GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 28, 2022

Aida Moussa
My Doctors Inn
8384 Metropolitan Parkway
Sterling Heights, MI 48312

RE: License #: AH500386237
Investigation #: 2022A1019052

Dear Ms. Moussa:

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 #:	AH500386237
Investigation #:	2022A1019052
Complaint Receipt Date:	05/13/2022
Investigation Initiation Date:	05/16/2022
Report Due Date:	07/12/2022
Licensee Name:	MDI Sterling Heights, LLC
Licensee Address:	4000 Town Center Southfield, MI 48075
Licensee Telephone #:	(248) 262-2357
Administrator:	Rebecca Holland
Authorized Representative:	Aida Moussa
Name of Facility:	My Doctors Inn
Facility Address:	8384 Metropolitan Parkway Sterling Heights, MI 48312
Facility Telephone #:	(586) 838-5900
Original Issuance Date:	03/30/2017
License Status:	REGULAR
Effective Date:	10/01/2021
Expiration Date:	09/30/2022
Capacity:	101
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A received inadequate care pertaining to her catheter.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/13/2022	Special Investigation Intake 2022A1019052
05/16/2022	Special Investigation Initiated - Letter Notified APS of the allegations via email referral template.
05/16/2022	APS Referral
06/09/2022	Inspection Completed On-site
06/09/2022	Inspection Completed BCAL Sub. Compliance
06/28/2022	Exit Conference

ALLEGATION:

Resident A received inadequate care pertaining to her catheter

INVESTIGATION:

On 5/13/22, the department received a complaint alleging that Resident A received improper catheter care. The complaint alleged that Resident A's catheter fell out on 1/2/22 or 1/3/22 and again on 1/5/22. The complaint alleged that the facility provided improper catheter care and the resident had to be hospitalized for a severe UTI and kidney infection on 1/12/22. The resident passed away on 1/30/22.

On 6/9/22, I conducted an onsite inspection. I interviewed administrator Rebecca Holland at the facility. Ms. Holland stated that Resident A moved into the facility on 12/31/21 and had a catheter upon move in for which she received home care services for. Ms. Holland stated that due to Resident A's dementia, she was unable to verbalize to staff if the catheter was out, so facility staff were responsible for checking the tubing and emptying the catheter bag at least once per shift. Ms. Holland stated that home care was responsible for anything additional such as

catheter placement and insertion. Ms. Holland acknowledged that Resident A's catheter came out on 1/4/22 and stated that home care came to the facility that same day to re-insert it. Ms. Holland initially stated that there had been multiple times that home care came out to tend to Resident A's catheter but then later after reviewing documentation stated that there were no additional issues with the catheter until 1/10/22, when staff noticed that she had a change in behavior and appeared lethargic. Ms. Holland reported that facility staff noticed that morning that the catheter came out again. Ms. Holland stated that Resident A's physician and daughter were contacted and she was sent out to the hospital for her change in mental status. Ms. Holland stated that Resident A never returned to the facility.

On 6/9/22, I interviewed Employee A at the facility. Employee A's recollection of Resident A's catheter care was consistent with that of Ms. Holland's. Employee A added that when she came in for her shift on 1/10/22, Resident A's behavior had changed from her baseline and that she seemed "different". Employee A stated that the catheter had come out again and she was also acting lethargic and not responding in the manner that she normally would. Employee A stated that the decision was made to send her to the hospital. Employee A stated that Resident A's physician and daughter were made aware.

CNS home care documentation was reviewed. On 1/4/22, home care staff completed their assessment and start of care with Resident A. On 1/4/22, home care staff documented "Pt had foley cath upon admission to assisted living facility and it became dislodged two days ago. Per staff pt had not had a wet brief in 2 days, pt denies and stated she had urinated. Order obtained from Dr for foley cath insertion."

I reviewed a physician's order dated 1/4/22 that read "home care to place FC for urinary retention".

Progress notes from the facility were reviewed. On 12/31/21, staff documented "Resident admitted to community w/family alert & oriented 1-2 meds faxed to pharmacy. Homecare CNS will be on board foley present." On 1/4/22, staff documented "Order faxed to homecare to reinsert FC for urinary retention, daughter made aware via home care nurse." On 1/7/22, staff documented "Seen by MD, spoke with daughter in detail regarding med regime [sic], foley care & behavior management. Daughter will follow up with urologist as recommended." On 1/10/22, staff documented "Res transported to ER for mental status change. Family & MD informed. Personal belongings remain in room. Foley dislodged."

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(1) A health facility or agency that provides services directly to patients or residents and is licensed under this

	article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization, which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.
For Reference MCL 333.20201	**(2) (e) A patient or resident is entitled to receive adequate and appropriate care, and to receive, from the appropriate individual within the health facility or agency, information about his or her medical condition, proposed course of treatment, and prospects for recovery, in terms that the patient or resident can understand, unless medically contraindicated as documented by the attending physician in the medical record.**
ANALYSIS:	Resident A had a foley catheter upon admission to the facility on 12/31/21. Documentation from home care indicates that the catheter became dislodged on 1/2/22, however home care services did not begin until 1/4/22. There is no evidence to support that the facility sought medical guidance or evaluation when Resident A's catheter initially became dislodged, as evidenced by the catheter being out when home care came to assess the resident on 1/4/22.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

Ms. Holland and Employee A attested that Resident A had a change in condition on 1/10/22, as described above, which resulted in hospitalization. Facility progress notes confirm this, however the facility did not complete and incident report or provide notification to the department of this occurrence.

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 incidents/accidents from occurring.** **(2) The original incident/accident report shall be maintained in the home for not less than 2 years.** **(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's change in condition and hospitalization were not reported to the department and an incident report was not completed.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/28/22, I shared the findings of this report with authorized representative Aida Moussa.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no changes to the status of the license at this time.

06/15/2022

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Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

06/27/2022

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