GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 13, 2024

Sheila Pruzinsky
Rose Senior Living - Clinton Township
44003 Partridge Creek Blv
Clinton Township, MI 48038

RE: License #: AH500337370
Investigation #: 2024A0585083
Rose Senior Living - Clinton Township

Dear Sheila Pruzinsky:

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

I. IDENTIFYING INFORMATION

License #:	AH500337370
Investigation #:	2024A0585083
Complaint Receipt Date:	09/16/2024
Investigation Initiation Date:	09/17/2024
Report Due Date:	11/16/2024
Licensee Name:	Rose Senior Living - Clinton Township
Licensee Address:	PO Box 2011 38525 Woodward Avenue Bloomfield Hills, MI 48303-2011
Licensee Telephone #:	(651) 766-4371
Authorized Representative/Administrator:	Shelia Pruzinsky
Name of Facility:	Rose Senior Living - Clinton Township
Facility Address:	44003 Partridge Creek Blv Clinton Township, MI 48038
Facility Telephone #:	(586) 840-0840
Original Issuance Date:	10/01/2014
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	127
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was not checked on for hours and was found on the floor faced down.	No
Additional Findings	No

III. METHODOLOGY

09/16/2024	Special Investigation Intake 2024A0585083
09/17/2024	Special Investigation Initiated - Telephone Contacted complainant to discuss allegations.
09/17/2024	APS Referral Emailed referral to Adult Protective Services (APS).
09/17/2024	Inspection Completed On-site Completed with observation, interview and record review.
09/17/2024	Inspection Completed – BCAL Sub. Compliance.
11/13/2024	Exit Conference. Conducted via email to authorized representative Shelia Pruzinsky.

ALLEGATION:

Resident A was not checked on for hours and was found on the floor faced down.

INVESTIGATION:

On 9/16/2024, the department received this complaint via BCAL online complaint system. The complaint alleged that Resident A was left unattended for over seven hours. The complaint alleged that staff did not do the two-hour rounds.

On 9/17/2024, a referral was made to Adult Protective Services (APS).

On 9/17/2024, I interviewed the complainant by telephone. The complainant stated that there is a camera in the room of Resident A. The complainant stated that on 9/12/2024, Resident A was put in bed around 7:00 p.m., and at 9:45 p.m. was the last time staff was actually in her room when they were dropping off laundry. She said that no one came back to Resident A's room to check on her until 4:00 a.m. in the morning and discovered her on the floor. The complainant explained that at 1:09 a.m., the camera footage showed Resident A almost completely out of the bed and then no other footage of someone coming in until 4:00 a.m. when a nurse aide discovered her on the floor. The complainant stated that although Resident A was discovered on the floor at 4:00 a.m., she was not notified until 7:00 a.m. The complainant stated that she was told that staff peeped in on Resident A. She said that the staff that peeped in did not walk over to Resident A to have physical contact with her.

On 9/17/2024, an onsite was completed at the facility. The administrator Shelia Pruzinsky was not at the facility today. I interviewed Employee #1 who stated that staff document in the system when they do rounds.

On 9/17/2024, I interviewed Employee #2 at the facility. Employee #2 stated that Resident A had a fall. She said that the family have a camera in the room. She stated that they reviewed their camera, and it revealed that staff did go in the room. She said that when the staff when in Resident A's room, they found her sleeping. She said the last time resident was checked on was at 1:07 a.m. and the next time they checked on her were at 4:13 a.m. She said that Resident A was on 2-3 hour checks. She said that the midnight shift supervisor (Employee #5) checked Resident A's vitals and she did not have any injuries.

On 9/17/2024, I interviewed Employee #3 at the facility. Employee #3's statements were consistent with Employee #2 regarding the incident. Employee #3 stated that staff did an assessment to make sure Resident A was okay and then they contacted the family.

On 9/17/2024, I interviewed Employee #4 at the facility. Employee #4's statement was consistent with Employee #2 regarding the incident. Employee #4 stated that Resident A's POA was called. He said that if it is a non-emergency (no injuries), some families don't want to be called that time of morning, they call later in the day and would not have called at 4:00 a.m.

On 9/18/2024, I interviewed Employee #5 by telephone. Employee #5 stated that she went in the room at 4:00 a.m. and found Resident A on the floor. She said that Resident A is monitored every two hours and the last time she was seen was at 2:00 a.m. in the bed. She explained that when they monitor residents, they go in the room and make sure they are in the bed. She said they updated the service plan, adding the hourly rounds. She said that their view showed the staff go into the room, but the family view of their camera showed nobody came over near the resident.

On 10/4/2024, I interviewed Ms. Pruzinsky by telephone. Ms. Pruzinsky stated that Resident A was checked on during the time of the incident. She said that Resident A was found on the mat, and she did not have any injuries. She explained that sometimes staff go into residents' rooms and if they are sleeping, they don't disturb them, but just look in at them to make sure that they are safe. Ms. Pruzinsky explained that upon review of Resident A's fall from bed without sustained injuries, her service plan was tweaked on 9/13, to hourly rounds during the night. That does not go back to 6/24/24 and they do not normally do hourly rounds, frequent rounds are appropriate. She shared copies of the previous Resident A's service plan, as well as the updated plan.

Service plan for Resident A dated 12/26/2023 read, "admitted to the facility on 10/23/2016. History of falls, has a history of getting up from sitting position and either transfer into wheelchair or walk, she is weak and unable to do so. Keep in a highly visible place when wake and frequent checks in bed."

Service plan for Resident A dated 06/27/2024 read in part, "*Potential or Actual risk for falls/injuries*: history of falls has a history of attempting to get up from a sitting position and either transfer into w/c (wheelchair) or walk. She is weak and unable to do so. Keep in a highly visible place when awake. Frequent checks when in bed, try and position her in the middle of the bed and not near the edge." In the section for *wellness check* it read, "24/7 safety rounds. Staff to make hourly rounds to make sure resident is safe and comfortable. If resident is in bed, staff to check on resident and make sure resident is in bed and reposition if needed to avoid falls. Every 1 hour daily."

The updated service plan read, "24/7 safety rounds. Staff to make increase in rounds during the night as necessary or when highly anxious (10-7-24) to make sure resident is safe and comfortable. If resident is in bed, staff to check on resident and make sure resident is in bed and reposition if needed to avoid falls. 3 times daily."

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.

R 325.1901	**Definitions.**
	(t) "Service plan" means a written statement prepared by the home in cooperation with a resident, the resident's authorized representative, or the agency responsible for a resident's placement, if any, that identifies the specific care and maintenance, services, and resident activities appropriate for the individual resident's physical, social, and behavioral needs and well-being, and the methods of providing the care and services while taking into account the preferences and competency of the resident.
ANALYSIS:	Resident A had an unwitnessed fall on 9/13/2024 where she was discovered on the floor. One staff indicated that Resident A was last seen in her bed at 2:00 a.m. and was discovered on the floor when staff went on rounds at 4:00 a.m. Another staff indicated that Resident A was last seen at 1:07 a.m. and was found at 4:13 a.m. The service plan dated 6/27/2024, indicated that staff is to make hourly rounds to make sure resident is safe and comfortable; if the resident is in bed, staff to check on resident and make sure resident is in bed and reposition if needed to avoid falls. It was revealed that staff did not provide wellness check every hour as indicated on the service plan. Therefore, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

11/13/2024

Brender Howard Date
Licensing Staff

Approved By:

11/13/2024

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