GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 23, 2024

John Altea
A&A Of Michigan, LLC
13187 Churchill Dr
Sterling Heights, MI 48313

RE: License #: AS630400389
Investigation #: 2024A0991028
A&A Of Bloomfield Hills

Dear John Altea:

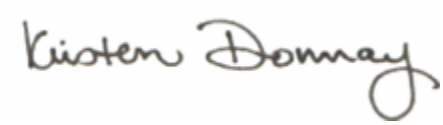
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.

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 (248) 975-5053.

Sincerely,



Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630400389
Investigation #:	2024A0991028
Complaint Receipt Date:	07/03/2024
Investigation Initiation Date:	07/03/2024
Report Due Date:	09/01/2024
Licensee Name:	A&A Of Michigan, LLC
Licensee Address:	13187 Churchill Dr Sterling Heights, MI 48313
Licensee Telephone #:	(586) 214-0684
Licensee Designee:	John Altea
Name of Facility:	A&A Of Bloomfield Hills
Facility Address:	4318 Squirrel Rd Bloomfield Hills, MI 48304
Facility Telephone #:	(586) 214-0684
Original Issuance Date:	08/27/2020
License Status:	REGULAR
Effective Date:	12/20/2023
Expiration Date:	12/19/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL ALZHEIMERS AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A has a pressure ulcer on her sacrum (buttocks) that has worsened to a stage 4 from her last hospital admission in March 2024. Resident A has a second pressure ulcer on her right upper back. There was no report of Resident A having a wound on her right upper back in March 2024. There is concern that Resident A was not being moved or turned in the facility.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/03/2024	Special Investigation Intake 2024A0991028
07/03/2024	APS Referral Received from Adult Protective Services (APS)
07/03/2024	Special Investigation Initiated - Telephone Call to APS worker, Angelique Evans
07/10/2024	Contact - Telephone call received From APS worker, Angelique Evans
07/11/2024	Inspection Completed On-site Unannounced onsite inspection interviewed staff, visiting nurse, and Resident A
07/11/2024	Contact - Document Received Hospital discharge paperwork, medication administration records, assessment plan, and health care appraisal
07/16/2024	Contact - Telephone call made To APS worker, Angelique Evans
08/22/2024	Exit Conference Via telephone with licensee designee, John Altea

ALLEGATION:

Resident A has a pressure ulcer on her sacrum (buttocks) that has worsened to a stage 4 from her last hospital admission in March 2024. Resident A has a second pressure ulcer on her right upper back. There was no report of Resident A having a wound on her right upper back in March 2024. There is concern that Resident A was not being moved or turned in the facility.

INVESTIGATION:

On 07/03/24, I received a complaint from Adult Protective Services (APS), alleging that Resident A has a pressure ulcer on her sacrum that has worsened to a stage 4 from her last hospital admission in March 2024. She also has a second pressure ulcer on her back that was not present in March 2024. There is concern that Resident A was not being moved or turned in the facility. I initiated my investigation on 07/03/24, by contacting the assigned APS worker, Angelique Evans. Ms. Evans stated that she spoke with Resident A's power of attorney (POA) and Resident A was discharged from the hospital and returned to the home. She stated that the POA did not have any concerns about Resident A returning to the facility. Resident A had wounds prior to moving into the facility and they did not feel that it was due to neglect. She stated that Resident A has back problems and screams when anyone tries to move her.

On 07/11/24, I conducted an unannounced onsite inspection at A&A of Bloomfield Hills. I interviewed the med tech from HomeMD who was at the home to see Resident A for wound care during my onsite inspection. She stated that the med techs visit the clients and then report back to a nurse. She stated that Resident A also receives nursing services through QCN Home Care. The med tech stated that she last saw Resident A on 06/06/24. The med tech was on vacation, and when she returned, Resident A was in the hospital. She stated that Resident A had one wound on her sacrum, which they were treating. She now has a new wound on her right shoulder/back. The med tech from HomeMD expressed concerns that staff in the house are not following through with the wound care recommendations. She stated that there was a staff person working in the home who recently left, and things seem to have gone downhill since then. She stated that the wound care nurse visits once a week and gives instructions regarding wound management. Resident A's wound covering is supposed to be changed three times a week. It is changed once by the wound care nurse, once by the home health care nurse, and one by staff at the facility. She stated that Resident A is supposed to be rotated every two hours, but every time she visits the home, Resident A is in the same position. She is always propped up, lying on her left side, facing the door. She stated that if any changes are made regarding Resident A's care, the staff are aware of it the same day. She expressed concern that the staff are not using the correct supplies to treat Resident A's wounds. She stated that the staff should be using super absorbers on Resident A's sacral wounds, but these have not been available in the home. They are

using ABD pads instead. She stated that ABD pads should not be used on the wound, as they leave moisture on the wound bed and prevent it from healing. The med tech from HomeMD stated that the home care company should be ordering the supplies and bringing them to the home, but the supplies are not there when she visits.

On 07/11/24, I interviewed the home health aide from HomeMD who was also visiting with Resident A. She stated that she comes to the home twice a week for four hours, on Mondays and Thursdays from 10:30am-2:30pm. She stated that her role is to visit with Resident A and provide her with companionship. She is not responsible for providing direct care or nursing services. She stated that staff from the home never rotate or reposition Resident A during the four hours that she is at the home visiting with Resident A. She stated that sometimes Resident A will yell out or say, “help me” while she is visiting with her, but otherwise Resident A seems to be doing okay in the home.

On 07/11/24, I attempted to interview Resident A, but she had some difficulty answering questions. She stated that she is not feeling well, because she has a cough that will not go away. She stated that staff at the home do move her, but she could not say how often.

On 07/11/24, I interviewed the licensee designee, John Altea. Mr. Altea stated that there are currently two residents living in the home, but he is planning on closing the home at the end of the month. Resident A will be moving to a different facility in Sterling Heights. He stated that Resident A was hospitalized at Beaumont Hospital- Royal Oak from 06/28/24-07/03/24. HomeMD advised them to send Resident A to the hospital because the wound on Resident A’s sacrum was not healing. Mr. Altea stated that Resident A wears briefs, so if she has a bowel movement, it goes towards the wound. It is difficult to keep it dry and clean. He stated that she started developing a second wound on her back a week or two before she went to the hospital. They were putting foam and Calmoseptine ointment on this wound as a precaution. He stated that this was not ordered by the nurse. Mr. Altea stated that he believed staff did notify the nurse about the second wound developing, but it was not documented anywhere. He then stated that they sometimes put Resident A in a hospital gown, so if the wound nurse came to the home and turned Resident A, they would have seen the new wound. He was not sure if anyone specifically asked the nurse to look at it.

Mr. Altea stated that they try to reposition Resident A every two hours. He stated that they turn her on her side and use pillows to position her, but if she is not comfortable, she will yell out. Resident A also complains that her back hurts and she is not comfortable. If she says that she does not want to move or that she is uncomfortable, then they will return her to her back. Mr. Altea stated that they were not documenting when they repositioned Resident A prior to APS coming out to the home, but they will be starting a log now. Mr. Altea stated that QCN Home Care is supposed to bring them wound care supplies, but sometimes they are late. He stated that he does not document his attempts to obtain the supplies. They use the supplies that are available in the home until QCN delivers the needed supplies. He stated that both QCN Home Care and

HomeMD do wound care when they come to the home. On the days they do not visit, staff provide wound care. He stated that they do not document when any of the visiting nurses or med techs come to the home. The visiting nurses typically give verbal instructions regarding how to care for the wounds. They do not leave any written instructions. He stated that the current order from the hospital is to remove the current dressing, clean the wound with wound cleanser, spray the gauze with Dakin's solution (wet the dry), pack the wound, and cover with a blue pad. He stated that they are changing the wound covering at 9:00am and 9:00pm or every time Resident A has a bowel movement.

On 07/11/24, I interviewed direct care worker, Ian Bajos. Mr. Bajos stated that he has worked in the home for two years. He stated that they rotate or reposition Resident A every two hours. He stated that sometimes Resident A yells that she does not like it, so they will reposition her every three hours instead. He stated that they use a long triangle pillow and rotate her to each side. He stated that the longest they go without repositioning her is three hours. She is never left in the same position for an extended period of time. Mr. Bajos stated that Resident A was previously prescribed Senna, which was causing her to have frequent bowel movements that were runny. This made it difficult to keep the wound area clean. He stated that he typically changes Resident A's brief three to four times during his shift, and he changes the wound covering too. Mr. Bajos stated that they noticed an area on Resident A's back was a little red about two weeks ago, but then when the nurse came out it had gotten worse and was black in the center. He stated that he told the licensee designee, John Altea, about the wound and they also told the visiting nurse. He stated that it was a new nurse, and he was not sure of her name. Mr. Bajos stated that they always have wound care supplies in the home. If something is missing, they tell the visiting nurse, and the nurse brings the supplies.

On 07/11/24, I interviewed direct care worker, Olive Torres. Ms. Torres stated that they reposition Resident A every two hours and do not let her stay in the same position for a long time. She stated that if she is on her side, she will pull the sheet and roll her onto her other side. They use a wedge pillow to position her. She stated that if Resident A screams, she explains to her that they have to move her because of her wound. Ms. Torres stated that she did notice some redness on Resident A's back and they were putting cream on it. Resident A went to the hospital from 06/28/24-07/03/24. The area on Resident A's back was covered when she returned from the hospital. Ms. Torres stated that there are different wound care nurses who come to the home, and they give different instructions on how to treat the wounds. She stated that they do not provide enough supplies for wound care, as the wound cover needs to be changed every day and night, and sometimes more often if it is wet or dirty. She stated that they tell the nurse when they are running low on supplies, and they use whatever supplies are available in the home in the meantime. Ms. Torres stated that they currently treat the wounds by spraying it with wound cleanser, patting it dry, putting Dakin's wetted gauze inside, and then covering it with a bandage. Ms. Torres stated that she typically works the night shift. She stated that she rotates Resident A at night. She keeps track in her

head of how frequently she repositions Resident A and does not write this down anywhere.

I reviewed a copy of Resident A's discharge instructions from Beaumont Hospital- Royal Oak dated 07/03/24. The wound care instructions for the wound located on the sacrum note that the frequency of dressing changes is Q12 (every) hours. The instructions state to cleanse the patient's sacral wound with Restore wound cleanser and then dry the site. Gently pack the patient's sacral wound with Dakin's solution moistened Kerlix, then cover with a Mextra dressing and secure with 3M Medipore tape q12 hours.

The discharge instructions for the wound located on Resident A's left-mid back note that the frequency of dressing changes is Q12 hours. The instructions state to cleanse the patient's left mid-back wound with Restore wound cleanser. Apply Triad to patient's left mid-back wound, then cover with dry 4x4 gauze and secure with 3M Medipore tape q12 hours. Remove old Triad cream with warm barrier wipes and soap/water.

I reviewed copies of Resident A's June 2024 and July 2024 medication administration records (MARs). They state Wound Care: 1. Cleanse with cleanser 2. Pat dry 3. Spray with Daikins 4. Pack lightly with sterile gauze 5. Cover with ABD. The MARs note that wound care was being completed once daily at 9:00am. The July 2024 MAR was not updated to reflect the new instructions from the hospital discharge paperwork.

I reviewed a copy of Resident A's assessment plan dated 12/26/22. It notes that Resident A is bed bound and requires assistance with toileting, grooming, bathing, and personal hygiene. The assessment plan does not include any information regarding how frequently Resident A should be repositioned and it does not include any information regarding her wound care.

I reviewed a copy of Resident A's health care appraisal dated 12/26/22. It notes that Resident A has hypertension, diabetes, and dementia. There was no indication that she had any wounds on the health care appraisal. The licensee designee, John Altea, stated that he did not have any additional documentation regarding Resident A's medical care or needs.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident A's personal needs were not attended to at all times. Resident A had a sacral wound which worsened to a stage 4 wound, and she also developed a new wound on her back. Although staff

	stated that they reposition Resident A every two hours, they did not have any documentation to show this was being completed. The visiting med tech and home health aide both did not believe Resident A was being repositioned every two hours as required. The med tech stated that Resident A was always in the same position when she came to the home. She also stated that staff were not always using the correct supplies to treat Resident A's wounds, as they were using ABD pads, which leave moisture on the wound bed and prevent it from healing. The home health aide stated that staff did not come in to reposition Resident A during her four-hour visits with Resident A at the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: (d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that staff were not following the recommendations of the health care professional regarding Resident A's wound care. Staff stated that they repositioned Resident A every two hours; however, they did not have any documentation to show this was being completed. Staff stated that at times Resident A screamed and did not want to be repositioned, but this was not recorded in the resident's record. The wound care instructions on Resident A's medication administration record did not match the discharge instructions provided by the hospital. The visiting med tech expressed concern that staff were not always using the correct supplies to treat Resident A's wounds and did not have the necessary supplies available in the home. She stated that staff were at times using ABD pads, which leave moisture on the wound bed and prevent it from healing.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the onsite inspection, I requested a copy of Resident A's health care appraisal. The health care appraisal was dated 12/26/22. It was not updated annually in 2023.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	The health care appraisal on file for Resident A was dated 12/26/22. It was not updated annually in 2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the investigation, the licensee designee, John Altea, stated that Resident A was receiving in-home nursing services and wound care through HomeMD and QCN Home Care. Staff stated that the visiting nurses often made changes to the treatment protocol for Resident A's wounds. They stated that these instructions were given verbally, and they did not have any written instructions from the home care nurses regarding wound care procedures. The instructions that were written on Resident A's medication administration record (MAR) did not match the instructions that were provided on the discharge paperwork from her hospitalization. Staff reported that they were changing Resident A's wound dressing several times a day. However, the documentation on the MAR showed that staff were only initialing that they were changing Resident A's wound dressing once daily, while the discharge instructions stated the dressing should be changed every 12 hours. This also differed from the instructions stated by the med tech,

who said the wound dressing is changed three times a week. The instructions for Resident A's wound care were unclear, as there was no documentation regarding the current protocol. Resident A's assessment plan did not include any information about how frequently she should be repositioned or any instructions for her wound care.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(11) A licensee shall contact a resident's physician for instructions as to the care of the resident if the resident requires the care of a physician while living in the home. A licensee shall record, in the resident's record, any instructions for the care of the resident.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the licensee did not record, in Resident A's record, up to date instructions for her wound care. The current wound care protocol was unclear, as there were no written instructions when changes were made by the visiting health care professionals. The instructions on Resident A's medication administration record did not match the discharge instructions from the hospital.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the onsite inspection, I reviewed a copy of Resident A's assessment plan dated 12/26/22. The assessment plan was not signed by Resident A's designated representative. The assessment plan was not updated annually in 2023, and it did not reflect Resident A's current needs, as it did not include any information regarding how frequently Resident A should be repositioned or any information regarding her wound care.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.

ANALYSIS:	The assessment plan on file for Resident A was dated 12/26/22. It was not signed by the designated representative and was not updated annually in 2023. The assessment plan was not updated to include Resident A's current status or wound care needs.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During my onsite inspection on 07/11/24, I observed medications and wound care supplies being stored by Resident A's bedside that were not in a locked cabinet. Resident A's Albuterol Sulfate inhaler, HySept sodium hypochlorite solution (Dakin's) 0.25% solution, and DermaKlenz wound cleanser were sitting on her bedside table during the onsite inspection.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Resident A's medications were not being stored in a locked cabinet or drawer during my onsite inspection on 07/11/24. I observed medications and wound care supplies being stored by Resident A's bedside that were not in a locked cabinet. Resident A's Albuterol Sulfate inhaler, HySept sodium hypochlorite solution (Dakin's) 0.25% solution, and DermaKlenz wound cleanser were sitting on her bedside table during the onsite inspection.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the onsite inspection on 07/11/24, I reviewed a copy of Resident A's discharge instructions from Beaumont Hospital- Royal Oak dated 07/03/24. The wound care instructions for the wound located on the sacrum note that the frequency of dressing changes is Q12 (every) hours. The instructions state to cleanse the patient's sacral wound with Restore wound cleanser and then dry the site. Gently pack the patient's sacral wound with Dakin's solution moistened Kerlix, then cover with a Mextra dressing and secure with 3M Medipore tape q12 hours.

The discharge instructions for the wound located on Resident A's left-mid back note that the frequency of dressing changes is Q12 hours. The instructions state to cleanse the patient's left mid-back wound with Restore wound cleanser. Apply Triad to patient's left mid-back wound, then cover with dry 4x4 gauze and secure with 3M Medipore tape q12 hours. Remove old Triad cream with warm barrier wipes and soap/water.

I reviewed copies of Resident A's June 2024 and July 2024 medication administration records (MARs). They state Wound Care: 1. Cleanse with cleanser 2. Pat dry 3. Spray with Daikins 4. Pack lightly with sterile gauze 5. Cover with ABD. The MARs note that wound care was being completed once daily at 9:00am. The July 2024 MAR was not updated to reflect the new instructions from the hospital discharge paperwork.

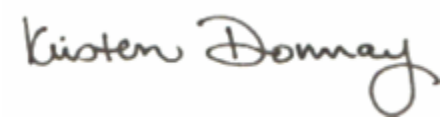
On 08/22/24, I contacted the licensee designee, John Altea, via telephone to conduct an exit conference. Mr. Altea stated that he is moving forward with closing A&A of Bloomfield Hills. He stated that the residents have moved to other locations. He visited with Resident A at her new placement, and she is doing well. He stated that he would submit a corrective action plan regarding the violations and would indicate that all of the residents have moved and the home is closing.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**

ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident A's medication administration record (MAR) was not updated to include the current wound care instructions following her discharge from the hospital on 07/03/24. The MAR noted that the dressing was being changed once daily rather than every 12 hours. It did not include the proper supplies, as it noted to used an ABD pad rather than a Mextra dressing. There were no instructions on the MAR regarding the wound on Resident A's back.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

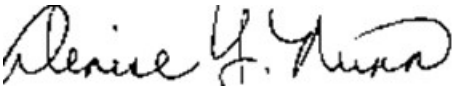
Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.



08/22/2024

Kristen Donnay Date
Licensing Consultant

Approved By:



08/23/2024

Denise Y. Nunn Date
Area Manager