voids. Briefs are stored (insert location of stored briefs). Staff to report changes in incontinence supply needs to nurse. Usually continent of bladder. (Resident C) does not require assistance with toileting. Staff to report changes in toileting needs to nurse. (Resident C) will need use of grab bar.*
> *Psychosocial: (Resident C) does not have current or history of disruptive, aggressive, verbal or socially inappropriate behavior. Staff to report to nurse if resident is observed to have a change in behavior."*

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	Interviews conducted revealed Resident C is incontinent of urine and can be resistant to care. Review of Resident C's service plan revealed these details were not included in the service plan so that caregivers can ensure the dignity of Resident C is met.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident C's medication is not administered.

INVESTIGATION:

The complainant alleged Resident C did not receive evening medication on 01/30/2024. The complainant alleged family was in Resident C's room until a little after 5:00pm. The complainant alleged family came back to the facility at approximately 7:00pm and the medication technician reported the 5:00pm medications were administered. The complainant alleged family was in the room at 5:00pm and no medications were administered.

SP4 reported she was the medication technician for Resident C on 01/30/2024. SP4 reported Resident C's medications are ordered for 5:00pm. SP4 reported per facility policy, medication technicians have one hour prior to administration time and one hour after administration time to administer medications. SP4 reported on 01/30/2024, around 5:00pm an emergency call light was going off that she responded to. SP4 reported she then went into Resident C's room around 5:30pm to administer medications.

I reviewed Resident C's medication administration record (MAR) for January 2024. The MAR revealed at 5:00pm, Resident C is prescribed Levetiracetam and a multivitamin. The MAR revealed both medications were charted they were administered.

I reviewed camera footage for 01/30/2024. The camera footage revealed SP4 entered Resident C's room with a bottle at approximately 5:40pm. The camera footage revealed SP4 was in the room for approximately five minutes.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.
ANALYSIS:	Interviews conducted and review of documentation revealed lack of evidence to support the allegation Resident C did not receive medication.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of Resident C's service plan revealed lack of detail on Resident C's involvement with hospice. Review of Resident C's service plan revealed the service plan was last updated on 01/23/2023.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	Review of Resident C's service plan revealed the service plan was not updated to reflect involvement with hospice and the service plan was not updated annually.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

02/09/2024

Kimberly Horst — Date
Licensing Staff

Approved By:

02/15/2024

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