GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 18, 2022

David Truetzel
Oakleigh Macomb Operations, LLC
8025 Forsyth Blvd.
St. Louis, MO 63105

RE: License #: AH500394648
Investigation #: 2022A1027068
Oakleigh of Macomb

Dear Mr. Truetzel:

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 authorized representative 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) 241-1970.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500394648
Investigation #:	2022A1027068
Complaint Receipt Date:	06/27/2022
Investigation Initiation Date:	06/28/2022
Report Due Date:	08/27/2022
Licensee Name:	Oakleigh Macomb Operations, LLC
Licensee Address:	Suite 201 40600 Ann Arbor Road Plymouth, MI 48170
Licensee Telephone #:	(586) 997-8090
Administrator:	Helen Bisbikis
Authorized Representative:	David Truetzel
Name of Facility:	Oakleigh of Macomb
Facility Address:	49880 Hays Road Macomb, MI 48044
Facility Telephone #:	(586) 997-8090
Original Issuance Date:	12/18/2019
License Status:	REGULAR
Effective Date:	08/07/2021
Expiration Date:	08/06/2022
Capacity:	101
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A's authorized representative was not notified of his fall.	Yes
Resident A's medications were not given at correct times.	No
The facility did not provide Resident A's records.	No
Additional Findings	No

The complainant identified some concerns that were not related to licensing rules and statues for a home for the aged. Therefore, only specific items pertaining to homes of the aged provisions of care were considered for investigation. The following items were that that could be considered under the scope of licensing.

III. METHODOLOGY

06/27/2022	Special Investigation Intake 2022A1027068
06/28/2022	Special Investigation Initiated - Telephone Voicemail left with complainant
06/28/2022	Contact - Telephone call received Telephone interview conducted with complainant. Plan to send email to complainant with contact information for follow up.
06/28/2022	Contact - Document Sent Email sent to complainant. Complainant to provide follow up email with information and details pertaining to the investigation
06/28/2022	Contact - Document Received Email received from complainant with requested documentation
07/07/2022	Contact - Telephone call made Telephone interview conducted with administrator Eleni Bisbikis and facility nurse Ursila Dela-Cruz
07/07/2022	Contact - Document Sent Email sent to administrator Ms. Bisbikis and nurse Ms. Dela-Cruz with requested documentation for investigation
07/13/2022	Contact - Document Received

	Email received from Ms. Dela-Cruz with requested documentation
07/18/2022	Special Investigation BCAL Sub Compliance
09/08/2022	Exit Conference Conducted by voicemail with authorized representative David Truetzel

ALLEGATION:

Resident A's authorized representative was not notified of his fall.

INVESTIGATION:

On the 6/27/2022, the department received a complaint forwarded by the online complaints department which read Resident A had a fall in which his daughter and son-in-law were not notified until they visited the facility on 3/12/2022. The complaint read Resident A was found by midnight shift staff in front of his recliner chair dressed in soiled incontinence underwear in which he had a cut on his elbow and a bruise on his shoulder. The complaint read the day shift staff member provided the details of the incident to Resident A's family visiting the facility.

On 6/28/2022, I conducted a telephone interview with the complainant in which read consistent with the complaint.

I reviewed Resident A's face sheet which read Resident A's responsible party/next of kin/guardian/designated representative/DPOA (Durable Power of Attorney) as well as financial responsible party was Relative A1.

I reviewed Resident A's admission contract which dated 5/20/2020 and signed by Relative A1.

I reviewed Resident A's incident report dated 3/12/2022 at 7:00 AM which read consistent with the complaint. The report read Resident A's nurse practitioner was notified on 3/12/2022 at 7:00 AM and his family, Relatives A2, were notified while at the facility on 3/12/2022 at 9:30 AM.

I reviewed Resident A's service plan dated 4/28/2021 which read it was reviewed by telephone with Relative A1, who lived out of state.

I reviewed Resident A's chart note dated 3/12/2022 at 9:30 AM which read consistent with the incident report.

I reviewed Resident A's general and health care DPOA designation forms which read Relative A1 was appointed for both.

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:	Review of facility documentation revealed Relative A1 was Resident A's appointed DPOA and authorized representative at the facility. Facility documentation read Resident A was observed on the floor in front of his recliner in which the facility notified Relatives A2, however they were not his appointed authorized representative. Based on this information, this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A's medications were not given at correct times.

INVESTIGATION:

On 6/27/2022, the department received a complaint forwarded by the online complaints department in which the complainant explained he needed to provide more details to the complaint.

On 6/28/2022, I conducted a telephone interview with the complainant in which he stated Resident A's medications were not given at the correct times. The complainant stated Resident A had discharged from the facility on 3/19/2022.

I reviewed Resident A's physician orders dated 3/12/2022 which read medications Amlodipine, Aspirin, Losartan, Pantoprazole, Vitamin D3 were to be administered at 8:00 AM. The orders read medication Baclofen was to be administered at 8:00 PM. The orders read medications Baza Antifungal Cream, Clobetasol cream, and Metoprolol were to be administered twice daily at 8:00 AM and 8:00 PM.

I reviewed Resident A's medication administration records (MARs) for January, February, and March 2022. The March 2022 MARs read consistent with the physician orders dated 3/12/2022. Additionally, the March 2022 MAR read Resident

A was out of the facility on 3/18/2022 and all medications were discontinued on 3/19/2022.

I reviewed Resident A's chart notes dated 3/17/2022 1:35 PM which in part read Resident A moved out per family request and all medications were sent with his family.

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:	Review of facility documentation revealed facility staff were responsible for administering Resident A's medications at 8:00 AM and/or 8:00 PM as prescribed by his licensed health care professional. The MARs read staff initialed Resident A's medications as administered in January, February, and March 2022, as well as at the times ordered by the licensed health professional. Based on this information, this allegation cannot be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility did not provide Resident A's records.

INVESTIGATION:

On 6/27/2022, the department received a complaint forwarded by the online complaints department in which the complainant explained he needed to provide more details to the complaint.

On 6/28/2022, I conducted a telephone interview with the complainant in which he stated that the facility did not provide Resident A's records that were requested by his family.

On 7/7/2022, I conducted a telephone interview with facility nurse Ursila Dela-Cruz, who stated Relatives A2 requested Resident A's records, but they were not his durable power of attorney, so the previous administrator emailed the records to Relative A1.

I reviewed Resident A's chart notes dated 3/17/2022 1:35 PM by Ms. Dela-Cruz which in part read Relatives A2 requested facility documentation in which they were not the DPOA. The note read one family member of Relatives A2 was observed yelling at Resident A and staff to request the facility documentation. The note read Ms. Dela-Cruz and the executive director called Relative A1 to report the incident who stated he would email the facility what documents were needed.

I reviewed email correspondences between Relative A1 and the previous administrator.

> Email dated 3/20/2022 at 1:59 PM from the previous administrator to Relative A1 read in part
>
> *Attached you will find the requested Medication List for your dad. Let me know if there is anything else the new community requires that I can assist with.*
>
> Email dated 3/20/2022 at 7:05 PM from Relative A1 to the previous administrator read in part
>
> *What I'd like a copy of are his medical records from your facility and the records of the prescriptions given to Dad by date/time.*

Emails dated 3/21/2022 at 5:57 PM, 3/24/2022 at 10:13 AM, and 3/25/2022 at 12:20 PM from Relative A1 sent to the previous administrator requested Resident A's medical and medication administration records. MARs dated February 2022 read they were scanned on 3/25/2022 at 12:59 PM and emailed to Relative A1.

I reviewed the *Medication List* emailed to Relative A1 from the previous administrator. The Medication List was titled *Physician's Orders* dated 3/12/2022 in which read the following information Resident A's name, date of birth, arrival date, code status, diagnoses, diet, and allergies. The orders read Resident A's primary care physician's name, address, phone, and DEA number. The orders read routine and as needed medication names, doses, routes, and times to be administered. The orders read to check Resident A's blood pressure twice daily at 8:00 AM and 8:00 PM, obtain monthly weights the second Friday of the month, apply hearing aids once daily in the morning and remove hearing aids once daily at bedtime. The orders read Resident A was allowed to have alcohol and had a textured modified diet. The diet order read *Level 2 Minced and moist diet with regular thin liquids, ground meat, food needs to be cut up in bite sized r/t choking precautions, alcohol allowed, resident does not want milk*.

I reviewed Resident A's service plan which read consistent with his physician orders.

Email correspondence dated 7/13/2022 from Ms. Dela-Cruz to the department read that the facility did not maintain a policy regarding providing resident records to family.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(b) An individual who is or has been a patient or resident is entitled to inspect, or receive for a reasonable fee, a copy of his or her medical record upon request in accordance with the medical records access act, 2004 PA 47, MCL 333.26261 to 333.26271. Except as otherwise permitted or required under the health insurance portability and accountability act of 1996, Public Law 104-191, or regulations promulgated under that act, 45 CFR parts 160 and 164, a third party shall not be given a copy of the patient's or resident's medical record without prior authorization of the patient or resident.**
ANALYSIS:	Review of facility records revealed Resident A's physician orders and MARs were emailed to Relative A1 which included the medical and medication orders prescribed by his licensed health care professional. Based on this information, this allegation cannot be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 9/8/2022, I shared the findings of this report with authorized representative David Truetzel by voicemail.

IV. RECOMMENDATION

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

07/18/2022

Jessica Rogers Date
Licensing Staff

Approved By:

09/07/2022

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