GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

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

August 27, 2020

RE: License #: AH820381235
Pomeroy Living Northville Assisted & Memory Care
40033 W. Eight Mile
Northville, MI 48167

Dear Ms. Ayoub:

Attached is the Renewal Licensing Study Report for the facility referenced above. The violations cited in the report require the submission of a written corrective action plan. 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 dates 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 authorized representative and a date.

Upon receipt of an acceptable corrective action plan and receipt of the annual fee, a regular license will be issued. If you fail to submit an acceptable corrective action plan, disciplinary action will result.

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 feel free to contact the local office at (248) 975-5053.

Sincerely,

Andrea Krausmann, Licensing Staff
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(586) 256-1632

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
RENEWAL INSPECTION REPORT

I. IDENTIFYING INFORMATION

License #:	AH820381235
Licensee Name:	Beacon Square Northville
Licensee Address:	Suite 130 5480 Corporate Drive Troy, MI 48098
Licensee Telephone #:	(248) 723-2100
Authorized Representative:	Manda Ayoub
Administrator:	Teresa Harnos
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
Capacity:	109
Program Type:	ALZHEIMERS AGED

II. METHODS OF INSPECTION

Date of On-site Inspection(s): 08/24/2020

Date of Bureau of Fire Services Inspection if applicable: 07/23/2020, 08/03/2020

Inspection Type: ☐ Interview and Observation ☒ Worksheet ☐ Combination

Date of Exit Conference: 08/27/2020

No. of staff interviewed and/or observed 11
No. of residents interviewed and/or observed 20
No. of others interviewed No visitors allowed per Governor's executive orders
Role

- Medication pass / simulated pass observed? Yes ☒ No ☐ If no, explain.

- Medication(s) and medication records(s) reviewed? Yes ☒ No ☐ If no, explain.
- Resident funds and associated documents reviewed for at least one resident? Yes ☐ No ☒ If no, explain. No resident funds currently being held.
- Meal preparation / service observed? Yes ☒ No ☐ If no, explain.

- Fire drills reviewed? Yes ☐ No ☒ If no, explain.
  Interviewed staff about disaster plan. Bureau of Fire Services reviews fire drills.
- Water temperatures checked? Yes ☒ No ☐ If no, explain.

- Incident report follow-up? Yes ☒ IR date/s:1/14/19 and 11/7/19 N/A ☐
- Corrective action plan compliance verified? Yes ☒ CAP date/s and rule/s: SIR2020A1011011 with CAP dated 1/24/20: R325.1976(6)
- Number of excluded employees followed up? Four N/A ☐

III. DESCRIPTION OF FINDINGS & CONCLUSIONS

This facility was found to be in non-compliance with the following rules:	
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	**Definitions.**
	(16) "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.

The owner, operator, and governing body of the home did not assure the home maintains an organized program to provide protection, supervision and assistance for its residents as evidenced by the following:

On 8/24/20, I observed Resident A's bed, in the assisted living area, had an assistive device commonly known as a Halo ring attached to the bed frame. The device is affixed to only one side of the bed, leaving the mattress readily able to shift away and create a gap between the device and the mattress, resulting in a possible entrapment zone. Resident A said the mattress shifts regularly.

In addition, the approximately 12" Halo ring had horizontal and vertical slats with spaces in between the slats large enough that Resident A demonstrated her hand/arm could slip through the ring and become accidentally entrapped. There was no protective barrier to close off these open spaces between the slats. Resident A said she had a cover for the device, but it has been missing for quite some time and she did not know where it went.

The facility's administrator Teresa Harnos provided a copy of the facility's policy titled *Bed Rail Devices*. It addresses monitoring for gaps between mattress and the device but no monitoring for gaps within the device where a hand/arm could be entrapped.

Resident A's service plan includes the use of the Halo ring, but it does not address the frequency of resident observation when the Halo ring is in use.

Note: The department's technical assistance addressing the use of assistive devices on or about the bed is available at: www.michigan.gov/afchfa

VIOLATION ESTABLISHED

R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.
For reference: R 325.1901	**Definitions.**
	(21) "Service plan" means a written statement prepared by the home in cooperation with a resident and/or the resident's authorized representative or agency responsible for a resident's placement, if any, and that identifies the specific care and maintenance, services, and resident activities appropriate for each 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.

The giving, taking or applying of prescription medications was not always addressed in the resident's service plan. For example: According to the medication administration record (MAR), Resident B is prescribed Ativan 0.5 mg every 8 hours as needed for anxiety. Resident B's service plan did not indicate that Resident B has the behavior of anxiety requiring treatment. Resident B's service plan provided no information on how the resident demonstrates this behavior to alert staff, nor did it include any specific care and services methodology for staff to address the behavior including the use of this medication.

VIOLATION ESTABLISHED

R 325.1932	**Resident medications.**
	(3) If a home or the home's administrator or direct care staff member supervises the taking of medication by a resident, then the home shall comply with all of the following provisions: **(c) Record the reason for each administration of medication that is prescribed on an as-needed basis.**

Staff did not always record the reason for each administration of medication that is prescribed on an as-needed basis. For example: Staff initials on Resident B's August 2020 MAR indicated staff administered her Ativan medication prescribed as needed on 8/1, 8/3, 8/5, 8/6, 8/17 and 8/19/20. However, there was no reason recorded for each of these administrations.	
VIOLATION ESTABLISHED	
R 325.1932	**Resident medications.**
	(5) A home shall take reasonable precautions to ensure or assure that prescription medication is not used by a person other than the resident for whom the medication is prescribed.
To ensure narcotic medication is not used by a person other than the resident for whom the medication is prescribed, the facility implemented a procedure of maintaining a controlled substance inventory sheets for all such medications. As confirmed by administrator Teresa Harnos, at the change of each shift the staff person who is about to leave their shift will meet with the staff person arriving for the next shift. Together, the two staff persons will manually count every narcotic medication in the medication cart for which they are responsible and ensure that the number of medications available in the cart matches the number on accountability sheets. Then, both staff persons are to sign the controlled substance inventory sheets indicating they are in agreement with the count. However, at approximately 12 pm, I observed that staff Rosa Martinez had already signed the controlled substance inventory sheet in Copper Harbor for 3pm shift change, when she would be conducting the count with the incoming shift staff and Ms. Martinez would be exiting for the day. Ms. Martinez did not wait until 3pm to conduct the count of narcotic medications and then sign the sheet along with the afternoon shift staff when that person arrives for duty and accepts responsibility for the medications. Therefore, the facility staff is not following the facility's procedure/policy in taking the reasonable precautions to ensure prescription medication is not used by a person other than the resident for whom the medication is prescribed.	
VIOLATION ESTABLISHED	
R 325.1944	**Employee records and work schedules.**
	(2) The home shall prepare a work schedule showing the number and type of personnel scheduled to be on duty on a

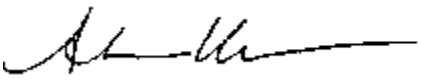
	daily basis. The home shall make changes to the planned work schedule to show the staff who actually worked.
For reference: R 325.1931	**Employees; general provisions.**
	(3) The home shall designate 1 person on each shift to be supervisor of resident care during that shift. The supervisor of resident care shall be fully dressed, awake, and on the premises when on duty.
Review of the facility's work schedule for 8/1-8/31/20 revealed the schedule did not include all types of personnel on duty. Specifically, the schedule did not identify the supervisor of resident care for each shift. While interviewing medication technician Rosa Martinez, who has worked at the facility for three years, Ms. Martinez said each med tech is the supervisor for their unit on each shift. This does not meet compliance with the rule that the home shall designate one person on each shift to be supervisor of resident care during that shift.	
VIOLATION ESTABLISHED	
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.
The home did not post the menu for the current week. There were no changes made to show the menu as actually served. On 8/24/20, the menu posted was dated for 8/2-8/8/20. According to the Monday 8/3/20 lunch menu, breaded fish, French fries, cole slaw, tomato wedges, and roll were to be served. Instead on Monday 8/24/20, I observed that residents were served Swedish meatballs, noodles, peas and roll were served.	
VIOLATION ESTABLISHED	
R 325.1976	**Kitchen and dietary.**
	(13) A multi-use utensil used in food storage, preparation, transport, or serving shall be thoroughly cleaned and sanitized after each use and shall be handled and stored in a manner which will protect it from contamination.
Kitchen manager Harry Bemis presented test strips to demonstrate that pots and pans washed in the three-part sink were sanitized. However, Mr. Bemis said other	

than observing the temperature gauge on the dishwasher, there was no means to demonstrate the other utensils such as dishes and silverware that are washed in the dishwasher are sanitized after each use. The temperature gauge does not indicate whether the temperature was hot enough for a long enough period of time to ensure sanitization.	
VIOLATION ESTABLISHED	
R 325.1976	**Kitchen and dietary.**
	(6) Food and drink used in the home shall be clean and wholesome and shall be manufactured, handled, stored, prepared, transported, and served so as to be safe for human consumption.
On 8/24/20, in Eagle Harbor memory care unit food storage, I observed two unopened containers of 1.4 quart thickened orange juice with the “use by” date of 5/9/20. In the main kitchen food storage, I observed food items such as individually wrapped lady finger cookies that had been removed from their primary package and it was missing. There were no expiration dates on the cookies to ensure they were safe for human consumption.	
REPEAT VIOLATION ESTABLISHED [Reference: Special Investigation Report #2020A1011011 with Corrective Action Plan dated 1/24/20]	

On 8/27/20, I reviewed the findings of this report with authorized representative Manda Ayoub via telephone.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan and receipt of the annual fee, renewal of the license is recommended.



8/27/20

Andrea Krausmann Date
Licensing Consultant