GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 23, 2023

LeeAnn Pennington
Mercy Services for Aging
873 W Avon Rd.
Rochester Hills, MI 48307

RE: License #: AL630299637
Investigation #: 2023A0605012
Mercy Bellbrook/McAuley

Dear Ms. Pennington:

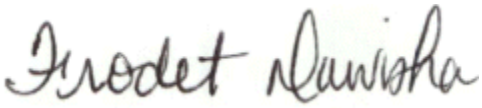
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630299637
Investigation #:	2023A0605012
Complaint Receipt Date:	01/04/2023
Investigation Initiation Date:	01/04/2023
Report Due Date:	03/05/2023
Licensee Name:	Mercy Services for Aging
Licensee Address:	873 W Avon Rd. Rochester Hills, MI 48307
Licensee Telephone #:	(248) 656-6300
Administrator:	Diane Scherer-Alexander
Licensee Designee:	LeeAnn Pennington
Name of Facility:	Mercy Bellbrook/McAuley
Facility Address:	873 W. Avon Road Rochester Hills, MI 48307
Facility Telephone #:	(248) 656-6306
Original Issuance Date:	02/12/2010
License Status:	REGULAR
Effective Date:	08/12/2022
Expiration Date:	08/11/2024
Capacity:	13
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 01/02/2023, direct care staff (DCS) James Lica was toileting Resident A who is on hospice. DCS left the bathroom. Resident A fell, hit the back of her head, and required four staples.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/04/2023	Special Investigation Intake 2023A0605012
01/04/2023	APS Referral Adult Protective Services (APS) referral made
01/04/2023	Special Investigation Initiated - Telephone I contacted APS and made a referral
01/05/2023	Inspection Completed On-site I conducted an unannounced on-site investigation. I interviewed Diane Scherer-Alexander who is the memory care program director, direct care staff (DCS) Damiona Cabil, Julia Slowiczek, LaChresha Sturgis, Resident A and Resident B.
01/10/2023	Contact - Telephone call made Discussed allegations with DCS James Lica and with Resident A's daughter/guardian Left message for DCS Tasia Ellis and hospice nurse with Accent Care to return my call
01/10/2023	Contact - Telephone call received Discussed allegations with Accent Care hospice nurse Danielle Wright
01/10/2023	Contact - Telephone call made Left message for APS worker Heather Goodin
01/12/2023	Contact - Telephone call received APS worker Heather Goodin will be substantiating her case
01/23/2023	Contact - Telephone call made Discussed allegations with DCS Tasia Ellis

01/23/2023	Exit Conference Conducted exit conference with licensee designee LeeAnn Pennington with my findings

ALLEGATION:

On 01/02/2023, direct care staff (DCS) James Lica was toileting Resident A who is on hospice. DCS left the bathroom. Resident A fell, hit the back of her head, and required four staples.

INVESTIGATION:

On 01/04/2023, intake #192501 was created per the incident report (IR) that was received regarding Resident A is on hospice and DCS James Lica left Resident A unattended on the toilet. Resident A fell and injured her head.

On 01/04/2023, I made a referral to Adult Protective Services (APS) that was assigned for investigation by APS worker Heather Goodin.

On 01/05/2023, I conducted an unannounced on-site investigation. I interviewed the Program Director Diane Scherer-Alexander, DCS Damiona Cabil, Julia Slowiczek, LaChresha Sturgis, Resident A and Resident B regarding the allegations. I reviewed Resident A's assessment plan, assistive device orders and scripts.

On 01/05/2023, Program Director Diane Scherer-Alexander who is also a licensed practical nurse (LPN) was interviewed regarding the allegations. Resident A is currently on hospice. Resident A was ambulatory on a walker but has since declined and is wheelchair bound. Ms. Scherer-Alexander stated that Resident A is only a one-person assist. On 01/02/2023, Ms. Scherer-Alexander received a telephone call from DCS James Lica informing her that Resident A fell. Mr. Lica explained the injuries to Ms. Scherer-Alexander and described the wound on Resident A's head. Mr. Lica advised there was bleeding from the laceration area, but that Mr. Lica stopped the bleeding by putting pressure on the wound. Ms. Scherer-Alexander told Mr. Lica that Resident A needed to go to the hospital. Mr. Lica called Resident A's daughters who elected to drive Resident A to the hospital themselves instead of an ambulance. Resident A's daughters arrived at the facility and transported Resident A to Ascension Rochester Hospital where Resident A received four staples on the back of her head and then was discharged back to the facility. Mr. Lica explained to Ms. Scherer-Alexander that he assisted Resident A onto the toilet heard Resident B who is in the room next door to Resident A, so Mr. Lica walked out of Resident A's room to the alcove, checked on Resident B and then returned to Resident A's bedroom only to find Resident A had fallen on the bathroom floor. Mr. Lica told Ms. Scherer-Alexander he was only gone for about five secs to check on Resident B. Ms. Scherer-Alexander stated that when Mr. Lica contacted her, DCS Tasia Ellis was with Mr. Lica in Resident A's bedroom. Ms. Scherer-Alexander advised that all staff are aware of policy that "if a staff member

assists a resident on the toilet, then at least one staff member must remain with the resident at all times." Ms. Scherer-Alexander in-serviced all DCS regarding policy on 01/03/2023 and 01/04/2023. I received a copy of the in-service training sign in sheet along with the policy.

On 01/05/2023, I interviewed DCS Damiona Cabil regarding the allegations. Ms. Cabil has been working for this corporation since 12/2020 and is contingent. Ms. Cabil was not working on 01/02/2023, but she heard what happened. She was informed by Ms. Scherer-Alexander that Resident A fell in the bathroom and hit her head. Ms. Cabil stated during her training, she was informed that policy is that staff members are never to leave any resident unattended and must be always with the residents in the room. Ms. Cabil stated that Resident A is a two-person assist since Resident A declined and went on hospice. She believes Resident A became a two-person assist sometimes in 07/2022 as it became difficult for one staff member to transfer or reposition Resident A given her large stature. Ms. Cabil has only worked with DCS James Lica once and during that shift, she never witnessed Mr. Lica leave any resident unattended. After the incident, Ms. Cabil stated she and all the other staff members were in-serviced on policy regarding Resident A.

On 01/05/2023, I interviewed DCS Julia Slowiczek regarding the allegations. Ms. Slowiczek has been with this corporation for three years. She works the morning shift from 7AM-3PM. She was not working on 01/02/2023 but was informed by Ms. Scherer-Alexander after returning to work that Resident A had an accident in the bathroom, fell and required to go to the hospital for stitches. Ms. Slowiczek was informed that DCS James Lica was supposed to have been in the bathroom with Resident A but had stepped out. Ms. Slowiczek stated that Resident A is a two-person assist after declining and that two staff members must assist Resident A on the toilet and at least one of the staff members must remain in the bathroom always with Resident A. She stated that was policy that was in training when she was hired regarding all residents whenever a staff member assisted the resident with any toileting. Ms. Slowiczek reported after the incident with Resident A, all staff members were in-serviced again on policy.

On 01/05/2023, I interviewed DCS LaChresha Sturgis regarding the allegations. Ms. Sturgis has been with this corporation for four years. She too works the morning shift from 7AM-3PM. She did not work on 01/02/2023 but was informed by her coworkers after returning to work that Resident A had fallen after being put on the toilet, injured her head, and got staples at the hospital. Ms. Sturgis reported that Resident A is a two-person assist since her decline. Depending on Resident A's mood, Resident A will attempt to get up to ambulate on her own, but that staff must assist her because she is in a wheelchair and cannot ambulate. Policy is that a staff member must be either a standby assist or stand at the door whenever a resident is assisted on the toilet to ensure their safety. Ms. Sturgis has never left Resident A or any other resident unattended. She stated that she has worked with DCS James Lica, and she has never witnessed him leaving a resident, including Resident A unattended. Ms. Sturgis completed the in-service training on policy regarding Resident A after this incident that was completed by Ms. Scherer-Alexander.

On 01/05/2023, I attempted to interview Resident A who was sitting in her wheelchair but was unsuccessful as her responses were “I don’t remember.” Resident A confirmed she fell but was unable to provide any details to the fall. Resident A likes living here and likes the staff. She stated that staff help her whenever she needs help.

On 01/05/2023, I attempted to interview Resident B who was sitting at the dining room table, but due to her dementia, I was unable to gather any information regarding the allegations. Resident B was observed sitting in her wheelchair and appeared to have good hygiene and interacting well with staff.

I reviewed Resident A’s assessment plan completed on 05/10/2022 and according to the assessment plan, Resident A ambulates independently without any devices, but does have a personal walker and wheelchair as needed. The assessment plan was not updated to reflect that Resident A is now wheelchair bound and is a two-person assist.

On 01/10/2023, I interviewed DCS James Lica via telephone regarding the allegations. Mr. Lica has worked for this corporation for about one year. He works the afternoon shift from 3PM-11PM. On 01/02/2023, Mr. Lica worked with DCS Tasia Ellis. Around 8PM, he and Ms. Ellis transferred Resident A onto the toilet as Resident A is a two-person assist. Mr. Lica and Ms. Ellis heard a noise outside so both stepped out and went into the living room to check on Resident B who was in the living room but ok. Mr. Lica and Ms. Ellis returned about five-10 seconds later, heard a noise in Resident A’s bedroom and found Resident A on the floor in a sitting position with the back of her head facing the direction of the door. Mr. Lica observed Resident A’s head bleeding from the back and did everything to stop the bleeding, which he did. Mr. Lica then called Ms. Scherer-Alexander and advised her what happened. He described the laceration and was advised by Ms. Scherer-Alexander to call Resident A’s daughters as Resident A needed to go to the hospital. Mr. Lica called Resident A’s daughter who elected to come to the facility and transport Resident A themselves to the hospital. Mr. Lica also contacted the hospice nurse. He cannot recall the name of the hospice nurse. Mr. Lica stated that policy is that at least one staff member must be with the resident in the room always. Resident A is a two-person assist; therefore, he or Ms. Ellis should have remained in the bathroom with Resident A and not have left her unattended. Mr. Lica stated this was an isolated incident and he completed an in-service on proper safety precautions when toileting residents by Ms. Scherer-Alexander.

On 01/10/2023, I interviewed via telephone Resident A’s daughter regarding the allegations. Resident A’s daughter stated that on 01/02/2023, she received a telephone call from DCS James Lica advising her that Resident A fell and required stitches. Mr. Lica advised her that she can either come to the facility to transport Resident A to the hospital or Mr. Lica can call an ambulance. Resident A’s daughter elected to transport Resident A herself to the hospital. Her and her sister went to the facility and when they arrived, she observed Mr. Lica cleaning Resident A’s wound with a warm compress. The would was located on the back of Resident A’s head. Resident A’s daughter stated that she nor her sister were able to transfer Resident A from the wheelchair into the car,

but that DCS James Lica did by himself. Resident A's daughter is not sure if Resident A is a two-person assist but stated that Resident A went on hospice in 08/2022. She stated that Mr. Lica is a tall man and large in stature; therefore, it was "easy," for Mr. Lica to transfer Resident A from the wheelchair into the car by himself. Resident A's daughter stated she is extremely happy and satisfied with the care that Resident A receives at this facility. She has no concerns about staff or about Resident A's care. She stated Resident A has rapidly declined where it has been difficult for staff to get Resident A to follow any directions or to do anything by herself.

On 01/10/2023, I discussed the allegations via telephone with Accent Care Hospice Registered Nurse Danielle Wright. Hospice RN stated according to Resident A's chart, on 01/02/2023 a call was received from DCS James Lica stating that Resident A fell and there was a laceration to the back of her head and required stitches. Hospice RN visits Resident A weekly. On 01/03/2023, hospice RN arrived at the facility where she was informed that Resident A had an unwitnessed fall from the toilet. She was informed that a staff member was initially with her but that the staff member stepped out leaving Resident A unattended to care for another patient and when the staff member returned, Resident A had fallen and hit her head. Hospice RN stated that Resident A was initially a one-person assist as she was ambulating with a walker but since Resident A's decline in 10/2022, Resident A became a two-person max transfer assist. Hospice RN stated this information should be in Resident A's assessment plan as the hospice RN in-serviced Ms. Scherer-Alexander regarding Resident A's change in the plan of care.

On 01/12/2023, I received a return call from APS worker Heather Goodin. Ms. Goodin stated based on her investigation, she will be substantiating her case for neglect.

On 01/23/2023, I interviewed DCS Tasia Ellis regarding the allegations via telephone. Ms. Ellis has been working for this corporation since 2020. On 01/02/2023, she and DCS James Lica were working the afternoon shift from 3PM-11PM. Around 8PM she and Mr. Lica were getting all the residents ready for bed. She and Mr. Lica assisted Resident A onto the toilet and Ms. Ellis noticed Resident A's brief was dry, so she let her sit on the toilet a little longer. Ms. Ellis stated that Mr. Lica stepped out of Resident A's bedroom because he heard a noise in the hallway. Mr. Lica was in the living room and then Ms. Ellis heard something in the hallway so she too Ms. Ellis stepped out of Resident A's bedroom and saw that everything was ok, so she returned. Ms. Ellis was gone for two minutes before returning to Resident A. She observed the bathroom door closed and heard a fall. As she opened the door, she saw Resident A's back of the head hit the corner of the wall. Resident A was bleeding, so she applied a warm compress to the back of the head while Mr. Lica called Ms. Scherer-Alexander to advise her what happened. Mr. Lica then called Resident A's daughters who opted to transport Resident A themselves to the hospital. Resident A required staples. Ms. Ellis stated this was an isolated incident and that policy states that a staff member must remain with the resident always when assisting a resident with toileting. She stated after this incident, she too was in-serviced on safety precautions when toileting a resident.

On 01/23/2023, I conducted the exit conference via telephone with licensee designee LeeAnn Pennington with my finds. Ms. Pennington acknowledged the findings and stated she does not have any questions.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Based on my review of Resident A's assessment plan completed on 05/10/2022, the assessment plan was not updated to reflect her decline in health, being wheelchair bound or that she is a two-person max assist. According to Accent Care Hospice RN, Resident A was a two-person max assist as of 10/2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on my investigation and information gathered, Resident A's personal needs, including protection and safety were not attended to at all times on 01/02/2023 by DCS James Lica and DCS Tasia Ellis. Mr. Lica and Ms. Ellis left Resident A unattended after transferring Resident A onto the toilet. Resident A attempted to get up from the toilet, falling on the floor and hitting the back of her head which resulted in a laceration that required Resident A to go to the hospital for stitches.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

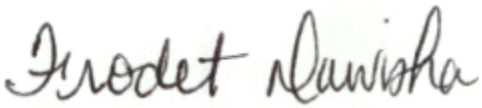
INVESTIGATION:

During the unannounced on-site investigation on 01/05/2023, I observed a medication bubble pack sitting in the Program Director, Diane Scherer-Alexander's office that was unlocked. Ms. Scherer-Alexander stated she received the new medication bubble pack that morning and was going to place the bubble pack in the locked medication cabinet located in the common room but had placed the bubble pack on the table in her room with her office door wide open. Ms. Scherer-Alexander then placed the bubble pack in a cabinet drawer but the cabinet drawer was not locked either. I advised Ms. Scherer-Alexander that all medications must be always kept in a locked cabinet or drawer when medication is not being administered.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	During my unannounced on-site investigation on 01/05/2023, I observed a medication bubble pack sitting on a side table in the Program Director Diane Scherer-Alexander's office instead of it in a locked cabinet or drawer.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

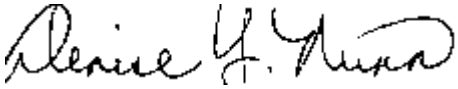
Contingent upon receiving an acceptable corrective action plan, I recommend no change to the status of the license.



01/23/2023

Frodet Dawisha Date
Licensing Consultant

Approved By:



01/23/2023

Denise Y. Nunn Date
Area Manager