GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 28, 2025

Katie Edwards
Symphony of Linden Health Care Center, LLC
30150 Telegraph Rd
Suite 167
Bingham Farms, MI 48025

RE: License #:	AL250281706
Investigation #:	2025A0872025
	Monet House Inn

Dear Katie Edwards:

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) 643-7960.

Sincerely,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL250281706
Investigation #:	2025A0872025
Complaint Receipt Date:	02/04/2025
Investigation Initiation Date:	02/04/2025
Report Due Date:	04/05/2025
Licensee Name:	Symphony of Linden Health Care Center, LLC
Licensee Address:	7257 N. Lincoln Lincolnwood, IL 60712
Licensee Telephone #:	(810) 735-9400
Administrator:	Katie Edwards
Licensee Designee:	Katie Edwards
Name of Facility:	Monet House Inn
Facility Address:	202 S. Bridge Street Linden, MI 48451
Facility Telephone #:	(810) 735-9400
Original Issuance Date:	06/25/2008
License Status:	REGULAR
Effective Date:	08/08/2023
Expiration Date:	08/07/2025
Capacity:	20
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
On 01/31/2025, a family member visited with Resident A for over 5 hours and only one staff was working. Concerns of inadequate staffing at this facility.	Yes
On 01/30/2025, Resident A was in the dining room alone at 2:30pm. Resident A was not acting normal, so family requested she be sent to the hospital where it was determined she had had a stroke. Concern of inadequate care of Resident A.	No

III. METHODOLOGY

02/04/2025	Special Investigation Intake 2025A0872025
02/04/2025	Special Investigation Initiated - Letter I exchanged emails with Relative A1
02/04/2025	APS Referral I made an APS complaint via email
02/11/2025	Inspection Completed On-site Unannounced
02/14/2025	Contact - Document Sent I emailed the licensee designee requesting information related to this complaint
02/17/2025	Contact - Document Received Documentation received from LD Edwards
03/26/2025	Contact - Document Sent I exchanged emails with Relative A1
03/26/2025	Contact - Document Received Documentation received from LD Edwards
03/28/2025	Contact - Telephone call made I interviewed staff Chelsea Sipili
03/28/2025	Contact - Telephone call made I interviewed Relative A2

03/28/2025	Contact - Document Received I received a copy of Resident A's death certificate
03/28/2025	Contact - Telephone call made I interviewed the Compassus director of clinical services, Janet Johnson
03/28/2025	Inspection Completed-BCAL Sub. Compliance
03/28/2025	Exit Conference I conducted an exit conference with the licensee designee, Katie Edwards

ALLEGATION: On 01/31/2025, a family member visited with Resident A for over 5 hours and only one staff was working. Concerns of inadequate staffing at this facility.

INVESTIGATION: On 02/03/2025, I exchanged emails with Relative A1. According to Relative A1, on 01/31/2025, she observed staff Chelsea Sipili working alone in the facility for five hours. Relative A1 said that Staff Sipili told her that she had been working alone the entire shift.

On 02/11/2025, I conducted an unannounced onsite inspection of Monet House Inn. I met with Resident A in the dining room of the facility where she had just finished lunch. Resident A was sitting at the table with two other residents, and I observed approximately 10 residents in the dining hall. All residents were being supervised by two staff during my inspection. I attempted to interview Resident A, but she was unable to participate in an interview. One of the other residents told me that Resident A cannot answer any questions. Resident A appeared to be clean and dressed appropriately as were the other residents I observed.

On 02/18/2025, I received AFC documentation related to this complaint. Resident A was admitted to this facility on 12/03/2024. As of 02/14/2025, there were 18 residents residing in Monet House Inn. I reviewed Resident A’s Health Care Appraisal dated 2/17/2025. Resident A is diagnosed with recurrent falls, poly osteoarthritis, essential hypertension, hyperlipidemia, dementia, physical debility, and she has a history of rhabdomyolysis. Resident A was observed to have adequate hygiene, she uses a wheelchair for mobility, and she receives hospice services.

According to Resident A’s Assessment Plan dated 12/03/2024, she requires limited assistance with bed mobility, transferring, personal hygiene, dressing, and toileting. Resident A uses a 4-wheel walker and needs physical help during bathing. Resident A wears pull ups, and incontinence pads due to occasional incontinence.

On 03/26/2025, I emailed the licensee designee, Katie Edwards requesting more information related to this complaint. LD Edwards emailed information and provided clarifying information about the staff schedule for Monet House Inn on 01/30/2025 and 01/31/2025. I reviewed the staff schedule, employee timecards, and the daily log for Monet House Inn for 01/30/2025 and 01/31/2025.

On 01/30/25, Ivory Selvy and Amanda Gow were scheduled to work from 6am-6pm. Staff Selvy's timecard showed that she worked from 5:53am – 6:24pm. Staff Gow's timecard showed that she worked from 5:58am – 6:20pm. LD Edwards said that in addition to Staff Selvy and Staff Gow, staff Rashanda Benedict also worked on 01/30/25 from 7:24am – 12:30pm. I verified this information from Staff Benedict's timecard.

01/30/2025, Andrew "Jacob" Niver and Termica Bryant were scheduled to work from 6pm-6am. Staff Niver's timecard showed he worked from 6:31pm – 6:14am. Staff Bryant's timecard showed she worked from 6:07pm – 6:09am.

On 01/31/2025, Ivory Selvy and Chelsea Sipili were scheduled to work from 6am-6pm. Staff Sipili's timecard corroborated that she worked from 5:53am – 6:24pm. Staff Selvy's timecard shows she clocked in at 5:55am and clocked out at 4:15pm. LD Edwards said that since Staff Selvy left early that day, the night shift supervisor (NS), Kesha Harris covered the remainder of Staff Selvy's shift. I reviewed NS Harris's timecard for 01/31/25 and noted that she clocked in at 8:02am and clocked out at 5:34pm.

On 01/31/2025, Heaven Peterson and Marie Darius were scheduled to work from 6pm-6am. Staff Peterson's timecard shows she worked from 6:05pm – 6:05am. Staff Darius's timecard shows she worked from 6:09pm – 6:21am.

On 03/28/2025, I interviewed Relative A2 via telephone. Relative A2 said that she is not aware that Monet House Inn was having staffing issues, and she is not aware of staff having to work the floor alone.

On 03/28/2025, I interviewed staff Chelsea Sipili via telephone. I reviewed the allegations with Staff Sipili and she confirmed that she worked alone in Monet House Inn on 01/31/2025 for approximately three hours. Staff Sipili told me that her co-worker left early that day, leaving her alone caring for the residents. Staff Sipili confirmed that Monet House Inn has 18 residents and some of them require 2-person assistance. Staff Sipili said that for several months, Monet House Inn was having staffing issues which led to only one staff on the floor at times. Staff Sipili told me that the staffing issue has been addressed, and management is now scheduling three staff per shift at this location.

On 03/28/2025, I conducted an exit conference with the licensee designee (LD), Katie Edwards, via telephone. I discussed the results of my investigation and explained which rule violation I am substantiating. LD Edwards said that she has been working with her corporate office to address staffing issues at this facility. LD Edwards stated that moving forward, she plans on scheduling three staff per shift at Monet House Inn to make sure

all resident needs are being met. LD Edwards agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours.
ANALYSIS:	As of 02/14/2025, there were 18 residents residing in Monet House Inn. According to Relative A1, on 01/31/2025, she observed staff Chelsea Sipili working alone in the facility for five hours. Relative A1 said that Staff Sipili told her that she had been working alone the entire shift. On 01/30/2025, Staff Ivory Selvy clocked out at 6:24pm and Staff Amanda Gow clocked out at 6:20pm. Staff Niver clocked in at 6:31pm and Staff Bryant clocked in at 6:07pm. Therefore, there was only one staff (Staff Bryant) working from 6:24pm – 6:31pm. On 01/31/2025, Staff Sipili clocked out at 6:24pm and Staff Harris clocked out at 5:34pm. Staff Peterson clocked in at 6:05pm and Staff Darius clocked in at 6:09pm. Therefore, there was only one staff (Staff Sipili) working from 5:34pm – 6:05pm. Staff Sipili confirmed that on 01/31/2025, for approximately three hours, she was the only caregiver caring for 18 residents at this facility. Staff Sipili told me that for several months, Monet House Inn was having staffing issues and she often had to work on the floor alone. I conclude that there is sufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: On 01/30/2025, Resident A was in the dining room alone at 2:30pm. Resident A was not acting normal, so family requested she be sent to the hospital where it was determined she had had a stroke. Concern of inadequate care of Resident A.

INVESTIGATION: On 02/11/2025, I conducted an unannounced onsite inspection of Monet House Inn. I met with Resident A in the dining room of the facility where she had just finished lunch. Resident A was sitting at the table with two other residents, and I observed approximately 10 residents in the dining hall. All residents were being supervised by two staff during my inspection. I attempted to interview Resident A, but she was unable to participate in an interview. One of the other residents told me that Resident A cannot answer any questions. Resident A appeared to be clean and dressed appropriately as were the other residents I observed.

On 02/18/2025, I received AFC documentation related to this complaint. Resident A was admitted to this facility on 12/03/2024. I reviewed Resident A's Health Care Appraisal dated 2/17/2025. Resident A is diagnosed with recurrent falls, poly osteoarthritis, essential hypertension, hyperlipidemia, dementia, physical debility, and she has a history of rhabdomyolysis. Resident A was observed to have adequate hygiene, she uses a wheelchair for mobility, and she receives hospice services.

I reviewed a facility staff incident report regarding Resident A dated 01/30/2025 at 2:30pm and the incident took place in the dining room of the facility. According to this document, "Resident was acting strange. Hospice came in in the morning and took vitals – normal. After lunch, staff got (Resident A) in a chair, noticed her face was droopy and arm was limp. She was also leaning to one side in chair. Family was visiting and requested to see PA – she was not in. Request DON (Director of Nursing) to see her, she came and took vitals. Family requested 911 to be called. Staff called 911."

I reviewed a progress note regarding Resident A dated 01/29/2025 completed by PA-C Kristen Dziadula. According to this document, Resident A was seen regarding chronic pain. PA-C Dziadula noted that Resident A was receiving acetaminophen every 6 hours for pain. PA-C Dziadula requested staff confirm that Resident A is receiving hospice services and if so, inquire if she is receiving comfort medication.

I reviewed another progress note regarding Resident A dated 02/03/2025 completed by PA-C Dziadula. According to this document, Resident A was seen regarding slurring of speech and weakness. PA-C Dziadula noted that according to staff, approximately two days prior, Resident A was "exhibiting some questionable symptoms of an acute stroke." PA-C Dziadula noted that at the time of her evaluation, Resident A was in no acute distress. PA-C Dziadula recommended that Resident A continue with hospice services and staff continue to monitor her.

On 03/26/2025, I exchanged emails with Relative A1. Relative A1 stated that Resident A passed away at Monet House Inn on 02/25/25. Relative A1 said that she feels that Resident A did not receive adequate care while she resided at Monet House Inn.

On 03/28/2025, I interviewed Relative A2 via telephone. Relative A2 said that she was Resident A's medical power of attorney at the time of her death. According to Relative A2, she feels that Resident A received "excellent" care while she resided at Monet

House Inn. Relative A2 told me that she feels staff were attentive to Resident A and they made sure that all her needs were met. Relative A2 said that she has “no concerns” about the care that Resident A received at Monet House Inn.

On 03/28/2025, I interviewed staff Chelsea Sipili via telephone. Staff Sipili confirmed that she worked with Resident A daily while Resident A resided at Monet House Inn. Staff Sipili told me that she feels that Resident A received good care while residing at this facility. Staff Sipili said that she and the other staff at this facility took good care of Resident A, and they made sure that her needs were met. Staff Sipili said that she feels that staff does a good job caring for all the residents at this facility.

On 03/28/2025, I reviewed the death certificate for Resident A. According to this document, Resident A died on 02/25/25 at the age of 95 years old. Resident A’s manner of death is listed as “natural”, and her cause of death is listed as “Cerebrovascular Disease.” An autopsy was not performed.

On 03/28/2025, I interviewed the Compassus director of clinical services (DCS), Janet Johnson. DCS Johnson said that Resident A began receiving hospice services on 01/02/25 until her death on 02/25/25. According to DCS Johnson, she reviewed all the nursing notes regarding Resident A and there were no concerns about abuse or neglect of Resident A while a resident of Monet House Inn. DCS Johnson told me that Resident A received home health aide services 2x’s per week and nursing services on average of 2x’s per week. DCS Johnson stated that in addition to home health and nursing services, Resident A also received services from a Compassus chaplain and/or social worker once per week.

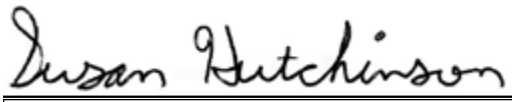
APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Relative A1 said that she feels Resident A received inadequate care while a resident of Monet House Inn. Relative A2 said that she feels Resident A received excellent care while a resident of Monet House Inn. PA-C Dziadula examined Resident A on 01/29/2025 and 02/03/2025. PA-C Dziadula noted that Resident A did not appear in distress during either examination and recommended that Resident A continue with hospice services. Compassus director of clinical services (DCS), Janet Johnson said that Resident A received services from Compassus Hospice from 01/02/2025 – 02/25/2025. DCS Johnson stated

	that according to the nursing notes, none of the hospice staff reported concerns of abuse or neglect of Resident A while she resided at Monet House Inn. Staff Chelsea Sipili said that she feels Resident A received good care while she resided at Monet House Inn. According to Staff Sipili, she and other staff were attentive to Resident A, and they made sure her needs were met. Resident A died on 02/25/2025 while under the care of Compassus hospice. According to her death certificate, she died of natural causes and her cause of death was cerebrovascular disease. I conclude that there is insufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 03/28/2025, I conducted an exit conference with the licensee designee (LD), Katie Edwards, via telephone. I discussed the results of my investigation.

IV. RECOMMENDATION

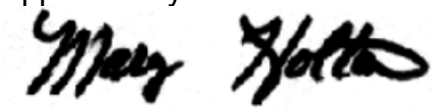
Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.



March 28, 2025

Susan Hutchinson Licensing Consultant	Date

Approved By:



March 28, 2025

Mary E. Holton Area Manager	Date