RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

November 12, 2017

Michele Walny
Oakmont Rochester Assisted
3466 South Blvd. W.
Rochester Hills, MI 48309

RE: License #: AH630338700
Investigation #: **2017A1009048**
Oakmont Rochester Assisted

Dear Ms. Walny:

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 (248) 975-5053.

Sincerely,

Linda Denniston, Licensing Staff
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(517) 899-5620

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630338700
Investigation #:	2017A1009048
Complaint Receipt Date:	09/12/2017
Investigation Initiation Date:	09/15/2017
Report Due Date:	11/12/2017
Licensee Name:	Pomkal Rochester Assisted, LLC
Licensee Address:	Suite 100 25480 Telegraph Road Southfield, MI 48033
Licensee Telephone #:	(248) 354-7200
Authorized Representative and Administrator:	Michele Walny
Name of Facility:	Oakmont Rochester Assisted
Facility Address:	3466 South Blvd. W. Rochester Hills, MI 48309
Facility Telephone #:	(248) 564-2200
Original Issuance Date:	05/22/2015
License Status:	REGULAR
Effective Date:	11/22/2015
Expiration Date:	11/21/2016
Capacity:	84
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A's disposable briefs are not changed regularly causing skin breakdown.	Yes
Resident B is not receiving her prescribed oxygen.	No
Staff stopped administering Resident B's prescribed eye drops before the required full 7 days of medication.	Yes

III. METHODOLOGY

09/12/2017	Special Investigation Intake 2017A1009048
09/15/2017	Special Investigation Initiated - Telephone Telephoned APS.
09/29/2017	Inspection Completed on site
09/29/2017	Exit Conference with Michele Walney, Regional Manager
10/02/2017	Telephoned Ms. Safronoff to discuss allegations.

ALLEGATIONS:

- **Resident A's disposable briefs are not changed regularly causing skin breakdown.**

- **Resident B is not receiving her prescribed oxygen.**

INVESTIGATION:

This complaint came to the bureau intake unit from Oakland County Adult Protective Services (APS). The complainants' name was not provided; therefore, I was unable to interview and gather further information from the complainant

On 9/29/17, I interviewed staff person Jennifer Skinner at the facility. Ms. Skinner told me that she was very familiar with Resident A and her care needs. Ms. Skinner reported, "The worst breakdown was in July and August. Both cheeks were red and raw. There was no oozing but it was extremely red and it was difficult to apply the cream. She is now getting out of bed more and the breakdown is better. Now, she has about a dime size red mark in the crack." Ms. Skinner explained that Resident A had

many bouts of diarrhea during those two months, which contributed to the breakdown. She also stated, “I can’t vouch for other shifts, but we checked her brief every hour and changed her when needed.”

I reviewed Resident A’s *Nurse Progress Notes* for 7/25 and 7/26. The 7/25 progress note read,” Nurse spoke to daughter regarding Helen's diarrhea and skin break down. Informed her that [Resident A] has had four episodes of loose stools today thus far and that upon assessment resident was noted to have excoriation to bilateral buttocks, no bleeding but very painful to touch.” A 7/26 note read, “…Care staff will continue 1 – 2 hour wellness and incontinent checks.”

On 9/29/17, I interviewed Oakmont Regional Manager, Michele Walney at the facility. Ms. Walney stated, “There was a problem with staff. The prior administrator is on sick leave. I am the acting administrator. We now have the right staff and we have enough staff. I have developed a check sheet for staff accountability that documents when they check and change [Resident A’s] briefs. I have made a lot of changes to get things back on track.”

The referenced check sheet for the month of August was shown to me by Ms. Walney. This check sheet was to be initialed every two hours by the staff person who checked and changed (if needed) Resident A’s brief. I noted that there were no initials (blanks) on approximately 50% of the sheet. Ms. Walney agreed staff not completing the sheet was unacceptable. A notation on the bottom of the sheet dated 8/17, read, “Resident buttocks breaking down again.”

I did not have the pleasure of interviewing Resident A on 9/29/17, as she was out of the building on an outing.

I did not see any prescription for oxygen in Resident B’s file. A home nurse, Deborah Mazur, reported that there is no prescription for oxygen for Resident B.

On 10/2, I interviewed APS investigator Pam Safronoff by telephone. Ms. Safronoff stated that, based on her investigation she also is not substantiating this allegation.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.

ANALYSIS:	Complainant alleged that Resident B is not receiving her prescribed oxygen the required 24/7. However, based on review of Resident B's file, there is no prescription for oxygen. This was confirmed by the home's nurse. Complainant alleged that Resident A's disposable briefs are not changed regularly causing skin breakdown. I reviewed the nurse's progress notes for 7/25 and 7/26, for Resident A. These notations indicated that Resident A did have diarrhea and subsequent skin breakdown on her buttocks. Resident A was to have staff assistance to check adult briefs and, if needed, change them every two hours. Based on the staff's accountability check lists, these checks were only done approximately 50% of the time. The record indicated that Resident A had skin breakdown again on 8/17/17.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

- **Staff stopped administering Resident B her prescribed eye drops before the required full seven days of medication.**

INVESTIGATION:

On 9/29/17, I reviewed Resident B's 8/15/17 through 9/14/17 medication administration record (MAR). This MAR noted that Resident A was to receive Tobramycin eye drops at 9:00 am and 9:00 pm. The prescription read, "Tobramycin 0.3%, one drop OD, bid, x7d". The MAR documented that Resident A had only received the 9:00 am dose of Tobramycin eye drops three days, 8/24, 8/25, and 8/26. A notation on the MAR next to the 8/26 entry read that it was, "D/Ced". The PM dose was given as prescribed.

On 9/29 I interviewed the acting Administrator and Authorized Representative, Michele Walney. Ms. Walney reported that they have no idea who put that notation on the MAR. They have done an investigation and interviewed all staff. No one admits to doing it. Ms. Walney explained that the notation was made in error and the AM medication should not have been discontinued at that time. Ms. Walney reiterated that there were problems with staff accountability in the past, and changes are being made to correct it.

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:	Resident B was to receive two doses daily of the Tobramycin prescription medication. The MAR revealed that she only received three of the required seven am doses of the medication because a staff person noted on the MAR, in error, that the am dose was discontinued. The staff did not administer medications consistent with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

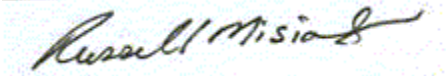
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, the license status will remain unchanged.

11/12/17

Linda Denniston — Date
Licensing Staff

Approved By:



11/13/17

Russell B. Misiak — Date
Area Manager