GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 10, 2019

Vijay Sahore
Assured Senior Living Group, LLC
25180 Lahser Road
Southfield, MI 48033

RE: License #: AH630382886
Investigation #: 2019A0585032
Royal Oak House

Dear Mr. Sahore:

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.

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 L. Howard

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 #:	AH630382886
Investigation #:	2019A0585032
Complaint Receipt Date:	04/19/2019
Investigation Initiation Date:	04/23/2019
Report Due Date:	06/19/2019
Licensee Name:	Assured Senior Living Group, LLC
Licensee Address:	25180 Lasher Road Southfield, MI 48033
Licensee Telephone #:	(248) 262-2205
Administrator:	Karen DeLaflor
Authorized Representative:	Vijay Sahore
Name of Facility:	Royal Oak House
Facility Address:	1900 N. Washington Ave. Royal Oak, MI 48073
Facility Telephone #:	(248) 585-2550
Original Issuance Date:	03/01/2018
License Status:	REGULAR
Effective Date:	09/03/2018
Expiration Date:	09/02/2019
Capacity:	57
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident soaked with perspiration and not changed as requested	No
Resident was found to have two Fentanyl patches on at one time causing overdose.	Yes
Medical records incomplete and had other resident information included.	No
Staff forgot to take bedridden resident meals on multiple occasions.	No
Additional Findings	Yes

III. METHODOLOGY

04/19/2019	Special Investigation Intake 2019A0585032
04/23/2019	Special Investigation Initiated - Telephone Interviewed the complainant regarding the allegations.
04/23/2019	APS Referral I a referral to Adult Protective Services (APS) for the allegations.
04/26/2019	Inspection Completed On-site Completed with observation, interview and record review.
04/26/2019	Inspection Completed-BCAL Sub. Compliance
06/10/2019	Exit Conference Conducted with Authorized Representative Vijay Sahore.

ALLEGATION:

Resident soaked with perspiration and not changed as requested.

INVESTIGATION:

On 4/19/19, the department received the allegations from the complaint via the BCAL Online complaint website.

On 4/23/19, I made a referral to Adult Protective Services (APS).

On 4/23/19, I interviewed the complainant by telephone. The complainant stated that on 1/18/19, her sisters went to the facility and observed Resident A's bed and clothes were soaked with perspiration. She stated that Resident A's clothing and bed was not changed until the next morning.

On 4/26/19, I interviewed the administrator Karen DeLaflor at the facility. Ms. DeLaflor stated that Resident A is on hospice. She stated that Resident A was on two-hour checks. Ms. DeLaflor stated that she doesn't have any knowledge of the incident and if it is requested to change clothing or bedding for resident, staff change bed and clothing immediately.

On 4/26/19, I randomly selected residents' room and observed them to be clean, free from odors. The residents appeared to be clean and no body odors were detected.

The service plan for Resident A notes hospice to provide shower twice weekly, with bed baths on Tuesday and Thursday by hospice. It also notes that Resident requires total assistance with hygiene and grooming needs. The plan notes Resident A requires total assistance of two with dressing and undressing.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(1) Personal care and services that are provided to a resident by the home shall be designed to encourage residents to function physically and intellectually with independence at the highest practical level.
ANALYSIS:	Based on observation and interview, this claim could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident was found to have two Fentanyl patches on at one time causing overdose.

INVESTIGATION:

The complainant stated that Resident A had on two fentanyl patches. She stated that they did not know how long that the resident had it on.

Ms. DeLaFlor stated that the hospice nurse came in and changed the order for Resident A from fentanyl 50 mg to 75 milligrams (mg). She stated the 75 mg came in on Thursday and was put on the resident by Brittany Jordan. Ms. DeLaFlor stated that Ms. Jordan failed to remove the 50 mg Fentanyl before putting the 75 mg on Resident A. She stated that Ms. Jordan said she could not find the old patch. Ms. DeLaFlor stated that Resident A was grouchy, and hospice was called. She stated the hospice nurse told them to remove the patches. She stated that Resident A was in pain the next day and was given prn (as needed) Vicodin. She stated the next day the 75 mg fentanyl patch was reapplied. Ms. DeLaFlor stated that the two patches were on Resident A for 72 hours. Ms. DeLaFlor gave me a copy of orders from Assured Hospice, medication administration record (MAR), and a copy of in-service for Ms. Jordan.

On 4/26/19, I interviewed medication technician Ms. Jordan at the facility. Ms. Jordan stated that she made an error. She stated she did not remove the fentanyl patch before putting new one on the resident. She stated that one was on for a few days. She stated that she didn’t feel that it affected her too much. She stated that Resident A was having leg pain. She stated that Resident A had both patches (50 mg and 75 mg) on for a day. She stated they called hospice and they were told to take off one patch. Ms. Jordan stated that she just made an honest mistake.

A review of new orders dated 1/16/19 for Resident A notes, when 75 mg fentanyl patch comes in, remove 50 mg patch and replace with 75 mg. It notes to please date patch when replaced.

The MAR for Resident A notes an order for Fentanyl 50 mg with instructions to apply one patch topically every 72 hours (remove old patch before applying new patch).

A review of the in-service documents notes that Ms. Jordan had a one on one training on 1/22/19. The in-service consisted of med pass review and removal of patches before replacing a new patch.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.

ANALYSIS:	Resident A was given double Fentanyl patch. Ms. Jordan did not follow physician instructions to remove the 50 mg fentanyl patch before placing a new order of 75 mg fentanyl patch.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Medical records incomplete and had other resident information included.

INVESTIGATION:

The complainant stated that they requested the records for Resident A. The complainant stated that the records that was given to her contained another resident's record in it. She stated that all the documents were not in it.

Ms. DeLaFlor stated that the records for Resident A is complete. She stated that no other resident's records are in the file of Resident A. She presented me with Resident A's file for my review.

I reviewed the file of Resident A. All documents in the file had the name of Resident A on it.

APPLICABLE RULE	
R 325.1942	**Resident records.**
	(2) A home shall assure that a current resident record is maintained and that all entries are dated and signed.
ANALYSIS:	Based on interview and record review this claim could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff forgot to take bedridden resident meals on multiple occasions.

INVESTIGATION:

The complainant stated that there have been times where staff forgot to bring resident her meals. She also stated that Resident A was bedridden.

Ms. DeLaFlor stated that if a resident does not want to eat in the dining room, they would offer then a tray to eat in their room.

A review of the service plan for Resident A notes that resident often forget that she has eaten and say that no one brought her meals. It also notes, resident has snacks in her room, and staff place a few on her bedside table.

Ms. Jordan stated that trays are offered to residents if they don't go to the dining room.

APPLICABLE RULE	
R 325.1951	**Nutritional need of residents.**
	A home shall meet the food and nutritional needs of a resident in accordance with the recommended daily dietary allowances of the food and nutrition board of the national research council of the national academy of sciences, adjusted for age, gender, and activity, or other national authority acceptable to the department, except as ordered by a licensed health care professional.
ANALYSIS:	The service plan notes that Resident A is offered and served meals regardless of whether she eats in her room or dining room. It also notes that Resident A sometimes forgets that she has eaten. Based on interview and record review, this claim could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS

Ms. DeLaFlor stated that she didn't know she had to report the medication error to the state. She stated that no harm was caused as a result of Resident A having on two Fentanyl patches.

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.
For Reference:	

R325.1901	**Definitions.**
	(17) "Reportable incident/accident" means an intentional or unintentional event in which a resident suffers harm or is at risk of more than minimal harm, such as, but not limited to, abuse, neglect, exploitation, or unnatural death.
ANALYSIS:	Staff placed Resident A at risk of harm by not removing an existing medication patch before placement of a new one. The facility did not complete a report regarding staff not following physician orders.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/10/19, I conducted an exit conference with the authorized representative Vijay Sahore of Royal Oak House. Mr. Sahore made no comments regarding the allegations.

IV. RECOMMENDATION

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

6/10/19

Brender Howard Date
Licensing Staff

Approved By:

6/10/19

Russell B. Misiak Date
Area Manager