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 #: 2024A1027092
Farmington Hills Inn

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. 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 #:	2024A1027092
Complaint Receipt Date:	09/11/2024
Investigation Initiation Date:	09/11/2024
Report Due Date:	11/10/2024
Licensee Name:	Alycekay Co.
Licensee Address:	30350 W 12 Mile Rd. 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 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:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff harmed and overmedicated residents.	No
Additional Findings	Yes

A violation of R 325.1932(2) concerning incomplete controlled substance forms was substantiated in Special Investigation Report 2024A1027091 and was conducted concurrently with this investigation.

III. METHODOLOGY

09/11/2024	Special Investigation Intake 2024A1027092
09/11/2024	Special Investigation Initiated - Letter Email sent to Julie Norman requesting documentation
09/12/2024	Contact - Document Received Email received from Julie Norman with requested documentation
09/16/2024	Inspection Completed On-site
09/23/2024	Contact - Document Sent Email sent to Ms. Norman requesting follow up documentation
09/26/2024	Contact – Document Received Email received from Ms. Norman
09/30/2024	Exit Conference Conducted by email with Julie Norman

ALLEGATION:

Staff harmed and overmedicated residents.

INVESTIGATION:

On 9/11/2024, the Department received allegations from Adult Protective Services (APS) concerning the mistreatment of residents. The allegations read on 9/3/2024, it was reported that Resident A, who has dementia, was given edible marijuana chocolates by Employee #1. Following this, Resident A fell, resulting in a black eye

and bloody nose. There were also claims that Resident A was neither sent to the hospital nor was her authorized representative informed of the incident.

Further allegations from APS indicated that Employee #2 intentionally overmedicated Resident B, who was subsequently taken to Beaumont Hospital. It was reported that Employee #2 admitted to bringing her own medications to the facility and selling them.

Additional allegations received from APS reported that Resident C, also diagnosed with dementia, was found with bruising on her left arm. It was alleged that Employee #3 had grabbed and yelled at Resident C. Despite being under investigation, Employee #3 was still employed at the facility.

On 9/12/2024, I received an email from administrator and authorized representative Julie Norman, which included the employee list and resident census. Resident B, Employee #1, and Employee #3 were not listed in the provided documents.

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

> Julie Norman, the authorized representative and administrator, reported that Resident A was very agitated and attempted to leave, prompting staff to contact Relative A1, the responsible party. Ms. Norman stated that Relative A1 brought in "*THC Crispy Wafer Bites*," and indicated she had used them before. Ms. Norman noted that Resident A experienced a fall the following week, after which she was evaluated by her physician and started on a new medication. Additionally, Ms. Norman clarified that Employee #1 did not provide resident care but was responsible for admissions and marketing.
>
> During an interview, Employee #4 confirmed Ms. Norman's account, explaining that Relative A1 brought in the wafers and were administered under her supervision on 8/30/2024. Employee #4 stated Resident A fell on 9/3/2024. While on-site, I reviewed Resident A's face sheet and an incident report dated 9/3/2024, which corroborated the staff statements. The report indicated that Relative A1 was notified of the incident on 9/3/2024 at 2:35 PM and emergency medical services was contacted at 3:15 PM.
>
> Regarding Resident B and Employee #2, Ms. Norman stated that Resident B resided in the memory care unit and was sent to the hospital, but this was not related to his medication. She also noted that Employee #2 had no disciplinary actions in her file and was trained on all medication carts. Ms. Norman expressed that she was unaware of any staff bringing in personal medications for sale.
>
> I interviewed Employee #2, who explained that Resident B was not feeling well, leading to his transfer to the hospital, during which he did not receive his medications that morning. Employee #2 stated that Resident B's power of attorney was notified by phone about his transfer and that he returned later that afternoon. She confirmed that Resident B had as-needed medications prescribed

but did not require them at that time. Employee #2 mentioned she maintained insulin for her diabetes in her car but never brought it into the facility or sold it.

While on-site, I reviewed Resident B's medication administration records and the narcotic count log, which showed that staff initialed his medications as prescribed.

Additionally, Employee #4 reported having no concerns regarding Employee #2's medication administration practices and was not aware of any staff bringing in personal medications for sale.

Concerning Resident C and Employee #3, Ms. Norman stated that on 9/4/2024 or 9/5/2024, Relative C1 notified her about bruising on Resident C. Ms. Norman reviewed four days of video footage from hallway cameras and found no suspicious activity around Resident C's room. The cause of the bruising remained unknown. Ms. Norman completed the investigation on 9/13/2024; however, Employee #3 had resigned during her training period and the investigation. Review of Employee #3's file revealed were no disciplinary actions in her file and training records were dated 8/12/2024.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	Staff attestations, observations and review of facility documentation revealed there was lack of evidence to support that staff harmed and overmedicated residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of Employee #3's file indicated that there was no verification of a completed Workforce Background Check. An interview with Ms. Norman revealed that Employee #3 had been working under staff supervision prior to her resignation, and the background check was still pending.

On 9/25/2024, Ms. Norman emailed to inform me that she could not locate Employee #3's Workforce Background Check.

APPLICABLE RULE	
R 333.20173a	**Covered facility; employees or applicants for employment; prohibitions; criminal history check; procedure; conditional employment or clinical privileges; knowingly providing false information as misdemeanor; prohibited use or dissemination of criminal history information as misdemeanor; review by licensing or regulatory department; conditions of continued employment; failure to conduct criminal history checks as misdemeanor; storage and retention of fingerprints; notification; electronic web-based system; definitions.**
	(5) If a covered facility determines it necessary to employ or grant clinical privileges to an applicant before receiving the results of the applicant's criminal history check or criminal history record information under this section, the covered facility may conditionally employ or grant conditional clinical privileges to the individual if all of the following apply: **(a) The covered facility requests the criminal history check or criminal history record information under this section upon conditionally employing or conditionally granting clinical privileges to the individual.** **(b) The individual signs a statement in writing that indicates all of the following:** **(i) That he or she has not been convicted of 1 or more of the crimes that are described in subsection (1)(a) to (g) within the applicable time period prescribed by each subdivision respectively.** **(ii) That he or she is not the subject of an order or disposition described in subsection (1)(h).** **(iii) That he or she has not been the subject of a substantiated finding as described in subsection (1)(i).** **(iv) That he or she agrees that, if the information in the criminal history check conducted under this section does not confirm the individual's statements under subparagraphs (i) to (iii), his or her employment or clinical privileges will be terminated by the covered facility as required under subsection (1) unless and until the individual appeals and can prove that the information is incorrect.** **(v) That he or she understands that the conditions described in subparagraphs (i) to (iv) may result in the**

	termination of his or her employment or clinical privileges and that those conditions are good cause for termination.
ANALYSIS:	Since Employee #3 did not have a Workforce Background Check during her employment at the facility, a violation was substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

09/26/2024

Jessica Rogers Date
Licensing Staff

Approved By:

09/30/2024

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