GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 4, 2022

Steven Tyshka
Waltonwood at University II
3280 Walton Boulevard
Rochester Hills, MI 48309

RE: License #: AH630336571
Investigation #: 2022A0784073
Waltonwood at University II

Dear Mr. Tyshka:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630336571
Investigation #:	2022A0784073
Complaint Receipt Date:	08/24/2022
Investigation Initiation Date:	08/26/2022
Report Due Date:	10/25/2022
Licensee Name:	Waltonwood II Ltd Dividend Hsg Assoc L.P.
Licensee Address:	7125 Orchard Lake Road Suite #200 West Bloomfield, MI 48322
Licensee Telephone #:	(248) 865-1606
Administrator:	Jonathan Hills
Authorized Representative:	Steven Tyshka
Name of Facility:	Waltonwood at University II
Facility Address:	3280 Walton Boulevard Rochester Hills, MI 48309
Facility Telephone #:	(248) 375-9664
Original Issuance Date:	11/26/2012
License Status:	REGULAR
Effective Date:	06/07/2022
Expiration Date:	06/06/2023
Capacity:	50
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A suffered physical abuse by staff	No
Resident B was not administered prescribed medication	Yes
Additional Findings	No

III. METHODOLOGY

08/24/2022	Special Investigation Intake 2022A0784073
08/26/2022	Inspection Completed On-site
08/26/2022	Special Investigation Initiated - On Site
10/04/2022	Exit Conference – Telephone Conducted with authorized representative Steven Tyshka

ALLEGATION:

Resident A suffered physical abuse by staff

INVESTIGATION:

On 8/24/2022, the department received this complaint from adult protective services (APS) Centralized Intake. Information provided on the complaint indicated APS did not accept the complaint for investigation.

According to the complaint, Resident A was moved from the facility on 8/11/2022 due to concerns of physical aggression from staff after it was noticed that Resident A had bruises on her body of unknown origin.

On 8/26/2022, I interviewed resident care director Derricka Mason at the facility. Ms. Mason confirmed Resident a was moved from the facility on 8/11/2022. Ms. Mason stated she was unaware of any concerns that Resident A had been abused by staff in any way. Ms. Mason stated she did recall that approximately one month after returning from a hospital stay on or about 5/27/2022, Resident A's power of attorney (POA) had shown some pictures to a staff member that reportedly showed bruises on Resident A's back. Ms. Mason stated she asked the POA if she could see the pictures and when the POA believed the bruises were sustained. Ms. Mason stated

the POA refused to show her the pictures and reported the bruises were obtained while Resident A was at the hospital and that the pictures were taken while Resident A was at the hospital. Ms. Mason stated that Resident A did not have bruises on her back at the time of the reporting.

I reviewed discharge documents for Resident A from Beaumont hospital, provided by Ms. Mason. Review of the documents revealed Resident A was at the hospital from 5/18/2022 to 5/26/2022.

I reviewed facility Progress Notes for Resident A for May 2022 through August 2022. The notes read consistently with statements provided by Ms. Mason revealing no related reporting or incidents regarding injuries or bruising to Resident A.

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: **(l) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician or physician's assistant. In case of a chemical restraint, a physician shall be consulted within 24 hours after the commencement of the chemical restraint.**

ANALYSIS:	The complaint alleged Resident A was observed with bruising on her back causing concern that Resident A may have been subjected to possible abuse. The resident care director, Ms. Mason, reported she was not aware of any physical abuse. Ms. Mason reported that Resident A's POA had apparently mentioned possible bruising on Resident A, and reportedly had pictures, to a staff member, but that the POA withdrew her concerns when Ms. Mason inquired about them. At the time of the investigation, Resident A was no longer living at the facility. Based on the findings, there is insufficient evidence to support a finding.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident B was not administered prescribed medication

INVESTIGATION:

According to the complaint, Resident B was moved out of the facility on 8/11/2022 with Resident A due to concerns that he was not being administered medication prescribed to him for Parkinson's disease. Specifically, it was discovered that from approximately 1/21/2022 to 4/25/2022, Resident A was not administered his Parkinson's medication due to the facility not adding the medication to his medical administration record (MAR) when he moved in on 1/21/2022.

When interviewed, Ms. Mason stated that from Resident B's admission date, 2/07/2022, until 4/25/2022, he did not receive Carbidopa-Levodopa, a medication he was prescribed for Parkinson's Disease. Ms. Mason stated that when new residents move to the facility, or a new medication is prescribed to a current resident, medication orders are sent to the pharmacy. Ms. Mason stated the pharmacy then faxes the medication order to the facility and sends the medication to the facility. Ms. Mason stated the medication is entered into the facilities medication administration (MAR) system. Ms. Mason stated administration begins once the facility receives the medication from the pharmacy. Ms. Mason stated the pharmacy never faxed the order or the sent the physical medication to the facility. Ms. Mason stated that prior admitting a resident, the facility receives a "physicians report" which includes a list of medications for the resident being admitting. Ms. Mason stated the facility did receive this report for Resident B prior to his move in date and that the report did list Carbidopa-Levodopa as one of his medications. Ms. Mason stated this list was not reviewed against the orders the facility received, so the missing medication was not discovered during the time Resident B was admitted. Ms. Mason stated that after approximately one month of living at the facility, she noticed Resident B was having difficulty walking so she obtained physical therapy for him. Ms. Mason stated that

after his physical therapy appointment, he had a follow up appointment with his primary physician in April 2022 which is when Resident B's physician noticed he was not receiving Carbidopa-Levodopa based on the medication list provided by the facility at that time. Ms. Mason stated Resident B began receiving the medication at that time.

I reviewed Resident A's *Physician Report*, dated 1/10/2022, provided by Ms. Mason. Under a section titled *Regular Medications*, the report listed several medications including Carbidopa-Levodopa.

I reviewed Resident A's MAR for April 2022 which indicated Resident B began receiving the Carbidopa-Levodopa on 4/22/2022.

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.
For Reference: R 325.1901	**Definitions**
	(14) "Medication management" means assistance with the administration of a resident's medication as prescribed by a licensed health care professional.
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.**

ANALYSIS:	The complaint alleged Resident B went several months, between his admission date in February 2022 and April 2022, without being administered his prescribed Parkinson's medication. The investigation revealed that Resident B did not receive this medication for the stated time frame. While Ms. Mason reported the missed medication was due to the pharmacy not sending the order or physical medication to the facility, she also reported the facility was provided a physician's report for Resident B prior to his admission which listed the missing medication. Ms. Mason stated the medication list provided in that report was not reviewed along against the orders received from the pharmacy to ensure each necessary medication was received as it was not the facilities common practice at the time. Because the facility had the necessary documentation available to them at the time Resident B was admitted to the facility to ensure he received all his medications and did not do so, the allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon received of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

9/12/2022

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Aaron Clum Date
Licensing Staff

Approved By:

09/26/2022

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