STATE OF MICHIGAN

COURT OF APPEALS

ROSEWOOD LIVING CENTER,

Petitioner-Appellant,

v

BUREAU OF HEALTH SYSTEMS,

Respondent-Appellee.

UNPUBLISHED
November 20, 2008

No. 277127
Wayne Circuit Court
LC No. 06-614423-AA

Before: Servitto, P.J., and Donofrio and Fort Hood, JJ.

PER CURIAM.

Petitioner, Rosewood Living Center, appeals by leave granted a circuit court order affirming the revocation of petitioner's nursing home license by defendant, Bureau of Health Systems (Bureau). Because the administrative hearing record included competent, material, and substantial evidence on the record as a whole of many dangerous violations of the nursing home rules such that a reasonable person applying a "common sense approach" could conclude the established violations seriously affected the health, safety, and welfare of the residents of the nursing home, the circuit court properly affirmed the ALJ's decision revoking respondent's license to operate its Rosewood facility, and we affirm.

I. Substantive Facts and Procedural History

This case arises out of on-site inspections made by respondent Bureau of Health Systems[1] at petitioner's facility on Seven Mile Road in Detroit in July 2003. At that time, the nursing home housed 104 resident patients. Respondent's surveyors found a multitude of violations of protocol that respondent's surveyors detailed in a 79-page report. The surveyor's report shows that petitioner committed the following violations[2]:

[1] When the inspections were performed, the Department of Consumer & Industry Services oversaw the inspections.

[2] Because of the volume and detail included in the report, not all of the violations detailed in the report are summarized here.

- Failed to document the facility's policies by setting them forth on letterhead with signatures and dates.

- Failed to initiate and implement preventative measures for pressure sores for patient #603 who was diagnosed as "severely impaired" and as "totally dependent on others for all activities of daily living." Left the patient lying on her back without turning her every two hours contrary to her resident assessment protocol which required repositioning at least every two hours. Patient #603's skin was also to be kept clean and dry but surveyors observed her wearing a brief saturated with urine contrary to her protocol. Patient #603 developed a stage two pressure ulcer measuring two centimeters in her coccyx area.

- Failed to provide physical therapy for patient #603 with only one documented session in June 2003 when she was to receive passive range of motion treatment therapy at least three to five times per week. There was no documented evidence that patient #603 had a physical therapy or occupational therapy evaluation in May, June, or July 2003. Since arriving, patient #603 had a marked decline in her functional abilities.

- Stored poisonous material in the kitchen area, specifically a red metal can of gasoline underneath the steam table in the dish room.

- Posted inconsistent meal menus resulting in residents not being aware of meal choices at meal times. Facility had less than half the number of bowls (44) required to serve all 104 patients.

- Left kitchen equipment, including a blender, large mixing bowl, deep fryer, and oven, grossly soiled with old food and other matter. Surveyors observed dark, stained, ceiling tiles with mold growth present over the prep sink adjacent to the meat slicer in the kitchen. On testing, the dish machine did not reach 180 degrees and did not properly sanitize dishes used to serve residents. The dish room floor was flooded with water due to the trap being plugged with food and other debris. The walk-in refrigerator contained uncovered, unlabelled, and undated luncheon meat as well as two spilled juice containers on the floor.

- Failed to conduct and document fire drills for over a year and a half since October 2001.

- Facility failed to establish an infection control program to investigate possible causes of infections, develop and implement corrective measures to decrease incidents of infection, and, ensure staff adherence to control practices despite the prevalence of infections in the facility. Records showed that the facility experienced in January 2003, a wound infection with Methicillin Resistant Staphylococcus Aureus (MRSA); in February 2003, nine upper respiratory infections and four urinary tract infections (UTI); in March 2003, four UTIs;

in April 2003, three UTIs; and in June 2003, three eye infections. No infection surveillance logs existed for May 2003.

- Left a fluorescent light in a shower stall hanging by black and red electrical wires, with a constant water drip from the corner of the ceiling and from the light fixture itself resulting in standing water on the floor, thereby leaving staff and residents at risk for electrocution. While being interviewed, two charge nurses reported that the shower room was being used by nursing assistants to shower residents at that time.

- The fire door that also acted as a smoke barrier to the third floor was not locked and had at least three holes in it.

- Approximately 43 resident rooms revealed exposed red and black wires hanging from ceilings where lights used to hang or protruding from walls that used to power outlets, call lights, and light switches. The wires were not capped.

- Left resident #12 unobserved in the smoking area, where she had no ashtrays and instead stamped out cigarettes on the floor.

- Individual resident's night-lights were not operational throughout entire first and second floor. Many more lights were not functional throughout the facility including in the medical records room, laundry room, shower room, occupational therapy room, and activity room.

- Broken light bulbs and broken glass were present on the floors in resident rooms and in hallways.

- An electrical cord connected to a commercial floor fan was covered with standing water. Water was penetrating an open junction. There were obvious water leaks from multiple pipes in the boiler room.

- Inadequate ventilation was observed in several rooms including at least four resident rooms, two restrooms, and a utility room that resulted in the pervasive odor of fecal matter and urine.

- Facility left a dumpster overflowing with trash including 46 wooden pallets, as well as the loading dock, which was covered with garbage, including a 24-yard dumpster filled to capacity emanating a foul odor with gnats and flies buzzing around it.

- Failed to properly sort and launder clothes and linens soiled with bodily fluids and fecal matter. Newly laundered clothes and linens were in a pile on the floor.

- Floors throughout the facility presented trip hazards including broken or cracked tiles and heavily soiled, scuffed, or sticky floors, as well as various grossly stained and soiled carpeted areas.

- Left dead bugs, flies, debris and "crud" in the activity room, with two window shades stored underneath the heaters. Many windows had heavy condensation or smoke stains that did not allow residents to see out of them.

- Failed to maintain proper air temperatures in excessive heat conditions. On July 20, 2003 surveyors measured the temperature in the middle of the residents' main dining room at 90 degrees.

As a result of the July 2003 survey, respondent's Director, Walter Wheeler, issued an emergency license revocation order. Wheeler found that petitioner had not been in compliance with state and federal law regulating long-term nursing homes since 1995. He found that the level of noncompliance, on numerous occasions since 1995, placed the residents' health, safety, and welfare at risk. Also, he found that petitioner had not complied with state and federal law for fire alarms, smoke detection, and sprinkler systems. He stated that the most recent survey included three immediate jeopardy violations, two harm citations and 53 citations[3] of potential risk. He did not, however, specifically identify those violations though we assume that the immediate jeopardy violations might include the storage of gasoline in the kitchen and the two areas with bare wires and standing water. Wheeler directed that the residents should be immediately transferred and directed that petitioner stop operating as a nursing home. Finally, per the Emergency License Revocation Order, petitioner's license would be revoked once the last resident was transferred. Petitioner transferred all residents by August 14, 2003, and its license was revoked.

Petitioner challenged the emergency revocation order and the matter proceeded to hearing before Administrative Law Judge Robert H. Mourning (ALJ). The ALJ held a series of hearings where it heard arguments and took a voluminous amount of testimony.[4] Ultimately, the ALJ issued a lengthy and very detailed proposed decision of 117 pages. The decision separately sets out 171 findings of fact[5] with regard to the proceedings. The ALJ then applied the relevant law to its explicit findings of fact and concluded that respondent had proven by a preponderance of the evidence that petitioner had violated two dozen rules and had not proven

[3] That number was later amended to 56 citations in an amended emergency license revocation order issued on January 14, 2004.

[4] The ALJ hearing commenced on October 7, 2004, and was continued on October 8, 2004, October 21-22, 2004, November 4-5, 2004, December 2-3, 2004, January 20-21, 2004, and was finally concluded on February 3, 2005.

[5] Many with multiple subsections.

violations of seven more rules.[6] In accordance with its findings, the ALJ then concluded that Director Wheeler had properly revoked petitioner's license stating specifically that:

> The central issue in this hearing is whether, under MCL 333.20168, Director Wheeler, on August 6, 2003, properly made a finding that deficiencies or

---

[6] In the order addressed by the ALJ, the ALJ specifically found that respondent *had* proven by a preponderance of the evidence that petitioner had violated:

1. MCL 333.20201(2)(e).
2. Michigan Administrative Code, R 325.20115(4)(a), (c), (c)(vi), (f).
3. Rule 325.20117(6).
4. Rule 325.20401(1).
5. Rule 325.20501.
6. Rule 325.20502(1).
7. Rule 325.20502(3), (4).
8. Rule 325.20507(a).
9. Rule 325.20604(1), (2).
10. Rule 325.20707(1), (4)(a) and MCL 325.20708(1), (4).
11. Rule 325.20707(4)(d).
12. Rule 325.20707(4)(i).
13. Rule 325.20710.
15. Rule 325.20711(3)(b), (4)(a).
16. Rule 325.20711(7).
18. Rule 325.20804.
19. Rule 325.21001(1).
21. Rule 325.21306(1).
25. Rule 325.21321(1), (2).
26. Rule 325.21322(5).
27. Rule 325.21322(10).
28. Rule 325.21322(15).
29. Rule 325.21325(1).
30. Rule 325.22003a.

Again, in the order addressed by the ALJ, the ALJ also specifically found that respondent *had not* proven by a preponderance of the evidence that petitioner violated:

14. Rule 325.20711(1)(c).
17. Rule 325.20803(3).
20. Rule 325.21304(2).
21. Rule 325.21306(2), (3).
22. Rule 325.21309(a).
23. Rule 325.21317(7), (8), (9).
24. Rule 325.21319(1).

violations of state law and administrative rules for nursing homes seriously affected the health, safety, and welfare of residents receiving care or services at Rosewood. Further, whether it was appropriate and reasonable for Director Wheeler to issue an emergency order revoking the license of Rosewood.

In 1999, Mohammad Qazi, the president of Ciena, met with Director Wheeler and assured him that Rosewood would comply with the applicable operating standards of license by BHS.[7] The members of the survey team, assigned to Rosewood, had a substantial amount of education, experience, and training in the evaluation of nursing homes. When the survey team arrived on July 20, 2003, they found that Rosewood was substantially in non-compliance with the state law and administrative rules for nursing homes. Moreover, on July 20, 2003, there was no social worker working in the facility. In addition, during the survey, the maintenance director, Mr. Lafferty, and the bookkeeper decided to resign.

The Administrative Law Judge finds that deficiencies or violations found during the current survey and the past record of non-compliance with licensing requirements warrants the revocation of Rosewood's license by BHS. In this case, BHS provided Rosewood with multiple opportunities to comply with the licensing requirements for nursing homes. However, standard surveys, complaint surveys, and life safety code surveys demonstrate that Rosewood continued to fail as a nursing home. Therefore, it is reasonable and appropriate for Director Wheeler to conclude that this facility cannot meet the licensing standards provided in state law and administrative rules and that the license should be revoked.

The ALJ then recommended that the Director of the Department of Community Health affirm the Bureau of Health System's August 6, 2003 decision to revoke petitioner's license to operate Rosewood Living Center.

On September 22, 2005, petitioner filed objections to the proposed opinion of the ALJ, along with a very lengthy supporting brief of 113 pages and several exhibits. Petitioner asserted in part that it appeared that the department intended from the beginning of the survey to shut down the nursing home; petitioner's staff testified that the same inspectors had seen the same conditions the previous year and had not flagged them as violations. Amongst other objections, petitioner claimed with regard to the gas can, that it was in the dish room, not the kitchen, and there was no heat source and no flames in the dish room and thus there was no flame risk; further, when notified of the deficiency, staff immediately removed the can and placed it in the garage. Petitioner asserted that, in contrast to the survey, it actually did conduct fire drills; it merely could not locate the binder in which the drill documentation was kept, but staff members

[7] "BHS" is respondent Bureau of Health Systems (Bureau).

testified that drills were indeed conducted. Petitioner denied that the shower room, where the surveyors had found the loose wiring, was used to shower patients.

On March 21, 2006, the Director of the Department of Community Health rejected petitioner's objections to the ALJ opinion. The director affirmed the emergency license revocation order and adopted the ALJ's proposed opinion in its entirety except for the ALJ's interpretation of Rule 325.21306(2).

Petitioner appealed to the circuit court, arguing in general that it had not received due process because respondent had never promulgated specific standards of what constituted a situation that endangered the health and safety of residents. Petitioner also contended that Director Wheeler had merely used an arbitrary, common sense standard.[8] After entertaining oral argument on the matter, the circuit court ruled as follows:

> If the rules and regulations promulgated by the State, that is, the standards and licensing for the nursing homes and nursing care facilities were so vague, that is, the rules and regulations, so vague, so overly broad, if you will, that one could not determine what would or would not violate the rules, I might agree with Rosewood. One need only look, I think, at the nature of many of the violations to see that common sense would dictate, probably even compel the result reached in

---

[8] Petitioner advanced the following arguments before the circuit court on appeal:

> 1. The Bureau violated the facility's constitutional due process rights by revoking petitioner's license without the proper legal authority.
>
> 2. The Bureau exceeded its statutory authority in issuing the emergency revocation.
>
> 3. The amended order is improper.
>
> 4. The final order is arbitrary, capricious, and clearly an abusive and unwarranted exercise of discretion.
>
> 5. The ALJ set forth no justification for his vague credibility determinations of witnesses.
>
> 6. The final order is not supported by competent, material, and substantive evidence.
>
> 7. The final order's reversal of a single finding of the ALJ is erroneous.
>
> 8. The ALJ erroneously granted the Bureau's motion to quash subpoena and for a protective order.

this case. I don't think there could be a reasonable, rational dispute that wire or wires hanging in a shower that was apparently being used because there was a shampoo container and it appeared that the floors or the walls of the shower stall were wet, would represent a danger to the health and safety of the residents of Rosewood. I think common sense would tell pretty much anyone that if someone who is in danger of developing decubitus ulcers and, in fact, had a stage 2 ulcer, is not being turned at least every two hours, that represents a danger certainly to that patient.

If one is to get physical – to have physical therapy – I went back through my notes because I couldn't remember the number of times the resident actually received therapy in June of '03 and July of '03, she was supposed to – I believe it was a female – receive the therapy three to five times per week. There was no notation reflecting that she had therapy in June of '03, none in July of '03. I don't think a reasonable argument could be made that that didn't represent, if not an absolute hazard, some real concern for the health and safety of that particular resident. The fact that there was no effective infection control committee. There was a coordinator, but there was a dearth of documentation that anyone, including this coordinator, had actually coordinated anything with respect to controlling infection or contamination within the Rosewood facility. The third floor crammed with all kinds [of] material, including broken furniture and the like, and apparently, at least according to one of the surveyors, had been used as a smoking area, cigarette butts and the like found. That represents a potential fire hazard. I haven't even gotten through half of the list, my own list, from reading the list of violations that the surveyor[s] found in this case.

As I indicated, there is a set of rules. They don't say, nor should they, that every time you have a resident who is not being turned who is at risk of developing decubitus ulcers, that's a violation. If it doesn't – one would not think that they would, that is, the regulations, say it's important for the health and safety of residents to not have clean linen stored on the floor of a closet and so forth. I think in practically every instance, I can't think of one where it wouldn't apply, but in practically every instance, common sense is to be applied in determining whether violations have occurred and whether certain standards have or have not been met. It is true, that Director Wheeler said in part that he based it on his feelings, but he also indicated that he was operating under [MCL] 333.20168. And during the course of the administrative hearing reference was made to the rules promulgated by the State as it pertains to the standards for licensing of nursing homes and nursing care facilities. I don't believe that there is an argument or a viable meritorious argument that Rosewood's constitutional right to due process was violated in this case.

Rosewood should have been aware of the standards to which it was being held. There were numerous violations, most of which could easily be determined to be – to cause risk of endangering the residents or affecting adversely their health, safety and welfare. There was no abuse of discretion in determining that Rosewood's license should be revoked and that the facility should be shut down

> and the residents moved. In *Spalding v Spalding*, 355 Mich 382 (1959), the Michigan Supreme Court discussed the standard for reviewing a claim of abuse of discretion in a civil matter and it said, as counsel pointed out: In order to have an abuse, the result must be so palpably and grossly violative of fact and logic – kind of sounds like common sense, doesn't it – that it evidences not the exercise of will, but the perversity of will; not the exercise of judgment, but the defiance thereof; not the exercise of reason, but rather of passion and bias. I cannot find and do not find, given that standard, that there was an abuse of discretion. The determination of the ALJ is affirmed.

In an order dated March 12, 2007, the circuit court affirmed the revocation of petitioner's nursing home license. It is from this order that petitioner sought leave to appeal from this Court, and we granted petitioner's application.

. Standard of Review

"This Court reviews a lower court's review of an administrative decision to determine whether the lower court applied correct legal principles and whether it misapprehended or misapplied the substantial evidence test to the agency's factual findings, which is essentially a clearly erroneous standard of review." *VanZandt v State Employees' Retirement Sys*, 266 Mich App 579, 585; 701 NW2d 214 (2005). A finding is clearly erroneous when, on review of the whole record, this Court is left with the definite and firm conviction that a mistake has been made. *Boyd v Civil Service Comm*, 220 Mich App 226, 234; 559 NW2d 342 (1996). Accordingly, this Court will overturn a circuit court decision if this Court is left with a definite and firm conviction that a mistake was made. *VanZandt, supra* at 585. This Court gives due deference to the expertise of an administrative agency, and will not "invade the province of exclusive administrative fact-finding by displacing an agency's choice between two reasonably differing views." *Widdoes v Detroit Public Schools*, 218 Mich App 282, 286; 553 NW2d 688 (1996).

III. Analysis

A.

Petitioner first argues that the circuit court erred when it incorrectly applied the abuse of discretion standard of review. Petitioner also asserts that had the circuit court applied the proper standard of review, the trial court would have been required to find the emergency revocation unlawful. Respondent responds that it is clear from the record that the circuit court considered more than just whether there was an abuse of discretion. Respondent also asserts that given the circuit court's emphatic rejection of petitioner's arguments, the outcome of this appeal did not turn on how the trial court articulated the abuse of discretion standard of review.

A final agency decision is subject to court review but it must be upheld if it is not contrary to law, is not arbitrary, capricious, or a clear abuse of discretion, is not otherwise affected by a substantial and material error of law, and is supported by competent, material, and substantial evidence on the whole record. Const 1963, art 6, § 28; MCL 24.306(1)(d); *VanZandt, supra* at 583-584; *Dignan v Michigan Pub School Employees Retirement Bd*, 253 Mich App 571, 576; 659 NW2d 629 (2002). "'Substantial evidence is that which a reasonable mind would

accept as adequate to support a decision, being more than a mere scintilla, but less than a preponderance of the evidence.'" *VanZandt, supra* at 584 (citation omitted). "If there is sufficient evidence, the circuit court may not substitute its judgment for that of the agency, even if the court might have reached a different result." *Id*. With regard to whether an agency decision is arbitrary or capricious, the circuit court must determine whether the decision lacks adequate determining principle, reflects an exercise of will or caprice without acknowledgment of principles, circumstances, or significance, reflects an absence of a principled and reasoned outcome, or reflects a freakish, whimsical, or humorous outcome. *Id*. at 584-585.

Our review of the record reveals that although the circuit court announced its intention to apply the abuse of discretion standard and even framed its conclusion in abuse of discretion terms, the trial court's analysis of the issues reflects that the circuit court actually applied the substantial evidence test to respondent's factual findings. The circuit court pointed out that the record contained facts to support the ALJ's decision and the director's decision. The circuit court specifically referenced the loose wiring in the shower, the bed sores on a patient who was not moved every two hours as she was supposed to have been managed given her susceptibility to decubitus ulceration, the complete lack of physical therapy for a patient, the failure of petitioner to have an infection control procedure, the fire hazard of patients smoking on the cluttered third floor and the storage of clean linen on the floor. The circuit court observed that those items comprised fewer than half of the violations noted when reviewing the file. After reviewing the record, it is obvious to us that the circuit court considered whether the record contained competent, material, and substantial evidence on the whole record to support the agency's decision. Thus, we cannot conclude that the court misapplied the standard of review. Accordingly, the trial court did not rule contrary to the applicable standard of review.

Petitioner also points out that not only did the circuit court erroneously apply the abuse of discretion standard, but it applied the wrong abuse of discretion standard when it cited *Spalding v Spalding*, 355 Mich 382; 94 NW2d 810 (1959), as a result of our Supreme Court's decision in *Maldonado v Ford Motor Co*, 476 Mich 372; 719 NW2d 809 (2006). An issue is not properly preserved if it is not raised before, addressed by, and decided by the trial court. *ISB Sales Co v Dave's Cakes*, 258 Mich App 520, 532-533; 672 NW2d 181 (2003). Because petitioner did not object and bring this issue to the circuit court's attention during the hearing, it is not preserved and we could decline to review this issue. But, even were this argument properly before us, to the extent that the circuit court referenced *Spalding, supra*, that asserted error was not dispositive. As respondent correctly points out in its brief on appeal, the *Maldonado* abuse of discretion standard explores whether a given outcome in a case fits within a reasonable, principled range of possible outcomes. *Maldonado, supra* at 388. The trial court, in examining the findings in the appeal emphasized that due to the conditions at the Rosewood facility, "common sense would dictate, probably even compel, the result reached in this case." Hence the record plainly shows that in its review of the record, the trial court certainly engaged in an analysis that endeavored to determine whether the revocation of petitioner's license fell within the principled range of outcomes based on the record before it. For these reasons, we find no

merit to petitioner's argument that had the trial court applied the proper standard of review it would have been compelled to find the emergency revocation unlawful.[9] No error occurred.

B.

Petitioner next contends that the circuit court's finding of no due process violation was clearly erroneous. Specifically, petitioner asserts that the trial court analyzed the wrong laws in deciding that petitioner's due process rights were not violated and also that the trial court erred in permitting respondent to use unpromulgated rules. Respondent argues that the circuit court properly recognized that MCL 333.20168, which incorporated violations of statutes and rules regulating nursing home operations, gave Rosewood sufficient notice that the conditions found at that facility could result in license revocation. Respondent also explains that it promulgated an extensive set of rules that give nursing homes adequate notice of operation requirements and when significant and dangerous violations of these requirements were discovered at Rosewood, its license was properly revoked.

We review de novo whether a trial court violated a defendant's right to due process. *Dep't of Community Health v Risch*, 274 Mich App 365, 377; 733 NW2d 403 (2007). Statutory construction is a question of law that this Court also reviews de novo. *General Motors Corp v Dep't of Treasury*, 466 Mich 231, 236; 644 NW2d 734 (2002).

In its brief on appeal petitioner argues specifically that respondent "refus[ed] to promulgate regulations informing regulated nursing homes how an alleged violation of the Licensure Regulations may be found to rise to the level of 'seriously affects,' thus justifying an emergency revocation." In support of its argument, petitioner relies on the following statute:

> (1) Upon a finding that a deficiency or violation of this article or the rules promulgated under this article seriously affects the health, safety, and welfare of individuals receiving care or services in or from a licensed health facility or agency, the department may issue an emergency order limiting, suspending, or revoking the license of the health facility or agency. . . . [MCL 333.20168(1).]

The main goal of judicial construction of a statute is to "ascertain and to give effect to the intent of the Legislature." *United Parcel Service, Inc v Bureau of Safety & Regulation*, 277 Mich App 192, 202; 745 NW2d 125 (2007). The first step in the analysis is to review the language of the statute. *Id*. If the statutory language of the statute is unambiguous, then we assume that the Legislature intended its plain meaning, and the statute must be enforced as written. *Roberts v Mecosta Co Gen Hosp*, 466 Mich 57, 63; 642 NW2d 663 (2002). "A

---

[9] Because the trial court's analysis satisfied the *Maldonado* standard we need not discuss the continued use of the *Spalding* abuse of discretion standard. We do however note that MCL 24.306(1)(e) specifically provides that the trial court's review of an agency decision is "if substantial rights of the petitioner have been prejudiced because the decision or order is . . . [a]rbitrary, capricious or clearly an abuse or unwarranted exercise of discretion." In satisfying the *Maldonado* standard, the standard set out in MCL 24.306(1)(e) has also been satisfied.

necessary corollary of these principles is that a court may read nothing into an unambiguous statute that is not within the manifest intent of the Legislature as derived from the words of the statute itself." *Id.*; see also *Lash v Traverse City*, 479 Mich 180, 194; 735 NW2d 628 (2007) (The judiciary may not speculate regarding the Legislature's intent beyond those words expressed in the statute.).

After reading the plain language of the statute, we conclude that petitioner's limited interpretation of MCL 333.20168(1) does not comport with the plain language of the statute. The statute is unambiguous. It does not require that respondent set forth rules specifically defining the phrase "seriously affects the health, safety, and welfare" of patients as argued by petitioner. That the statute does not define the phrase does not mean that respondent must set forth a definition. Instead, the plain language of the statute requires only a violation, and a finding that the violation seriously affects the health, safety, and welfare of the patient. As such, we decline to read more into the statute as suggested by petitioner.

Petitioner also relies on MCL 333.20171 as mandating that respondent was obligated to define "seriously affects the health, safety, and welfare." MCL 333.20171 provides in pertinent part:

> (1) The department, after obtaining approval of the advisory commission, shall promulgate and enforce rules to implement this article, including rules necessary to enable a health facility or agency to qualify for and receive federal funds available for patient care or for projects involving new construction, additions, modernizations, or conversions.
>
> (2) The rules applicable to health facilities or agencies shall be uniform insofar as is reasonable.
>
> (3) The rules shall establish standards relating to:
>
> (a) Ownership.
>
> (b) Reasonable disclosure of ownership interests in proprietary corporations and of financial interests of trustees of voluntary, nonprofit corporations and owners of proprietary corporations and partnerships.
>
> (c) Organization and function of the health facility or agency, owner, operator, and governing body.
>
> (d) Administration.
>
> (e) Professional and nonprofessional staff, services, and equipment appropriate to implement section 20141(3).
>
> (f) Policies and procedures.
>
> (g) Fiscal and medical audit.
>
> (h) Utilization and quality control review.
>
> (i) Physical plant including planning, construction, functional design, sanitation, maintenance, housekeeping, and fire safety.
>
> (j) Arrangements for the continuing evaluation of the quality of health care provided.

(k) Other pertinent organizational, operational, and procedural requirements for each type of health facility or agency.

Contrary to petitioner's argument, the plain language of MCL 333.20171 merely indicates that respondent "shall promulgate and enforce rules to implement this article," and does not specifically require respondent to define the phrase "seriously affects the health, safety, and welfare." The majority of MCL 333.20171 discusses standards relating to ownership and ownership interests; the facility's organization and administration; appropriate staff and equipment; policies and procedures; fiscal and medical audits; quality control review; the physical surroundings including design, sanitation, maintenance, housekeeping, and fire safety; arrangements for the continuing evaluation of the quality of health care provided and other pertinent requirements. Nowhere does that statute require respondent to define precisely what constitutes a violation that seriously affects the health, safety, and welfare of patients. The plain language of the statute belies petitioner's argument.

Despite the foregoing, the basic thrust of petitioner's due process argument is not lost on us. Petitioner complains that a basic tenant of due process is missing here where it claims that there were no clear standards to be utilized in performing tasks as a nursing home. Due process enforces the rights enumerated in the Bill of Rights and includes both substantive and procedural due process. *Kampf v Kampf*, 237 Mich App 377, 381-382; 603 NW2d 295 (1999). Procedural due process serves as a limitation on government action and requires government to institute safeguards in proceedings that affect those rights protected by due process, including life, liberty, or property. *Id*. at 382. Due process is a flexible concept applied to any adjudication of important rights. *Thomas v Pogats*, 249 Mich App 718, 724; 644 NW2d 59 (2002).

The essence of due process is to ensure fundamental fairness. *Reed v Reed*, 265 Mich App 131, 159; 693 NW2d 825 (2005) (internal citations omitted). The procedural protections, which include fundamental fairness, are based on what the individual situation demands. *Thomas, supra* at 724. Fundamental fairness includes: (1) consideration of the private interest at stake; (2) the risk of an erroneous deprivation of such interest through the procedures used; (3) the probable value of additional or substitute procedures; and (4) the interest of the state or government, including the function involved and the fiscal or administrative burdens imposed by substitute procedures. *Dobrzenski v Dobrzenski*, 208 Mich App 514, 515; 528 NW2d 827 (1995). "Due process in civil cases generally requires notice of the nature of the proceedings, an opportunity to be heard in a meaningful time and manner, and an impartial decisionmaker. The opportunity to be heard does not mean a full trial-like proceeding, but it does require a hearing to allow a party the chance to know and respond to the evidence." *Hinky Dinky Supermarket, Inc v Dep't of Community Health*, 261 Mich App 604, 606; 683 NW2d 759 (2004), quoting *Cummings v Wayne Co*, 210 Mich App 249, 253; 533 NW2d 13 (1995).

While it is true that both MCL 333.20168(1) and MCL 333.20171 do not specifically require respondent to define the phrase "seriously affects the health, safety, and welfare" and do not require respondent to define precisely what constitutes a violation that seriously affects the health, safety, and welfare of patients, the Michigan Department of Consumer and Industry Services, Bureau of Health Systems, Division of Health Facility Standards and Licensing has promulgated myriad administrative rules that address nursing homes and nursing care facility standards. These administrative rules are published in the Michigan Administrative Code.

Michigan Administrative Code, R 325.20101, *et seq*. These administrative rules are separated into twenty separate parts and contain a comprehensive set of guidelines addressing nursing home standards.[10]

Petitioner's argument fails considering the existence of these administrative rules. The rules are categorized into parts for ease of use and the parts are further separated into individual rules with subparts providing specific guidance on individual subject areas. The record shows here that the ALJ concluded that respondent had proven by a preponderance of the evidence that petitioner had violated two dozen rules when the ALJ concluded that Director Wheeler had properly revoked petitioner's license. For example, Rule 325.20401 provides specifically that nursing homes must make policy manuals available to inspectors, which petitioner did not do in this case. As just one other example, Rule 325.20507 provides that nursing homes should have an infection control committee, another action that petitioner did not take. Petitioner's argument

---

[10] The twenty parts include the following sections:

1. General Provisions, Rule 325.20101 – Rule 325.20118.
2. Licensure, Rule 325.20201 – Rule 325.20215.
3. Access to Nursing Homes and Patients, Rule 325.20301 – Rule 325.20304.
4. Administrative Management of Homes, Rule 325.20401 – Rule 325.20407
5. Patient Care, Rule 325.20501 – Rule 325.20509.
6. Physician Services, Rule 325.20601 – Rule 325.20606.
7. Nursing Services, Rule 325.20701 – Rule 325.20714.
8. Dietary Services, Rule 325.20801 – Rule 325.20806.
9. Pharmaceutical Services, Rule 325.20901 – Rule 325.20906.
10. Other Services, Rule 325.21001 – Rule 325.21003.
11. Records, Rule 325.21101 – Rule 325.21105.
12. Medical Audit, Utilization Review, and Quality Control, Rule 325.21201 – Rule 325.21204.
13. Buildings and Grounds, Rule 325.21301 – Rule 325.21328
14. Child Care Homes and Child Care Units, Rule 325.21401 – Rule 325.21411.
15. Certification, Rule 325.21501 – Rule 325.21515.
16. Nursing Facilities for Care of Mentally Ill Patients, Rule 325.21601 – Rule 325.21605.
17. Nursing Facilities for Care of Mentally Retarded Patients, Rule 325.21701 – Rule 325.21705.
18. Nursing Facilities for Care of Tuberculosis Patients, Rule 325.21801 – Rule 325.21807.
19. Hearing Procedure, Rule, Rule 325.21901 – Rule 325.21922.
20. Education and Training of Unlicensed Nursing Personnel, Rule 325.22001 – Rule 325.22004.

that without clarification regarding the meaning of the phrase "seriously affects the health, safety, and welfare" as used in MCL 333.20168, it had no notice whatsoever that the conditions at its facility could result in the revocation of its license is completely without merit. The existence of the comprehensive administrative rules specifically applying to nursing homes promulgated by the Bureau demonstrate that that petitioner had notice of the standards to which it was supposed to adhere in order to safeguard the health, safety, and welfare of its residents but did not. Petitioner has not shown that the circuit court's finding of no due process violation was clearly erroneous.

C.

Next, petitioner contends that the circuit court erred by deferring to the Bureau's use of unpromulgated criteria to support emergency revocation and as a result violated its due process rights when it improperly based the emergency revocation on a "draft version" of Bureau policy and Medicaid rules. Respondent argues that petitioner's argument is false because there is no factual support in the record for petitioner's assertion that respondent used unpromulgated criteria as basis for the revocation of its license. As previously stated, a circuit court's review of administrative proceedings is limited to determining whether the decision was authorized by law and supported by competent, material, and substantial evidence on the whole record. Const 1963, art 6, § 28; *VanZandt, supra* at 588. And, here, competent, material, and substantial evidence on the whole record adequately supported the ALJ's decision that Director Wheeler based his revocation solely on the authority granted to the Bureau under MCL 333.20168. This is a factual dispute, and this Court gives due deference to the expertise of an administrative agency, and will not "invade the province of exclusive administrative fact-finding by displacing an agency's choice between two reasonably differing views." *Widdoes, supra* at 286.

D.

Petitioner argues that the circuit court erred by applying an abuse of discretion standard of review and as a result affirming respondent's agency action that was arbitrary, capricious, and ultimately an abuse of discretion. In support of its argument, petitioner asserts that Director Wheeler's decision was arbitrary, capricious, and an abuse of discretion because he created and applied his own unwritten standards. Respondent contends that the circuit court found that there was no abuse of discretion when Rosewood's license was revoked under MCL 333.20168 after numerous violations of the nursing home rules put its residents in danger.

A final agency decision is subject to court review but it must be upheld if it is not contrary to law, is not arbitrary, capricious, or a clear abuse of discretion, is not otherwise affected by a substantial and material error of law, and is supported by competent, material, and substantial evidence on the whole record. Const 1963, art 6, § 28; MCL 24.306(1)(d); *VanZandt, supra* at 583-584; *Dignan, supra* at 576. In other words, in reviewing the circuit court's ruling on an agency's decision, this Court considers whether the substantial evidence test was met. "Substantial evidence is the amount of evidence that a reasonable person would accept as being sufficient to support a conclusion; it may be substantially less than a preponderance of the evidence." *Wayne Cty v Michigan Tax Comm*, 261 Mich App 174, 186-187; 682 NW2d 100 (2004). Thus, here, the test is whether a reasonable person would agree that Director Wheeler had sufficient evidence to support his conclusion to revoke petitioner's license on an emergency basis. As discussed by the circuit court, the test arguably is a "common sense" test and we agree that a "common sense approach" should be applied to these circumstances. A "common sense

approach" is one in which a reasonable person weighing the facts would find the conclusion clearly evident.

Petitioner first points out that rule violations are common in the industry and that the average number of violations per nursing home is nine. While the number of violations is important in the analysis, we agree with petitioner's contention that the mere existence of "some number" of violations should not result in license revocation. Though importantly, here, the July 2003 survey revealed that petitioner had over 40 violations, or more than four times the average. Ultimately, after a ten day hearing, the ALJ upheld twenty-four specific violations. But merely totaling the violations does not address the severity of the violations. Under a "common sense approach," the decision maker must consider both the number of violations and the severity of the violations. For example, although failing to post an alternate lunch menu or having an operational window-covering in a patient's room are violations, under a "common sense approach" they cannot compare to the severity of petitioner's violations of having exposed wiring dripping with water in a shower stall used to shower residents, storing gasoline under a steamer unit in the dish room which is used in meal preparation and service, or having a nonoperational fire safety door coupled with innumerable uncapped exposed wires throughout the facility. The risks posed by petitioner's violations we just mentioned are clearly evident to any reasonable person. And as evidenced by the record, these examples just barely scratch the surface of the deplorable and dangerous conditions in the Rosewood facility.

Petitioner also points out that, when questioned, Wheeler could not point to specific standards on which he based his decision to revoke petitioner's license. It is impossible to apply a "bright line" objective rule regarding when licenses can be revoked under MCL 333.20168, instead, the circumstances require the more subjective "common sense approach" we have applied. While the "common sense approach" is not one of mathematical certainty, nonetheless the approach necessarily employs a sliding scale test requiring a searching inquiry into both the number of violations present as well as the severity level of the individual violations and their effect on the health, safety, and welfare of the residents of the nursing home. Here, surveyors found many violations ranging from minor to extremely severe in petitioner's facility and, the record contains competent evidence to support those violations, such that a reasonable person applying a "common sense approach" could decide that those violations were sufficient to support Director Wheeler's decision that the patients in petitioner's facility were endangered. As a result, the circuit court did not err when it affirmed respondent's agency action to revoke petitioner's license.

E.

Finally, petitioner argues that the circuit court erred by affirming the Bureau's actions in excess if its statutory authority. Petitioner asserts in particular that respondent ignored the statutory presumption found in MCL 333.21799b(6) that the nursing home should remain open. Respondent argues that since petitioner's assertion that the Bureau relied on specified unpromulgated criteria in revoking its license was objectively false, the circuit court did not err by disregarding petitioner's assertion.

Interestingly, in its brief on appeal, petitioner fails to quote the entire subsection of MCL 333.21799b(6), the statute on which it relies. MCL 333.21799b(6) provides in its entirety:

> (6) *If the department determines that a nursing home's patients can be safeguarded and provided with a safe environment,* the department shall make its

> decisions concerning the nursing home's future operation based on a presumption in favor of keeping the nursing home open. [MCL 333.21799b(6) (emphasis added).]

Thus, the statutory presumption found in MCL 333.21799b(6) that the nursing home should remain open applies *only* in those circumstances where the Bureau determines that the nursing home's residents can be "safeguarded and provided with a safe environment[.]"

Given the fire hazards from patients who smoked and the nonoperational fire door, the uncovered, wet, electrical wires in the shower area, the storage of a poisonous substance in the kitchen, the unlabeled and uncovered food in the refrigerator, the filthy conditions in the food preparation areas, the storage of waste, and the failure to have an infection control procedure, the record reflects that the patients at petitioner's facility would not have been able to be "safeguarded and provided with a safe environment" within a reasonable time, as a direct result of just a few of the serious violations present at petitioner's facility. The record reflects that the dangerous conditions present at the facility were too many in number and the severity level so high that the dangerous conditions were endemic to the facility. Thus, as a practical matter, petitioner would not have been able to cure the dangerous conditions such that a safe and healthy living environment would be provided for the patients in a reasonable period of time. Further, in light of petitioner's history contained in the administrative record, petitioner cannot demonstrate that it would have complied with the alternative options it proposes in its brief on appeal that Wheeler could have taken short of closure, or even that the alternatives could have been completed in a timely fashion ensuring the health, safety, and welfare of the residents, particularly given the number and severity of violations.

That being said, we recognize that petitioner did take immediate steps to rectify a few of the most dangerous violations found by the survey, such as moving the gasoline can from the dish room to the garage and shutting down the shower stall that was an electrocution hazard. Petitioner disputes the finding that staff did not turn patient #603 every two hours by arguing in part that the patient's other medical conditions made the development of bed sores unavoidable along with a host of other disputes regarding other survey findings. While we have scoured the record in this case, this Court's review rightly does not encompass a point-by-point factual review. This Court gives deference to an agency's findings of fact, particularly with regard to witness credibility and evidentiary questions. A reviewing court does not resolve conflicts in evidence or decide on witness' credibility. *Black v Dep't of Social Services*, 195 Mich App 27, 30; 489 NW2d 493 (1992). Because the record evidence supports the agency's findings of fact, the statutory presumption, MCL 333.21799b(6), simply does not apply to this case and the circuit court did not err by affirming the Bureau's exercise of its statutory authority.

IV. Conclusion

Because the administrative hearing record included competent, material, and substantial evidence on the record as a whole of many dangerous violations of the nursing home rules such that a reasonable person applying a "common sense approach" could conclude the established violations seriously affected the health, safety, and welfare of the residents of the nursing home,

the circuit court properly affirmed the ALJ's decision revoking respondent's license to operate its Rosewood facility on an emergency basis.

Affirmed.

/s/ Deborah A. Servitto
/s/ Pat M. Donofrio
/s/ Karen M. Fort Hood