GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 15, 2021

Vijay Sahore
Assured Senior Living Group, LLC
25180 Lahser Road
Southfield, MI 48033

RE: License #: AH630382886
Investigation #: 2021A1027021
Royal Oak House

Dear Mr. Sahore:

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 licensee authorized representative 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) 284-9727.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AH630382886 |
| | |
| **Investigation #:** | 2021A1027021 |
| | |
| **Complaint Receipt Date:** | 03/02/2021 |
| | |
| **Investigation Initiation Date:** | 03/05/2021 |
| | |
| **Report Due Date:** | 05/01/2021 |
| | |
| **Licensee Name:** | Assured Senior Living Group, LLC |
| | |
| **Licensee Address:** | 25180 Lahser Road<br>Southfield, MI 48033 |
| | |
| **LicenseeTelephone #:** | (248) 262-2205 |
| | |
| **Administrator:** | Karen DeLaFlor |
| | |
| **Authorized Representative:** | Vijay Sahore |
| | |
| **Name of Facility:** | Royal Oak House |
| | |
| **Facility Address:** | 1900 N. Washington Ave.<br>Royal Oak, MI 48073 |
| | |
| **Facility Telephone #:** | (248) 585-2550 |
| | |
| **Original Issuance Date:** | 03/01/2018 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 09/03/2020 |
| | |
| **Expiration Date:** | 09/02/2021 |
| | |
| **Capacity:** | 57 |
| | |
| **Program Type:** | ALZHEIMERS<br>AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A received an antipsychotic medication in error. | Yes |
| Resident A's laundry was not completed. | No |
| The facility did not provide Resident A meals. | No |
| Resident A lacked protection. | No |
| Additional Findings | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 03/02/2021 | Special Investigation Intake<br>2021A1027021 |
| 03/05/2021 | Special Investigation Initiated - Telephone<br>Interviewed complainant via telephone. |
| 03/17/2021 | Contact - Document Sent<br>Email sent to administrator requesting documentation pertaining to investigation. |
| 03/19/2021 | Contact - Document Received<br>Received requested documentation from administrator K. DeLaFlor |
| 03/23/2021 | Contact - Telephone call made<br>Telephone interview conducted with administrator K. DeLaFlor |
| 03/25/2021 | Contact - Document Received<br>Received requested documentation from administrator K. DeLaFlor |
| 03/30/2021 | Contact - Document Received<br>Received requested documentation from admin K. DeLaFlor |
| 04/07/2021 | Contact - Document Sent<br>Requested MARs from administrator K. DeLaFlor |

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|---|---|
| 04/07/2021 | Contact - Telephone call made<br>Requested documentation from OneCare Pharmacy LTC |
| 04/07/2021 | Contact - Telephone call made<br>Requested documentation from Dr. Karoub's office |
| 04/14/2021 | Contact - Telephone call made<br>Left voicemail with OneCare Pharmacy LTC |
| 04/14/2021 | Contact - Telephone call made<br>Left voicemail with employee M. O'Neil. |
| 04/14/2021 | Contact - Telephone call made<br>Left voicemail with employee A. Reynolds |
| 04/14/2021 | Contact - Telephone call received<br>Telephone interview conducted with OneCare Pharmacist H. Boutros |
| 04/15/2021 | Contact - Document Received<br>Received requested documentation from admin K. DeLaFlor |
| 04/15/2021 | Contact - Telephone call received<br>Telephone interview conducted with staff nurse M. O'neil. |
| 04/15/2021 | Inspection Completed-BCAL Sub. Compliance |
| 04/15/2021 | Contact - Telephone call received<br>Telephone interview conducted with shift supervisor A. Reynolds |
| 04/16/2021 | Contact - Telephone call received<br>Telephone interview conducted with administrator Karen DeLaFlor and director of nursing Yacrisha Wilson |
| 04/22/2021 | Inspection Completed On-site |
| 04/26/2021 | Contact - Telephone call made<br>Telephone interview conducted with staff nurse Michelle O’Neil |
| 4/26/2021 | Exit Conference<br>Conducted with authorized representative Vijay Sahore |

**ALLEGATION:**

**Resident A received an antipsychotic medication in error.**

**INVESTIGATION:**

On 3/2/21, the department received a complaint alleging Resident A received an antipsychotic medication in error.

On 3/5/21, I conducted a telephone interview with the complainant. The complainant stated Resident A was administered the antipsychotic medication Quetiapine Fumarate. The complainant stated she discovered the antipsychotic medication on the pharmacy bill and immediately called to discuss it with the facility. The complainant stated she spoke with staff nurse Michelle O'neil who reported she did not know why the medication was on the bill and it was a mistake. The complainant stated the pharmacy bill also read Resident A was receiving Calmoseptine cream three times per day. The complainant stated Resident A did not have wound areas requiring Calmoseptine cream and alleged that the facility did not apply it to her bottom area three times per day. The complainant stated Resident A discharged from the facility on 1/20.

On 3/23/21, I conducted a telephone interview administrator Karen DeLaFlor. Ms. DeLaFlor stated the administration of the antipsychotic medication Quetiapine Fumarate was a result of their pharmacy entering the medication into Resident A's medication administration record in error. Ms. DeLaFlor stated the medication error was reported to Resident A's physician, authorized representative, and the pharmacy. Ms. DeLaFlor stated Resident A was not harmed after receiving it. Ms. DeLaFlor stated Calmoseptine is a standard cream ordered and applied to prevent skin breakdown on buttock area.

On 4/14/21, I conducted a telephone interview with OneCare pharmacist Hany Boutros. Mr. Boutros stated the pharmacy entered the antipsychotic medication Quetiapine Fumarate in error. Mr. Hany stated the reason why the error occurred because Resident A's prescription was written on the same prescription as another resident. Mr. Boutros stated the medication error was recognized shortly after entry and discontinued; however, the medication could have still been dispensed in error due to timing of the discontinuation of the medication.

On 4/15/21, I conducted a telephone interview with staff nurse Michelle O'Neil. Ms. O'Neil statements were consistent with Ms. DeLaFlor and Mr. Boutros. Ms. O'Neil stated Calmoseptine acts as a "barrier" cream and is ordered as a standard treatment when residents wear briefs.

On 4/15/21, I conducted a telephone interview with afternoon shift supervisor April Reynolds. Ms. Reynolds statements were consistent with Ms. DeLaFlor and Ms. O'Neil.

On 4/16/21, I conducted a telephone interview with administrator Ms. DeLaFlor. Ms. DeLaFlor stated medications are entered by the pharmacy then verified again by facility staff.

I reviewed the facility's physician medication order policy. The policy read the pharmacy transcribes the medication order into the residents Electronic Medication Record (EMR), then a facility staff member verifies the medications were entered correctly. Facility staff electronically approve the order before it is moved into the EMR for administration to the resident. The physician medication order policy was updated on 10/27/20 to read that two facility staff members are required to verify medications after pharmacy enters them.

| **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:**<br>**(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.** |
| **For Reference: R325.1901** | **Definitions.** |
| | **(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.** |

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| **ANALYSIS:** | Interviews with facility staff, the pharmacist and review of facility records revealed a medication error occurred as result of the pharmacy staff entering the medication incorrectly. Facility staff did not reasonably follow the physician medication order policy to ensure medications were entered correctly. Based on this information, this allegation can be substantiated. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION:**

**Resident A's laundry was not completed.**

**INVESTIGATION:**

On 3/2/21, the department received a complaint alleging Resident A's laundry was not completed.

On 4/16/21, I conducted a telephone interview with administrator Karen DeLaFlor. Ms. DeLaFlor stated Resident A's family was to complete laundry for Resident A. Ms. DeLaFlor stated the application for admission agreement reads there are additional costs for the facility to complete laundry services. Ms. DeLaFlor stated Resident A's application for admission agreement read no additional costs for laundry. Ms. DeLaFlor stated the facility provides weekly linen services such as towels and washcloths at no additional cost.

On 4/22/21, I conducted an on-site inspection at the facility. I observed a sufficient supply of clean linen available for resident use. I interviewed assistant administrator Joel Schoenberg and his statements were consistent with Ms. DeLaFlor.

Review of Resident A's application for admission was consistent with statements from Ms. DeLaFlor.

| **APPLICABLE RULE** | |
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| **R 325.1935** | **Bedding, linens, and clothing.** |
| | **(1) The home shall make adequate provision for the laundering of a resident's personal laundry.** |

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| **ANALYSIS:** | Interviews with the facility staff and review of facility documentation revealed Resident A's laundry was not incorporated into the admission agreement as an additional cost, however the facility provided weekly linen services at no additional cost. Based on this information, this allegation cannot be substantiated. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**The facility did not provide Resident A meals.**

**INVESTIGATION:**

On 3/2/21, the department received a complaint alleging the facility did not provide Resident A meals.

On 4/16/21, I conducted a telephone interview with administrator Karen DeLaFlor and facility director of nursing Yacrisha Wilson. Ms. DeLaFlor stated the facility provides three meals per day and snacks to all residents. The Ms. Wilson stated Resident A had moments of confusion and would report to staff that she did not eat. Ms. Wilson stated dietary aides would remind Resident A that she had eaten and provide her additional food if needed.

On 4/22/21, I conducted an on-site inspection at the facility. I observed lunch being served including pork chops with gravy, sweet potatoes, broccoli, and cauliflower along with bread. The food appeared appetizing and portion sizes were sufficient. The amount of food prepared for 35 residents appeared to be sufficient.

Review of the facility Sysco food purchasing log, meal census and menus for October through December were consistent with statements from Ms. DeLaFlor.

| **APPLICABLE RULE** | |
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| **R 325.1952** | **Meals and special diets.** |
| | **(1) A home shall offer 3 meals daily to be served to a resident at regular meal times. A home shall make snacks and beverages available to residents.** |

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| **ANALYSIS:** | Interviews with facility staff and review of facility documentation revealed it cannot be determined for certain, but it would be assumed that the facility provided Resident A with meals while at the facility. Based on this information, this allegation cannot be substantiated. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**Resident A lacked protection.**

**INVESTIGATION:**

On 3/2/21, the department received a complaint alleging the facility neglected Resident A.

On 3/5/21, I conducted a telephone interview with the complainant. The complainant stated Resident A had a large cut on the front of her shin. The complainant stated on 10/26 the facility nurse had planned to change the wound dressing on Monday, Wednesdays, and Fridays. The complainant alleged the facility did not answer the call lights.

Review of facility progress notes read on 10/18/20, Ms. O'Neil completed wound care to the Resident A's right shin area. On 11/2, Ms. Wilson provided wound care to a small skin tear on Resident A's calf.

On 4/22/21, I interviewed staff nurse Yacrisha Wilson and Ms. DeLaFlor. Ms. Wilson did not recall treating the small skin tear on Resident A's calf and stated she would have obtained orders for further wound care if the area required it. Ms. DeLaFlor stated the facility will request home care services for residents with a wound requiring care beyond first aide. Once the home care nurse evaluates the wound, the treatment plan is incorporated on the medication administration record to be completed. Ms. DeLaFlor stated Resident A's wounds did not require further intervention beyond the initial treatment from Ms. O'Neil and Ms. Wilson.

On 4/26/21, I conducted a telephone interview with Michelle O'Neil. Ms. O'Neil stated the wound did not require dressing changes. Resident A's family would provide showers and cover it with gauze afterwards. Ms. O'Neil's statements were consistent with Ms. Wilson's and Ms. DeLaFlor.

On 4/22/21, I conducted an interview with administrative assistant Joel Schoenberg at the facility. Mr. Schoenberg stated Resident A's call light was not working for approximately half of a day. Mr. Schoenberg obtained a call light from another room,

in the interim, of their contracted company coming to fix it. Mr. Schoenberg stated he confirmed the interim call light was working and showed Resident A's family the call light log.

I observed the call light log on a monitor with Mr. Schoenberg. Mr. Schoenberg stated the facility's call light log only shows the number of times a resident pushes their call button. Mr. Schoenberg stated the call light log reviews only the previous two months. The call light log I observed showed residents who had pressed the call button from 2/19/21 through the present.

On 4/22/21, I conducted an interview with Ms. DeLaFlor. Ms. DeLaFlor and I reviewed the general orientation policy which stated the expectation of caregivers is to answer the calls lights as soon as possible. Ms. DeLaFlor stated that if two caregivers are working together with a resident, then there would be some delay in responding to a resident's call light.

Review of Resident A service plan was consistent with Ms. DeLaFlor's statements.

Review of the medication administration record was consistent with Ms. DeLaFlor's statements.

Review of staff training revealed caregivers are provided training on different topics throughout the year such as dementia, hydration, resident safety and supervision, fire safety. Ms. Wilson stated new caregivers review written material as well as videos during orientation then shadow other caregivers in the facility. The new caregivers demonstrate their skills and are required to be competent prior to providing care independently.

| **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:** | Interviews with facility staff and review of facility documentation revealed the facility provided care consistent with Resident A's service plan. Based on this information, this allegation cannot be substantiated. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

Review of facility documentation revealed a medication error occurred on 10/26/20. The medication Quetiapine Fumarate was given by facility staff from 10/26/20 through 11/13/20.

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1924** | **Reporting of incidents, accidents, elopement.** |
| | **(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.** |
| **For Reference: R 325.1901(17)** | **Definitions**<br><br>**(17) "Reportable incident/accident" means an intentional or unintentional event in which a resident suffers harm or is at risk of more than minimal harm, such as, but not limited to, abuse, neglect, exploitation, or unnatural death.** |
| **ANALYSIS:** | Review of facility documentation revealed a medication error had occurred. The facility corrected the error, notified Resident A's physician, and her authorized representative. However, Resident A was at risk for minimal harm and did not notify the department. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**INVESTIGATION:**

Review of facility documentation revealed the medication administration record was not always initialed when the medication was given. For example, Calmoseptine/Vitamin A&D was not initialed as given on the following dates: 11/9/20, 11/11, 11/21, 11/30, 12/6, and 12/7.

Ms. Reynolds stated Resident A was out of the facility for medication administration on some days in December. Review of the medication administration records revealed when Resident A was out of the facility, the facility staff were able to initial the record and annotate an exception as to why the medication was not given. On 12/16/20, the following medications were not initialed and no reason for exception

was given: Aspirin, Calmoseptine/Vitamin A&D, Citalopram, Lisinopril, Multivitamin, Potassium chloride, Vitamin D3, Zinc sulfate.

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1932** | **Resident medications.** |
| | **(3) If a home or the home's administrator or direct care staff member supervises the taking of medication by a resident, then the home shall comply with all of the following provisions:**<br>**(b) Complete an individual medication log that contains all of the following information:**<br>**(v) The initials of the person who administered the medication, which shall be entered at the time the medication is given.** |
| **ANALYSIS:** | Review of facility documentation revealed facility staff did not always initial when a medication was given. Facility staff did not mark any reason for the missed doses and the MARs were left blank, therefore it cannot be confirmed why the medication administration was not completed as scheduled. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

On 4/26/21, I shared the findings of this report with authorized representative Vijay Sahore. Mr. Sahore verbalized understanding of the citations.

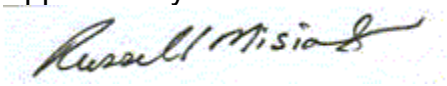
## IV. RECOMMENDATION

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

4/23/21

Jessica Rogers Date
Licensing Staff

Approved By:



4/23/21

_____

Russell B. Misiak Date
Area Manager