GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 12, 2024

Manda Ayoub
Pomeroy Living Northville Assisted & Memory Care
40033 W. Eight Mile
Northville, MI 48167

RE: License #: AH820381235
Investigation #: 2024A0784091
Pomeroy Living Northville Assisted & Memory Care

Dear Manda Ayoub:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 #:	AH820381235
Investigation #:	2024A0784091
Complaint Receipt Date:	09/10/2024
Investigation Initiation Date:	09/12/2024
Report Due Date:	11/09/2024
Licensee Name:	Beacon Square Northville
Licensee Address:	Suite 130 5480 Corporate Drive Troy, MI 48098
Licensee Telephone #:	(248) 723-2100
Administrator:	Sandra Salvati
Authorized Representative:	Manda Ayoub
Name of Facility:	Pomeroy Living Northville Assisted & Memory Care
Facility Address:	40033 W. Eight Mile Northville, MI 48167
Facility Telephone #:	(248) 349-0400
Original Issuance Date:	03/25/2016
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	109
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Inadequate supervision of Resident A	Yes
Resident A was not charged according to his contract	No
Additional Findings	No

III. METHODOLOGY

09/10/2024	Special Investigation Intake 2024A0784091
09/12/2024	Special Investigation Initiated - On Site
09/12/2024	Inspection Completed On-site
09/26/2024	Contact - Document Sent Request for additional investigative documentation sent to administrator Sandra Salvati via email
09/26/2024	Contact - Document Received Investigative documents received via email
10/25/2024	Contact - Document Received Additional requested documents/information received via email from Ms. Salvati
11/01/2024	Contact - Telephone call made Interview with employee 1
11/12/2024	Exit - Email SIR sent to authorized representative Manda Ayoub

ALLEGATION:

Inadequate supervision of Resident A

INVESTIGATION:

On 9/11/2024, the department received this online complaint.

According to the complaint, Resident A had four falls during his time at the facility due to a lack of adequate supervision. The facility was informed that Resident A needed to be regularly watched. Resident A was taken to the hospital on or about 6/16/2024 after having a fall, hitting his head and sustaining a brain bleed. Resident A did not return to the facility.

On 9/12/2024, I interviewed administrator Sandra Salvati at the facility. Ms. Salvati stated she did not know the exact number of falls Resident A had while at the facility. Ms. Salvati confirmed Resident A had a fall on hitting his head but was not aware of the extent of the injury as he had not returned to the facility. Ms. Salvati stated the date of incident was 6/18/2024. Ms. Salvati stated that when Resident A moved to the facility, he was unable to walk on his own. Ms. Salvati stated Resident A had a tendency to attempt to walk on his own and that on several occasions he tried to get up and walk on his own as he had poor awareness as he often did not use his call pendent to summon staff for assistance. Ms. Salvati stated Resident A's authorized representative was aware that Resident A would attempt to walk on his own and that the facility was unable to offer one on one supervision.

I reviewed Resident A's *MOVE IN RECORD*, provided by Ms. Salvati, which indicated a move in date of 2/22/2024.

I reviewed Unusual Occurrence Reports for Resident A, provided by Ms. Salvati dated 2/25/2024, 3/04/2024, 6/13/2024 and 6/18/2024. Under a section titled *Describe the incident based on the resident's own words or what the first responder observed*, the report dated 2/25/2024 read "Resident said he was trying to get out of his wheelchair! Resident was observed sitting up on the floor next to his bed. I observed bump on right upper forehead. Staff went in to answer pendent light". Corrective measures noted on this report read "encourage to use pendant to call for assistance". Under this same section, the report dated 3/04/2024 read, in part, "Observed resident laying on the floor on his right side. When asked what happened he stated, "I was trying to get up". No c/o [complaint] of pain with range of motion". Corrective measures noted on this report read "Placed a floor mat next to the bed and kept bed in a low position". Under the same section, the report dated 6/13/2024 read "Resident states he was trying to get up from his wheelchair". Corrective measures noted on this report read "tilt back wheelchair seat". Under the same section, the report dated 6/18/2024 did not provide any information or description regarding the incident, but only provided the associates name who observed the incident. Corrective measures noted on this report read "remind resident not to get up and push his pendant for help". Under a section titled *Immediate investigation findings*, on the 6/18/2024 report, the report read "Resident was laying on the floor on his right side facing the bathroom next to his wheelchair. Resident brief was dry. The remote control to his TV was tucked in front of his pants. Resident was wearing socks by there were no shoes. No other clutter on the floor".

I reviewed Resident A's service plan, provided by Ms. Salvati. Within a section titled *Focus*, dated 2/26/2024, the plan included a subsection which read, in part, "Fall

related to poor safety awareness due to CVA [Cerebrovascular accident], decreased mobility due to hemiparesis to the right side, impulsiveness, observed by staff removing lanyard from around his neck, family reports multiple falls at home. At times I choose to slide to the floor from my chair". Within this subsection was included a section for "Actions" which read consistently with corrective actions noted in the incident reports.

When interviewed, Ms. Salvati was asked why the corrective measure of "tilt back wheelchair seat" was added to the service plan. To the question, Ms. Salvati stated "I assume because he kept trying to get up out of his wheelchair".

I reviewed *Progress Notes* for Resident A dated from 2/22/2024 to 6/18/2024. The notes read consistently with notes reviewed within the incident reports provided by Ms. Salvati. Nursing specific notes, within the progress notes, indicated Resident A had been in rehab due to decreased mobility and right sided weakness related to a previous stroke. Additionally, nursing notes indicated Resident A was oriented x2 [can identify self and the physical space one is in] and had been diagnosed with vascular dementia [a condition caused by lack of blood that carries oxygen and nutrients to a part of the brain. It causes problems with reasoning, planning, judgement and memory].

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.**
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(2)(l) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician or physician's assistant. In case of a chemical restraint, a physician shall be

	consulted within 24 hours after the commencement of the chemical restraint.
ANALYSIS:	The compliant alleged Resident A was inadequately supervised while living at the facility and had at least four falls related to the lack of appropriate supervision. Review of facility progress notes and incident reports specific to Resident A confirmed he had four falls during his tenure, from 2/22/2024 to 6/18/2024. Ms. Salvati described Resident A as a person with a high fall risk and poor safety awareness which she reported was known about Resident A upon his admission to the facility. Ms. Salvati admitted the facility could not provide one on one care for Resident A, even though without staff being readily present, it was highly possible he may fall given his propensity to attempt to transfer and walk on his own. Corrective measures after each of the four falls were, “encourage to use pendant to call for assistance”, “Placed a floor mat next to the bed and kept bed in a low position”, “tilt back wheelchair seat”, and “remind resident not to get up and push his pendant for help”, respectively. Given Resident A’s admitted and demonstrated lack of safety awareness, the plan in place and corresponding corrective measures were not adequate or appropriate. Additionally, one of the corrective measures put in place, “tilt back wheelchair seat”, was put in place as a means of reducing Resident A’s ability to get out of his wheelchair which is viewed by the department as a form of restraint given that this practice reduces a person’s ability to do something they may otherwise want to do and is not an appropriate means of supervision in lieu of staffs ability to keep a resident safe. Based on the findings, the facility is not in compliance with these rules.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A was not charged according to his contract

INVESTIGATION:

According to the complaint, Resident A lived at the facility until 6/18/2024, at which date he went to the hospital after a fall. The facility was notified on 6/19/2024 that Resident A would not be moving back and all of Resident A’s personal effects were removed on 6/28/2024. Resident A’s was charged for the month of July 2024 even though he was no longer living at the facility.

When interviewed, Ms. Salvati stated the facility received Resident A's 30-day written notice of voluntary discharge on 6/24/2024. Ms. Salvati stated that charges to a resident account continue for 30 days, according to contract, once a facility has received the notice. Ms. Salvati stated Resident A's fees included the apartment rent as well as the level of care. Ms. Salvati stated the facility offers four levels of care with level four requiring the most care. Ms. Salvati stated the cost for level four care is $2000.00 and that Resident A's rent was $5700.00 a month.

I reviewed an email from Ms. Salvati to the facilities corporate staff, provided by Ms. Salvati, dated 7/25/2024. The email read, in part, "[Resident A's] wife gave her 30-day notice".

On 11/01/2024, I interviewed employee 1 by telephone. Employee 1 was named by Ms. Salvati the person who could explain Resident A's charges for June and July 2024. Employee 1 stated Resident A's account was charged for the rent of the apartment from 6/01/2024 to 6/30/2024 and from 7/01/2024 to 7/24/2024. Employee 1 stated the account is charged for rent for 30-days from the date of voluntary discharge notice per contract. Employee one stated that since Resident A left the facility on 6/18/2024, his account was not charged for care after that date as he did not return to the facility. Employee 1 state Resident A was also given a $50.00 a day credit towards the rent from 6/18/2024 to 7/24/2024, per his contract, since his apartment was empty for that time. Employee 1 stated that after Resident A's payment for June of $7,700.00 and a credit of $1800.00 [$50.00/Day rent credit for the 36 days after 6/18/2024 until 7/24/2024], the total charges on Resident A's account for June and July came out to $1879.55.

I reviewed Resident A's contract which read consistently with Ms. Salvati and employee 1's statements.

I reviewed Resident A's bill for June and July 2024 which read consistently with employee 1's statements.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(3) At the time of an individual's admission, a home or the home's designee shall complete a written resident admission contract between the resident and/or the resident's authorized representative, if any, and the home. The resident admission contract shall, at a minimum, specify all of the following: **(b) The services to be provided and the fees for the services.**

ANALYSIS:	The complaint alleged Resident A was not charged according to his contract after he left the facility on 6/18/2024. Interviews with Ms. Salvati and employee 1, as well as review of Resident A's contract and billing, did not support the allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

Aaron L Clum 11/01/2024

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Aaron Clum Date
Licensing Staff

Approved By:

Andrea L Moore 11/04/2024

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