GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 20, 2021

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

RE: License #: AH630382886
Investigation #: 2022A1019004
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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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.

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) 284-9730.

Sincerely,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630382886
Investigation #:	2022A1019004
Complaint Receipt Date:	10/12/2021
Investigation Initiation Date:	10/12/2021
Report Due Date:	12/11/2021
Licensee Name:	Assured Senior Living Group, LLC
Licensee Address:	25180 Lahser Road Southfield, MI 48033
Licensee Telephone #:	(248) 262-2205
Administrator:	Laura Smigielski
Authorized Representative:	Vijay Sahore
Name of Facility:	Royal Oak House
Facility Address:	1900 N. Washington Ave. Royal Oak, MI 48073
Facility Telephone #:	(248) 585-2550
Original Issuance Date:	03/01/2018
License Status:	REGULAR
Effective Date:	09/03/2021
Expiration Date:	09/02/2022
Capacity:	57
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A had a black eye that was not reported to family.	Yes
Additional Findings	No

III. METHODOLOGY

10/12/2021	Special Investigation Intake 2022A1019004
10/12/2021	Comment Complaint was forwarded to LARA from APS.
10/12/2021	Special Investigation Initiated - Letter Emailed administrator requesting information/ documentation.
10/19/2021	Inspection Completed On-site
10/19/2021	Inspection Completed-BCAL Sub. Compliance
10/20/2021	Exit Conference

ALLEGATION:

Resident A had a black eye that was not reported to family.

INVESTIGATION:

On 10/12/21, the department received a complaint that on 10/7/21, Resident A was observed to have a black eye. The complaint read that the injury was not reported to Resident A's family. Due to the anonymous nature of the complaint, I was unable to obtain additional information.

On 10/19/21, I conducted an onsite inspection. I interviewed administrator Laura Smigielski at the facility. Ms. Smigielski stated that she received a call from someone at Adult Protective Services (APS) on 10/12/21 inquiring about Resident A. Ms. Smigielski stated that the caller wanted to know if Resident A was competent for interview but did not disclose the nature of the inquiry. Ms. Smigielski stated that

Resident A's son was at the facility later that same day and asked him if things were ok with Resident A, as she was unclear why APS was asking about her. Ms. Smigielski stated that Resident A's son informed her that Resident A had a black eye and proceeded to show her a picture that was taken on 10/5/21 of significant bruising to her right eye. Ms. Smigielski stated that she was never informed of any incident or injury to Resident A and was not provided with an incident report from staff outlining what occurred. Ms. Smigielski stated that when she went to see Resident A on 10/12/21 after speaking with his son, she had a small, discolored area under her eye but it was much less noticeable than the photo she was shown. Ms. Smigielski stated she began asking staff about the incident and nurse Jaimie Kraydich then provided her with an incident report.

The incident report dated 10/12/21 read:

> Resident reported an incident where an unknown CG was attempting to remove clutter from walker. Resident reports "going to grab" the items and accidentally hitting herself in the face. Resident cannot recall when this was and answered with "Honey, I don't know when this happened." Resident has a purple/blue mark under R eye but this has been present on face for several weeks and is not a new occurrence.

The incident report does not identify that Resident A's authorized representative or physician were notified. A licensing file reviewed that the incident report was never submitted to the department.

On 10/19/21, I interviewed Ms. Kraydich at the facility. Ms. Kraydich reported that she filled out the incident report on 10/12/21 when she became aware of the incident after observing the discoloration on her face. Ms. Kraydich stated that she had not seen the bruising to her face prior to 10/12/21 and stated that staff did not report any injury to Resident A that could have caused the bruise. Ms. Kraydich stated that after Resident A informed her that a staff member was present when the injury occurred, she began questioning other staff members if they were involved or had any observations. Ms. Kraydich stated that all staff interviewed had the same response and attested "They just assumed we knew about it."

Ms. Smigielski stated that human resources staff Aditi Paliwal began interviewing staff and obtaining statements to attempt to determine when the injury occurred and which staff was involved. Ms. Paliwal provided documentation pertaining to her interviews that read:

> Tamara Hawkins- Shift supervisor- 10/4 heard form Raznin that Arniece (agency) was trying to take her tray away from her room. [Resident A] thought Arniece was taking her medication away. Arniece told her that its just the trash, [Resident A] tried to grab Arniece's hand & pull the tray from her hand. Arniece tried to get her hand off- in turn her hand accidentally hit [Resident A's] hand & [Resident A] hit

her own face with her hand. Heard that Raznin notified Jaime [sic] but did not confirm this.

Raznin- Caregiver- Raznin was on MC side. Came to [Resident A] room & Arnice [sic] mentioned about the incident. Raznin did not notify Jaime [sic]. She thought Arniece did.

Arniece- Never returned my phone call

Ms. Smigielski reviewed facility schedules and confirmed that Arniece Sewell worked with Resident A on 10/2/21 and 10/3/21 and the last date she worked at the facility was 10/12/21. Ms. Smigielski affirmed that staff are trained to notify her or Ms. Kraydich of any resident injury regardless of circumstance.

On 10/19/21, I interviewed Resident A at the facility. I observed a small blue mark under her right eye. Resident A stated that she obtained the injury when a staff member came in to clean her room. Resident A stated that she went to remove some items off the tray attached to her walker but that she didn't want the items removed. Resident A stated that she reached for the tray and accidentally hit herself in the face. Resident A stated, "It was nothing serious, it was an accident." Resident A could not recall when the incident happened or which staff was involved. Resident A appropriately answered my entire line of questioning and I found her to be a credible historian regarding the event.

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.
ANALYSIS:	Resident A was accidentally injured during an encounter with staff sometime around 10/5/21. Staff involved did not report the incident to management per protocol and Resident A's family and physician were not notified at the time the incident occurred. As of 10/19/21, the department had not received an incident report on the injury.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [For reference, see special investigation report (SIR) 2021A1027021, CAP dated 4/28/21]**

On 10/20/21, I shared the findings of this report with authorized representative Vijay Sahore. Mr. Sahore verbalized understanding of the citation and did not have any additional questions.

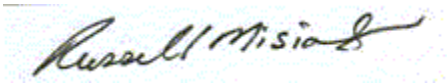
IV. RECOMMENDATION

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

10/20/21

Elizabeth Gregory-Weil — Date
Licensing Staff

Approved By:



10/20/21

Russell B. Misiak — Date
Area Manager