GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 17, 2021

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

RE: License #: AH630338700
Investigation #: 2021A1027042
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 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 #:	AH630338700
Investigation #:	2021A1027042
Complaint Receipt Date:	07/15/2021
Investigation Initiation Date:	07/15/2021
Report Due Date:	09/14/2021
Licensee Name:	Pomkal Rochester Assisted, LLC
Licensee Address:	Suite 130 5480 Corporate Drive Troy, MI 48098
Licensee Telephone #:	(248) 354-7200
Administrator:	Bridget Burghardt
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:	08/07/2020
Expiration Date:	08/06/2021
Capacity:	84
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Hospice resident lacked care.	Yes
Facility staff were not trained.	No
Additional Findings	No

III. METHODOLOGY

07/15/2021	Special Investigation Intake 2021A1027042
07/15/2021	Special Investigation Initiated - Letter Email sent to administrator B. Burghardt requesting documentation
07/15/2021	Contact – Document Received Requested documentation received from administrator B. Burghardt
07/30/2021	Inspection Completed On-site Observations made, Staff and resident interviews conducted and documentation obtained
08/09/2021	Contact - Telephone call made Telephone interview conducted with hospice nurse
08/09/2021	Contact - Telephone call made Telephone call made and voicemail left with Resident B's spouse
08/09/2021	Contact - Telephone call made Telephone interview conducted with Resident C's son
08/09/2021	Contact - Telephone call received Telephone interview conducted with Resident B's spouse
08/16/2021	Contact – Document Received Documentation received from hospice agency
08/17/2021	APS Referral Adult Protective Services (APS) referral sent by email
08/17/2021	Inspection Completed-BCAL Sub. Compliance

08/18/2021	Contact – Document Received Requested documentation received from administrator B. Burghardt
08/24/2021	Exit Conference Conducted with authorized representative M. Ayoub

ALLEGATION:

Hospice resident lacked care.

INVESTIGATION:

On 7/15/21, the department received an anonymous complaint which alleged a male resident receiving hospice services was being neglected. Due to the anonymity of the complaint, I was unable to contact the complainant.

On 7/30/21, I conducted an on-site inspection at the facility. Administrator Bridget Burghardt provided a list of residents receiving hospice services, in which there were three male residents. Ms. Burghardt stated all facility caregivers receive training then complete a competency evaluation with skills demonstration. I interviewed residents while on-site. I interviewed Resident A who resides in assisted living and is dependent for care. Resident A stated caregivers provide adequate care. Resident A was sitting in his chair finishing his breakfast in which he appeared clean and groomed. Resident A's room was clean and organized. Resident B and Resident C reside in the memory care and were not able to answer questions appropriately due their diagnoses of dementia. I observed Resident B who was wearing a clean plaid shirt and jeans. I observed Resident C who was wearing a clean stripped shirt and khakis. I observed Resident B and C's rooms which were clean and organized. I observed approximately 20 assisted living residents and seven memory care residents during lunch, who appeared clean and groomed. I interviewed facility staff. I interviewed facility caregiver Toi Glymph, who was assigned to the assisted living unit. Ms. Glymph stated she conducts two-hour checks on all residents, sometimes even more frequently per their service plan. Ms. Glymph stated she has not experienced any other caregiver not providing residents care nor residents with soiled clothing or wet briefs. I interviewed facility caregiver Canya Thrower, who assigned to the memory care unit. Ms. Thrower's statements were consistent with Ms. Glymph. Ms. Thrower stated upon arrival to her shift, residents have been cleaned and changed. In addition, Ms. Thrower stated all the memory care residents have intact skin and receive good care. Ms. Thrower stated all the memory care residents come to the dining area and are assisted with meals, if needed.

On 8/9/21, I conducted a telephone interview with Resident A, B, and C's hospice nurse. The hospice nurse stated she has observed Residents A, B and C with wet

briefs at her visits and has assisted caregivers with changing them. The hospice nurse stated the residents are not always provided thorough peri-care.

On 8/9/21, I conducted a telephone interview with Resident C's son. Resident C's son stated his father has resided at the facility for three years, however, due to the COVID-19 pandemic, his visits have been limited. Resident C's son stated Resident C recently started to receive hospice services and has declined. Resident C's son stated he has not witnessed his father have soiled briefs. Resident C's son stated there had been times when staff have not groomed Resident C's beard and when family informed staff of the concern, it was corrected.

On 8/9/21, I conducted a telephone interview with Resident B's spouse. Resident B's spouse stated there was one incident in Spring 2021 when Resident B had feces all over himself and his room. Resident B's spouse stated she spoke with the facility's wellness director regarding her concern, however since that one incident, there has not been any other issues regarding his care.

I reviewed Resident A, B and C's service plans. Resident A's service plan read he is not able to call for assistance, requires two-hour checks, needs assistance and supervision with all meals, likes to sit up in the chair while eating and requires one person assist for oral hygiene morning and night. Resident B's service plan read he requires wellness checks every hour, one person assistance for grooming, toileting, dressing, oral care every 12 hours and assistance with eating. Resident C's service plan read he requires wellness checks every hour, one person assistance for grooming, toileting, dressing, oral care every 12 hours and assistance with eating.

I reviewed staff documentation regarding service plan tasks assigned to them for Resident A, B and C for June and July 2021. Review of the tasks performed for Resident A revealed caregivers did not always chart a task was completed. For example, the task assigned to staff was to ensure Resident A had adequate intake which required staff assistance and supervision with all meals at 0900, 1300 [1:00 pm], and 1800 [6:00 pm] in which staff were to initial the date/time the task was completed. The tasks report for Resident A's "adequate intake" read that staff did not always initial the task as completed on the following dates/times: 6/6/21 at 0900, 1300 and 1800, 6/19 at 0900 and 1300, 6/20 at 1800, 6/26 at 0900 and 1300, 6/28 at 1800, 6/30 at 1800, 7/8 at 1800, 7/11 at 0900 and 1300, and 7/13 at 0900 and 1300. Resident A's task documentation read staff were to complete oral hygiene every morning and night. The tasks report for Resident A read staff did not always initial oral hygiene as completed twice daily on the following dates 6/5, 6/6, 6/11, 6/19, 6/20, 6/26, 6/28, 6/30, 7/8, 7/11 and 7/13. Review of Resident B's task report revealed that staff did not always initial when an assigned task was completed. For example, the tasks report for Resident B read "Eating: Requires assistance for eating" at 0900, 1300 and 1800. The report read the task was not always initialed as completed on 6/1 at 0900 and 1300, 6/16 at 1800, 6/24 at 1800, 6/27 at 1800, 6/30 at 1300, 7/2 at 1800, 7/3 at 100, 7/4 at 1800, 7/5 at 1800, 7/8 at 1800, 7/10 at 1800 and 7/13 at 1800. In addition, the tasks report for Resident B read "Oral Care

Routine: requires assistance with oral care every 12 hours." The report read the task was not always initialed as completed twice a shift on 6/16, 6/24, 6/27, 7/2, 7/3, 7/4, 7/5, 7/8, 7/10, 7/13 and 7/16. Review of Resident C's task list revealed staff did not always initial when as assigned task was completed. For example, the task report for Resident C read "Eating: Requires assistance for eating" at 0900, 1300 and 1800. The report read staff did not always initial the task as completed on 6/1 at 0900 and 1300, 6/16 at 1800, 6/27 at 1800, 6/30 at 1300, 7/2 at 1800, 7/3 at 1800, 7/4 at 1800, 7/5 at 1800, 7/8 at 1800, 7/10 at 1800 and 7/13 at 1800. In addition, the task report for Resident C read "Oral Care Routine: requires assistance with oral care every 12 hours" in which staff did not always initial the task as completed twice a shift on 6/1, 6/16, 6/24, 7/2, 7/3, 7/4, 7/5, 7/8, 7/10, 7/13 and 7/16.

I reviewed the hospice notes for Resident A, B and C. Resident A's hospice notes read Resident A signed onto hospice services on 12/9/20 with a diagnosis of malignant neoplasm of brain. The hospice notes from 5/25/21 read (Resident A) requires 1:1 attention when eating due to dysphasia. The hospice notes from 6/7 read "Per son, meal tray was in front of patient (Resident A) when he walked in. Patient continues to be 1:1 feed. Son John states no one came in to assist (Resident A) so he helped him." The hospice notes from 7/4 read "Arrived to patient sitting in recliner, self-feeding breakfast, observed patient and cough and threw up clear liquid with pieces of egg." Resident B's hospice notes read Resident B signed onto hospice services on 12/19/20 with a diagnosis of frontotemporal dementia. Resident B's hospice notes read consistent with his service plan. Resident C's hospice notes read Resident C signed onto hospice services on 5/6/21 with a diagnosis of Alzheimer's Disease. Resident C's hospice notes read consistent with his service plan.

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, resident's family, and resident's hospice staff as well as observations revealed it could not be determined which hospice resident was referenced in the complaint, thus three male hospice resident charts were reviewed. Review of facility documentation revealed Residents A, B, and C service plans were consistent with tasks assigned to facility staff, however staff did not always mark the tasks as completed. Since the task documentation was left blank, it cannot be determined if caregivers completed the assigned tasks or not, thus based on this information, this allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Facility staff were not trained.

INVESTIGATION:

On 7/15/21, the department received an anonymous complaint which alleged employees were not trained to care for the facility's population.

On 7/30, I conducted an on-site inspection at the facility. Administrator Bridget Burghardt stated all facility caregivers receive training then a competency evaluation. While on-site, Ms. Burghardt provided a copy of the training PowerPoint presentation which included training on resident falls, reporting incidents, resident elopement and wandering, blood borne pathogens/infection control, standard precautions, hand hygiene, personal protective equipment (PPE), employee health, dementia training, dysphagia and Heimlich maneuver, back safety, resident change in condition and in-services. While on-site, Ms. Burghardt provided copies of the medication technician and Certified Nursing Assistant (CNA)/Caregiver competency evaluations. The medication technician competency evaluation read facility staff are required to complete a skills demonstration in which the observer and staff must sign and check off the following skills for infection control, vital signs, medication cart, documentation, supervision in event the Wellness Nurse is unavailable, and a medication observation audit. The medication observation audit evaluation read general observations, pouring liquid medications, as needed (PRN) medications, ophthalmic medications, sublingual medications, inhaler medications, rectal medications, topical patch medications, blood glucose monitoring, insulin injections and medication cart. The CNA/caregiver competency evaluation read facility staff are required to complete a skills demonstration in which the observer and staff must sign and check off the following skills for infection control, foods and fluids, personal/basic care, documentation, and miscellaneous.

I reviewed the training records for the following staff Toi Glymph, Canya Thrower, Kiara Adams and Bricca Scott. The training records read consistent with their job position and with statements from Ms. Burghardt.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following: **(a) Reporting requirements and documentation.** **(b) First aid and/or medication, if any.** **(c) Personal care.** **(d) Resident rights and responsibilities.** **(e) Safety and fire prevention.** **(f) Containment of infectious disease and standard precautions.** **(g) Medication administration, if applicable.**
ANALYSIS:	Review of facility documentation and staff training records revealed staff were trained according to their assigned position. Based on this information, this allegation cannot be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 8/24/2021, I shared the findings of this report with licensee authorized representative Manda Ayoub. Ms. Ayoub verbalized understanding of the findings.

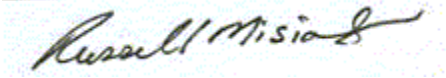
IV. RECOMMENDATION

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

Jessica Rogers 8/19/21

Jessica Rogers Date
Licensing Staff

Approved By:



8/19/21

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Russell B. Misiak Date
Area Manager