GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 30, 2023

Aida Moussa
Westwood Macomb Senior Living LLC
16700 23 Mile Road
Macomb, MI 48044

RE: License #: AH500391642
Investigation #: 2024A0784003
Westwood Inn

Dear Aida 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. 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 #:	AH500391642
Investigation #:	2024A0784003
Complaint Receipt Date:	10/05/2023
Investigation Initiation Date:	10/05/2023
Report Due Date:	12/04/2023
Licensee Name:	Westwood Macomb Senior Living LLC
Licensee Address:	16700 23 Mile Road Macomb, MI 48044
Licensee Telephone #:	(586) 228-9700
Administrator/Authorized Representative:	Aida Moussa
Name of Facility:	Westwood Inn
Facility Address:	19759 23 Mile Road Macomb, MI 48042
Facility Telephone #:	(586) 228-9700
Original Issuance Date:	09/14/2021
License Status:	REGULAR
Effective Date:	03/14/2023
Expiration Date:	03/13/2024
Capacity:	147
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Inadequate protection and supervision for Resident A	Yes
Additional Findings	No

III. METHODOLOGY

10/05/2023	Special Investigation Intake 2024A0784003
10/05/2023	Special Investigation Initiated - Telephone Attempted with Complainant
10/05/2023	Contact - Document Sent Email sent to Complainant requesting additional information
10/05/2023	Contact - Document Received Email from complainant with requested information
10/05/2023	APS Referral
10/06/2023	Inspection Completed On-site
10/06/2023	Exit - Onsite With executive director Desiree Rasberry and administrator/authorized representative Auda Moussa

ALLEGATION:

Inadequate protection and supervision for Resident A

INVESTIGATION:

On 10/05/2023, the department received this online complaint.

According to the complaint, on 8/26/2023, at approximately 5am, Resident A was dragged from her bed, across the floor and into the hallway by Resident B at which time she sustained severe open wounds on her left leg and right arm. The facility originally reported Resident A was discovered on the floor in her room with minor wounds and that Resident B had been sent to a psychiatric unit for evaluation. After further inquiry, the facility nurse (Nurse 1) reported Resident A had fallen but did not

report she was dragged. After further questioning of the incident, executive director Desiree ultimately divulged the full details of Resident A being dragged across the floor. Resident B is back in the facility. Resident A passed away on 9/03/2023.

On 10/05/2023, I received a document from Complainant, via email, outlining events specific to Resident A between 8/26/2023 and 9/19/2023. Complaint indicated, within the email, feeling Resident A was not protected when Resident B was allowed back into the facility. According to the document, on the morning of 8/26/2023, Resident B was observed, by video, going towards Resident A's door. Review of the video was reportedly unable to confirm Resident B went into the room, however Resident A was discovered on her floor with minor injuries and hospice was notified. On 8/28/2023, staff reported Resident A, who is never in her room, had pulled herself out of her chair and fell, was anxious and fidgety and would not eat and was in her bed having fallen asleep after several hours of the anxious, fidgety behavior. On 8/29/2023, at 9pm, Resident A was observed to be anxious and fidgety having not received her morphine yet. During a family visit on 8/30/2023, Resident A's hospice nurse pulled back Resident A's covers exposing large bandages on her right leg and left arm and two swollen knees. The hospice nurse removed the bandages revealing and open wound on Resident A's left leg and torn flesh on her arm which the facility had indicated occurred from the two previous incidents reported as falls. Discussion ensued with executive director Desiree who reported that on 8/27/2023, she viewed the video footage from the morning of 8/26/2023 and observed Resident B was pulling Resident A into the hallway by her arm. Ms. Desiree reported she thought these facts had been reported already. It was later observed that Resident B had returned to the facility. Concerns about Resident B being back in the facility were reported to Ms. Desiree who stated moving Resident B was not a good idea but would work on possibly getting a lock on Resident A's door. On 8/31/2032, while family was visiting, Resident B was observed walking into Resident A's room and stated "she is in my bed" believing Resident A was in her room with no apparent precautions having been taken to prevent Resident B from acting in the same manner with Resident A as she did.

On 10/06/2023, I interviewed executive director Desiree Rasberry at the facility. Administrator/authorized representative Auda Moussa was present during the interview. Ms. Rasberry stated that she was familiar with the incident involving Resident A and Resident B on the morning of 8/26/2023. Ms. Rasberry stated that video footage of the incident did confirm Resident B walked into Resident A's room and pulled her into the hallway. Ms. Rasberry stated it was her understanding that the staff member, Associate 1, who originally reported the incident to Resident A's authorized representative, had reported consistent with what was on the video. Ms. Rasberry stated that after speaking with associate 1, it appeared she had reported that Resident A had been pulled out of bed that morning but did not indicate that she had been pulled out and dragged to the hallway. Ms. Rasberrry stated Resident A did not obtain new injuries from the incident but did have existing skin tears which opened up. Ms. Rasberry stated Resident A did have wounds related to other falls. Ms. Rasberry stated Resident B was known to wander but had not had any previous

incidents involving altercations with other residents. Ms. Rasberry stated Resident B has had issues with anxiety which may have led to the incident. Ms. Rasberry stated Resident B was sent out for a psychiatric evaluation after the incident and was deemed appropriate to return to the facility. Ms. Rasberry stated that Resident B was placed on new medications and staff were instructed to “keep an extra eye on her”. Ms. Moussa stated more specifically that staff were directed to check on Resident B at least every hour. Ms. Rasberry stated this was a verbal instruction and was not added to the service plan. Ms. Rasberry confirmed she did receive notification that Resident B had gone back into Resident A’s room after returning to the facility reportedly believing it was her room. Ms. Rasberry stated Resident B has not had a similar incident since returning to the facility.

I reviewed Charting Notes for Resident B dated between 7/01/2023 and 8/28/2023, provided by Ms. Rasberry. Notes dated 8/03/2023 read, in part, “staff reported, resident has been observed wandering in other residents rooms and sleeping on their bed. Resident needs constant re-direction from staff”. Notes dated 8/26/2023 read, in part, Supervisor reported resident was observed going in other residents room early morning, hallway cameras showed resident was observed dragging the other resident out of her room in MC [memory care] hallway”.

I reviewed Resident B’s S*ervice Plan*, provided by Ms. Rasberry. According to the *LAST REVISION* section, the last update done for Resident A’s service plan was 6/15/2022. Within a section titled *BATHING*, the plan read, in part, “PARANOID BEHAVIOR WITH DILLUSIONS AND HALLUCINATIONS. WILL NEED LOTS OF MONITORING AND REDIRECTIONS”. Within a section titled *BEHAVORAL ISSUES*, the plan read, in part, “PARANOID HALLUCINATIONS”

I reviewed *Charting Notes* for Resident A dated between 7/21/2023 and 8/30/2023, provided by Ms. Rasberry. Notes dated 7/21/2023 read, in part, “Supervisor reported resident was observed on the floor in MC common area, resident tried to get up from the chair when she lost her balance, resident C/O [complains of] right hip pain from the fall”. Notes dated 7/25/2023 read, in part, Midnight supervisor reported resident was observed on the floor in MC common area, stating resident tried to get up from her wheelchair when she lost her balance and fell on her buttocks”. Notes dated 8/01/2023 read, in part, Midnight supervisor reported resident was observed on the floor in MC common area, stating resident tried to get up from the wheelchair and lost her balance”. Notes dated 8/22/2023 read, in part, “Midnight staff reported resident observed on the floor in MC common area”. Notes dated 8/23/2023 read, in part, “Staff reported resident was observed on the floor in MC common area, staff stated resident slid out of the wheelchair”. Notes dated 8/24/2023 read, in part, Midnight staff reported resident was observed on the floor in her room, 2 small skin tears observed near right arm from fall”. Notes dated 8/26/2023 read, in part, “Supervisor reported residents arm skin tears were opened due to incident where other resident was observed dragging her out of her room by pulling her arm”. Notes dated 8/30/2023 read, in part, “Midnight supervisor notified resident was observed

on the floor in her room next to her bed, resident has skin tear on her right arm and bruising near forehead from fall skin tear/abrasion near right knee".

I reviewed Resident A's *Service Plan*, provided by Ms. Rasberry. According to the *LAST REVISION* section, the last update done for Resident A's service plan was 6/03/2022. Within a section titled *BATHING*, the plan read, in part, "VERY HIGH ANXIETY. VERY UNSTEADY GAIT. WILL NEED FREQUENT REMINDERS. VERY POOR SHORT-TERM MEMORY. HIGH FALL RISK". Within a section titled AMBULATION & MOBILITY, the plan read, in part, "USES WALKER AND CANE FOR AMBULATION. STAND BY MONITORING FOR AMBULATION. VERY HIGH FALL RISK. LOSSES BALANCE WHILE WALKING".

I reviewed facility video footage, provided by Ms. Rasberry, of the 8/26/2023 incident. The footage was consistent with the description provided in the complaint in that Resident B can be seen entering Resident A's room and coming out shortly after pulling Resident A by her arm into the hallway and leaving her there.

APPLICABLE RULES	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(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: R 325.1901	**Definitions**
	(p) "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.
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative

For Reference: R 325.1901	Definitions
	(t) "Service plan" means a written statement prepared by the home in cooperation with a resident, the resident's authorized representative, or the agency responsible for a resident's placement, if any, that identifies the specific care and maintenance, services, and resident activities appropriate for the individual resident's physical, social, and behavioral needs and well-being, and the methods of providing the care and services while taking into account the preferences and competency of the resident.
ANALYSIS:	The complaint alleged Resident A was not protected after an incident in which she was dragged from her room by Resident B into the hallway and Resident B was subsequently not supervised adequately. The investigation confirmed the alleged incident in which Resident B pulled Resident A into the hallway. While evidence did not support that this kind of behavior was consistent with Resident B's history, it was revealed that Resident B did return to the facility and attempted to enter Resident A's room, again, apparently believing it was her room. Facility charting for Resident B indicated that, on at least one occasion, prior to the incident, Resident B was observed entering resident rooms believing it was her room. Resident B's service plan also indicated Resident B frequently wanders, has paranoid delusions, and requires constant redirection. When interviewed, Ms. Rasberry reported that upon Resident B's return to the facility, staff were advised to provide additional supervision to Resident B, however this direction was not documented in Resident B's service plan, which had not been updated as of June 2022, and, as evidenced by Resident B entering Resident A's room again without staff's knowledge, apparently was not adequate for her supervision. Review of facility charting notes for Resident A revealed that Resident A had falls on multiple occasions, while also sustaining injuries at times, between 7/21/2023 and 8/30/2023 with no additional corrective measures put in place on her service plan, which also had not been updated since June of 2022, to provide additional protection and supervision for Resident A. Based on the findings, the facility is not in compliance 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.

11/16/2023

Aaron Clum — Date
Licensing Staff

Approved By:

11/29/2023

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