GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 2, 2022

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

RE: License #: AH630338700
Investigation #: 2022A0585015
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.

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 (517) 284-9730.

Sincerely,

Brender L. Howard

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(313) 268-1788

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

I. IDENTIFYING INFORMATION

License #:	AH630338700
Investigation #:	2022A0585015
Complaint Receipt Date:	12/14/2021
Investigation Initiation Date:	12/14/2021
Report Due Date:	02/13/2022
Licensee Name:	Pomkal Rochester Assisted, LLC
Licensee Address:	Suite 130 5480 Corporate Drive Troy, MI 48098
Licensee Telephone #:	(248) 354-7200
Administrator:	Carmin Harris
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:	08/07/2021
Expiration Date:	08/06/2022
Capacity:	84
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A's psychotropic medication was found to have been stopped by nurse with no explanation.	Yes
Additional Findings	No

III. METHODOLOGY

12/14/2021	Special Investigation Intake 2022A0585015
12/14/2021	Special Investigation Initiated - Telephone Contacted complainant to discuss allegations.
12/14/2021	APS Referral Emailed allegations to Adult Protective Services (APS)
12/14/2021	Inspection Completed On-site Completed with observation, interview and record review.
02/02/2022	Exit Conference Conducted with authorized representative Manda Ayoub.

ALLEGATION:

Resident A's psychotropic medication was found to have been stopped by nurse with no explanation.

INVESTIGATION:

On 12/14/21, the department received the allegations from a complainant via the BCHS Online Complaint website.

On 12/14/21, a referral was made to Adult Protective Services (APS).

On 12/14/21, I spoke to the complainant by telephone. He stated that when he looked the prescription drug summary for the month of July 2021, he noticed that Resident A's medication Seroquel tablet (Quetiapine Fumarate) was not listed. He stated that they were not notified of the medication being stopped or changed. He stated that when he inquired about the medication being stopped, the nurse found an entry that was made removing Resident A from this drug but there was no explanation as to why it was removed. He stated that no one could give him an

explanation. He stated that the nurse he spoke to is no longer employed at the facility and he could not get additional information.

On 12/14/21, I completed an onsite at the facility and interviewed the administrator Carmin Harris at the facility. She stated that she was not there at the time of the medication changes and did not know any information as to why the medication was stopped. Ms. Harris gave me copies of Resident A's service plan, Resident A's medication administration record (MAR), Resident A's progress notes.

The service plan for Resident A read, she was admitted to the facility on 8/23/18 with diagnoses that included atrial fibrillation and fluttering, Alzheimer's disease, hypertension, type 2 diabetes, insomnia, and major depressive disorder. The plan read, the medication for Resident A is to take all medications safely and as ordered. The plan notes, that Resident A needs help with medications due to cognitive loss.

Resident A's MAR for July shows that the medication Seroquel was discontinued on 6/7/21 and was not given on 6/8 – 6/30. There was nothing written in the progress notes or on the MAR indicating the reason for the discontinuation of Seroquel.

Progress note read:

Seroquel tablet 25 mg, date of order 8/23/18, 8/28/19, 9/18/19, 10/9/19 – give 1 tablet by mouth in the evening for agitation.

Seroquel tablet 50 mg, date of order 12/9/19, 1/3/20, 4/12/21 to be given 1 tablet by mouth two times a day for agitation.

Seroquel tablet 50 mg, date of order 6/2/21 to be given in the afternoon for anxiety.

Physician note dated 8/2/21 read, patient used to be on Seroquel which was discontinued in the past but now she started to act out again…..will start on a lower dose 25 mg twice a day and continue to monitor clinically.

APPLICABLE RULE	
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: **(e) Adjust or modify a resident's prescription medication with instructions from a prescribing licensed health care professional who has knowledge of the medical needs of the resident. A home shall record, in writing, any instructions regarding a resident's prescription medication.**

ANALYSIS:	The MAR shows that medication Seroquel (Quetiapine Fumarate) was discontinued but it did not tell why it was discontinued. There was nothing in the notes that indicate why or by whom it was stopped. This could have caused an adverse reaction to the Resident A. Therefore, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 2/2/2022, I shared the findings of this report with authorized representative Manda Ayoub.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

02/02/2022

Brender Howard Date
Licensing Staff

Approved By:

01/31/2022

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