GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 27, 2025

Randi Bowles
American House Rochester Hills
3565 S. Adams Rd
Rochester Hills, MI 48309

RE: License #: AH630397557
Investigation #: 2025A1035043
American House Rochester Hills

Dear Randi Bowles:

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.

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) 335-5985.

Sincerely,

Jennifer Heim, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909
(313) 410-3226
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630397557
Investigation #:	2025A1035043
Complaint Receipt Date:	03/27/2025
Investigation Initiation Date:	03/31/2025
Report Due Date:	05/27/2025
Licensee Name:	AH Rochester MC Subtenant LLC
Licensee Address:	Ste 1600 One Towne Square Southfield, MI 48076
Licensee Telephone #:	(248) 203-1800
Administrator:	Janet Difazio
Authorized Representative:	Randi Bowles
Name of Facility:	American House Rochester Hills
Facility Address:	3565 S. Adams Rd Rochester Hills, MI 48309
Facility Telephone #:	(248) 734-4488
Original Issuance Date:	01/16/2020
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	50
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Failure to maintain a safe environment for Resident A.	No
Additional Findings: Medications are not stored properly. Medications are pre-popped.	Yes

III. METHODOLOGY

03/27/2025	Special Investigation Intake 2025A1035043
03/31/2025	Special Investigation Initiated - Letter
04/24/2025	Contact - Face to Face
05/22/2025	Inspection Complete. BCAL Sub Compliance.
05/22/2025	Exit Conference.

ALLEGATION:

Failure to maintain a safe environment for Resident A. Resident A received poor quality of care.

INVESTIGATION:

On March 27, 2025, the Department received a complaint forwarded from Adult Protective Services (APS) which read:

> "On 02/28/2025 Resident A went to bed at 5:15pm. Resident A was seen again in bed at 11:30am on 03/01/2025. Resident A was tucked into the bed so tight she could not move. It is unknown if Resident A got up during the night. It is unknown if Resident A's brief was changed. It is unknown if Resident A was provided breakfast or her medications today. Resident A cannot communicate and answer questions due to her dementia/Alzheimer's. Staff at the facility could not say if Resident A was changed, fed or provided medication.
>
> Resident A has lived at the American House since April of 2024. Resident A has got out of the facility 6 times. On 02/16/2025 Resident A got out of the facility and was walking down a busy road in just a tee shirt in the cold. Someone found Resident A and drove her back to the facility. Resident A was outside for approximately 10 minutes. Staff never noticed Resident A missing until someone brought her back to the facility."

On April 24, 2025, an onsite investigation was conducted. While onsite I interviewed Randi Bowles Authorized Representative who states the facility has made serval attempts to maintain safety and meet the needs for Resident A. Administrator states the facility was unable to maintain a safe and secure environment for Resident A therefore gave a 30-day discharge notice. Administrator states Resident A paced the home continuously. There have been no reports of Resident A receiving poor quality of care. There have been no reports of Resident A being tucked into bed so tight she couldn't move.

Through record review Resident A successfully eloped from facility approximately six times. Facility followed facility policy and procedures related to elopement. Each incident had been investigated with route cause analysis. Education was provided to staff following each event. Progress notes indicate the facility attempted to meet the needs of Resident A and family. Progress indicates facility attempted to have Resident A seen by geriatric psychiatric services and implementation of a 1:1 sitter, POA declined both options.

Due to the anonymous nature of the complaint, I was unable to obtain additional information from the complainant.

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:	Through record review Resident A had successfully eloped from the facility on multiple accounts. The Facility followed incident and accident policy and procedures. Facility educated staff post occurrence. Facility initiated a 30-day discharge notice related to not being able to maintain a safe and secure environment for Resident A. There is no evidence to support Resident A received poor quality of care. There is no evidence to support Resident A was tucked tightly in bed where she couldn't move.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

Additional Findings:

Medications are not stored properly. Medications are pre-popped.

INVESTIGATION:

Through direct observation medication cup with multiple medication noted unattended on top of medication cart.

Through direct observation multiple unlabeled medication cups with medications observed in top drawer of medication cart.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	Through direct observation crushed medication in medication cup noted unattended on top of medication cart 1. Through direct observation three medication cups unlabeled noted with pre-popped medications in top drawer of second medication cart.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

05/22/2025

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Jennifer Heim, Health Care Surveyor Date
Long-Term-Care State Licensing Section

Approved By:

05/22/2025

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