GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 11, 2025

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

RE: License #:	AL250331306
Investigation #:	2025A0872026
	Degas 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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 #:	AL250331306
Investigation #:	2025A0872026
Complaint Receipt Date:	02/12/2025
Investigation Initiation Date:	02/13/2025
Report Due Date:	04/13/2025
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:	Degas House Inn
Facility Address:	202 S Bridge Street Linden, MI 48451
Facility Telephone #:	(810) 735-9400
Original Issuance Date:	05/01/2014
License Status:	REGULAR
Effective Date:	05/25/2024
Expiration Date:	05/24/2026
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A is not able to feed herself and needs staff assistance. On 02/10/25 at 5pm, Resident A's lunch was sitting on her bedside table, untouched.	Yes
There was fecal matter on Resident A's bathroom floor for over a week and a pile of dust/trash on her floor for 3 days.	No
Additional Findings	Yes

III. METHODOLOGY

02/12/2025	Special Investigation Intake 2025A0872026
02/13/2025	APS Referral I made an APS complaint via email
02/13/2025	Special Investigation Initiated - Letter I made an APS complaint
02/14/2025	Contact - Document Received I exchanged emails with APS Worker, Dan Spalthoff
02/20/2025	Inspection Completed On-site Unannounced
02/28/2025	Contact - Document Received Email received from APS Spalthoff
04/01/2025	Contact - Document Sent I emailed the licensee designee requesting information related to this complaint
04/03/2025	Contact - Document Received AFC documentation received from LD
04/04/2025	Contact - Document Sent I exchanged emails with LD Edwards
04/04/2025	Contact - Telephone call made I interviewed staff Chazielle Cochran

04/04/2025	Contact - Telephone call made I spoke to LD Edwards
04/10/2025	Exit Conference I conducted an exit conference with the licensee designee, Katie Edwards
04/10/2025	Inspection Completed-BCAL Sub. Non-Compliance

ALLEGATION: Resident A is not able to feed herself and needs staff assistance. On 02/10/25 at 5pm, Resident A's lunch was sitting on her bedside table, untouched.

INVESTIGATION: On 02/14/25, I exchanged emails with Adult Protective Services Worker (APS), Dan Spalthoff. According to APS Spalthoff, he met with Resident A at Degas House Inn on 02/13/25. Resident A told APS Spalthoff that sometimes she needs help with her meals. Resident A needs staff to assist her with reaching and cutting her food and reported that staff does help her when needed. Resident A told APS Spalthoff that she needs staff assistance with mobility and staff is prompt with assisting her. Resident A reported to APS Spalthoff that she likes it at this facility, staff assists her with bathing, and she does not feel neglected. APS Spalthoff sent me a photograph of Resident A's lunch which was still sitting at her bedside and discovered by Relative A1 on 02/10/25 at 5pm.

On 02/20/25, I conducted an unannounced onsite inspection of Degas House Inn. I interviewed Resident A who was resting in her room after eating lunch. I reviewed the allegations with Resident A, and she said that the allegations are not true. Resident A said that she can feed herself and she does not require staff assistance. Resident A said that she does not have any trouble chewing food and she can use utensils to feed herself. Resident A told me that she either eats meals in her room or she goes down to the dining room and eats with the other residents. I asked Resident A to show me that she can reach her bedside table, so Resident A moved her hand and grasped one of the cups of water that was sitting there. Resident A's grasp was weak, and she did not seem to have adequate control over the fine motor skills it takes to feed herself.

I asked Resident A if staff showers her and she said, "They ask me, but I won't let them." Resident A said that staff offers her a shower on a regular basis, but she refuses so they give her a bed bath instead. Resident A stated that she has a catheter bag which staff empties. Resident A said that if she must have a bowel movement, staff assists her to the bathroom. Resident A told me that she uses a wheelchair for mobility and often stays in bed. Resident A said that the meals at this facility are good, and she said that she always gets enough to eat.

On 04/04/25, I reviewed AFC paperwork related to this complaint. Resident A was admitted to Degas House Inn on 09/10/24 and she was discharged on 03/24/25.

According to Resident A's assessment plan, she requires "total dependence" with eating, mobility, transfers, bathing, personal hygiene, toileting and dressing. Resident A wears briefs, she is incontinent of her bowels and bladder, and she is generally bedbound although she does use a wheelchair with assistance. Resident A has impaired use of both hands.

I reviewed Resident A's health care appraisal and her face sheet. Resident A is diagnosed with acute metabolic acidosis, hypertensive chronic kidney disease, duodenitis with bleeding, difficulty in walking, altered mental state, and weakness.

I reviewed progress notes from Physician's Assistant (PA-C) Kristen Dziadula from December 2024 through March 2025. During this time frame, PA-C Dziadula examined Resident A on nine separate occasions. PA-C Dziadula last saw Resident A on March 13, 2025. PA-C Dziadula noted that Resident A is under the care of hospice and the hospice nurse asked PA-C to evaluate Resident A due to delusions, hallucinations, and a possible urinary tract infection (UTI). PA-C Dziadula stated that Resident A was resting in bed during her examination, and she was in no acute distress. PA-C Dziadula noted that Resident A suffers from dementia, and she has a foley catheter with cloudy urine. PA-C Dziadula ordered a urine culture to rule out a UTI.

I reviewed a hospice note regarding Resident A dated 03/06/25, completed by registered nurse (RN) Dori Lengyel. According to this note, Resident A was resting in bed at the time of the visit. Resident A was still eating and drinking fluids. Relative A1 expressed concern to RN Lengyel that Resident A was not moving her right arm, but RN Lengyel noted that Resident A moved it "just fine" during her examination.

I reviewed a hospice note regarding Resident A dated 03/07/25, completed by hospice aide, (HA) Lakeia Young. During this visit, HA Young showered Resident A, performed routine catheter care, and provided personal care.

On 04/04/25, I interviewed staff Chazielle Cochran via telephone. Staff Cochran said that she has worked at this facility for approximately one year and she typically works 6am-6pm. Staff Cochran confirmed that she worked on 02/10/25 and was in charge of providing care to Resident A. Staff Cochran told me that as of that date, Resident A was on a pureed diet and although she was sometimes able to feed herself, staff would often assist her with eating. Staff Cochran confirmed that Resident A was served lunch on 02/10/25 and Staff Cochran was unable to assist Resident A with eating. Therefore, Resident A did not eat lunch that day and her lunch tray was still sitting on her bedside table by dinnertime. Staff Cochran confirmed that Resident A's assessment plan stated that she required assistance with feeding.

On 11/09/22, I completed investigation #2022A0872058 regarding Resident A and Resident B receiving improper care. I concluded that on one occasion, it took over five hours for staff to respond to Resident A's call light and during that time, Resident B was sitting in a wet brief. Both residents stated that staff often neglected their personal care. Family reported that they spent 8-12 hours a day caring for Residents A and B because

staff were failing to do so. Staff Melissa White and Trinidy Tomlin stated that on occasion, staff were unable to respond to resident needs timely. The licensee designee, Kimberly Gee submitted a corrective action plan dated 11/21/22 stating that the licensee and director will review staff schedules and assignments sheets to ensure proper levels of staff are provided.

On 03/15/23, I completed investigation #2023A0872020 regarding inappropriate resident care of Resident C. I concluded that Resident C fell in December 2022 and laid on the floor for a significant period of time without staff assistance. Numerous staff reported that staff is required to check on the residents every two hours or more often if needed.

On 03/21/23, I recommended revocation of this license. On 05/25/23, a settlement agreement was reached, and the facility agreed not to admit residents to this facility for 6 months. Once the 6-months was up, a 6-month provisional license was issued during which the facility was allowed to admit residents back into the facility. The licensee designee agreed to conduct weekly audits of the staffing at this facility and produce those audits to the licensing consultant. This facility remained on a provisional license until 05/24/24 at which time they were given a regular license.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
ANALYSIS:	**(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.**
	APS Spalthoff sent me a photograph of Resident A's lunch from 02/10/25 that was still sitting on her bedside tray, uneaten, as of 5pm. APS Spalthoff substantiated against this facility for neglect of Resident A. Resident A told me that she sometimes needs assistance with feeding. On 02/20/25, I asked her to demonstrate that she can reach her bedside table and feed herself. Resident A was able to demonstrate that she could reach her cup of water that was sitting on her bedside table. However, I noted that Resident A's grasp was weak, and she did not seem to have adequate control over the fine motor skills it takes to feed herself. Resident A's Assessment Plan states that she requires "total dependence" with eating, mobility, transfers, bathing, personal hygiene, toileting and dressing.

	Staff Chazielle Cochran said that she worked on 02/10/25 and she was too busy to assist Resident A with eating her lunch, therefore, Resident A did not eat lunch on 02/10/25. I conclude that there is sufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Ref. SIR #20222A0872058, CAP dated 11/21/22.** **SIR #2023A0872020, Settlement Agreement dated 05/25/23.**

ALLEGATION: There was fecal matter on Resident A's bathroom floor for over a week and a pile of dust/trash on Resident A's floor for 3 days.

INVESTIGATION: On 02/14/25, I exchanged emails with Adult Protective Services Worker (APS), Dan Spalthoff. According to APS Spalthoff, he met with Resident A at Degas House Inn on 02/13/25. APS Spalthoff said that he found Resident A's room and bathroom to be clean and she reported that staff cleans her room once per week.

On 02/20/25, I conducted an unannounced onsite inspection of Degas House Inn. I interviewed Resident A who was resting in her room after eating lunch. Resident A told me that she has never observed feces or trash on the floor in her room or in her bathroom. I asked Resident A if the facility has staff that cleans her room, and she said that staff cleans her room and sweeps her floor.

I inspected Resident A's room and attached bathroom. I found both her room and bathroom to be clean with no malodourous odor. I did not see any evidence of feces or trash on the floors or surfaces in her room or bathroom.

On 04/04/25, I interviewed staff Chazielle Cochran via telephone. Staff Cochran said that she has never seen feces on the floor in Resident A's room and she has never found Resident A's room or bathroom to be excessively dirty.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.

ANALYSIS:	APS Spalthoff conducted an unannounced onsite inspection on 02/13/25 and found Resident A's room, bathroom, and other areas of the facility to be clean with no evidence of trash or fecal matter on the floor. On 02/20/25, I conducted an unannounced onsite inspection of this facility. Resident A told me that she has never seen feces or trash on the floor in her room or in her bathroom. I inspected Resident A's room and attached bathroom. I found both her room and bathroom to be clean with no malodourous odor. I did not see any evidence of feces or trash on the floors or surfaces in her room or bathroom. Staff Chazielle Cochran said that she has never seen feces on the floor in Resident A's room and she has never found Resident A's room or bathroom to be excessively dirty. I conclude that there is insufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 02/20/25, I conducted an unannounced onsite inspection of Degas House Inn. I interviewed Resident A who was resting in her room after eating lunch. I asked Resident A how many staff are working on a typical day, and she said she does not know.

On 02/28/25, I received an email from APS Worker, Daniel Spalthoff. According to APS Spalthoff, staff Chazielle Cochran was the only staff working in Degas House Inn on 02/10/25. Staff Cochran reported to APS Spalthoff that since she was working alone, she did not have time to assist Resident A with eating her lunch. APS Spalthoff said that he spoke to the shift supervisor (SS), Keesha Harris who confirmed that Staff Cochran was the only staff working on 02/10/25. SS Harris told APS Spalthoff that she was a "floater" and was working between Degas House Inn and Homer House Inn on 02/10/25. APS Spalthoff said that he is substantiating against Degas House Inn for being short staffed on 02/10/25 which resulted in Resident A not getting her lunch.

On 04/04/25, I reviewed AFC paperwork related to this complaint. Resident A was admitted to Degas House Inn on 09/10/24 and she was discharged on 03/24/25. According to Resident A's assessment plan, she requires "total dependence" with eating, mobility, transfers, bathing, personal hygiene, toileting and dressing. She wears briefs, she is incontinent of her bowels and bladder, and she is generally bedbound

although she does use a wheelchair with assistance. Resident A has impaired use of both hands.

I reviewed the resident register for Degas House Inn. As of 03/23/25, there were 17 residents in this facility which I confirmed via email with the licensee designee (LD), Katie Edwards.

On 04/04/25, I interviewed staff Chazielle Cochran via telephone. Staff Cochran said that she has worked at this facility for approximately one year and she typically works 6am-6pm. Staff Cochran confirmed that she worked at Degas House Inn on 02/10/25 and oversaw caring for Resident A. Staff Cochran told me that her co-worker did not come to work so Staff Cochran had to work the floor alone. Staff Cochran confirmed that the shift supervisor (SS), Kesha Harris was also working that day, but SS Harris was also working at Homer House Inn. I asked Staff Cochran how many times she has had to work alone at Degas House Inn, and she said that she believes this is the only time she worked alone. Staff Cochran confirmed that there were more than 12 residents residing at Degas House Inn on 02/10/25.

On 04/04/25, I received an email and the daily staffing log from the licensee designee, Katie Edwards. According to LD Edwards, there was one staff plus a floater working at this facility on 02/10/25. I confirmed this information with the staffing log.

On 10/22/22, I completed investigation #2022A087250 regarding inadequate staffing, and I substantiated R 400.15206(2). Seven staff told me that at times, there was only one staff plus a floater working per shift at this facility. All staff reported that there were several residents who required a hoyer lift for transfers and most residents required significant staff assistance with personal care, protection and supervision. According to the Resident Register dated 09/01/22, there were 16 residents at this facility. I reviewed the staff assignment logs and determined that although two staff were scheduled for each shift, oftentimes one staff would call off, leaving only one staff working. On 10/22/22, I received a corrective action plan from the licensee designee, Kimberly Gee stating that the assistant living director would be responsible for identifying the acuity of each Inn and staffing accordingly. The licensee designee would also educate the assistant living director and the assistant living director regarding sufficient staffing.

On 03/15/23, I completed investigation #2023A0872020 regarding inadequate staffing and substantiated R 400.15206(2). According to the licensee designee, Melissa Sevegney, the previous licensee designee, Kimberly Gee did not require staff assignment sheets. Therefore, there was no record of how many staff were working at the time of my investigation. Relative C1 was unable to reach any staff via telephone for approximately 11 hours and there were no progress notes from staff indicating that Resident C was checked on 12/18/22 although Resident C required significant supervision and personal care.

On 03/21/23, I recommended revocation of this license. On 05/25/23, a settlement agreement was reached, and the facility agreed not to admit residents to this facility for

6 months. Once the 6-months was up, a 6-month provisional license was issued during which the facility was allowed to admit residents back into the facility. The licensee designee agreed to conduct weekly audits of the staffing at this facility and produce those audits to the licensing consultant. This facility remained on a provisional license until 05/24/24 at which time they were given a regular license.

On 04/10/25, I conducted an exit conference with the licensee designee, Katie Edwards. I discussed the results of my investigation and explained which rule violations I am substantiating. I also told LD Edwards that I am recommending a provisional license. LD Edwards said that she is increasing the staffing at this facility, and she is also going to be onsite for approximately three days per week to ensure adequate staffing and resident care. LD Edwards also reported that she is conducting in services and education to staff and management to ensure adequate staffing and resident care.

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:	APS Spalthoff determined that there was only one staff working on 02/10/25. He substantiated against the facility for being short staffed. I reviewed the resident register for Degas House Inn. As of 03/23/25, there were 17 residents in this facility which I confirmed via email with the licensee designee (LD), Katie Edwards. According to staff Chazielle Cochran, she was the only staff working on 02/10/25 and there were more than 12 residents residing in the facility at that time. According to LD Edwards, there was one staff plus a floater working at this facility on 02/10/25. I confirmed this information with the staffing log. I conclude that there is sufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	According to APS Spalthoff, staff Chazielle Cochran was the only staff working in Degas House Inn on 02/10/25. According to Resident A's Assessment Plan, she requires "total dependence" with eating, mobility, transfers, bathing, personal hygiene, toileting and dressing. She wears briefs, she is incontinent of her bowels and bladder, and she is generally bedbound although she does use a wheelchair with assistance. Resident A has impaired use of both hands. I reviewed the resident register for Degas House Inn. As of 03/23/25, there were 17 residents in this facility which I confirmed via email with the licensee designee (LD), Katie Edwards. According to staff Chazielle Cochran, she was the only staff working on 02/10/25 and there were more than 12 residents residing in the facility at that time. According to LD Edwards, there was one staff plus a floater working at this facility on 02/10/25. I confirmed this information with the staffing log. I conclude that there is sufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Ref. SIR #2022A087250, CAP dated 10/22/22** **SIR #2023A0872020, Settlement agreement dated 05/25/23**

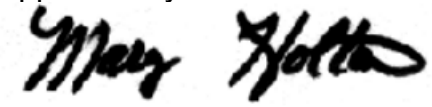
IV. RECOMMENDATION

Contingent upon receipt of an appropriate corrective action plan, I recommend the issuance of a 6-month provisional license.

April 10, 2025

Susan Hutchinson Licensing Consultant	Date

Approved By:



April 10, 2025

Mary E. Holton Area Manager	Date