GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 23, 2023

Nelson Noel-Chua
The Legacy at Shelby Crossing
13712 21 Mile Road
Shelby Township, MI 48315

RE: License #: AH500315088
Investigation #: 2023A0784086
The Legacy at Shelby Crossing

Dear Nelson Noel-Chua:

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.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500315088
Investigation #:	2023A0784086
Complaint Receipt Date:	08/22/2023
Investigation Initiation Date:	08/25/2023
Report Due Date:	10/21/2023
Licensee Name:	Trilogy Healthcare of Macomb LLC
Licensee Address:	303 N. Hurstbourne Pkwy. Suite 200 Louisville, KY 402225182
Licensee Telephone #:	(502) 412-5847
Administrator/Authorized Representative:	Nelson Noel-Chua
Name of Facility:	The Legacy at Shelby Crossing
Facility Address:	13712 21 Mile Road Shelby Township, MI 48315
Facility Telephone #:	(586) 532-2100
Original Issuance Date:	04/22/2013
License Status:	REGULAR
Effective Date:	01/22/2023
Expiration Date:	01/21/2024
Capacity:	35
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Lack of adequate medical attention.	No
Resident A was not administered prescribed medication.	Yes
Additional Findings	No

III. METHODOLOGY

08/22/2023	Special Investigation Intake 2023A0784086
08/25/2023	Inspection Completed On-site
08/25/2023	Special Investigation Initiated - On Site
08/25/2023	Exit Conference Conducted with administrator/authorized representative Nelson Noel-Chua

ALLEGATION:

Lack of adequate medical attention.

INVESTIGATION:

On 8/22/2023, the department received this online complaint. A referral was made to adult protective services (APS).

According to the complaint, Resident A was admitted to the facility on 5/12/2023, having moved from *Shelby Crossing Skilled Nursing Facility*, located on the same campus, after receiving rehabilitation for foot and hip fractures and surgery on her left hip. Resident A suffers from hypertension and Chronic Heart Disease for which she has been on the blood thinner Warfarin (Coumadin – used to reduce blood clotting) for several years. Prior to moving to the facility, on 5/11/2023, Resident A's primary physician (Physician A) put a hold on this medication as Resident A's INR (internal normalized ratio – indicates the bloods ability to clot) was high. After moving to the facility on 5/12/2023, Resident A's family and authorized representative (Relative A), visited Resident A daily. As they visited, it was observed that Resident A's legs began to swell, and each day facility staff were requested to reach out to Physician A or the facilities on-call nurse to have her leg evaluated for possible treatment. It was not until 5/16/2023, when Resident AR insisted staff obtain medical

attention, due to Resident A's leg continuing to swell and was hard to the touch which are warning signs of blood clots, that Physician A1 was notified. On 5/17/2023, Physician A1 evaluated Resident A and ordered a doppler test (used to test for blood clots) which revealed two blood clots in Resident A's leg, at which point she had to be immediately taken to the hospital.

On 8/25/2023, I interviewed administrator/authorized representative Nelson Noel-Chua at the facility. Mr. Noel-Chua confirmed Resident A was admitted to the facility on 5/12/2023 from the nursing home located on the same campus. Mr. Noel-Chua stated that Resident A had been at the nursing home for rehabilitation after having left hip surgery. Mr. Noel-Chua stated Resident A had pain and swelling in her left leg and hip areas coming into the facility. Mr. Noel-Chua stated that staff had not reported any noticeable difference in the leg swelling for Resident A between 5/12/2023 and 5/17/2023 as the swelling had not changed from the base line swelling since Resident A came to the facility on 5/12/2023. Mr. Noel-Chua stated it was not until late in the evening on 5/16/2023 that Relative A, requested Resident A have an X-ray as Relative A1 we concerned due to ongoing swelling and pain in Resident A's leg. Mr. Noel-Chua stated that a request was made for Physician A to come to the facility. Mr. Noel-Chua stated Physician A came to the facility on 5/17/2023 and ordered an X-ray and Doppler be completed for Resident A's hip and both legs due to swelling. Mr. Noel-Chua stated that results for Resident A's Doppler showed she had blood clots. Mr. Noel-Chua stated that Resident A would have been sent out to the hospital at that time, however Relative A requested the facility not have her sent out yet so he could talk with Resident A's Cardiologist first thing on 5/18/2023 to have an additional opinion about what the next step should be. Mr. Noel-Chua stated that Relative A was initially hesitant to have Resident A sent out to the hospital, but after further discussion, Relative A agreed to this and so Resident A was sent out on 5/18/2023. Mr. Noel-Chua stated it was not clear to staff, prior to 5/17/2023, that Resident A had additional pain or swelling as she had similar pain and swelling when she came into the facility on 5/12/2023. Mr. Noel-Chua stated facility nurses do enter *Progress Notes* in the facility's computer system based on staff reporting and observations of changes with residents and that the notes do not indicate noticeable differences in Resident A's condition from her baseline upon entering the facility. Mr. Noel-Chua denied that Relative A communicated a desire to have additional X-rays done for Resident A until the evening of 5/16/2023. Mr. Noel Chua stated several staff cared for Resident A or encountered Relative A between 5/16/2023 and the evening of 5/16/2023 and did not report that Relative A expressed concern over additional swelling or a need for X-rays. Mr. Noel Chua stated the facility sought appropriate medical attention based on the best information they had.

Mr. Noel-Cua provided nine staff statements signed by Associates 1-9 who either came into direct contact with or may have encountered Relative A/Resident A's family between 5/12/2023 and the evening of 5/16/2023. Each of the statements

attests that staff did not recall anyone reporting increasing swelling in Resident A's leg during that time.

I reviewed a Statement of Witness Form, provided by Mr. Noel-Chua, signed by Nurse 2. Mr. Noel-Chua explained that the statement was taken regarding an investigation into Resident A not receiving prescribed blood pressure medication between 5/12/2023 when she entered the facility and 5/17/2023 when she was placed back on the medication after her Doppler test results came back. Mr. Noel-Chua stated each of the facilities nurses were interviewed regarding their knowledge of and contact with Resident A.

I reviewed Progress Notes, dated between 5/12/2023 and 5/18/2023, for Resident A, provided By Mr. Noel-Chua. The notes read consistently with statements provided by Mr. Noel-Chua. The statement read, in part, that Nurse 1 reported "she did not have contact with the resident until 5/16/2023 in the late evening when [Relative A] had requested and E-ray for [Resident A]".

I reviewed hospital admission documentation for Resident A from *Henry Ford Health*, provided by Mr. Noel-Chua. The documentation confirmed Resident A was admitted on 5/18/2023 related to the Doppler test.

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: **(c) Assure the availability of emergency medical care required by a resident.**

ANALYSIS:	The complaint alleged the facility did not seek adequate medical attention for Resident A related to swelling in her leg from blood clots. The investigation revealed Resident A was admitted to the facility with swelling and pain in her hip and legs related to a recent hip surgery. Administrator/authorized representative Nelson Noel-Chua reported that due to Resident A's condition coming into the facility, Resident A's condition did not change in a way that was clear to staff between 5/12/2023 and 5/16/2023, when Relative A requested an X-ray, that Resident A required additional medical attention. Mr. Noel-Chua stated that when Relative A requested the X-ray for Resident A, actions were taken promptly to have Resident A evaluated which ultimately led to further testing and Resident A being taken to the hospital. Review of staff progress notes and statements indicate consistency with Mr. Noel-Chua's statements and do not support a lack of adequate medical attention based on the information available to staff.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was not administered prescribed medication.

INVESTIGATION:

According to the complaint, Resident A's blood pressure medication was supposed to reinstated after she moved into the facility on 5/12/2023, however, due to poor communication by responsible facility staff, the medication was not reinstated prior to Resident A forming the blood clots in her leg.

When interviewed, Mr. Noel-Chua stated that Nurse 2 was responsible for Resident A's admission on 5/12/2023. Mr. Noel-Chua stated Resident A did have her coumadin (blood pressure medication) held at the nursing home prior to admission to the facility on 5/12/2023, but stated a new order was written for Resident A and her coumadin should have continued to be administered from 5/12/2023. Mr. Noel-Chua stated Nurse 2 had received a verbal report from the nursing home nurse on 5/12/2023 regarding the new coumadin order but did not receive the actual order or notification from Physician A. Mr. Noel-Chua stated Nurse 2 initially reported she had attempted to contact Physician A on 5/12/2023 but did not get a response. Mr. Noel-Chua stated Nurse 2 was, coincidentally, going on vacation on 5/12/2023 and believed she had passed on the information regarding Resident A's need for her coumadin order to Nurse 3. Mr. Noel-Chua that Nurse 2 reported she had also thought she sent a text to Physician A on 5/12/2023 regarding the need for the

coumadin. Mr. Noel-Chua stated that when interviewed, Nurse 3 stated she did not recall ever receiving notification from Nurse 2 to follow up with Physican A regarding Resident A's coumadin. Mr. Noel-Chua stated Nurse 2 also reported that, after she returned from vacation on 5/30/2023, the text message she though she sent to Physician A was still in "draft" status and never sent. Mr. Noel-Chua stated that when while it was not clear from the medical reporting that the lack of medication "caused" the issue with Resident A's blood clotting, she was supposed to be getting the medication.

I reviewed a typed statement dated 5/30/2023, provided by Mr. Noel-Chua, and signed by Nurse 2, which read consistently with statements provided by Mr. Noel-Chua regarding Nurse 2's recollection of events.

I reviewed a typed statement dated 5/23/2023, provided by Mr. Noel-Chua, and signed by Nurse 3, which read consistently with statements provided by Mr. Noel-Chua regarding Nurse 3 reporting she did not recall receiving any reporting from Nurse 2 on 5/12/2023 regarding Resident A's new coumadin order.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.
For Reference: R 325.1901	**Definitions**
	(n) "Medication management" means assistance with the acquisition and administration of a resident's prescribed medication.
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.

ANALYSIS:	The complaint alleged that due to poor communication with the nursing home by the facility on 5/12/2023, the facility did not obtain Resident A's new blood pressure medication order leading to Resident A not receiving the prescribed medication between 5/12/2023 and 5/17/2023. When interviewed administrator/authorized representative Mr. Nelson Noel-Chua admitted that Resident A did not receive her medication due what appears to be poor communication and inadequate actions by nursing staff to ensure Resident A was receiving her medication as ordered. This was also confirmed by statements dictated from witness interviews with Nurse2 and Nurse 3. Based on the findings, the facility is not complaint with these rules.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

9/26/2023

_____

Aaron Clum Date
Licensing Staff

Approved By:

10/22/2023

_____

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