GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

Eric Simcox
Oakleigh Macomb Operations, LLC
8025 Forsyth Blvd.
St. Louis, MO 63105

April 25, 2024

RE: License #: AH500394648 - Oakleigh of Macomb
Investigation #: 2024A1011011

Dear Mr. Simcox:

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 licensee's 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 submit your corrective action plan to your usual assigned HFA licensing staff Brender Howard.

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,

Andrea Krausmann, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(586) 256-1632
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500394648
Investigation #:	2024A1011011
Complaint Receipt Date:	03/19/2024
Investigation Initiation Date:	03/20/2024
Report Due Date:	05/18/2024
Licensee Name:	Oakleigh Macomb Operations, LLC
Licensee Address:	Suite 201 40600 Ann Arbor Road Plymouth, MI 48170
Licensee Telephone #:	(586) 997-8090
Administrator:	Helen Bisbikis
Authorized Representative:	Eric Simcox
Name of Facility:	Oakleigh of Macomb
Facility Address:	49880 Hayes Road Macomb, MI 48044
Facility Telephone #:	(586) 997-8090
Original Issuance Date:	12/18/2019
License Status:	REGULAR
Effective Date:	08/07/2023
Expiration Date:	08/06/2024
Capacity:	101
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 3/4/2024 Resident A had stroke symptoms and facility did not seek medical attention for him.	Yes
Resident A was lifted inappropriately, by staff using the Hoyer Lift, resulting in Resident A's head banged on a wall and a small scratch on his right leg.	Yes
On 3/11/2024, Resident A did not receive assistance with his personal care.	No
Additional Findings	Yes

III. METHODOLOGY

03/19/2024	Special Investigation Intake 2024A1011011
03/20/2024	Special Investigation Initiated - Telephone Called APS worker Stephanie Howard, who forwarded the allegations. Voice mail was full and would not accept messages.
03/20/2024	Contact - Telephone call made Called APS supervisor Vikki Bleil and left voice mail that I am unable to leave a VM with Stephanie Howard APS worker. Please have her call me.
03/20/2024	Contact - Telephone call received APS worker Stephanie Howard returned my call. Interview conducted.
04/11/2024	Inspection Completed On-site Interviews conducted, records reviewed, observations made.
04/25/2024	Exit Conference – SIR #2024A1011011 sent to authorized representative Eric Simcox via email.

ALLEGATION:

On 3/4/2024 Resident A had stroke symptoms and facility did not seek medical attention for him.

INVESTIGATION:

On 3/19/2024, the allegations were received from adult protective services (APS), as the complaint was initiated there. The name and contact information of the complainant was not provided. On 3/20/2024, I interviewed APS worker, Stephanie Howard. Ms. Howard explained that Resident A had experienced various symptoms including not being able to stand on 3/4/2024, but the resident's authorized representative refused to allow the home to send him to the hospital. Subsequent follow up revealed Resident A had suffered a stroke, and he is no longer able to stand.

On 4/11/2024, in the absence of administrator Helen Bisbikis, I met with Wellness Director Shannon Bryan and Regional Operations Manager Sara Reynolds at the facility. Upon request, Ms. Bryan provided copies of Resident A's service plans and notes that Ms. Bryan wrote about the 3/4/2024 incident.

Resident A's previous 8/24/2023 service plan indicated he could ambulate and transfer independently with a walker although he was a fall risk with an unsteady gait. He required one person minimal physical assistance for bathing, he has a personal caregiver, and requires minimal assistance dressing and grooming and he was continent and independent in toileting. He was also independent with eating a diabetic diet.

Resident A's service plan was then updated on 3/05/2024 to reveal he required a wheelchair and two-person physical assistance with a Hoyer lift for ambulation and transfer. The service plan indicated he was still a fall risk with unsteady gait, and required minimal physical assistance for bathing, dressing and grooming. However, he was now incontinent, and required hands on two person assistance with brief changes. He also now needed assistance with eating.

Review of Ms. Bryan's notes revealed on 3/04/2024 at 4:09 pm "Caregiver observed resident leaning to (L) side. Caregiver notified writer. Resident immediately assessed. Assessment done (L) side of face had slight drooping, (L) arm weakness, weakness in legs. Resident able to answer questions. Personal caregiver present called POA [power of attorney] on speaker and stated 'he does not want him to go out on his way'. POA arrived [name] and stated he also did a neurological test and feels he didn't have a stroke. Writer expressed resident should go to the hospital for further evaluation and POA denied."

Ms. Bryan's notes on 3/05/2024 at 12:43 pm reveal, "Care Conference with POA. POA stated today that it appears resident had a stroke. POA is signing him up with hospice and going over updated Careplan [sic]. Staff aware".

Ms. Bryan's notes on 3/05/2024 at 6:20 pm reveal, "Resident is signed up with VNA hospice. Resident is a 2 person assist and uses a hoyer lift. POA educated on hospice and what they provide. Care plan updated. Staff aware"

On 4/11/2024, Ms. Bryan affirmed that the facility did not contact medical assistance for Resident A on 3/04/2024, because Resident A's power of attorney did not want him to go to the hospital, although staff observed a significant difference in Resident A's well-being.

It should also be noted that Resident A's records provided by Ms. Bryan contained no diagnosis of dementia/cognitive impairment prior to the medical event on 03/04/2024.

On 4/11/2024, Ms. Bryan provided a copy of Resident A's General Durable Power of Attorney papers signed and dated 1/10/2022. The papers indicate the instrument was effective immediately and shall continue if Resident A becomes incapacitated physically or mentally. In regard to Resident A's medical care, the papers read, "Medical Decisions: To arrange and contract for my medical, hospital, nursing and/or convalescent care; to give my permission for medical treatment and any required operations, surgical or medical procedures; to further give my permission for release of any and all medical data and records pertaining to the undersigned, including history, diagnosis, course of treatment and prognosis. This clause shall be superseded if I have executed a durable power of attorney for medical care under MCLA 700.496." These papers included no statement granting the power of attorney the right to deny medical care to Resident A. Also, I confirmed with Ms. Bryan, that there was no separate durable power of attorney for medical care.

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:	On 3/04/2024 facility staff observed and reported to Ms. Bryan that Resident A's left side of face had slight drooping, left arm weakness, and weakness in legs. Resident A was able to answer questions. Rather than assuring the availability of emergency medical care and notifying Resident A's physician of his significant change in condition, the facility notified Resident A's authorized representative, and followed the authorized representative's decision to not seek emergency medical care for Resident A. The home did not assure the availability of emergency medical care required by Resident A on 3/04/2024 when he suffered a change in his baseline condition.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A was lifted inappropriately, by staff using the Hoyer Lift, resulting in Resident A's head banged on a wall and a small scratch on his right leg.

INVESTIGATION:

According to APS worker, Stephanie Howard, the complainant alleged that on at least one occasion, the complainant observed staff improperly lifted Resident A, using the Hoyer lift. Reportedly, Resident A's head was banged against a wall and his leg pinched against the Hoyer and a wall. The complainant also reportedly observed a scratch on the resident's right leg and bruising on his back.

On 4/11/2024, I interviewed caregivers Staff #1 and Staff #2 separately, at the facility. Both individuals provide care to Resident A including transferring him utilizing the Hoyer lift. Both staff affirmed having been trained to use the lift, and both said that two staff are always required to implement the device.

Staff #1 explained that when transporting Resident A in the Hoyer from his bedroom to the adjoining living room, the Hoyer had to be turned and it was difficult to fit the resident, the Hoyer device, and two staff through the wall opening into the next room. Staff #1 said staff had to "be careful" because Resident A's "legs are sensitive". Staff #1 explained how she had to hold Resident A's legs while another moved him in the Hoyer device through the opening and stated that bumping into the wall would occur. Staff #1 said Resident A did having bruising on his leg, and staff would "Try to be careful". Staff #1 said that difficulty in moving Resident A from room to room was the reason for Resident A's bed having been moved into his living room. Now, Staff #1 explained, Resident A is lifted and transported only a short distance from his recliner chair to his bed, rather than from his bedroom into the living room.

Staff #2 said that when transferring Resident A from the bedroom to the living room, “He would swing his legs and just get little marks (on his legs)”. Staff #2 also affirmed that is why the decision was made to move his bed from his bedroom to the living room.

On 4/11/2024, I interviewed Resident A briefly, as he was in his recliner chair and dozed off and on all day. Resident A said he was “Excellent” and denied having any concerns or complaints of the care he receives. Resident A legs were mostly covered. The small areas exposed on his calves did not appear to have scratches.

On 4/11/2024, I interviewed Resident A’s hospice nurse (HN#1) at the facility. HN#1 said she has been caring for Resident A since his stroke on 3/5/2024, coming in twice a week and as needed. HN#1 said Resident A did have scattered bruising to his back on 3/18/2024, and she showed me a photograph of it on her phone. HN#1 said she did not believe the bruising was from any injury or abuse, but rather something internal going on like burst blood vessels underneath the skin. HN#1 explained that bruising is known to happen to hospice patients, as blood can pool, especially when the patient is unable to get up and walk around. HN#1 said Resident A does get skin tears and explained them being related to previous falls usually when he would try to get out of bed unattended.

On 4/11/2024, I observed that Resident A has an alarm on his bed, presumably to alert staff when he gets out of bed unattended.

On 4/11/2024, I met with business office manager Staff #3 at the facility. Upon request of Hoyer Lift training documentation, from the employee records, Staff #3 provided an “Oakleigh of Macomb Inservice Sign-in Sheet Date: 3/18/2024 Facilitator: DON [Director of Nursing title but no name] Hoyer Lift”. The form had signatures from 24 staff, but no signature or name of the facilitator.

On 4/11/2024, Wellness Director Ms. Bryan provided a list of 42 caregivers and she highlighted 20 names of caregiver staff that do not work with Resident A. Ms. Bryan explained that the un-highlighted names reveal the 22 caregivers that do provide care to Resident A, including using the Hoyer lift. Of these 22 employees that provide care to Resident A, only 13 staff had signed the 3/18/2024 Hoyer lift Inservice sign-in sheet, to indicate they attended the training. Staff #1’s signature was present but not Staff #2.

Staff # 3 provided additional documentation demonstrating that three of these 13 employees also completed testing of competency evaluation. Other training documentation that was presented, pertained to employees that do not provide care to Resident A, according to Ms. Bryan’s list of caregivers.

There was no evidence that the remaining nine staff, who provide care to Resident A according to Ms. Bryan, received any training in using the Hoyer Lift [Staff persons #2, 5, 6, 7, 8, 9,10, 11, and 12]

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(7) The home's administrator or its designees are responsible for evaluating employee competencies.
For reference: R325.1944	**Employee records and work schedules.**
	(1) A home shall maintain a record for each employee which shall include all of the following: **(d) Summary of experience, education, and training.**
ANALYSIS:	Staff #1 explained that she held Resident A's legs, while another staff moved Resident A in the Hoyer device, as they transferred through the wall opening and that bumping into the wall could occur. Staff #2 said "He would swing his legs and just get little marks (on his legs)". Consequently, Resident A's bed had been moved from his bedroom into his living room. Documentation revealed that only 13 of the 22 caregivers, that provide care to Resident A, attended an in-service pertaining to the Hoyer lift. Additional documentation confirmed three of these 13 staff completed competency evaluation. There was no evidence that the remaining nine of the 22 caregivers providing care to Resident A, had completed any training in use of the Hoyer lift. Therefore, the home's administrator or designee was not responsible for evaluating competency of each employee before they implemented using the Hoyer lift with Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

On 3/11/2024, Resident A did not receive assistance with his personal care.

INVESTIGATION:

According to Ms. Howard, the complainant alleged that on 3/11/2024 [no specific time identified] Resident A's breakfast was still on the table and he was dressed in clothing from the previous day. When asked to change Resident A's clothing,

Oakleigh of Macomb staff reportedly refused. In addition, Resident A's bed linen was soiled with urine.

I reviewed Ms. Bryan's notes about Resident A, and there were no notes about documented between 3/09 to 3/13/2024, and no references to these lack of personal care allegations.

In my interview, HN#1 said the facility care giver staff assist Resident A with his meals and they are aware of how much Resident A eats and informs her. HN#1 said sometimes Resident A refuses a meal or sometimes he is "out of it, like today", referring to his sleeping during the day. During her regular visits, HN#1 affirmed having observed Resident A be clean, wear clean clothing, and having clean bed linen. HN#1 explained that a hospice aide comes into the home twice a week to provide bed baths to Resident A, and to change his bed linen. HN#1 said she has no concerns of the personal care he receives.

On 4/11/2024, I interviewed facility chef Staff #4. Staff #4 explained that Resident A typically eats his meals in his room. Staff #4 explained how kitchen staff delivers the meals and care givers assist him with eating the meal. Staff #4 said kitchen staff and himself make rounds of the building at least four times during the day to pick up meal trays from resident rooms. Staff #4 explained that if a caregiver sees that a meals has not been eaten, the kitchen staff might leave the tray for the care giver to offer the meal again a bit later, after the resident is more alert and possibly more receptive to eating.

In my separate interviews with Staff #1 and Staff #2, their statements aligned with the chef about pick up of meal trays. Staff #1 explained how some days Resident A feeds himself with one hand, but staff are present and assist as needed. Staff #1 said the facility staff document the percentage of food that was eaten, the time frame and the behavior of the resident. Staff #1 also said that the hospice aide provides bed baths, but she did not know who was responsible for changing his bed linen. Staff #1 said residents are changed every day. Staff #1 explained a recent change in Resident A's care, that midnight staff now get him up, his brief and clothes are changed and he is in his recliner chair before she arrives to start day shift.

Staff #2 also said the caregiver staff documents the amount of food that Resident A eats at each meal and that kitchen staff picks up the meal trays. Staff # 2 said hospice staff provide Resident A's baths, but she was unsure who changes his bed linen. Staff #2 said she observed his bed linen had stains last week, so she changed the linen because "I like things nice". Staff #2 said Resident A's clothes are sometimes changed by midnight shift. Staff #2 said Resident A wears pajamas.

Resident A's service plan dated 3/5/2024 indicates he requires one person assistance for bathing, dressing, and grooming with minimal physical assist. The service plan does not specify that Hospice staff provides Resident A with bathing.

There is no information about who is responsible for changing Resident A's bed linen.

In my interview with Wellness Director, Ms. Bryan said that the hospice aide provides bed baths to Resident A and also changes his bed linen, but that facility staff will also change the bed linen, if needed. Ms. Bryan presented the facility's activities of daily living (ADL) logs where staff document the percentage of food that Resident A eats at each meal and the duration of time it took him to eat. Staff documentation reveals three meals offered daily and most every day at least some food is eaten. Staff also document their initials each time Resident A is dressed/undressed and each time facility staff provide showers. Staff initials indicate Resident A's clothing is changed twice daily. Staff initials also indicate he is receiving showers twice a week by facility staff. This is unclear, as HN#1, Ms. Bryan and facility staff have said that hospice aide provides bed baths.

On 4/11/2024, I observed Resident A to appear clean, no notable odor, and wearing clean clothing. I observed staff assist him with eating his meal. I also observed his bed linen appeared clean.

APPLICABLE RULE	
R 325.1933	**Personal care of residents.**
	(2) A home shall afford a resident the opportunity and instructions when necessary for daily bathing, oral and personal hygiene, daily shaving, and hand washing before meals. A home shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Interviews, observation, and staff ADL documentation indicate Resident A receives the personal care that he needs with eating, dressing/undressing, and bathing. It is unclear as to when Resident A's bed linen is to be changed and who is to do it, but there was no evidence to indicate it was not done. It is also unclear as to who is doing Resident A's bathing, as interviews indicate the hospice aide bathes Resident A, but ADL documentation indicate facility staff are doing it. There was no evidence to indicate bathing was not done.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Resident A's service plan was updated on 3/05/2024, but it did not include the specific care and services appropriate for the individual's needs, and the methods of

providing the care and services. For examples, Resident A's 3/05/2024 service plan did not include information of the hospice aide coming to the facility and providing his bed baths. There was no information about who was responsible for changing Resident A's bed linen nor how often it was to be changed. There were no methods of how staff are to handle Resident A and specifically his legs, when transporting him in the Hoyer lift.

APPLICABLE RULE	
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, if any.
For reference: R325.1901	**(1) 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:	Resident A's service plan was updated on 3/05/2024, but it lacked the specific care and services appropriate for the individual's needs, and the methods of providing the care and services, such as who provides his bathing assistance and linen changes and when these are to occur. Also, there were no methods of how to use the Hoyer lift with Resident A to prevent injuries.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

The facility posted a daily listing of food items available at each individual meal, much like a restaurant's menu. Staff #4 said the facility serves the current residents a regular diet and therapeutic or special diets of pureed, minced and moist, diabetic, and mechanical soft meals. However, there were no weekly menus for the regular and therapeutic or special diets posted for the current week.

APPLICABLE RULE	
R 325.1953	**Menus.**
	(1) A home shall prepare and post the menu for regular and therapeutic or special diets for the current week. Changes shall be written on the planned menu to show the menu as actually served.
ANALYSIS:	The home currently serves a regular diet and therapeutic or special diets of pureed, minced and moist, diabetic, and mechanical soft meals. However, there were no weekly menus for the regular and therapeutic or special diets posted for the current week.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 4/11/2024, I observed two bedside assistive devices along the sides of Resident A's bed. There were two grab bars, each one placed to the side of the bed at the pillow area. Each grab bar was an upside-down U-shaped metal tubing that extended to the ground with an attached board that slid between the mattress and the bed frame. Neither grab bar device was secured to the bed frame. There was an approximate 12 inch opening between the U shape tubes, which would allow for the resident's head or limbs to become entangled. The devices also easily moved away from the side of the mattress creating a gap where the resident's head or limbs could become entangled. The use of these devices was not mentioned in Resident A's service plan.

Upon request for the facility's policy regarding the use of bedside assistive devices, regional operations manager Sarah Reynolds contacted regional nurse Kathy McMonagle and licensee authorized representative Eric Simcox by telephone. Ms. Reynolds then said both Ms. McMonagle and Mr. Simcox reported that the facility has "no policy" on the use of bedside assistive devices "because we don't do bedrails". Ms. Reynolds explained that the facility does not allow any bedside assistive devices in the home, because of the risk of entanglement injury and possibly even death as a result. Ms. Reynolds said Resident A's family must have brought in the devices, unbeknownst to administrative staff.

In a separate interview, Staff #1 said Resident A had the bedside assistive devices in place for over a month, and also that she is aware of at least three other residents that have bedside assistive devices in use.

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: **(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	**(1) 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.
ANALYSIS:	Contrary to the home not allowing bedside assistive devices due to the risk of injury or death to the resident, Resident A had two bedside assistive devices in place for over a month. Therefore, home did not assure an organized program of protection for its residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

4/23/2024

Andrea Krausmann Date
Licensing Staff

Approved By:

04/25/2024

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