GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 8, 2022

Manda Ayoub
Pomeroy Living Orion Assisted & Memory Care
101 Scripps Road
Lake Orion, MI 48360

RE: License #: AH630377767
Investigation #: 2022A0585051
Pomeroy Living Orion Assisted & Memory Care

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.

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) 284-9730.

Sincerely,

Brender L. Howard

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street, P.O. Box 30664
Lansing, MI 48909
(313) 268-1788
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630377767
Investigation #:	2022A0585051
Complaint Receipt Date:	04/22/2022
Investigation Initiation Date:	04/22/2022
Report Due Date:	06/22/2022
Licensee Name:	Beacon Square Orion LLC
Licensee Address:	Suite 230 5480 Corporate Drive Troy, MI 48098
Licensee Telephone #:	(248) 723-2100
Administrator:	Alex Reed
Authorized Representative:	Manda Ayoub
Name of Facility:	Pomeroy Living Orion Assisted & Memory Care
Facility Address:	101 Scripps Road Lake Orion, MI 48360
Facility Telephone #:	(248) 621-3100
Original Issuance Date:	10/11/2017
License Status:	REGULAR
Effective Date:	04/11/2022
Expiration Date:	04/10/2023
Capacity:	128
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A had a contusion on her forehead and her left eye was blackened, with swelling to her left elbow and bruising to her groin and left hip area. Facility did not take her for medical assessment.	Yes
There is no documentation of Resident A falling.	No
Additional Findings	No

III. METHODOLOGY

04/22/2022	Special Investigation Intake 2022A0585051
04/22/2022	Special Investigation Initiated - Telephone Called Adult Protective Services (APS) to discuss allegations. A message was left with APS worker John Cavanaugh.
04/26/2022	Inspection Completed On-site Completed with observation, interview and record review.
04/26/2022	Inspection Completed-BCAL Sub. Compliance
06/08/2022	Exit Conference Conducted with authorized representative Manda Ayoub.

ALLEGATION:

Resident A had a contusion on her forehead and her left eye was blackened, with swelling to her left elbow and bruising to her groin and left hip area. Facility did not take Resident A for medical assessment.

INVESTIGATION:

On 4/22/2022, the licensing department received a complaint from Adult Protective Services (APS) with allegations, that on 4/21/2022, [Resident A] was observed with a contusion on her forehead and her left eye was blackened. Resident A also had bruising and swelling to her left elbow and bruising to her groin and left hip area. There is a large hematoma on Resident A's left hip. The complaint alleges that there is concern that Resident A is being neglected in the facility, as there was no

documentation of her falling and the facility did not take Resident A for a medical assessment.

On 4/25/2022, a call was received from APS worker John Cavanaugh. He stated that Resident A allegedly had a fall and got herself up. He stated that Resident A fell on the 21st but an incident report was not completed by the staff when she found out that Resident A had fallen. He stated that staff did not do an assessment for injury and delayed treatment by not sending her to the hospital. He stated that staff did not notify the daughter of Resident A's incident.

On 4/26/2022, I completed an onsite at the facility. I interviewed the administrator Alex Reed at the facility. Ms. Reed stated that Resident A has low safety awareness and bruises easily. She explained that no one knew that Resident A had a fall because she got herself up and it was never reported by the staff. She stated that Resident A was independent but have since been upgraded to a one person assist. Ms. Reed stated that an in-service about reporting was completed with staff.

On 4/26/2022, an interview was completed with director of wellness, Vanessa Holdamp. She stated that Resident A was taken to the hospital by private transportation. She stated that resident came back from the hospital with no new orders. She stated that staff did not report that the resident had fallen, after being notified by Resident A that she had fallen and got herself up.

On 4/26/2022, I interviewed Resident A at the facility. Resident A stated that she fell, and she stood herself back up. She stated that she did not call for help from staff. She stated that she told the staff the next day about her fall.

Service plan for Resident A, dated 12/27/2021 and revised 4/26/2022 read, "Resident admitted to the facility on 12/22/2021 with diagnoses that includes Dementia, and anxiety disorder. The plan read, "I am requiring more support with transfers due to weakness and unsteady gait. I will attempt to self-transfer at times. One person assist transfer with gait belt (initiated 4/26/22). The plan read, "falls balance issues, change physically ability, cognitive changes, poor safety awareness, history of CVA and visual changes put me at risk for fall and injury. I do not consistently use my walker or cane. My family is aware that my falls are not completely preventable and that I do not like to stay out in the common areas or attend activities. I have weakness and unsteady gait; I do not always wait for assistance with transfers and will attempt to self-transfer."

Training documents were reviewed for Employee A. Employee A completed a 1:1 in-service on 4/22/22 for reporting changes in condition, evidence of injury.

Several attempts were made to contact Employee A. As of the date of this report, no contact has been made.

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: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
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 supervisor, of the home or an agent or employee of the home, or when the resident's service plan states that the residents needs continuous supervision.
ANALYSIS:	Resident A fell and got herself back up. Resident A did not call for assistance from staff but told the staff the next day about her fall. The staff did not follow up after being informed about the fall and did not do an assessment of Resident A. No follow up was completed for Resident A until Resident A's family member came and inquired about the injuries to Resident A. This delayed the treatment that could have been more than minimal harm. Therefore, this claim was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

There is no documentation of Resident A falling.

INVESTIGATION:

Ms. Reed stated that when Employee A went into Resident A's room, she told her that she had fallen but Employee A did not do a report. She stated that once it was brought to their attention about the fall, they completed an incident report. Ms. Reed explained that staff who the incident was reported to was given a one-on-one in-service about completing reports.

An incident was received from administrator that read, “On 4/21/2022, at 8:30 a.m., resident was observed with bruising around her left eye, her forehead, her left arm and left thigh when coming out of her bathroom. Med tech ask resident what happened. Resident stated, “I fell last night.”. Resident was taken to the hospital by family for further evaluation. Resident returned same day with no new orders. In the section for Action Taken to Prevent recurrence reads, resident to be seen by PCP. Resident family brought in lower bed. Community will update service plan.”

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(1) The home shall complete a report of all reportable incidents, accidents, and elopements. The incident/accident report shall contain all of the following information: **(a) The name of the person or persons involved in the incident/accident.** **(b) The date, hour, location, and a narrative description of the facts about the incident/accident which indicates its cause, if known.** **(c) The effect of the incident/accident on the person who was involved, the extent of the injuries, if known, and if medical treatment was sought from a qualified health care professional.** **(d) Written documentation of the individuals notified of the incident/accident, along with the time and date.** **(e) The corrective measures taken to prevent future incident/accidents from occurring.**
ANALYSIS:	An incident report was completed regarding the incident of Resident A. This claim could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 06/08/2022, I conducted an exit conference with licensee authorized representative Manda Ayoub by telephone.

IV. RECOMMENDATION

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

06/08/2022

Brender Howard Date
Licensing Staff

Approved By:

06/07/2022

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section