GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 22, 2024

Mark McNeary
Midland Retirement, LLC
PO Box 1359
Aberdeen, SD 57402

RE: License #: AH560387542
Investigation #: 2024A1035008
Primrose of Midland

Dear Mr. McNeary:

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) 241-1970.

Sincerely,

Jennifer Heim, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(313) 410-3226

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH560387542
Investigation #:	2024A1035008
Complaint Receipt Date:	11/20/2023
Investigation Initiation Date:	11/27/2023
Report Due Date:	01/26/2024
Licensee Name:	Midland Retirement, LLC
Licensee Address:	815 N 2nd Street Aberdeen, SD 57401
Licensee Telephone #:	Unknown
Administrator:	Jennifer Rockafellow
Authorized Representative:	Mark McNeary
Name of Facility:	Primrose of Midland
Facility Address:	5600 N. Waldo Road Midland, MI 48640
Facility Telephone #:	(989) 575-3255
Original Issuance Date:	05/31/2019
License Status:	REGULAR
Effective Date:	11/30/2023
Expiration Date:	11/29/2024
Capacity:	106
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Discharge without proper notice.	Yes
Additional Findings	No

III. METHODOLOGY

11/20/2023	Special Investigation Intake 2024A1035008
11/27/2023	Special Investigation Initiated - Letter
11/29/2023	Contact – Documents Received
01/17/2024	Contact – Onsight investigation
01/18/2024	Contact – Additional Information Requested from Complainant
01/19/2024	Contact – Additional Information Received
03/05/2024	Exit Conference Conducted by phone with AR Mark McNeary

ALLEGATION:

Discharge without proper notice.

INVESTIGATION:

On November 27, 2023, the department received a complaint through the online complaint system which read: "Resident A is a patient at Brightwell Behavioral Health's geriatric inpatient psychiatric unit currently. BBH is an acute care unit, responsible for stabilizing patients experiencing mental health crises. Resident A was admitted to BBH on 11/7/2023 following an incident of aggression at Primrose. I had a discussion with Lakeen on 11/8 where she said she was unsure if they would accept the patient back to their facility and would meet with her regional team. On 11/9 Lakeen reported "at worst case" they would not accept him permanently but would allow him back and see how things went and allow family time to find alternative placement if needed. On 11/14 I spoke with Lakeen, she reported she wasn't sure what the process would look like for the patient to return. On 11/16 Lakeen reported he can return with a 1:1 provided by family once cleared for discharge. Lakeen confirmed this on 11/21 when the patient was cleared. On 11/22,

Lakeen reported they will not accept the patient back leaving him in a placement crisis."

On November 27, 2023, writer requested Resident A's Incident report related to incident occurring on November 6, 2023, progress notes, MAR, admission contract, service plan, and discharge policy.

On November 29, 2023, facility provided Resident A's Occupancy agreement, progress notes, initial assessment, MAR, and program statement. Upon thorough review of documents provided Resident A was admitted on November 3, 2023. Initial resident evaluation was completed at 16:17 11/3/2023 which indicated Resident A summary triggers "resident uses anti-psychotic medications, agitation, anxious, fluctuates emotionally, requires regular prompting due to confusion and disorientation." Upon admit Resident A had orders for scheduled and PRN medication to assist with mood and behaviors. PRN medication ordered for every six hours as needed that was administered three times from admit to emergency department transfer. Initial progress note states family request Resident A receive PRN Ativan to assist with transition and decrease behaviors. On November 6, 2023, around 1300 it was noted Resident A became agitated, multiple calls made to family as the behaviors increased, resident started punching walls and punching fist together. Resident A was given PRN Ativan and redirected. At approximately 1826 the DON was notified Resident A was observed in another resident's room and was escorted out. Staff escorting resident out of room noted blood on Resident A's hands. Resident A exhibited increase agitation and verbal behavior during this time according to progress notes. Resident A was sent to emergency department for further evaluation around 2130.

On January 17, 2024, an onsite investigation was conducted. While onsite I interviewed Lakeen Arndt Director of Nursing and Jennifer Rockafellow Executive Director. Lakeen reported that Resident A was sent to "geriatric psychiatric facility" to stabilize behaviors and medication after Resident A had increased behaviors and an altercation with Resident B. Writer requested investigation or documentation related to altercation, writer was informed this was an internal document and will not be disclosed. Lakeen disclosed Resident B name that was involved in altercation. Resident B progress notes and service plan requested. Upon review of Resident B progress notes it was noted Resident B sustained an injury that required ten sutures with no indication of altercation with Resident A. Police department notified of incident and investigated. Police report was received and reviewed. Assigned State Licensure employee notified of incident.

On January 19, 2024, Brightwell Behavioral Health provided Resident A's progress notes which indicated stabilization of medication and behaviors. Notes indicate Resident A was cleared to return to Primrose of Midland on November 15, 2024, returning to facility on Friday November 19, 2024. Resident A's discharge was delayed related to an IM PRN being administered. On November 20, 2024, Lakeen was informed Resident A was cleared to return to Primrose of Midland with a transfer

date on Wednesday November 22,2024. On November 21, 2024, Lakeen notified Brighten Behavioral Health the facility had positive COVID-19 residents and Resident A would need to remain at Brighton Behavioral Health with a five-day isolation prior to return. On November 22, 2024, family reported to Brighten Behavioral Health they had been informed by Lakeen that Resident A would not be permitted to return to Primrose of Midland and was provided two options for placement.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(15) A home may discharge a resident before the 30-day notice if the home has determined and documented that either, or both, of the following exist: **(a) Substantial risk to the resident due to the inability of the home to meet the resident's needs or due to the inability of the home to assure the safety and well-being of the resident, other residents, visitors, or staff of the home.**

ANALYSIS:	Upon thorough review of documentation and interview it is determined the facility did not follow facility policy and provide proper discharge notice. According to Occupancy agreement "Primrose may transfer or discharge a Resident for any of the following: medical reason, his or her welfare or that of other Residents, For non-payment of his or her stay Upon a Thirty (30) day notice. Upon Less Than a Thirty (30) day Notice Primrose may terminate this agreement with less than 30 days' notice if it has been determined and documented that either, or both, of the following exist: i. Substantial risk to the Resident due to the inability of the Home to meet the Residents' needs due to inability of the Home to assure the safety and well-being of the Resident, other Residents, Visitors, or Staff of the Home. ii. A substantial risk or an occurrence of the destruction of property Primrose will provide not less than 24 hours verbal notice and issued in writing before discharge stating the reason for the discharge, including substantial risk, alternative to discharge that have been attempted, if any; location resident will be discharged; the right of the resident to file a complaint with the department. The notice will be provided to the Resident, his or her authorized representative, and responsible agency for Resident placement." Violation established related to not providing discharge notification according to facility Occupancy Agreement.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

01/23/2024

Jennifer Heim — Date

Licensing Staff

Approved By:

02/22/2024

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