GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 27, 2022

Manda Ayoub
Pomeroy Living Northville Assisted & Memory Care
40033 W. Eight Mile
Northville, MI 48167

RE: License #: AH820381235
Investigation #: 2022A1027064
Pomeroy Living Northville 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed by the 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) 241-1970.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820381235
Investigation #:	2022A1027064
Complaint Receipt Date:	05/31/2022
Investigation Initiation Date:	05/31/2022
Report Due Date:	07/30/2022
Licensee Name:	Beacon Square Northville
Licensee Address:	Suite 130 5480 Corporate Drive Troy, MI 48098
Licensee Telephone #:	(248) 723-2100
Administrator:	Jason Johnson
Authorized Representative:	Manda Ayoub
Name of Facility:	Pomeroy Living Northville Assisted & Memory Care
Facility Address:	40033 W. Eight Mile Northville, MI 48167
Facility Telephone #:	(248) 349-0400
Original Issuance Date:	03/25/2016
License Status:	REGULAR
Effective Date:	09/25/2021
Expiration Date:	09/24/2022
Capacity:	109
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A lacked protection.	No
Additional Findings	Yes

III. METHODOLOGY

05/31/2022	Special Investigation Intake 2022A1027064
05/31/2022	Contact - Telephone call received Telephone interview with licensing staff Elizabeth Gregory-Weil.
05/31/2022	Special Investigation Initiated - Letter Email sent to administrator Alex Reed requesting information/documentation pertaining to Resident A
05/31/2022	Contact - Document Received Email received from Ms. Reed with requested information/documentation
06/28/2022	Contact – Document Sent Email sent to administrator Jason Johnson requesting Resident A's narcotic count sheets
06/28/2022	Contact – Document Received Email received from Mr. Johnson with narcotic count sheets
06/28/2022	Inspection Completed-BCAL Sub. Compliance
09/06/2022	Exit Conference Conducted by telephone with authorized representative Manda Ayoub

ALLEGATION:

Resident A lacked protection.

INVESTIGATION:

On 5/31/2022, the department was forwarded a complaint from Adult Protective Services (APS) which read Resident A moved into the facility on 5/23/2022 and signed onto hospice services. The complaint read Resident A had recovered from

COVID-19 and had terminal blood cancer. The complaint read Resident A's family medicated him without consent of the facility and tried to over-medicate him to facilitate his death. The complaint read Resident A did not have a power of attorney nor guardian but verbalized his wishes regarding power of attorney, as well as that he did not want to be a do not resuscitate (DNR), however his family did. The complaint read Resident A's family was locking staff out of his room. The complaint read Resident A passed away on 5/29/2022 due to the nature of the preceding allegations.

On 5/31/2022, I conducted a telephone interview with licensing staff Elizabeth Gregory-Weil who stated she had received a telephone call from the facility's administrator to discuss an incident in relation to Resident A. The administrator stated to Ms. Gregory-Weil that Resident A had transitioned from independent to assisted living in which he had received hospice services prior. The administrator stated to Ms. Gregory-Weil that Resident A had received a comfort pack of hospice medications in which his family had administered one dose of a medication at the assisted living facility because they were not aware of the facility's policy. The administrator stated to Ms. Gregory-Weil that facility staff educated Resident A's family regarding their policy in which facility staff administered medications. The administrator stated to Ms. Gregory-Weil that family had not administered medications after the one incident. The administrator stated to Ms. Gregory-Weil that she had contacted the police who reported that it was not a criminal matter as well as conducted an APS referral.

I reviewed Resident A's face sheet which read consistent with the complaint. The face sheet read Resident A's son was his responsible party and second emergency contact. Additionally, the face sheet read Resident A's Daughters #1 and #2 were listed as first and third emergency contacts, consecutively.

I reviewed Resident A's service plan which read consistent with the complaint. The plan read Resident A received hospice services through AccentCare Hospice. The plan read Resident A had mild memory loss and needed assistance with his medications due to cognitive loss. The plan read staff were to provide all medications per physician orders.

I reviewed Resident A's chart notes.

> Note dated 5/23/2022 17:46 [5:46 PM] and titled move-in note/new/return in part read
>
> *"Resident verbalizes that he is doing well and he is in no pain. Daughter states that residents tramadol was changed to three times daily as needed and that his pain has been manageable. Accent Care Hospice to assess resident tomorrow morning. Resident was changed into his pajamas upon his request and residents medications include PRN [as needed] Tramadol and Ativan, will get clarification*

on any other medications from Accent Care Hospice tomorrow as none is or was listed on his discharge instructions."

Note dated 5/25/2022 13:21 [1:21 PM] titled general note in part read

"Writer met resident today and his daughters, [Resident A's Daughter #1 and #2], were present. Accent Care hospice nurse was in the room as well and medications were discussed. Ultram was changed to scheduled BID [twice daily], Ativan changed from PRN to scheduled and Timolol eye drops started as well per daughters' request as resident had been eye drops prior."

Note dated 5/25/2022 14:43 [2:43 PM] titled physician note in part read

"He is conversing well he denies any concerns. He states that he is generally comfortable but gets pain from time to time but he has meds for that. He is generally confused with some things and a poor historian throughout the conversation."

Note dated 5/26/2022 16:55 [4:55 PM] titled general note read

"Resident had complaints of uncontrolled pain in his back and right leg. Accent care Hospice notified. Nurse, Kim was out to see resident. Resident's daughters, [Resident A's Daughter #1 and #2] at bedside. New orders: morphine 0.25 ml every 3 hours PRN for pain, Norco 5-325 BID. Tramadol discontinued. Resident received a dose of morphine and PRN dose of Ativan and is resting comfortably at present time."

Note dated 5/26/2022 at 19:29 [7:29 PM] titled general note read

"Writer was informed around 3:45 PM that resident's daughter had given him a dose of morphine at 3:30 PM. This medication was given to them while he was at independent living (0.25 ml). Family reported their father was experiencing pain, agitation and restlessness. Resident came from independent living where he was signed onto another hospice. While at independent living family was shown how to properly administer morphine and was given the prescription morphine bottle while there. Writer educated family not to administer morphine to their father and explained that in assisted living medications are administered by med techs or nurses, not family members. Family was in agreement and stated they would like to take the medication home. DOW/hospice was made aware as well and hospice nurse, Kim was in to assess resident."

Note dated 5/26/2022 at 19:44 [7:44 PM] titled general note in part read

"Writer went to see resident after 6:30 PM morphine dose was administered per med tech (approximately 30 minutes after administration). Family stated that resident is "restless and agitated" and would like hospice nurse to see him. Call

was returned to writer by on call hospice nurse at 7:37 PM and nurse states she will be out to see resident in the next hour."

Note dated 5/26/2022 at 20:20 [8:20 PM] titled orders – administration note read

"PRN Administration was: Ineffective. Follow-up Pain Scale was: 10"

Note dated 5/26/2022 at 20:28 [8:28 PM] titled orders – administration note read

"Residents daughter said that she does not want resident to have medication"

Note dated 5/26/2022 at 20:34 [8:34 PM] titled orders – administration note read

"Resident was sleeping daughter did not want dad to be woken up"

Note dated 5/27/2022 at 02:36 [2:36 AM] titled orders – administration note read:

"around 9pm [Resident A's] son notified writer that he spoke with Yolonda hospice nurse in regard to increasing Resident A's Ativan Tablet 0.5 MG (LORazepam) to Ativan tablet 1 mg every 4 hrs as needed for agitation and restlessness. to also increase morphine sulfate solution 100 mg/5ml 0.25 mL frequency to every 2hrs as needed for pain/shortness of breath. Yolonda hospice nurse notified writer of the medication change around 9:30 pm that its waiting to be signed by the doctor karen."

Note dated 5/27/2022 15:00 [3:00 PM] titled general note read

"Hospice nurse was in to see resident this morning. Family at bedside. Resident is noted to be restless. Per hospice: morphine order changed to (10 mg) 0.5 ml every 4 hours ATC [around the clock], Ativan 1 mg at bedtime and 1 mg PRN every 4 hours, haldol 1 mg every 6 hours for agitation. Norco was discontinued. Anna Vodopyanov NP aware. Hospice nurse drew up syringes containing new doses of morphine. Haldol to arrive tonight (family aware). Hospice nurse to come out tonight to draw up syringes."

Note dated 5/28/2022 11:29 titled general note in part read

"hospice nurse Joy Price RN from Accentcare Hospice visited pt this morning, assessed condition and reviewed medication regimen with daughter [Resident A's daughter #1] at bedside, and with facility nurse. Pt was unresponsive during visit, appeared comfortable. Estimate life expectancy at a few days. Shared this with [Resident A's daughter #1] and she is understanding. She verbalizes satisfaction with pt current symptom management."

Note dated 5/28/2022 14:07 [2:07 PM] titled general note in part read

“Writer has been rounding on resident every hour, his condition remains fragile. Hospice nurse in this early afternoon, medications reconciled. Narc sheets updated. All discontinued medications prepared to return to pharmacy.”

Note dated 5/29/2022 02:30 [2:30 AM] titled general note in part read

“Resident was monitored every hour. Med tech and writer went in the room about 0215 and noticed resident was not breathing and no vital signs. Hospice Nurse notified and will be in the building. Family notified and will be arrived shortly.”

I reviewed Resident A’s medication administration records (MARs) which read consistent with the chart notes and hospice physician orders dated 5/27/2022.

I reviewed Resident A’s AccentCare hospice notes.

Visit note titled Hospice Care Consultant Initiation Visit dated 5/24/2022 in part read

“[Resident A] IS A 95 YR OLD MALE, RECENTLY HOSPITALIZED AT TROY BEAUMONT FOR A FALL AND COVID 19 DIAGNOSIS. HE WQS [SP] PREVIOULSY LIVING AT POMEROY ROCHESTER INDEPENDENT, BUT HIS NEEDS HAVE INCREASED AND REQUIRES A HIGHER LEVEL OF CARE. [RESIDENT A] WAS DIAGNOSED WITH MULTIPLE MYLELOMA IN JANUARY 2022. HE IS NOT SEEKING AGGRESSIVE TREATMENTS FOR CA [CANCER]. HE HAS CHRONIC BACK PAIN, HISTORY OF SACRAL PRESSURE SORE. HE IS IN AGREEMENT WITH NO FURTHER HOSPITALIZATIONS AND FOCUS OF COMFORT AT POMEROY. HE SIGNED HIS OWN CONSENTS.”

Additionally, the note read Resident A’s contact/communication with family and friends was daily. The note read there was no indication of caregiver compliance risk factors present nor actual/potential abuse/neglect identified.

Visit note titled RN Hospice Start of Care dated 5/24/2022 in part read

“PATIENT RECENTLY HAD COVID INFECTION WAS HOSPITALIZED FAMILY WOULD LIKE PATIENT TO REMAIN AT THIS NEW FACILITY FOCUS ON END OF LIFE. PATIENT IS VERY LETHARGIC UNABLE TO STAY AWAKE DURING THIS VISIT. FAMILY DESCRIBED SEVERE WEAKNESS SINCE HOSPITALIZED WITH COVID. PATIENT IS VERBAL AND ORIENTATED ABLE TO PARTICIPATE IN HIS MEDICAL CARE DECISIONS.”

Visit note titled SN Hospice Subsequent Visit dated 5/25/2022 in part read

“*PT APPEARS COMFORTABLE AT THIS VISIT. DISCUSSED WITH DTR’S ABOUT ORDERING MORPHINE WHEN THE TRAMADOL IS NO LONGER EFFECTIVE, THEY AGREE TO THIS.”*

Visit note titled SN Hospice PRN Visit dated 5/28/2022 in part read

"PATIENT CARE DUE TO UNEXPECTED STATUS CHANGE"

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(d) A patient or resident is entitled to privacy, to the extent feasible, in treatment and in caring for personal needs with consideration, respect, and full recognition of his or her dignity and individuality.**
ANALYSIS:	Review of documentation revealed Resident A had a terminal diagnosis in which he consented and received hospice services for end-of-life care next to his spouse at the facility. The facility chart notes revealed Resident A's family provided one dose of medication at the facility, which was previously prescribed to him, however, it was an isolated incident in which the family was educated by staff. The AccentCare hospice notes and facility documentation did not indicate Resident A's family continued to provide medications after the isolated incident. Additionally, facility documentation did not indicate Resident A's family locked staff from his room. Chart notes revealed staff conducted hourly checks towards Resident A's end of life. Based on this information, there is insufficient evidence to support these allegations.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of Resident A's narcotic count sheets revealed the count for medication Morphine 100 mg/5 mL give 10 mg/ 0.5 mL read on 5/27/2022 at 9:10 PM there were 18 syringes and on 5/28/2022 at 10:00 AM there were 17 syringes available in which there were no syringes administered to Resident A between the two doses.

Additionally, Resident A's narcotic count sheets did not always correspond to the doses administered on the MAR. For example, Resident A's narcotic count sheet for Morphine 100 mg/5 mL give 5 mg/ 0.25 mL every three hours as needed read on 5/27/2022 at 9:49 (AM or PM not indicated on the sheet however next dose was administered by same employee at 2:00 PM and resident had a scheduled dose at 10:00 AM) the medication was administered by Employee #1 however the MAR lacked documentation corresponding to the narcotic count sheet. Also, Resident A's narcotic count sheet read Lorazepam 1 mg take one tablet by mouth every four hours as needed, as well as a second order read to administer one tablet at bedtime in which Employee #1 documented one dose was administered on 5/28/2022 at 11:30 AM however the MAR read the medication was refused.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(5) A home shall take reasonable precautions to ensure or assure that prescription medication is not used by a person other than the resident for whom the medication is prescribed.
ANALYSIS:	Review of Resident A's narcotic count sheets along with the MARs revealed there was inconsistent documentation on the controlled substance inventory sheets in which staff did not follow the facility's procedure to ensure narcotic medications were not used by a person other than the resident for whom the medication is prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/6/2022, I shared the findings of this report with authorized representative Manda Ayoub by telephone, who 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.

6/27/2022

_____

Jessica Rogers Date
Licensing Staff

Approved By:

09/02/2022

_____

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