GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 20, 2025

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

RE: License #:	AL250281706
Investigation #:	2025A0872032
	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 #:	2025A0872032
Complaint Receipt Date:	03/31/2025
Investigation Initiation Date:	03/31/2025
Report Due Date:	05/30/2025
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:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive her insulin injections for over a month. Resident A is not receiving some of her other medications properly as well.	Yes

III. METHODOLOGY

03/31/2025	Special Investigation Intake 2025A0872032
03/31/2025	APS Referral I made an APS referral online
03/31/2025	Special Investigation Initiated - Letter I made an online APS referral
04/10/2025	Inspection Completed On-site Unannounced
04/11/2025	Contact - Document Sent I emailed the licensee designee requesting information about this complaint
04/14/2025	Contact - Document Received AFC documentation received
05/20/2025	Exit Conference I conducted an exit conference with the licensee designee, Katie Edwards
05/20/2025	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: Resident A did not receive her insulin injections for over a month. Resident A is not receiving some of her other medications properly as well.

INVESTIGATION: On 04/10/2025, I conducted an unannounced onsite inspection of Monet House Inn Adult Foster Care (AFC) facility. I interviewed Resident A in her bedroom. According to Resident A, she was admitted to Monet House Inn in February 2025. Prior to this, Resident A resided in an AFC facility in Flint, Michigan for approximately 2.5 years.

Resident A stated that when she was admitted to Monet House Inn, her previous AFC home did not provide a list of all Resident A's medications. Resident A said that at her previous AFC home, she was on two injections of insulin but when she arrived at Monet House Inn, staff did not give her any of these injections. Resident A told me that she spoke with staff about the error and staff told her that the insulin injections were not on her medication list, and they did not have a doctor's order for them so staff would not be able to administer them. According to Resident A, staff worked with Resident A's doctor and recently, insulin injections were ordered. Resident A told me that she does not believe that Monet House Inn staff are to blame for her not receiving her medications and said that all her other medications have been administered as prescribed. Resident A also said that fortunately, even without her insulin injections, she did not have any medical issues, and her condition remained stable.

On 05/15/2025, I reviewed AFC paperwork related to this complaint. Resident A was admitted to Monet House Inn on 02/19/2025. According to Resident A's Health Care Appraisal dated 02/19/2025, she is diagnosed with Lewy body dementia, diabetes mellitus, chronic obstructive pulmonary disease, congestive heart failure, anxiety, and depression. Resident A uses a wheelchair for ambulation and does not have any special diet orders.

I reviewed Resident A's medication orders from Ascension Genesys Hospital dated 02/14/2025. The following medications were ordered for Resident A upon her discharge from the hospital: albuterol 2.5mg every 6 hours as needed for difficulty breathing, aspirin 81mg 2x's per day, atorvastatin 20mg 1x per day, bethanechol 10mg 1x per day, Biofreeze 4% topical gel every 12 hours as needed for pain, diclofenac 1% topical gel every 8 hours, duloxetine 60mg 1x per day, furosemide 40mg 1x per day, gabapentin 100mg 1x per day, insulin pen 25 units subcutaneous 2x's per day, loratadine 10mg 1x per day, losartan 25mg 1x per day, metoprolol tartrate 25mg 2x's per day, ondansetron 4mg every 8 hours as needed for nausea/vomiting, polyethylene glycol 17 grams every 24 hours as needed for constipation, prednisone 20mg 1x per day, quetiapine 100mg 1x per day, and Trelegy Ellipta 1 puff 1x per day.

I reviewed Resident A's medication administration records (MARs) for February – April 2025. I noted that Resident A was administered her medications as prescribed except for the following:

- Atorvastatin on 2/20, 2/21, 2/23, 2/24, 2/26, 2/27, 2/28, and 4/08. According to the MAR, this medication was not administered due to "other/see nurse notes"
- Aspirin on 3/08, 3/10, 3/14, 3/16, and 3/17 at 9am due to "other/see nurse notes" and on 3/07, 3/08, 3/09, 3/11, 3/12, and 3/14 at 5pm due to "other/see nurse notes"

Resident A's insulin pen 25 units subcutaneous 2x's per day was not listed on the MAR for February 2025.

On Resident A's March 2025 MAR, Resident A was prescribed an insulin pen 10 units 2x's per day beginning on 03/30/2025 and discontinued on 04/02/2025. Resident A was

not administered this medication on 03/30/2025, 03/31/2025, or 04/01/2025 at 9am and not on 03/30/2025 or 03/31/2025 at 5pm due to “other/see nurse notes.”

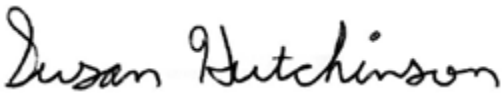
On Resident A’s April 2025 MAR, Resident A was prescribed an insulin pen 15 units 1x per day and one for 25 units 1x per day beginning on 04/03/2025. Resident A was not administered the 15-unit insulin pen on 04/08/2025 due to “other/see nurse notes.”

On 05/20/2025, I conducted an exit conference with the licensee designee (LD), Katie Edwards. I discussed the results of my investigation and explained which rule violation I am substantiating. LD Edwards looked through Resident A’s MARs and said that typically if staff indicates a medication was not passed due to “other/see nurses notes” it means that the medication is on order and is not available at the facility. LD Edwards said that approximately one month ago, she implemented a morning audit to ensure that if a medication is not available, staff are following up with the doctor and/or pharmacy to receive the medication so it can be administered as prescribed. LD Edwards agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident A was discharged from the hospital on 02/14/2025. The doctor ordered that Resident A receive an insulin pen due to diabetes, but the insulin pen was not administered as prescribed. Staff failed to administer Resident A Atorvastatin and Aspirin on several occasions as well. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

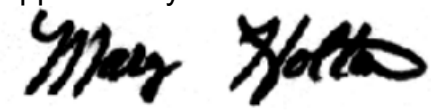
Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.



May 20, 2025

Susan Hutchinson Licensing Consultant	Date

Approved By:



May 20, 2025

Mary E. Holton Area Manager	Date