GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 11, 2024

Robert Kornfeld
Redford Village MI Wellness LLC
25330 West Six Mile Rd
Redford Charter Twp., MI 48240

RE: License #: AH820410349
Investigation #: 2024A0585018
The Orchards at Redford Village

Dear Robert Kornfeld:

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
PROFANITY USED

I. IDENTIFYING INFORMATION

License #:	AH820410349
Investigation #:	2024A0585018
Complaint Receipt Date:	01/23/2024
Investigation Initiation Date:	01/24/2024
Report Due Date:	03/22/2024
Licensee Name:	Redford Village MI Wellness LLC
Licensee Address:	25330 West Six Mile Rd Redford Charter Twp., MI 48240
Licensee Telephone #:	(718) 838-1500
Administrator:	Zalmen Fishman
Authorized Representative:	Robert Kornfeld
Name of Facility:	The Orchards at Redford Village
Facility Address:	25330 6 Mile Rd Redford Charter Twp, MI 48240
Facility Telephone #:	(313) 531-6874
Original Issuance Date:	06/06/2023
License Status:	REGULAR
Effective Date:	12/06/2023
Expiration Date:	07/31/2024
Capacity:	56
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was assaulted by an employee.	Yes
Additional Findings	No

The complainant identified some concerns that were not related to licensing rules and statues for a home for the aged. Therefore, only specific items pertaining to homes of the aged provisions of care were considered for investigation. The following items were that that could be considered under the scope of licensing.

III. METHODOLOGY

01/23/2024	Special Investigation Intake 2024A0585018
01/24/2024	Special Investigation Initiated - Letter Referral was made to Adult Protective Services (APS).
01/30/2024	Inspection Completed On-site Completed with observation, interview and record review.
02/06/2024	Contact - Document Received Additional allegations received. Added to this intake.
02/07/2024	Contact - Telephone call made. Called administrator Zalmen Fishman for additional information. A message was left to return call.
02/08/2024	Contact - Document Received Additional information received.
02/12/2024	Contact - Document Received Information received involving the facility investigation.
03/12/2024	Exit Conference. Conducted via email.

ALLEGATION:

Resident A was assaulted by an employee.

INVESTIGATION:

On 1/24/2024 and on 2/6/2024, the department received the allegations from Adult Protective Services (APS) via the BCHS Online Complaint website. The complaint alleged that a Resident [A] was on the floor and blood was around him and a staff member admitted to hitting the resident after the resident swung on him.

On 2/29/2024, complaint was received from Adult Protective Services (APS) with the same allegations sent on 1/14/2024 and 2/6/2024. Additionally, the complaint alleged that Resident A was held down in a chair by a staff member and another staff member was there but did not intervene.

On 1/30/2024, an onsite was completed at the facility. I interviewed administrator Zalmen Fishman at the facility who stated that Resident A is a PACE participant. He stated that they have biweekly meetings with PACE regarding all the participants. He stated that they are doing an investigation regarding staff hitting Resident A.

During the onsite, I interviewed Employee #1 who stated that Resident A was having behavioral problems. She said that [Employee #1] allegedly hit Resident A and is suspended pending an investigation. She said that Resident A was hitting a staff and, he chased another resident attempting to grab them. Employee #1 stated that as they were attempting to keep Resident A from hitting the other residents, he pulled away and fell. She said that he ran into the wall. She stated that when the staff called her, she came to the facility with the police and 911 was called. She said that Resident A was sent to the hospital. She said that once the police got to the facility, Resident A had calmed down. She said that Resident A did not have any injuries from the fall. Employee #1 stated that she in the process of completing an investigation regarding a staff hitting Resident A. Employee #1 shared copies of witness statements, suspension documents, inservice sign-in sheets and a copy of her investigation documents. Employee #1 stated that they will be in communication with PACE to find a more suitable facility for Resident A. She said that all staff was in-serviced on dementia care, aggressive residents, and residents' rights.

Statements from staff:

"On 1/23/2024, I witnessed a female resident screaming and she was screaming "he slapped me". Following that he attacked a female aid restrained him and put him in his room. Her name is [Employee #3]. He banged on his door and came back out his room aggressively chasing aid who is currently pregnant. [Resident A] started walking around the halls after trying to attack the aid again which is pregnant. Then he goes back in his room grab a can of pringles and threw it at me, [Employee #3, and Employee #4], then the police came. I called his sister two different times in the midst of the altercation." Signed by Employee #2

"I [Employee #3] was in the dining area at 8 p.m. doing night care. We heard yelling from the room. [Resident A] was in the room with another resident slapping her in

the face. We took the resident out the room. He followed us out and he tried to attack Employee #4 and I told him to go to his room then he came back out and attacked me. I put him back in his room, then he came back in and throwed something at me and my coworkers. The police and Employee #1 arrived." Signed by Employee #3

"Around 8 p.m. we were doing pm care. I heard a resident screaming ...found another resident in Resident A's room scared and told us that she was being smacked by Resident A. He then came into the dining room swinging at me trying to smack me, then [Employee #3] was standing near and he swung on her, and she restrained him and put him in his room. He started banging on the door coming back out aggressive and started walking around throwing things. We called and notified family and [Employee #1]. [Employee #1 approached with police, and they took him." Signed by Employee #4.

"When I came in the back, the workers were saying one of the residents scream so I went to go check and [Resident B] was scared like he was hitting her." Signed by Employee #5

Email was received from Mr. Zalmen that Employee #1 has been terminated from the facility. The email shows that immediate action was taken which involved: employee removed scheduled pending investigation, statements obtained from staff, staff in-service on abuse policy and types of abuse, staff training on management of resident behaviors, and staff in-serviced on copy cell phone and video recording policy.

Documents of the incident noted, "on 2/20/2024, videoed incident of an assumed physical altercation between resident [A] and employee was submitted from an unknown source to Employee #1. The assumed date of the incident is 1/23/2024 occurring between 8-9 pm. Video footage displayed an aggressive resident [A] being restrained by an employee [3]. Other employees visibly and audibly present on video are Employee #2, Employee #3, Employee #4 and Employee #5."

A video of the incident was sent to me for review. The video showed the following:

> Employee #3, the female staff member, is visible holding Resident A down on a chair with both hands behind his back. Employee #3 grabbed Resident A around his neck holding him down in the chair.
>
> Employee #2, a male staff member, did not try to intervene, but you can hear a male voice and other staff members laughing in the background.
>
> Employee #2 then started yelling for Employee #3, who was restraining Resident A, to let Resident A up. Employee #3 told Employee #2, not to record her.

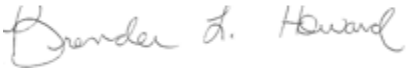
Resident A was screaming for his "daddy." Employee #3 asked Resident A if he was going to "chill out" and Resident A replied, "I'm going to chill out." Then Employee #3 let Resident A up. Employee #2, who recorded the video stated, "that nigga's mouth is bleeding" and Employee #3 replied, "I didn't give a fuck what happened to him.".

APPLICABLE RULE	
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 rights; 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, or physician's assistant. In the 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 Resident A swung on the staff and the staff hit him. The staff was found to be Employee #2. A review of a video showed that Employee #3 was restraining Resident A with both hands behind his back and then proceeded to put her hands around his neck holding him down in a chair. Employee #3 did not restrain Resident A in a dignified manner. It did not appear that Employee #3 took the proper steps to assist with Resident A's behavior during this episode. Another employee recorded the incident and did not assist with Resident A. The employees were terminated for other reasons and not for the current incident regarding Resident A. The facility did not comply with this rule of protection.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



03/11/2024

Brender Howard Date
Licensing Staff

Approved By:

03/11/2024

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