GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 21, 2023

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

RE: License #: AH500391642
Investigation #: 2024A1027005
Westwood Inn

Dear Licensee:

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 authorized representative 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 877-458-2757.

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 #:	AH500391642
Investigation #:	2024A1027005
Complaint Receipt Date:	10/13/2023
Investigation Initiation Date:	10/13/2023
Report Due Date:	12/12/2023
Licensee Name:	Westwood Macomb Senior Living LLC
Licensee Address:	16700 23 Mile Road Macomb, MI 48044
Licensee Telephone #:	(586) 228-9700
Administrator:	Desiree Rasberry
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?
Resident A lacked care and protection.	Yes
Additional Findings	No

III. METHODOLOGY

10/13/2023	Special Investigation Intake 2024A1027005
10/13/2023	Special Investigation Initiated - Letter Email sent to APS to inform them the allegations were assigned for investigation
10/17/2023	Contact - Document Received Additional allegations received through the online complaint system.
11/14/2023	Inspection Completed On-site
11/15/2023	Inspection Completed-BCAL Sub. Compliance
12/21/2023	Exit Conference Conducted by email with authorized representative Aida Moussa and Desiree Rasberry

ALLEGATION:

Resident A lacked care and protection.

INVESTIGATION:

On 10/13/2023, the Department received a complaint from Adult Protective Services (APS) which read Resident A used a wheelchair for mobility and needed assistance for daily tasks. The complaint read Resident A had a heart attack on 07/10/2023 and received hospice services.

The complaint alleged the following:

-A medical bed was delivered in July for Resident A but that night she was left in a chair overnight.

-Resident A defecated in her pants and her clothing was placed in the closet with feces on it.

-On 08/01/2023, Resident A fell out of bed during the night and sustained a rugburn and her daughter was not notified until the next morning.

-On 09/05/2023, Resident A was anxious, and reported she could not fall asleep for fear of dying.
-On another date an aide blamed Resident A for urinating on the floor.
-On 09/18/2023 Resident A was anxious and combative in which her daughter was informed in the middle of the night.
-Resident A remembered a struggle on 09/18/2023 when she did not want to get undressed for bed.
-On 09/27/2023, Resident A alleged she was beaten on her chest by an unknown dark-skinned woman.

On 10/17/2023, the Department received additional allegations which alleged there were "*several instances of abuse/neglect*."

On 10/25/2023, email correspondence with the APS worker read in part Resident A expired on 10/18/2023.

On 11/14/2023, I conducted an on-site inspection at the facility. I interviewed administrator Desiree Rasberry who stated Resident A moved into the facility on 7/1/2023. Ms. Rasberry stated Resident A sustained a heart attack shortly after moving into the facility in which she was hospitalized and returned to the facility on Assured Hospice services.

Ms. Rasberry stated she communicated with Resident A's daughter consistently. Ms. Rasberry stated she addressed concerns from Resident A's daughter in which she felt Resident A received care consistent with her needs.

Ms. Rasberry stated Resident A was left in her chair one night and not checked on by staff. Ms. Rasberry stated Employee #1 was on duty that night and stated she had not received communication that Resident A had returned to her apartment from the hospital, so she did not check on her throughout that night. Ms. Rasberry stated Resident A did not sustain injuries from the incident. Ms. Rasberry stated Employee #1 was re-educated by Employee #2. Ms. Rasberry stated Employee #1 was "*one of my best employees*" and had not received complaints from residents nor other staff.

Ms. Rasberry stated she was informed about Resident A's allegations of abuse from her daughter. Ms. Rasberry stated she investigated the allegations in which there were different descriptions provided by Resident A and her daughter of the alleged staff member. Ms. Rasberry stated she reviewed facility cameras located in the hallways in which revealed there were three different staff members who entered Resident A's apartment. Ms. Rasberry stated she interviewed those staff in which did not reveal there were concerns related to her care that night. Ms. Rasberry stated Employee #2 assessed Resident A with her hospice nurse in which no bruising was identified. Ms. Rasberry stated she could not substantiate the allegations. Ms. Rasberry stated Resident A also received potent medications such as morphine and haloperidol in which may have contributed to increased confusion.

Ms. Rasberry stated Resident A was fall risk in which two falls occurred on night shift when she fell out of her bed. Ms. Rasberry stated she and Resident A's hospice nurse had observed a rub mark on her forehead in which after further investigation it was determined she had fallen on 9/27/2023. Ms. Rasberry stated Employee #3 was on duty that night and notified the medication technician of Resident A's fall; however, Employee #3 should have notified the supervisor on duty per the facility's policy. Ms. Rasberry stated Employee #3 was provided education with disciplinary actions in her file and no longer worked for the facility. Ms. Rasberry stated all staff were educated on the facility's policies and procedures through the employee handbook.

While on-site, I reviewed Employee #1's file which read consistent with statements from Ms. Rasberry. Employee #1's Workforce Background Check was dated 1/7/2022 and read she was eligible for hire. The file read in part Employee #1 electronically signed the abuse and neglect, resident's rights acknowledgement, and acknowledgement employee handbook on 1/7/2022.

While on-site, I reviewed Employee #3's file. Employee #3's Workforce Background Check was dated 8/25/2023 and read she was eligible for employment. The file read in part Employee #3 electronically signed the abuse and neglect acknowledgement, resident's rights acknowledgement, and employee handbook on 8/26/2023.

On 11/15/2023, I conducted a telephone interview with Employee #2 whose statements were consistent with Ms. Rasberry. Employee #2 stated she conducted a verbal education and demonstration with Employee #1 after Resident A was left in the chair throughout the night. Employee #2 stated she had not received complaints from residents, residents' families nor staff regarding Employee #1's care prior or since the incident.

I reviewed Resident A's face sheet which read in part she admitted to the facility on 6/30/2022. The face sheet read in part Resident A had history of falls, muscle weakness, unsteady gait.

I reviewed Resident A's service plan dated 7/5/2023 which read in part Resident A was one person assist with transfers, toileting, showers, dressing, grooming/oral care, and utilized a wheelchair for transportation. The plan read in part Resident A preferred to sleep in her bed. The plan read in part Resident A was calm and cooperative and alert and orientated x3. The plan read in part Resident A lacked behavioral issues such as being combative or agitation.

I reviewed Resident A's physician orders which read consistent with statements from Ms. Rasberry.

I reviewed Resident A's incident reports.

Incident report dated 9/1/2023 at 1:44 AM read "*Resident fell while trying to get out of bed*." The report read her vitals were taken. The report read Resident A had "*carpet burn*" on her forehead but no other injuries were noted. The report read the staff supervisor was notified. The report read corrective measures were to ensure the resident's floor mats were always in place. The report read Resident A's daughter was notified by telephone on 9/1/2023 at 1:55 AM and Resident A's physician was notified by text on 9/1/2023 at 1:52 AM.

Incident report dated 9/27/2023 at 10:00 AM read "*Resident had a fall in her room at 6:00 AM which was not reported by staff to the supervisors*." The report read in part Resident A sustained a small abrasion near her forehead. The report read in part education was provided to staff on reporting falls for residents' well-being and safety. The report read in part Resident A's hospice nurse was notified. The report read in part Resident A's daughter was notified by telephone on 9/27/2023 at 11:00 AM and her physician was notified on 9/27/2023 at 10:10 AM.

Incident report dated 9/27/2023 at 3:00 PM read "*Resident and family reported staff (midnight staff) is rough with resident while providing care.*" The report read in part staff were educated about residents right to refuse care and Resident A's hospice service was notified. The report read in part Resident A's daughter was present in her room at that time and her physician was notified on 9/27/2023 at 3:10 PM.

I reviewed Resident A's chart notes dated 7/1/2023 to 10/18/2023 which read consistent with the incident reports.

Note dated 7/1/2023 read in part Resident A admitted to the facility and was a high fall risk. The note read in part Resident A had an old scar near her forehead from a previous fall.

Notes dated 7/10/2023 read in part Resident A was observed with a change in condition in which she was transported to the hospital and diagnosed with a heart attack.

Note dated 7/20/2023 read in part Resident A returned to the facility and Assured hospice services were initiated.

Note dated 9/19/2023 read in part midnight shift staff reported Resident A was observed combative/agitated refusing care in which her family and hospice were notified. The note read in part hospice nurse ordered for as needed medication to be administered which staff noted were effective.

Note dated 9/27/2023 read in part Resident A reported midnight shift staff were rough and abusive towards her. The note read in part a skin assessment was done with Employee #2 and the hospice nurse in which a small abrasion was

observed near her forehead. The note read in part no bruising was observed on Resident A and she denied pain.

Notes dated 9/28/2023 and 9/29/2023 read in part the hospice nurse assessed Resident A and her orders for morphine were changed due to increased restlessness.

Note dated 10/12/2023 read in part Resident A was transitioning and her hospice nurse was visiting daily.

Note dated 10/18/2023 read in part Resident A expired.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
R 325.1901	**Definitions.** **Rule 1. As used in these rules:**
	(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:	Review of Resident A's medical records revealed she required staff assistance for activities of daily living in which she had declined and received hospice services. Staff attestations, review of Resident A's medical records and facility documentation revealed there was insufficient evidence to support Resident A was abused by staff therefore this specific allegation could not be substantiated. Review of chart notes and incident reports revealed staff communicated with Resident A's daughter, physician, and hospice agency. Resident A's service plan read she preferred to sleep in her bed in which appeared an isolated incident occurred where this specific preference was not followed by staff. Additionally, the plan read Resident A lacked behaviors including agitation and combativeness in which was inconsistent with staff attestations and her chart notes. Therefore, Resident A's care was not always consistent with her service plan nor was the plan updated to reflect her behavioral needs, thus these specific allegations were substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of this license remain unchanged.

11/16/2023

Jessica Rogers Date
Licensing Staff

Approved By:

12/19/2023

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