GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 30, 2024

Julie Norman
Farmington Hills Inn
30350 W. Twelve Mile Road
Farmington Hills, MI 48334

RE: License #: AH630236784
Investigation #: 2024A1027091
Farmington Hills Inn

Dear Ms. Norman:

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 877-458-2757.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AH630236784 |
| | |
| **Investigation #:** | 2024A1027091 |
| | |
| **Complaint Receipt Date:** | 09/09/2024 |
| | |
| **Investigation Initiation Date:** | 09/10/2024 |
| | |
| **Report Due Date:** | 11/08/2024 |
| | |
| **Licensee Name:** | Alycekay Co. |
| | |
| **Licensee Address:** | 30350 W 12 Mile Rd.<br>Farmington Hills, MI 48334 |
| | |
| **Licensee Telephone #:** | (248) 851-9640 |
| | |
| **Authorized Representative/ Administrator:** | Julie Norman |
| | |
| **Name of Facility:** | Farmington Hills Inn |
| | |
| **Facility Address:** | 30350 W. Twelve Mile Road<br>Farmington Hills, MI 48334 |
| | |
| **Facility Telephone #:** | (248) 851-9640 |
| | |
| **Original Issuance Date:** | 12/29/2000 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 08/01/2024 |
| | |
| **Expiration Date:** | 07/31/2025 |
| | |
| **Capacity:** | 137 |
| | |
| **Program Type:** | ALZHEIMERS<br>AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Employee #1 verbally abused Resident A, and overmedicated residents. | No |
| Additional Findings | Yes |

Complaint investigations are limited to allegations within the past year; therefore, allegations not within that timeframe were not investigated.

## III. METHODOLOGY

| | |
|---|---|
| 09/09/2024 | Special Investigation Intake<br>2024A1027091 |
| 09/10/2024 | Special Investigation Initiated - Letter<br>Email sent to Julie Norman requesting documentation for Employee #1 |
| 09/12/2024 | Contact - Document Received<br>Email from Ms. Norman received with requested information |
| 09/16/2024 | Inspection Completed On-site |
| 09/16/2024 | Inspection Completed-BCAL Sub. Compliance |
| 09/17/2024 | Contact - Telephone call made<br>Voicemail left for Relative A1 |
| 09/30/2024 | Exit Conference<br>Conducted by email with Julie Norman |

**ALLEGATION:**

**Employee #1 verbally abused Resident A, and overmedicated residents.**

**INVESTIGATION:**

On 9/9/2024, the Department received allegations from Adult Protective Services (APS) accusing Employee #1 of verbally abusing Resident A, who reportedly has a restraining order against Employee #1. Additionally, the allegations claim that Employee #1 overmedicated three different residents, leading to their deaths, with concerns that these overdoses might have been intentional.

An on-site inspection was previously conducted on 6/14/2024, in response to a complaint alleging that Employee #1 had cursed at and abused residents. At that time, Employee #1's file was reviewed, confirming her eligibility for employment, completion of required training, and that she had received disciplinary action on 2/13/2023, which included education on the Resident Abuse policy.

On 9/12/2024, email correspondence with administrator Julie Norman and authorized representative confirmed that neither Ms. Norman nor Employee #2 had received any complaints regarding Employee #1's care or medication administration. The email noted that last month, Ms. Norman had discussed a concern with a family member about Employee #1 not allowing sufficient time for a resident to respond before entering his room. Employee #1 has been verbally reminded of the importance of respecting residents' privacy.

On 9/16/2024, I conducted an on-site inspection and interviewed staff.

Julie Norman, the authorized representative and administrator, reported that Resident A has been at the facility for an extended period and that she had not been notified of any restraining order against Employee #1. Ms. Norman clarified that while Employee #1 administers Resident A's medications, she does not typically provide direct care.

Ms. Norman also mentioned that Relative A1 is currently Resident A's guardian. However, Resident A recently requested that this guardianship be revoked, and the court's decision on this matter was unknown at this time.

Ms. Norman expressed no concerns about Employee #1's medication administration, describing Employee #1 as a "*phenomenal caregiver*" who is well-regarded by families and who works with residents on hospice services, administering medications as per physician orders. Additionally, Ms. Norman noted that no residents have recently passed away in Employee #1's assigned hallway.

Employee #2's statements were consistent with Ms. Norman's account.

When interviewed, Resident A stated, "*I don't have that*" in response to questions about a restraining order and did not express concerns regarding the care staff. Resident A indicated that she didn't need a guardian as per the court's directive.

While on-site, I examined the controlled substance narcotic forms and medication records for each resident on medication cart #1, where Employee #1 frequently worked. The records showed that Employee #1 consistently signed the forms, and the narcotic counts appeared to be accurate.

During the on-site, Resident A's file showed that she moved into the facility on 8/3/2022, which was before the period related to some of the allegations. The file

indicated that Relative A1 was her legally appointed guardian but did not include any information about a restraining order.

A review of Employee #1's file revealed no disciplinary actions related to medication administration, consistent with the findings from a prior review in June 2024.

On 9/17/2024, I left a voicemail with Relative A1 with no return call received.

| **APPLICABLE RULE** | |
|---|---|
| **MCL 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 right; 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:**<br>**(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:** | Staff attestations, an interview with Resident A, and a review of facility records all indicated a lack of evidence that Employee #1 physically harmed residents during medication administration. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

An examination of the facility's Controlled Substance Narcotic Forms for medication carts #1 and #4 revealed several deficiencies. Specifically, the logs were often incomplete: staff did not consistently sign to verify narcotic counts were completed or perform narcotic counts. Furthermore, for medication cart #4, the Controlled Drug Receipt/Proof-of-Use/Disposition Forms were frequently missing dates, quantities of medication, and staff signatures.

| **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:** | Review of narcotic count logs and controlled substance forms revealed they were incomplete; therefore, a violation was substantiated for this rule. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

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

Jessica Rogers 09/23/2024

Jessica Rogers Date
Licensing Staff

Approved By:

Andrea L. Moore 09/30/2024

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