GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

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

October 13, 2023

RE: License #: AH630377767
Investigation #: 2023A1022016
Pomeroy Living Orion Assisted & Memory Care

Dear Manda Ayoub:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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 authorized representative and a date.
- Be signed and dated.

Please review the enclosed documentation for accuracy and contact me with any questions.

Sincerely,

Barbara P. Zabitz, R.D.N., M.Ed.
Health Care Surveyor
Health Facility Licensing, Permits, and Support Division
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Mobile Phone: 313-296-5731
Email: zabitzb@michigan.gov

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AH630377767 |
| | |
| **Investigation #:** | 2023A1022016 |
| | |
| **Complaint Receipt Date:** | 11/22/2022 |
| | |
| **Investigation Initiation Date:** | 11/29/2022 |
| | |
| **Report Due Date:** | 01/22/2023 |
| | |
| **Licensee Name:** | Beacon Square Orion LLC |
| | |
| **Licensee Address:** | Suite 130<br>5480 Corporate Drive<br>Troy, MI 48098 |
| | |
| **Licensee Telephone #:** | (248) 723-2100 |
| | |
| **Administrator:** | Bill Brown |
| | |
| **Authorized Representative:** | Manda Ayoub |
| | |
| **Name of Facility:** | Pomeroy Living Orion Assisted & Memory Care |
| | |
| **Facility Address:** | 101 Scripps Road<br>Lake Orion, MI 48360 |
| | |
| **Facility Telephone #:** | (248) 621-3100 |
| | |
| **Original Issuance Date:** | 10/11/2017 |
| | |
| License **Status:** | REGULAR |
| | |
| **Effective Date:** | 04/11/2023 |
| | |
| **Expiration Date:** | 04/10/2024 |
| | |
| **Capacity:** | 128 |
| | |
| **Program Type:** | AGED<br>ALZHEIMERS |

## II. ALLEGATION(S)

The complainant identified concerns that are not related to or addressed in licensing rules and statutes for a home for the aged. Therefore, only specific items pertaining to homes for the aged provisions of care were considered for investigation. The following items were those that could be considered under the scope of licensing.

| | **Violation Established**? |
|---|---|
| The facility did not attempt to prevent the Resident of Concern (ROC) from falling. | Yes |
| The ROC was found with bruising and skin tears to her right arm on 11/21/2022, but no one at the facility was able to explain what had happened. | No |
| The facility was understaffed. | No |
| The facility did not ensure that the ROC was taken to meals, did not ensure that she was dressed properly and did not ensure that incontinence products were available. | No |

## III. METHODOLOGY

| | |
|---|---|
| 11/22/2022 | Special Investigation Intake<br>2023A1022016 |
| 11/29/2022 | Special Investigation Initiated - Letter<br>Information requested from the assigned APS employee. |
| 12/08/2022 | Contact - Telephone call made<br>APS referral source is the ROC's daughter. Daughter interviewed by phone. |
| 01/10/2023 | Contact - Telephone call made<br>Investigation completed remotely by phone. |
| 03/31/2023 | Contact - Document Sent<br>Email exchange with facility |
| 04/14/2023 | Contact - Document Received<br>Email exchange with facility |

| | |
|---|---|
| 10/13/2023 | Exit Conference |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**ALLEGATION:**

**The facility did not attempt to prevent the Resident of Concern (ROC) from falling.**

On 11/22/2022, the Bureau of Community and Health Systems (BCHS) received a complaint from via Adult Protective Services (APS) that read, “[Name of the Resident of Concern (ROC)] has a lot of falls at Pomeroy Living. She was recently at another facility for COVID and did not have any falls…”

On 12/5/2022, BCHS received a second complaint directly from complainant/family member #2 that read, “She (the ROC) was additionally noted (on 11/22/2022) to have bruising to her right upper and lower arm, with cuts and scrapes along her right lower arm and elbow. We were not notified of any falls or injuries… She has 30 falls since she has been a resident at Pomeroy Living - Orion's memory care facility, which has been less than a year. The falls have all been unwitnessed, and she is typically found on the floor. The staff are unaware of the mechanism of these falls.”

On 12/08/2022, I interviewed complainant/family member #1 by phone. The complainant expressed concern that there had been no consistent interventions to address the ROC’s many falls. According to the complainant, the family had found the ROC another placement and she was no longer living at the facility, but while she was there, other than keeping her in the common area during the day, they did not seem to be very proactive about keeping the ROC safe. Most of the ROC’s falls occurred in her room and they were unwitnessed. Complainant/family member #1 said she had been advised to provide a different type of mattress for the ROC and they discussed placing a fall mat by her bed but did not follow through due to concerns that the ROC could slip on the mat if she got out of bed at night. complainant/family member #1 went on to say that the facility seemed to be relying on the ROC activating her call pendant when she needed assistance, but that the ROC did not always remember to use the pendant.

On 1/10/2023, I interviewed the director of wellness and the interim executive director by phone. When they were asked to describe the interventions that they used to address and prevent falls, they stated that when appropriate, they made referrals to physical and occupational therapy; the use of a mat by the bed if the resident was known not to try to get out of the bed by themselves; and, especially in the memory care unit, they relied on the engagement of residents in activities to keep them occupied as well as concentrating them in one area where the care givers could easily keep their eyes on them. When they were asked what methods were used when residents were in their rooms, the director of wellness described how motion sensors were used to alert staff when the door to the room was opened but did not capture motion within the room. Care staff members were to make wellness rounds on residents in their rooms at least once every two hours and to respond to pendant alerts in a timely manner. According to the executive director, the goal was to respond in less than 5 minutes.

When I asked the interim executive director to explain what the facility did to protect the ROC from repeated falls, the interim executive director replied (by email 3/31/2023) referred to the following documentation.

According to a progress note dated 4/25/2022, on 4/23/2022, a physical therapist (PT) and an occupational therapist (OT) evaluated the ROC after a caregiver reported that the ROC had a fall. The PT wrote, “Recommended lower hospital bed. Daughter said that she just changed her mom's bed to low bed on Thursday and she wants to see how she does with that as her mom will not like hospital bed. One hour checks are in effect, also recommended 24 hour one on one supervision if family agrees for fall prevention. Daughter and nurse notified. Patient was educated about fall prevention and use of AD (assistive device) with caregiver assist for ambulation. RW (rolling walker) provided to patient to use with External assist.”

On 5/17/2022, the ROC was discharged from occupational therapy. The OT recommended that the ROC have moderate physical assistance with all transfers, use a wheelchair while alone in her room, use a walker with physical assistance and the use of a gait belt to walk, and to wear shoes with a back as recommended by the OT. The OT also recommended that the ROC sleep in a bed that could be lowered closer to the floor. The OT wrote, “POA (Power of Attorney) is educated on risk of height of bed and that hospital bed would be safest option- POA is declining at this time.”

On 10/20/2022, a progress note indicated that “the resident was observed on the floor laying on her left side next to her bed facing her bathroom at about 2am… Family was notified of this occurrence, and it was suggested that maybe we get a bed alarm and the daughter stated she is up and down so much it would be going off all the time. She stated she would think about it and if she wanted to move forward, she would reach out regarding the cost.”

On 11/21/2022, a progress note indicated “at approx 1pm this resident stated she fell but unable to state where she fell… resident has poor safety awareness: poor vision: will ambulate without assist grabbing onto items in the various areas for balance: will bump into objects when ambulating… “

On 11/24/2022, a progress note indicated “Resident was observed lying on floor between bed and night stand. She states that she hit her head… Her daughter, [name of family member #1] was called as was EMS. EMS spoke with daughter who refused transport to hospital.”

On 11/25/2022, a note indicated that the ROC was again evaluated by the OT. According to the OT’s documentation, “Patient found in and out of sleep in wheelchair in common area with aides for supervision… Patient demonstrated decreased attention span and overall tolerance… patient to continue OT services next week to help decrease frequency of falls and increase ADL (activities of daily living) participation.

The facility was asked to provide the care staff’s pendant response time for the ROC, from 10/1/2022 until she moved out of the building. Review of the response time revealed response times greater than 15 minutes as follows:

10/2 at 8:55 am, 43 minutes
10/5 at 6:55 pm, 49 minutes
10/14 at 8:60 pm, 18 minutes
10/18 at 11:30 am, 2 hours 11 minutes
11/28 at 2:23 pm, 37 minutes

When I asked the interim executive director to explain the ROC’s long wait times, the interim executive director replied (by email 4/14/2023) “Speaking with staff, [name of the ROC] was not able to make her needs known consistently. Sometimes she was able to tell what she needed sometimes; she did not know she pressed the pendant. At times, despite answering to a pendant light, the staff forgets to turn off the pendant, the extended response time does not necessarily mean that they were not attended to.”

Review of the ROC’s service plan revealed that for safety interventions, staff were to redirect the ROC “if seen self ambulating without assistance,” (resident to) ambulate with a walker, (resident to have) 1-person physical assistance and gait belt, to wear socks with grips on the bottom purchased by the family, and (staff) to remind to lock the wheelchair brakes before sitting down. Further, according to the ROC’s service plan, “AMBULATION: Can not ambulate long distances without guidance or assistance” and “AMBULATION: Has a history of falls which puts the resident at risk if she ambulates unassisted.”

| 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:**<br><br>**(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.** |
| **For Reference: R325.1901** | **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 supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.** |
| **ANALYSIS:** | The ROC's service plan identified that she was a fall risk. Although the ROC received both OT and PT services, the ROC continued to experience falls. A full assessment was not completed, and effective interventions were not implemented by the facility.<br><br>The facility then proposed at least two fall interventions that would be the family's responsibility and/or at the ROC's expense: the use of a hospital bed and a personal care giver to attend the ROC around the clock.<br><br>Further, alerts from the ROC's pendant were not answered in a timely manner, making it more likely that the ROC would attempt to get up on her own from bed or chair and more likely that she would experience a fall.<br><br>For these reasons, the violation is established. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION:**

**The Resident of Concern (ROC) was found with bruising and skin tears to her right arm on 11/21/2022, but no one at the facility was able to explain what had happened.**

**INVESTIGATION:**

According to both complainant/family member #1 and complainant/family member #2, on 11/21/2022, a visitor, described as a "family friend/caregiver," reported to the family that the ROC was found to have bruising on both her right upper and lower arm, as well as cuts and scrapes along her right lower arm and elbow. The complainant/family member #1 stated that that no one in the facility was able to explain how the ROC was injured and that no one in the family was notified on these injuries.

According to the facility's investigative report, written by the interim executive director, dated 11/21/2022, "(On) 11/21/2022 during the morning routine, resident was assisted by the employee with incontinence care, and changing of her clothing. Staff noticed blue bruises on the right arm, and abrasions areas to the right posterior forearm… The nurse was alerted and when she asked [name of the ROC] what happened, [name of the ROC] said that she fell but she did not know when and where. (On) 11/21/2022, noon time, the granddaughter [name of complainant/family member #2] called and requested to meet at the facility, with her mother, [name of complainant/family member #1], and me to discuss the noted bruises on the arm, and the state of "undress" of [name of the ROC] … The bruise to the upper arm did not appear to have finger marks, and the abrasions below on the forearm could indicate that she could have bumped into an object. I (the interim executive director) explained to the daughter and the granddaughter that the nurse did not get a chance to call the family because the family friend had already contacted them."

On 11/21/2022, wellness nurse #1 documented in the ROC's progress notes, "RN requested to observe a bruise and abrasion to rt (right) upper ext (extremity). Range of motion within normal limit no discomfort noted to sight and pain med for generalized pain was just given at 1 pm. Family caregiver [name of family friend/caregiver] was at chairside and [name of family friend/caregiver] notified med tech of bruising and abrasion."

According to the interim executive director (per email on 3/31/2023), "Regarding the family notification of the bruises noted on 11/21/2022, the visitor called the family before they gave the staff a chance to notify the family…"

| 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:** | The family was appraised of the ROC's bruising and abrasion by the family friend/caregiver at approximately the same time as the wellness nurse, who conducted the assessment of the injuries. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**The facility was understaffed.**

**INVESTIGATION:**

According to complainant/family member #2, many of the family's complaints were a direct result of insufficient staffing. The complainant/family member #2 stated, "There are times when it takes staff upwards of 50 minutes to answer my grandmother's emergency call light." The complainant/family member #2 went on to say that for 20 residents, there were "only 2 caregivers available at a time. Upon my (complainant/family member #2) visiting, there are often many residents who are very agitated, begging for help, and there is not enough staff to redirect and see to everyone's needs. I am concerned that the residents are not regularly checked on or checked on with adequate frequency."

According to the director of wellness, the facility employed caregivers, medication technicians and licensed nurses. The majority of the care staff worked 8-hour shifts, but there were some medication technicians and all of the licensed nurses who worked 12-hour shifts.

The director of wellness went on to say that there were between 20 and 25 residents on each of the facility's 3 floors. Optimal scheduling for caregivers was 7 scheduled on the day shift, 6 on the afternoon shift and 5 on the overnight shift. The memory care unit, on the first floor, had 3 caregivers scheduled on the AM shift, 3 on the PM shift and 1 on the overnight shift. For the second floor, a general assisted living unit, there were 3 caregivers on the AM shift, 2 on the PM and 2 on the overnight shift. For the third floor, another general assisted living unit with the smallest census and the most independent residents, there was only 1 caregiver scheduled for each shift.

For medication technicians, optimal scheduling was 3 scheduled on both the day shift and the afternoon shift, but just 1 on the overnight shift.

The facility was not able to have a consistent schedule for licensed nurses. In addition to the wellness director who was a licensed nurse, they tried to schedule a licensed nurse at least 8 hours per day, 7 days a week.

Review of the facility's staffing schedule for the time period 11/20/2022 through 11/25/2022 revealed that the number of caregivers assigned was less than optimal for the following shifts:
For 11/22/2022, 6 caregivers were present on the day shift.
For 11/23/2022, 5 caregivers were present on the day shift.
For 11/24/2022, 6 caregivers were present on the day shift and 4 caregivers on the overnight shift.
For 11/26/2022, 4 caregivers were present on the overnight shift.

For medication technicians, the schedule reflected the optimal number of employees.

When the interim executive director was asked to explain why the facility had less than optimal staffing for the shifts listed, she responded (by email 4/14/2023), "Med techs and nurses are part of the care and wellness staff and they do provide care to the residents. Their job cannot account for 8 hours so they are to assist with call lights, medication pass and meals etc."

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1931** | **Employees; general provisions.** |
| | **(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.** |
| **ANALYSIS:** | Although the staffing of caregivers was less than optimal on the 5 shifts listed, the facility had adequate medication technicians available to help the caregivers provide care. Three of the 5 shifts listed occurred during business hours when senior managers such were available to help as well. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**The facility did not ensure that the ROC was taken to meals, did not ensure that she was dressed properly and did not ensure that incontinence products were available.**

**INVESTIGATION:**

According to complainant/family member #2, “Today (11/21/2022) my grandmother was found by a visitor to be sitting in a wheelchair parked in the corner of her room. She was sitting in a diaper without pants on. She is unable to dress or undress herself so she did not dress herself in this manner… Despite being charged for incontinence care, there have been times where my grandmother has been found to be dressed by the staff in no brief, diaper, or undergarment at all… There are times when she (the ROC) is not taken for a meal, we do not know how often this happens, however I (the complainant) can assume it occurs with significant frequency as my grandmother has lost 25-30 lbs in the time she has been residing in Pomeroy… “

At the of the interview with the facility managers, the director of wellness stated that they were familiar with the complaints alleged by the ROC’s family, as they had brought many of them to their attention. Regarding the incident of 11/22/2023, the facility provided their investigative report, written by the interim executive director, dated 11/21/2022, “(On) 11/21/2022 during the morning routine, resident was assisted by the employee with incontinence care, and changing of her clothing… Per staff reports, [initials of caregiver #1], resident declined to have pants put on because she was not sure if she had to use the restroom again, and she was worried that might soiled her pants; resident asked to sit in a w/c (wheelchair) by the heater and covered with a blanket. Staff had asked the resident if she wanted to lay down in bed, but the resident declined… “

When the wellness director was asked about the provision of incontinence products, the wellness director explained that if a resident was fully incontinent, the cost of incontinence products was included in the overall cost for incontinence care. The wellness director went on to say that residents and families could choose not to have the incontinence products stored in the resident rooms, but at no time had the facility run out or otherwise not have incontinence products available for any resident including the ROC. When asked specifically about the ROC, the wellness director stated that the ROC’s family had requested that incontinence products not be kept in her room.

Regarding meal consumption, the facility provided the contents of an email from the previous administrator to complainant/family member #1, dated 10/18/2022, that read in-part, “I (previous administrator) talked with the med tech down there regarding your mother (the ROC). She did eat breakfast today but is stating to the

person here she did not. But I did confirm with the med tech, and she did go down to eat breakfast… “

Also, regarding meal consumption, the facility provided a progress note, dated 11/23/2022, written by the interim executive director, that documented “visited with resident around 9am she was asleep I her bed, staff had assisted her with breakfast and she wanted to go back to sleep… Visited with resident again for lunch and assisted her to the dining room for lunch. Consumed 100% of lunch.”

Regarding dressing and the availability of incontinence products, the facility provided another email, this time from the complainant/family member #1 to the previous administrator, dated 10/12/2022. According to this email, “The same day my mother (the ROC) was dressed with no undergarments, I (complainant/family member #1) was there with [name of complainant/family member #2] as well. There were no incontinence supplies available in her room and I noted there was a diaper in her bathroom garbage can. I recall in our meeting that I specifically requested that diapers not be placed on my mom, in order for her to retain some of her dignity. My mother is either continent and does not require incontinence supplies or assistance to dress her properly, or she is incontinent and her state of dress was inappropriate. It cannot be both.”

No other documentation regarding meal consumption, dressing, toileting, or incontinence product use was provided by the facility.

The service plan gave the following instructions for the ROC:

For meal consumption, “Requires reminders for meals.”

For dressing, “Needs minimal physical assistance (i.e. tying shoes, obtaining clothes from closet, putting on coat).”

For incontinence and toilet use, “Is incontinent of bladder… Is incontinent of bowels… Requires reminders/cues to use the toilet.”

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1933** | **Personal care of residents.** |
| | **(1) A home shall provide a resident with necessary assistance with personal care such as, but not limited to, care of the skin, mouth and teeth, hands and feet, and the shampooing and grooming of the hair as specified in the resident's service plan.** |

| | |
|---|---|
| **ANALYSIS:** | From the service plan, it appeared that the ROC was mostly independent for dressing and eating. The ROC may have been mostly independent for toilet use, although she was incontinent. The family's issues were with the ROC's overall trend of weight loss and with two occasions when the ROC was found to be inappropriately dressed from the waist down. There is not enough evidence to establish that the ROC was not routinely provided the level of assistance that she needed. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

I reviewed the findings of this investigation with the authorized representative (AR) on 10/13/2023. When asked if there were any comments or concerns with the investigation, the AR stated that there were none.

## IV. RECOMMENDATION

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

10/13/2023

_____

Barbara Zabitz Date
Licensing Staff

Approved By:

10/04/2023

_____

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