GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 10, 2019

Manda Ayoub
Pomeroy Living Rochester Assisted
3466 South Blvd. W.
Rochester Hills, MI 48309

RE: License #: AH630338700
Investigation #: 2019A0585034
Pomeroy Living Rochester Assisted

Dear Ms Ayoub:

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.

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,

Brender L. Howard

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(313) 268-1788

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630338700
Investigation #:	2019A0585034
Complaint Receipt Date:	05/16/2019
Investigation Initiation Date:	05/20/2019
Report Due Date:	07/15/2019
Licensee Name:	Pomkal Rochester Assisted, LLC
Licensee Address:	Suite 100 25480 Telegraph Road Southfield, MI 48033
Licensee Telephone #:	(248) 354-7200
Administrator:	Brad Peruski
Authorized Representative:	Manda Ayoub
Name of Facility:	Pomeroy Living 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:	08/07/2018
Expiration Date:	08/06/2019
Capacity:	84
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Residents are being verbally, physically, and emotionally abused.	Yes
The facility does not have enough staff on duty.	No
Residents are not getting their medication on time.	No
Additional Findings	No

III. METHODOLOGY

05/16/2019	Special Investigation Intake 2019A0585034
05/20/2019	Special Investigation Initiated - Telephone Interviewed the complainant by telephone.
05/21/2019	APS Referral I reported the allegations to Adult Protective Services (APS).
05/22/2019	Inspection Completed On-site Completed with observation, interview and record review.
05/22/2019	Inspection Completed-BCAL Sub. Compliance
08/13/2019	Exit Conducted with authorized representative Manda Ayoub.

ALLEGATION:

Residents are being verbally, physically and emotionally abused.

INVESTIGATION:

On 5/16/19, the department received the allegations from the complaint via the BCAL Online complaint website. On 6/20/19, the department received additional allegations via adult protective services.

On 5/20/19, I received the allegations via email from the facility. On 5/24/19, I received additional allegations with additional residents from the facility. The email noted the following:

On 5/17/19 at approximately 10:00 a.m. writer (Lisa Markey-director of wellness) received a report from Resident B that while she was receiving care, the evening before, the caregiver had used a gloved hand to cover her mouth. When the resident was turned over onto her side, she had yelled out in pain and it was at that point that the staff placed a gloved hand over her mouth, in an attempt to silence her yelling. Resident B then proceeded to describe the individual and the time of the occurrence." This report noted that an investigation was completed, and it was determined that the caregiver was Thelma Wellons. It notes, Ms. Wellons was interviewed, and she denied the allegations.

At approximately 10:00 a.m. of 5/24/19, writer (Lisa Markey-Director of Wellness) received a phone call from Adult Protective Services that another complaint had been submitted to her office regarding possible abuse toward Resident C, D, G, and H. Four separate reports of investigation were completed as follows.

The reports notes, that an interview was conducted with Resident C and her son. It notes, son has no concerns regarding the staff. No comment was made by Resident C.

The report notes, that an investigation was completed for Resident D. It notes Resident D feels that at times the staff rush her to and from the bathroom. She feels that although she can walk, she needs the staff to oversee her steps from the recliner to her bathroom until she is seated, on either one. She admits to being rushed at times and the staff often do not stand to wait until she has made it back safely to her recliner before "bolting out the door". It notes, Resident D was unable to give any specific names at that time. The report also notes that Resident D also reported that she feels as though the staff are mumbling to her. She feels as though they are intentionally speaking to her in mumbled voices, which makes it difficult for her as she already struggles with being hard of hearing. The reports note that after the investigation, it was the conclusion that the staff needed to be reminded to speak clearly and to respect Resident D's wishes to have oversight when she walks to and from the toilet.

The report for Resident G notes that resident admits to having slow mornings, where care staff do not show up as readily as she would like them to. It also notes, in the evenings, it appears to her that the staff are more in a rush to get their tasks completed.

On 5/21/19, I made a referral to adult protective services (APS). This case was assigned to APS worker Madalyn Gareau.

On 5/21/19, I interviewed the complainant by telephone. The complainant stated that residents at the facility are being abused. She stated that she talked to Resident B, C, D, E, F and G and they all have expressed concerns that they are afraid of some staff. Complainant stated that she had spoken to management and they do not do anything because the staff that was abusive is still working there.

The complainant stated that management told her that what was provided was not enough evidence. She stated that Resident B does not have memory problems and neither do the other resident that is listed in the complaint. She stated that some of the staff was rough and talk mean to the residents.

On 5/22/19, I interviewed the administrator Brad Peruski at the facility. Mr. Peruski stated that there are a couple of staff that they are keeping their eyes on. He stated that he investigated all allegations. He stated they spoke to care aides Jessica Simpson and Thelma Wellons and could not substantiate the claims of abuse. Mr. Peruski provided service plans, incident reports, shower sheets, and investigations reports for review.

On 5/22/19, I interviewed director of wellness Lisa Markey at the facility. Ms. Markey stated that she was informed that Resident B had issues the night before. She stated that it was alleged that staff rolled Resident B over in pain. She stated that the resident stated that staff placed a glove over her mouth. She stated that Resident B told her that two people came in her room during the midnight shift and she had soiled her clothes. Ms. Markey stated that staff allegedly gave her the “stink eye”. She stated the two staff was determined to be care aides Lashaundra George and Jessica Simpson. Ms. Markey explained that she interviewed Resident B, and human resource coordinator Tracy Black interviewed Ms. George. She stated that neither one knew about the incident. She stated they reviewed the camera and they camera revealed that staff went into Resident B’s room with clean items and left with tied up bags containing dirty items. She stated that they could not substantiate the claim. She stated that because the claim could not be substantiated, they ensured Ms. George and Ms. Simpson no longer worked with Resident B. She stated that there have been no other issues with the staff. She stated that staff complete training orientation, 2-3 days shadowing other caregivers, and must complete a competency evaluation prior to working on their own.

On 5/23/19, I interviewed Ms. Jessica Simpson by telephone. She stated that she has never abused any resident and has never heard of any other staff being abusive. She stated that she doesn’t know anything about the incident with Resident B or with any other resident.

On 5/23/19, I interviewed care aide Alesha James at the facility. She stated that two of the residents have told her that they didn’t want Ms. Simpson to come into their room because she was not friendly and could be rough. She stated that she did not say anything to the nurse or management about Ms. Simpson.

On 5/23/19, I interviewed care aide Diana Ayale at the facility. Ms. Ayale stated that she has never had any problems with residents. She stated that Resident B told her that staff was being mean to her and she advised Resident B to talk the manager about it.

On 5/23/19, I interviewed Resident B at the facility. Resident B stated that there are good and bad workers working at the facility. She stated that staff was supposed to put her in the bed at night and she was dominating. She stated that she talked to the lady (staff). She stated that one of the staff was Ms. Simpson but she did not know the other staff name that was in her room. She stated Ms. Simpson was strong and was very aggressive when putting her to bed. She stated that the staff pushed her to the side of the bed hurting her. She stated that Ms. Simpson told her to shut up and then put her hand over her mouth. She stated that the other staff with Ms. Simpson told her that would shut her up now. Resident B stated that Ms. Simpson was using the same glove that she had cleaned her up with. She stated, that on another night she thought the same staff hit her on the shoulder during the provision of care. Resident B stated that she told others not to allow the worker to help her anymore. She stated that she told them that she no longer wanted that worker in her room. She stated that it was hard to say if it was really the same person because her hairstyle was different, but she sounded the same. She stated that she feared Ms. Simpson and the other staff. She stated that on another night, during the midnight shift, two staff came in to assist her and she can't remember who it was. She stated that the staff were talking and never changed her, but they said that they were going to leave it and let the next shift clean me up. She stated the staff at night is awful and mean to her.

On 5/23/19, I interviewed Resident C who stated she fell in the bathroom of her room at the facility. She stated that no one was with her at the time. She stated that she went to the bathroom and tripped. Resident C stated that she pushed the call button for help, but no one came to help her. She stated that after no one came she took her shoe and pound on the wall. Resident C stated that she asks the aides to help her and they tell her that she can walk on her own. She stated the aides do not assist her and they are mean. Resident B stated she is afraid to walk alone, and the staff will not help her. She said that most of the staff are mean and she did not give a specific name.

On 5/23/19, I interviewed Resident D at the facility. Resident D stated that staff can be nasty. She stated that staff would not help her off the toilet. She stated that staff was too busy out talking to somebody about shopping. She stated that she had to get herself off the toilet. She stated they would not help her. She stated that she writes down everything. She stated that she would not escort her back to her chair and that staff left out before she was able to sit down and write her notes. She stated that she did not know her name, but she remember that she was a med tech.

On 5/23/19, I interviewed Resident E at the facility. Resident E stated that staff is rough, and they hurt his body when they were turning him. He stated that the staff make him feel unsafe. He stated that the staff do not have a good attitude. He stated that when they take him to the bathroom, they rush him, and he need more time. Resident E stated when he tells them they are being rough; they never apologize but continue to be rough. Resident E did not remember the name of the staff who was being rough. Resident E stated that sometimes it is all of them.

On 5/23/19, I interviewed Resident G at the facility. Resident G stated that staff always rushing her. She stated they are always in a hurry. She stated that they can be rough at times. Resident G stated that all the staff seems to be in a hurry and could not provide a name of a specific staff.

On 5/23/19, I interviewed Resident H at the facility. Resident H stated that some of them are helpful. She stated that some of the aides ignore her when she requests help. She stated that the aides act like she be imposing most of the time they come in to help her. Resident H could not provide a name of the staff.

I was given documentation that employees had been given resident rights and abuse training.

I reviewed the service plans of B, C, D, E, F, G and H.

Resident B's service plan notes that she requires total assistance with all ADL care. The plan also notes, the resident is not ambulatory and two persons with Hoyer lift to transfer.

The service plan for Resident C notes use walker for ambulation. It also notes, resident needs transfer assistance.

The service plan for Resident D notes that residents will ring call lights frequently, anticipate resident needs. It also notes, that she is incontinent of bowel and bladder, requires incontinence care and linen changes.

The service plan for Resident E notes that assistance needed to use toilet and maintain bladder continence. It also notes Resident E have fall issues and to call for assistance.

The service plan for Resident F notes one person assist with dressing and assistant with showers.

The service plan for Resident G notes resident does not walk and requires total assistance with dressing, bathing and grooming. It also notes Resident G is incontinent of bladder and care need to be provided.

The service plan for Resident H notes, one person assists for bathing and grooming.

APPLICABLE RULE	
R 325.1931 (2)	**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:	While I did not find that residents are being mentally and physically abused, there does appear to be consistent statements of rough handling and reported undignified staff statements towards residents during the provision of care. Interviews with staff reveal the facility trains new staff on the proper provision of care, resident rights and responsibilities, and resident abuse. Residents B, C, D, E, G, and H all reported staff to resident interactions that were inconsistent with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility does not have enough staff on duty.

INVESTIGATION:

The complainant stated that the facility does not have enough staff. She stated there is one staff taking care of twenty residents. She stated that there are some residents who are not getting their showers because of the lack of staff.

Mr. Peruski reported facility is adequately staffed on first, second, and third shift. Mr. Peruski stated there are nine resident care aides in the facility on first and second shift and five resident care aides on third shift. Mr. Peruski explained the resident care aides also pass medications.

I interviewed staff scheduler Lakeisha Thomas by telephone. Ms. Thomas's statements were consistent with Mr. Peruski statements. Ms. Thomas stated that the number of staff assignments are based on the census. She stated that when they have call ins or no shows, staff stay over to fill the shift. She stated that staff are also called and asked to pick up shift vacancies.

Ms. James stated that she did not know how many staff supposed to be scheduled on first, second and third shift at the facility. Ms. James stated that she works the best she can. She stated that staff work together. She stated that some staff work harder than others, but for the most part staff work together to attend to the needs of the residents.

Ms. Ayale statements were consistent to Ms. Thomas. She stated that staff are called in and asked to pick up shift vacancies.

Mr. Peruski provided me with a copy of the staff schedule for the requested dates of 5/22, 5/29, 6/8, 6/9, 6/11, 6/15, 6/16, and 6/19/19 for my review. The schedule was consistent with Mr. Peruski's statements. Mr. Peruski also provided me with a copy of the resident shower sheets.

During my interview with Resident B, C, D, E and H, they all stated that there is enough staff at the facility. Resident B stated that although there is enough staff, they don't do what they are supposed to do when they come in the room. All the residents interviewed stated that they do not have a problem with getting showers.

I reviewed the shower sheets for Residents B, C, D, E, F, G and H. The shower sheets note that showers were given consistent to resident's service plans.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	Resident interviews and personal observations reveal resident provision of care including showers are provided. The facility had sufficient staff to provide for the needs consistent with service plans.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents are not getting their medication on time.

INVESTIGATION:

This allegation was received at a different time and was submitted anonymously. Therefore, I was not able to clarify the complainants concerns or gather more information.

Ms. Markey stated that procedures are in place for staff to follow when administering their medication which includes giving it to the residents at the time prescribed.

Ms. Ayale stated that she administers medication according to the resident's medication administration record (MAR). Ms. Ayale stated that she administers by the time listed on the MAR.

Resident B, C, D, E, F, G, and H stated that they did not have problem with getting their medication. They indicated that medication is given on time.

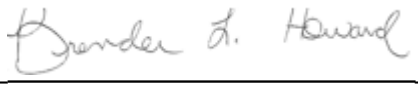
I reviewed the medication administration records (MAR) for Residents B, C, D, E, F, G and H. The MAR documents that all medication was given as prescribed.

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, C, D, E, F, G and H's service plan identifies that it is staff's responsibility to ensure they receives their medication. Interview with Ms. Markey reveals medication administration procedures that consider and provide steps for staff to follow to ensure residents are given their medication on time. Review of the MAR reveals staff administered medication as prescribed. Inspection of MARs revealed medication was properly given to Residents B, C, D, E, F, G and H as ordered. Based on these findings' allegation could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 8/13/19, I shared the findings of this report with the licensee authorized representative Manda Ayoub by telephone.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remains unchanged.



8/13/19

Brender Howard
Licensing Staff

Date

Approved By:

8/13/19

Russell B. Misiak
Area Manager

Date