STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

March 15, 2019

Manda Ayoub
Pomeroy Living Rochester Assisted
3466 South Blvd. W.
Rochester Hills, MI 48309

RE: License #: AH630338700
Investigation #: **2019A0585022**
Pomeroy Living Rochester Assisted

Dear Ms 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.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

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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,

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(313) 268-1788

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630338700
Investigation #:	2019A0585022
Complaint Receipt Date:	02/19/2019
Investigation Initiation Date:	02/20/2019
Report Due Date:	04/21/2019
Licensee Name:	Pomkal Rochester Assisted, LLC
Licensee Address:	Suite 100 25480 Telegraph Road Southfield, MI 48033
Licensee Telephone #:	(248) 354-7200
Administrator:	Elizabeth Edelstein
Authorized Representative:	Manda Ayoub
Name of Facility:	Pomeroy Living Rochester Assisted
Facility Address:	3466 South Blvd. W. Rochester Hills, MI 48309
Facility Telephone #:	(248) 564-2200
Original Issuance Date:	05/22/2015
License Status:	REGULAR
Effective Date:	08/07/2018
Expiration Date:	08/06/2019
Capacity:	84
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Staff dropped Resident A on 12/26/18 and picked her up by her legs to put her back in the bed.	Yes
The staff did not report the incident to the authorized representative and the department.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/19/2019	Special Investigation Intake 2019A0585022
02/20/2019	Special Investigation Initiated - Telephone Called complainant, no answer. Left message to call back.
02/20/2019	Contact - Telephone call received Complainant called returned call. Resident passed away on 1/8/19.
02/20/2019	APS Referral Adult Protective Services referral made providing allegations as received.
02/28/2019	Inspection Completed On-site Completed with observation, interview and record review.
02/28/2019	Inspection Completed-BCAL Sub. Compliance
03/27/2019	Exit Completed with Authorized Representative Manda Ayoub.

ALLEGATION:

Staff dropped Resident A on 12/26/18 and picked her up by her legs to put her back in the bed

INVESTIGATION:

On 2/19/19, the department received the allegations from an anonymous complainant via the BCAL Online Complainant website.

On 9/17/18, I made a referral to adult protective services (APS).

On 2/20/19, I interviewed the complainant by telephone. The complainant stated that Resident A is a two person assist. She stated, the facility completed an assessment and they were aware that she needed two people at all time with assist. She stated that on 12/26/18, when the staff went to pick Resident A up, they dropped her. She said they didn't use the gait belt. She stated Resident A hit her back and complained of pain. She stated that she was told this by Resident A. She stated the resident said that the two aides came in and picked her up by the elastic of her pants and dropped her. The complainant stated that she told the owner about the incident, but she has not heard anything from them.

On 2/28/19, I interviewed the administrator Elizabeth Edelstein and the regional director Teresa Harnos at the facility. Ms. Edelstein stated that Resident A was only at the facility for a short period of time. She stated there was no incident for 12/26/18 or 12/27/18 but stated that it sounded vaguely familiar. She stated that she heard Resident A fell when she got here, and she think they dropped her. She stated that she could not find the incident report. She stated that she did not know where it was.

On 2/28/19, I interviewed the nurse Karen Hope at the facility. Ms. Hope stated that Resident A's daughter said that resident was dropped. She stated that she talked to the staff. She stated nobody knew anything about a drop and they did not substantiate the claim. She stated they checked Resident A from head to toe. Ms. Hope said they told the family that Resident A was new to the facility and it was just her transitioning.

On 2/28/19, I interviewed resident care aides Lakeshia Thomas, Lashawn Dillon and Shanericka Hollis at the facility. All resident care aides interviewed stated they did not know anything about Resident A falling. They stated they help each other out with transporting residents and when the medication technician is not busy, they assist with the care of the residents.

I reviewed the service plan for Resident A. The plan notes that Resident A is to be provided with physical assistance as needed to increase independence and ensure safety mobility. It also notes two persons assist.

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.
ANALYSIS:	Resident A is dependent upon staff for all transfers. It was alleged that staff dropped Resident A and did not report it. An interview of the administrator reveal that she somewhat remembers the incident but did not complete an incident report. Interviews with staff reveal they are aware that Resident A required two staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The staff did not report the incident to the authorized representative and the department.

INVESTIGATION:

The complainant stated the staff picked Resident A up after the fall and never reported the incident to her. She stated she found out from the Resident because she was complaining about her back.

Ms. Edelstein stated that she remembers the incident, but she doesn't know if it was reported. She stated that she cannot find the incident report.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.

ANALYSIS:	Resident A was dropped during a transfer by staff. The facility did not report the incident to the authorized representative, or to the department.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL ALLEGATION:

Ms. Edelstein stated that Resident went to the hospital on 1/2/19 and the family did not bring her back. She stated the resident passed away on 1/8/19. Ms. Edelstein stated that she could not find all the records for Resident A.

In an email from Ms. Edelstein, it was noted that there were no progress notes nor any other care info that was entered into the system for Resident A. It notes, the daily care services provided for Resident A would have been logged manually by the care staff on the printed personal care daily logs.

APPLICABLE RULE	
R 325.1942	**Resident records.**
	(4)A home shall keep a resident's record in the home for at least 2 years after the date of a resident's discharge from the home.
ANALYSIS:	Records were requested from the administrator for Resident A. The administrator could not locate all the records for Resident A. The facility failed to retain Resident A's record after discharged from the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

The findings of this report were shared with authorized representative Manda Ayoub on 3/27/2019.

IV. RECOMMENDATION

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

3/27/18

Brender Howard   Date
Licensing Staff

Approved By:

3/26/19

Russell B. Misiak   Date
Area Manager