GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 20, 2021

David Truetzel
Oakleigh Macomb Operations, LLC
8025 Forsyth Blvd.
St. Louis, MO 63105

RE: License #: AH500394648
Investigation #: 2021A1027036
Oakleigh of Macomb

Dear Mr. Truetzel:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed by the licensee authorized representative and dated.

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.

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 #:	AH500394648
Investigation #:	2021A1027036
Complaint Receipt Date:	06/16/2021
Investigation Initiation Date:	06/16/2021
Report Due Date:	08/16/2021
Licensee Name:	Oakleigh Macomb Operations, LLC
Licensee Address:	Suite 201 40600 Ann Arbor Road Plymouth, MI 48170
Licensee Telephone #:	(586) 997-8090
Administrator:	Justin Niemi
Authorized Representative:	David Truetzel
Name of Facility:	Oakleigh of Macomb
Facility Address:	49880 Hays Road Macomb, MI 48044
Facility Telephone #:	(586) 997-8090
Original Issuance Date:	12/18/2019
License Status:	REGULAR
Effective Date:	08/07/2020
Expiration Date:	08/06/2021
Capacity:	101
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility provided a discharge notice letter for Resident A.	No
Resident A lacked protection.	Yes
Additional Findings	No

III. METHODOLOGY

06/16/2021	Special Investigation Intake 2021A1027036
06/16/2021	Special Investigation Initiated - Letter Email request for documentation sent to administrator J. Niemi
06/17/2021	Contact - Document Received Requested documentation received from administrator J. Niemi
07/09/2021	Contact - Document Sent Requested additional documentation from administrator J. Niemi
07/12/2021	Contact - Telephone call received Telephone interview conducted with administrator J. Niemi
07/14/2021	Contact - Document Received Received requested documentation from J. Niemi
07/16/2021	Contact - Telephone call made Left voicemail with facility staff Antoinette Storch
07/16/2021	Contact - Document Sent Email sent to J. Niemi requesting clarification and additional documentation
07/19/2021	Contact - Telephone call made Telephone interview conducted with facility staff Antionette Storch
07/19/2021	Contact - Telephone call made Telephone interview conducted with director of nursing Ursila Cruz
07/19/2021	Contact - Telephone call made Telephone interview conducted with facility staff Abigail Blasco

07/19/2021	Contact - Telephone call made Telephone interview conducted with facility staff Ericka Campbell
07/19/2021	Contact - Telephone call made Left voicemail with Resident A's private caregiver
07/20/2021	Contact - Telephone call made Telephone interview conducted with Resident A's private caregiver
07/23/2021	Contact – Document Received Received requested documentation from J. Niemi
07/29/2021	Exit Conference Conducted with authorized representative D. Truetzel

ALLEGATION:

The facility provided a discharge notice letter for Resident A.

INVESTIGATION:

On 7/19/21, the department received a complaint alleging the facility provided a 30-day discharge notice for Resident A for not being able to meet her needs.

On 7/12/21, I conducted a telephone interview with administrator Justin Niemi. Mr. Niemi stated the facility provided Resident A's family with a 30-day discharge notice. He stated director of nursing Ursila Cruz has had multiple long conversations with Resident A's family and has tried to accommodate all her requests. Mr. Niemi stated Resident A's family has requested multiple facility staff no longer provide care and have exhausted all efforts to meet expectations.

On 7/16/21, I conducted a telephone interview with the complainant. The complainant stated the 30-day discharge notification was sent to her by email on 6/28. The complainant stated there was a meeting with Resident A's hospice nurse, director of nursing Ursila Cruz, manager Brittany, Resident A's private caregiver and herself on 6/18 with no mention of not being able to meet Resident A's needs. The complainant stated she has spoken with facility management one other time at a meeting in January and had never been informed that the facility was not able to manage Resident A.

On 7/20/21, I conducted a telephone interview with Resident A's private caregiver. Resident A's private caregiver stated in the June meeting with Ms. Cruz that they discussed re-creating Resident A's service plan along with checklist for staff to ensure they are completing Resident A's safety checks when they enter her room.

Resident A's caregiver stated Ms. Cruz planned to submit the updated service plan with checklist to Resident A's family for review. Resident A's caregiver stated Resident A's daughter attempted to follow up a week later to inquire about receiving the documentation and in return received an email with a 30-day discharge notification letter. Resident A's caregiver stated she felt the discharge letter was a retaliation against Resident A and her family for requesting staff follow the service plan.

I reviewed Resident A's 30-day discharge notification letter. The letter reads consistent with statements from Mr. Niemi. The letter reads the facility is "not being able to meet the kind of services and skills that (Resident A) requires per family request." The letter reads "we feel we have exhausted all efforts."

I reviewed Resident A's admission contract. The admission contract reads under the discharge heading, "Oakleigh Macomb will not retain a resident if any of the following occur: Oakleigh Macomb cannot meet the needs of the Resident due to medical and other reasons." The admission contract read "If Oakleigh Macomb initiates the discharge, Oakleigh Macomb agrees to provide the requisite written notice as described below and provide Resident with written notice of the following: Reason(s) for discharge, Effective date of discharge, Resident's right to file a complaint with the state licensing agency."

I reviewed the facility's discharge policy. The policy reads consistent with statements from Mr. Niemi and the admission contract. The policy reads a "Resident may be given a 30-day notice to move from the Community if the Resident: Requires a higher level of care, and transfer or discharge is necessary to meet the Resident's welfare which otherwise cannot be met by the Community."

I reviewed Resident A's progress notes. Progress note from 1/6/21 read a meeting occurred with Ms. Cruz and Resident A's family discussing the facility's interventions for Resident A's behaviors were not effective. Progress note from 1/7 read Resident A had become combative/agitated and facility nurse Rinku Topiwala updated Resident A's private caregiver. Progress note from 1/13 read Ms. Cruz held a phone conference with Resident A's daughter, who discussed her concerns regarding the facility caregivers, Resident A's medications and Resident A's neighbor in which the facility staff modified her room to reduce noise/stimuli at night. Progress note from 1/14 read Resident A's son was notified of a medication change and Resident A's room was changed per family request. Progress note from 1/26 read Ms. Curz held a care conference with Resident A's daughter regarding Resident A's toilet schedule in which Ms. Cruz updated Resident A's service plan. Progress notes from 2/2, 2/25, 4/1 and 4/29 read Ms. Cruz spoke with Resident A's daughter in which there were no concerns. Progress note from 5/17 read Resident A was having increased agitated behavior, a prophylactic antibiotic started for a urinary tract infection per her hospice team and Resident A's daughter was updated of the new medication. Progress note from 5/31 read facility staff noted Resident A had increased anxiety, facility staff gave Resident A her as needed medication as prescribed and Resident

A's was daughter notified. Progress note from 6/2 read Resident A was observed with increased anxiety/agitation becoming combative, facility staff gave Resident A's as needed medication as prescribed and Resident A's daughter was notified. Progress note from 6/19 read a care conference was held on 6/18 with Resident A's hospice nurse, Resident A's private caregiver, Resident A's daughter, resident care coordinator Brittany and Ms. Cruz. The progress note read the care conference discussed Resident A had become more agitated and staff were unable to redirect her. The progress note read Resident A's hospice nurse recommended increasing Resident A's medication and discussed the option of a smaller group home where Resident A could have more care. The progress note read Ms. Cruz would update Resident A's service plan and Resident A's daughter declined to have Resident A's medications increased, as well as recommendation for smaller group home.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(13) A home shall provide a resident and his or her authorized representative, if any, and the agency responsible for the resident's placement, if any, with a 30-day written notice before discharge from the home. The written notice shall consist of all of the following: **(a) The reasons for discharge.** **(b) The effective date of the discharge.** **(c) A statement notifying the resident of the right to file a complaint with the department. The provisions of this subrule do not preclude a home from providing other legal notice as required by law.**
ANALYSIS:	Interview with the complainant and facility staff, along with review of facility documentation revealed the facility followed the Resident A's Admission Contract agreement. Based on this information, this allegation cannot be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A lacked protection.

INVESTIGATION:

On 6/16/21, the department received a complaint alleging Resident A was treated abusively by facility staff, lacked care and nightly safety checks were not completed per her service plan resulting concerns for her safety.

On 7/12/21, I conducted a telephone interview with administrator Justin Niemi. Mr. Niemi stated Resident A was admitted to the facility in December 2020. Mr. Niemi stated upon admission, Resident A's family placed three cameras in Resident A's room. Mr. Niemi stated all facility staff were informed of the Resident's A cameras and that the facility allows surveillance devices. Mr. Niemi stated the facility does not have a video surveillance policy.

On 7/16/21, I conducted a telephone interview with the complainant. The complainant stated she observed video footage in January 2021 of Resident A falling and treatment by facility staff. The complainant stated she observed Resident A fall in her bathroom. The complainant stated she observed facility staff Antoinette Storch walk into Resident A's bathroom shortly after the fall in which she attempted to assist Resident A to a standing position. The complainant stated she observed Resident A say she was in pain and unable to stand. The complainant stated she did not observe Ms. Storch assess Resident A, nor did she ask how she was doing or let her know that she needed to obtain help to stand her up. The complainant stated she then observed Ms. Storch leave the bathroom. The complainant stated she observed Ms. Storch come back to the bathroom and attempt to lift Resident A again. The complainant stated she observed Resident A crying. The complainant stated she observed Resident A had a bowel movement on the floor and Ms. Storch mumbles "she went right here on the floor." The complainant observed another facility staff member in the Resident A's bathroom doorway watching Ms. Storch care for Resident A. The complainant observed Ms. Storch wash bowel movement off the wall and stated, "Who raised you?" The complainant observed Ms. Storch and the other facility staff member start laughing. The complainant observed Ms. Storch continue to clean Resident A with the other staff member watching then assisted Resident A to standing a position in which she was having difficulty with walking. The complainant stated she did not observe anyone assess Resident A for injury after the fall. The complainant stated she has video footage of facility staff providing care without informing Resident A of who they are and what they are doing. The complainant stated she has video footage of Resident A crawling on the floor after a fall because nightly safety checks were not completed. The complainant stated staff do no conduct two-hour safety checks throughout the night. The complainant stated she has observed no staff enter Resident A's room for an eight-hour time frame and is concerned about her safety as well as lack of care. The complainant stated she has been in contact with Mr. Niemi and director of nursing Ursila Cruz with her concerns. The complainant stated Ms. Cruz stated she has worked to train staff and hold them accountable, but that there is nothing more the facility can do, when she had expressed the above concerns regarding Resident A's care to Ms. Cruz.

On 7/19/21, I conducted a telephone interview with facility staff Antoinette Storch. Ms. Storch stated when a resident has a fall, facility staff first ensure the resident is safe, the medication technician is notified and obtains the resident's vital signs, then incident report is completed. Ms. Storch stated Ms. Cruz is also notified. Ms. Storch stated all residents receive two-hour safety checks unless a resident requires more frequent checks which is indicated in resident service plans. Ms. Storch stated she had been counseled and is no longer able to care for Resident A.

On 7/19/21, I conducted a telephone interview with director of nursing Ursila Cruz whose statements were consistent with Ms. Storch. Ms. Cruz stated Ms. Storch received a verbal warning in April 2021 due to another incident with Resident A and was no longer able to provide care for Resident A. Ms. Cruz stated the frequency of safety checks are written in each resident's service plan and "it (safety checks) does not happen all the time." Ms. Cruz stated she is unable to obtain the activities of daily living logs from their electronic charting system which includes the two-hour safety checks completed by facility staff for Resident A.

On 7/19/21, I conducted a telephone interview with facility staff Abigail Blasco, who works the afternoon shift. Ms. Blasco's statements were consistent with Ms. Storch and Ms. Cruz. Ms. Blasco stated she completes two-hour safety checks per the service plan for Resident A including checking her brief throughout the afternoon to ensure it is dry. Ms. Blasco stated Resident A becomes agitated and combative at times but is re-directable. Ms. Blasco stated Resident A wanders into other resident rooms, which often means she must use restroom. Ms. Blasco stated she feels Resident A becomes anxious when needing to use the restroom and sometimes will not sit on the toilet. Ms. Blasco stated if Resident A starts to become anxious and unable to use the toilet, she will continue to try to have her use the restroom throughout the shift.

On 7/19/21, I conducted a telephone interview with facility staff Ericka Campbell, who works third shift. Ms. Campbell's statements were consistent with the above staff interviews. Ms. Campbell stated she conducts two-hour safety checks or follows the safety checks written in the resident service plans for all residents including Resident A. Ms. Campbell stated Resident A sleeps mostly through the night and sometimes will not allow staff to change her brief. Ms. Campbell stated staff continue to try to change Resident A's brief and sometimes she must obtain assistance from another caregiver.

On 7/20/21, I conducted a telephone interview with Resident A's private caregiver. Resident A's private caregiver stated upon admission to the facility, the family had informed the facility of Resident A's behaviors such as anxiousness when needing to use the bathroom. Resident A's caregiver stated the facility staff said their facility could manage Resident A's behaviors and staff are trained in dementia care. For example, Resident A's caregiver stated Resident A has a baby doll she believes is real and carries it around the facility. Resident A's caregiver stated she observed Ms. Storch approach Resident A without speaking and take her baby away from her.

Resident A's caregiver stated she observed Resident A ask, "What are you doing?" Resident A's caregiver stated she took the baby doll back from Ms. Storch, gave it back to Resident A and Ms. Storch walked away. Resident A's caregiver stated in the June meeting, she had expressed her concerns that facility staff were not following Resident A's service plan, such a two-hour safety checks and toileting. Resident A's caregiver stated Ms. Cruz stated staff were documenting completion of the safety checks in their electronic system but that she could re-create a new service plan with a checklist to be placed in the Resident A's room to ensure they are completing the task.

I observed the video surveillance footage of Resident A's fall in January 2021. The video footage observed was consistent with statements from the complainant.

I reviewed Resident A's service plan. The plan read Resident A is independent and wanders. The plan read Resident A has poor self-awareness and history of falls. The plan read Resident A is one person assist. The plan read Resident A requires reminders/encouragement related to Alzheimer's. The plan read Resident A is incontinent of bowel and bladder. The plan read to prompt Resident A to use the restroom every two hours. The plan read Resident A has two-hour safety checks and staff to ensure resident is safely in bed when doing safety/two-hour checks.

I reviewed facility's progress notes for Resident A. The progress notes read from Resident A had falls without injury on the following dates: 1/5/21, 1/12, 1/16, 1/18, 5/31, 6/28, and 7/1.

I reviewed the facility's Post Fall Management Policy and Procedure. The fall policy read "do not attempt to move resident until assessment is complete, obtain and record vital signs, assess for injuries, assess for change in range of motion, assess for pain and location of pain."

I reviewed Ms. Storch's training records. Ms. Storch's training records read she was trained on resident care including bathing and dressing, as well as fall precautions/what to do if a resident has a fall. The training records read Ms. Storch performed the duties listed in the training with dignity and respect to the residents. Ms. Storch's new hire orientation check list read she was trained on caring communication part 1, mistreatment, resident rights and responsibilities, abuse and neglect, caring compassion – angry quest, caring compassion – active listening and activities – dementia training. Ms. Storch's employee file contained a verbal warning on 4/8/21 in which Ms. Storch was educated on how to appropriately approach a resident. The verbal warning read Ms. Storch was removed from care of that resident per the daughter of the resident request. Ms. Storch's training records contained an elder abuse and neglect test, as well as a learning guide for caring for patients with dementia from 4/30/21.

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.
For Reference: R 325.1901	**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.
ANALYSIS:	Interviews with the complainant and facility staff, along with review of facility documentation as well as video surveillance footage revealed Resident A had dementia with behaviors and was high risk for falls. The video surveillance footage from 1/12/21 revealed Ms. Storch did not treat Resident A with dignity nor follow the facility's fall management policy, thus the facility did not provide Resident A protection and ensure her safety.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 7/29/2021, I shared the findings of this report with licensee authorized representative David Truetzel. Mr. Truetzel 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.

7/26/21

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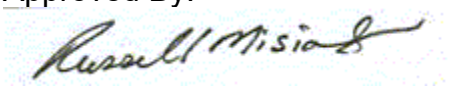
Jessica Rogers Date
Licensing Staff

Approved By:



7/28/21

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Russell B. Misiak Date
Area Manager

Addendum:

On 8/20/21, I received a message from the complainant concerning statements in the special investigation report. On 8/23/21, I conducted a telephone interview with the complainant. The complainant stated the facility recommended Resident A's medications be increased. The complainant stated Resident A had already been prescribed and receiving medications for behaviors thus she was not agreeable to the facility's recommendations to increase Resident A's medications. The complainant stated Resident A's geriatric psychiatrist did not recommend increasing her medications. Additionally, the complainant stated the discharge notice letter read the facility could not meet the demands of Resident A's family, however it did not specifically indicate the reasons care could not be provided for Resident A. Also, the discharge letter did not advise the family could contact the department to file a complaint.

I reviewed Resident A's medication administration records (MARs) from May and June 2021. The MARs read Resident A was prescribed Clonazepam 0.5 mg tablet take half tablet by mouth twice daily and Mirtazapine 15 mg take one tablet by mouth once daily at 4:00 pm and administer with ice cream, The MARs read Resident A was prescribed the following PRN (as needed) medications Ativan gel 0.5 mg/ml apply contents of one syringe to inner wrist every six hours as needed if (Resident A) refuses as needed tablets and Lorazepam 0.5 mg tablet take one tablet by mouth every six hours as needed for anxiety and administer with ice cream.

On 8/30/21, I conducted a telephone interview with administrator Justin Niemi. Mr. Niemi stated at Resident A's care conference in June, her hospice nurse recommended the family seek alternative living such as an adult foster care setting for closer care. Mr. Niemi stated facility management agreed with the recommendation from hospice, thus provided a discharge notification letter.

Previous review of Resident A's progress notes revealed Resident A had increased behaviors in May and June 2021. I reviewed Resident A's hospice nursing notes. Hospice nurses' note from 6/21/21 read "facility staff reporting increased behaviors" and "facility staff still struggle with behaviors with patient even after treatment."

The discharge notice letter was dated 6/28/21. The department received the complainants' allegations on 6/16/21, the complainant was interviewed on 7/16 and additional allegations were received on 07/19/21 in which an investigation had been previously opened.

ADDENDUM RECOMMENDATION

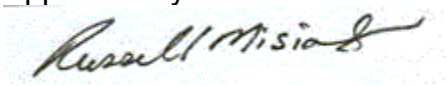
Contingent upon receipt of an acceptable corrective action plan for SIR #2021A1027036 dated 7/20/21, I recommend the status of the license remain unchanged.

9/3/21

_____

Jessica Rogers Date
Licensing Staff

Approved By:



9/3/21

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Russell B. Misiak Date
Area Manager