GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 28, 2022

Trina Watson
Waterford Oaks Senior Care Inc.
6474 Oak Valley Rd.
Waterford, MI 48237

RE: License #: AL630337056
Investigation #: 2023A0611003
Waterford Oaks Senior Care, Inc. West

Dear Ms. Watson:

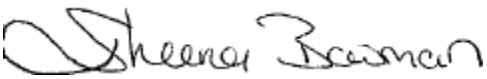
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



Sheena Bowman, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd, Suite 9-100
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630337056
Investigation #:	2023A0611003
Complaint Receipt Date:	10/24/2022
Investigation Initiation Date:	10/25/2022
Report Due Date:	12/23/2022
Licensee Name:	Waterford Oaks Senior Care Inc.
Licensee Address:	3385 Pontiac Lake Road Waterford, MI 48328
Licensee Telephone #:	(248) 681-4788
Administrator:	Trina Watson
Licensee Designee:	Trina Watson
Name of Facility:	Waterford Oaks Senior Care, Inc. West
Facility Address:	3387 Pontiac Lake Road Waterford, MI 48328
Facility Telephone #:	(248) 682-6788
Original Issuance Date:	05/14/2013
License Status:	REGULAR
Effective Date:	01/09/2022
Expiration Date:	01/08/2024
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A had a fall, and her son was not notified right away. When the son spoke to the facility, he was informed that Resident A fell on 08/01/22 and he was notified on 08/04/22 that Resident A had pain. The facility brought in a portable X-ray machine and saw Resident A's hip was fractured. Resident A's hip was replaced at the hospital.	Yes

III. METHODOLOGY

10/24/2022	Special Investigation Intake 2023A0611003
10/25/2022	Special Investigation Initiated - On Site I completed an unannounced onsite. I interviewed the licensee designee, Trina Watson and the home manager Fritzie Vader. I also spoke to the executive director, Lisa Perreault. I obtained copies of Resident A's incident reports, resident register, and a request for an X-ray for Resident A.
10/26/2022	Contact - Telephone call made I made a telephone call to Resident A's son. The allegations were discussed.
10/26/2022	Contact - Telephone call made I made a telephone call to the administrator, Ashley Liskey at Pine Tree Place. The allegations were discussed.
10/26/2022	Contact – Document Received I received a copy of Resident A's X-ray results.
10/26/2022	Contact - Telephone call made I made a telephone call to staff member, Loraine Caldwell. The allegations were discussed.
10/26/2022	Contact - Telephone call made I left a voice message for staff member, Jessica Hang requesting a call back.
10/26/2022	Contact - Telephone call received I received a return phone call from former staff member, Jessica Hang. The allegations were discussed.

10/26/2022	Exit Conference I completed an exit conference with the licensee designee, Trina Watson via telephone.
10/28/2022	APS Referral An Adult Protective Services (APS) referral was made.

ALLEGATION:

Resident A had a fall, and her son was not notified right away. When the son spoke to the facility, he was informed that Resident A fell on 08/01/22 and he was notified on 08/04/22 that Resident A had pain. The facility brought in a portable X-ray machine and saw that Resident A hip was fractured. Resident A's hip was replaced at the hospital.

INVESTIGATION:

On 10/25/22, I received the abovementioned allegations. The specific allegations are: Resident A had a fall, and her son was not notified right away. When the son spoke to the facility, he was informed that Resident A fell on 08/01/22 and he was notified on 08/04/22 that Resident A had pain. The facility brought in a portable X-ray machine and saw that Resident A's hip was fractured. Resident A's hip was replaced at the hospital. Resident A was in the hospital for 10 days and then sent to a rehab. She was at the rehab for almost 2 weeks and released and taken to a different AFC home because they felt she wasn't safe at Waterford Oaks Senior Care. She went to this other facility for about a month, and she passed away. It's believed that Waterford Oaks Senior Care, Inc West was negligent on their part for letting this happen and is the reason Resident A had such a sudden death.

On 10/25/22, I completed an unannounced onsite. I interviewed the home manager Fritzie Vader and the licensee designee Trina Watson. I also spoke to the executive director, Lisa Perreault. I obtained copies of Resident A's incident reports, the resident register, and a request for an X-ray for Resident A.

On 10/25/22, I interviewed the home manager, Fritzie Vader. Regarding the allegations, Ms. Vader stated Resident A fell on 08/01/22. Resident A did not complain of any pain until 08/04/22. On 08/04/22, Resident A complained that her hip was hurting. Ms. Vader contacted Resident A's son around 10:20am. Resident A's son was informed about Resident A's hip pain, and he was informed that she needed to go to the hospital. Resident A's son was asked if he wanted to transport Resident A to the hospital and; his response was to obtain a mobile X-ray at the AFC group home.

Ms. Vader stated she called Resident A's son again around 4:00pm. Ms. Vader informed Resident A's son that Resident A was still in pain as she could not bear weight. Resident A's son still wanted an X-ray to be completed. Ms. Vader informed

Resident A's son that they were still waiting for an X-ray to be completed. Ms. Vader stated Resident A did not appear to be in pain, but she could not stand up. At an unknown time, staff member, Loraine Caldwell contacted Resident A's son to inform him that Resident A was miserable as she was still in pain and needed to go to the hospital. Resident A's son stated he could not take her to the hospital because he was positive for COVID-19. Resident A's son stated he will send his sister to the AFC group home.

Ms. Vader stated Resident A's daughter arrived to the AFC group home around 8:00pm. Resident A's daughter advised the staff to give Resident A a Tylenol. Resident A's daughter said Resident A does not look like she is in pain. Ms. Vader stated the mobile X-ray arrived around 10:00pm. The results from the X-ray indicated that Resident A had a fractured hip. Resident A was then admitted into St. Joseph hospital. Resident A had surgery on her hip. The AFC group home did not have a copy of the X-ray results. Ms. Vader is uncertain as to how long Resident A was in the hospital. Following Resident A's discharge from the hospital she was sent to a rehab facility. Ms. Vader does not know how long Resident A was at the rehab facility nor the name of the rehab facility.

Ms. Vader stated she had a care conference with Resident A's son and daughter. Ms. Vader does not remember the date of the care conference. Resident A's son reported during the care conference that Resident A was not doing well and; he was considering putting her into hospice as her health was declining. Resident A's son stated he could not afford to return Resident A back to the AFC group home. Resident A's son was asked to provide a 30-day notice. Resident A's son stated he did not want to make a decision regarding whether or not Resident A will be returning to the AFC group home. Ms. Vader stated she and the licensee designee, Trina Watson had a second meeting with Resident A's son and daughter. At this meeting, Resident A's son decided to send Resident A back to an AFC group home she previously lived at.

On 10/25/22, I interviewed the licensee designee, Trina Watson. Regarding the allegations, Ms. Watson confirmed that Resident A was in the hospital for about 10 days and then was sent to a rehab facility. Ms. Watson does not know the name of the rehab facility. Ms. Watson stated the second meeting with Resident A's son and daughter was held either at the end of August 2022 or at the beginning of September 2022. During the meeting, Resident A's son decided to move Resident A back to an AFC group home called Pine Tree because the AFC group home (Waterford Oaks Senior Care, Inc) was too expensive. Resident A resided at Pine Tree prior to being admitted into the AFC group home (Waterford Oaks Senior Care, Inc). Ms. Watson stated when Resident A was admitted into the AFC group home, Resident A's son said that he discharged Resident A from Pine Tree because she was not safe there as there were incidents of her falling. Ms. Watson stated Resident A's monthly cost was increased as her level of care increased. Ms. Watson asked for a 30-day notice, but she never received one. Ms. Watson stated a fee was applied to Resident A's account as a 30-day notice was not provided. During the meeting, Ms. Watson agreed to a payment arrangement with Resident A's son; which was to split the balance into two payments. Ms. Watson stated she received the first payment, but she has not received the second payment. Ms.

Watson stated the same day of the second meeting, Resident A's son and daughter removed all of Resident A's belongings from the AFC group home.

Ms. Watson stated she sent an invoice to Resident A's son regarding the remaining balance on 10/21/22. Ms. Watson is able to see that Resident A viewed the invoice on 10/21/22 and again on 10/24/22. The AFC group home does not have any hospital records because Resident A never returned to the AFC group home when she was discharged from the hospital.

On 10/25/22, Ms. Perreault provided copies of the resident register, incident reports, and a copy of the X-ray order. Ms. Perrault was recently hired at the AFC group home. I observed the resident register. According to the resident register, Resident A's discharge date is 09/01/22. Ms. Watson stated the discharge date must be the same day as the second meeting and the day Resident A's son and daughter removed Resident A's belongings from the AFC group home.

On 10/25/22, I observed two incident reports for Resident A dated 08/01/22 and 08/04/22. The incident report dated 08/01/22 at 11:30pm indicates that upon shift change check, Resident A was found on the floor in her bathroom. Resident A was checked for injuries and placed back into bed. The incident report indicates that Resident A's son was notified on 08/02/22 at 9:00 am.

The incident report dated 08/04/22 at 10:15pm indicates that Resident A had been complaining of hip pain all day. Resident A was unable to bear weight. The family was asked to send her to the ER. The family requested an X-ray first. The X-ray results indicated that Resident A had a fractured hip. Resident A fell on 08/01/22 but she did not complain of any pain until 08/04/22. Resident A was taken to St. Joseph hospital.

On 10/25/22, I observed a request for a portable X-ray for Resident A due to being in pain from a fall. The request for the portable X-ray was made to Medical Diagnostic Services, Inc on 08/04/22.

On 10/26/22, I made a telephone call to Resident A's son. Resident A's son confirmed Resident A's full name. Regarding the allegations, Resident A's son confirmed that he was notified by the AFC group home the following morning (08/02/22) after Resident A fell on 08/01/22. Resident A's son agreed that it was reasonable for the AFC group home to notify him the following morning of the incident given the incident took place at 11:30pm. Resident A's son stated when he was notified about the fall, he was told that Resident A was not hurt. The AFC group home contacted Resident A's son on 08/04/22 regarding Resident A complaining of hip pain. Resident A's son stated he does not remember the name of the staff member that called him. Resident A's son stated the AFC group home suggested that Resident A receive an X-ray and he agreed. The AFC group home did not mention taking Resident A to the hospital.

Resident A's son stated he received a second call from staff member Jessica Hang. Resident A's son stated Jessica Hang is very responsible and she cares for the

residents. Resident A's son was informed that Resident A's X-ray results indicated that Resident A had a fractured hip. Resident A's son was informed that Resident A needed to go to the hospital. Resident A had surgery as her hip needed to be replaced. Following Resident A's discharge from the hospital she was sent to Canterbury on the Lake rehab facility. Resident A was at the Canterbury on the Lake for at least 10 days. Resident A was then admitted to Pine Tree, which is an AFC group home in Clarkston, MI. Resident A was admitted into Pine Tree on 08/30/22 and she passed away on 09/30/22 at the age of 93 years old. Resident A was placed in hospice soon after her admission into Pine Tree due to her Dementia.

Resident A's son stated while Resident A was in the hospital she had stopped eating as she had problems with swallowing. Resident A would only take small amounts of liquids. This problem increased when Resident A went to Canterbury on the Lake. Resident A's son stated Resident A's death certificate indicates her cause of death as natural causes. Resident A's death certificate also indicates that Resident A had congested heart failure, hypertensive heart disease, and Alzheimers. Resident A stated he believes that when Resident A fractured her hip, she no longer had the ability to eat which lead to her death. Resident A's son stated Resident A's monthly fee increased at the AFC group home (Waterford Oaks Senior Care Inc.) this year due to her level of care increasing. Resident A could no longer do anything for herself including dressing herself.

On 10/26/22, I made a telephone call to the administrator, Ashley Liskey at Pine Tree Place. The allegations were discussed. Ms. Liskey stated when Resident A was re-admitted into Pine Tree Place, she was lethargic, and she had a UTI. Resident A's UTI was being treated but it was not improving. Resident A was also bed bound. Resident A was sent to the hospital approximately within the first week of her admission. Resident A was in the hospital for about 5-6 days. When Resident A returned to Pine Tree Place, she was enrolled in hospice per the recommendation from the hospital. Ms. Liskey stated normally when a resident is in hospice, the cause of death is not documented.

Ms. Liskey stated based on her experience when someone is elderly and suffers a fall and a subsequent surgery it takes a toll on the body and makes it difficult for the person to bounce back. Resident A was initially discharged from Pine Tree Place in May 2021 because she was receiving VA benefits and Pine Tree Place does not accept VA benefits. Resident A was re-admitted to Pine Tree Place because the family was not happy with the care, she was receiving at Waterford Oaks Senior Care Inc. The family contacted Ms. Liskey about two weeks before Resident A fell pertaining to bringing her back to Pine Tree Place.

Ms. Liskey provided a copy of the Oakland County Medical Examiner report via text message. According to the Oakland County Medical Examiner report, Resident A was last known alive on 09/30/22 at 11:49pm and; she was found dead on 10/01/22 at 12:00am. There is nothing listed for the cause of death.

On 10/26/22, I received a copy of Resident A's X-ray results. According to the X-ray results, the examination revealed slightly impacted subcapital fracture of the left femoral neck with slight superior displacement of the fractured femoral neck and varus deformity. There was also some demineralization and degenerative arthritic changes. Resident A's impression of her left hip was impacted subcapital fracture with varus deformity. The X-ray results was electronically signed by Emmanuel Milroy MD on 08/04/22 at 9:59pm.

On 10/26/22, I made a telephone call to staff member, Loraine Caldwell. Regarding the allegations, Ms. Caldwell stated Resident A was complaining that her leg was hurting, and she was having trouble standing. Ms. Caldwell contacted Ms. Vader and Ms. Vader asked her if she had received her X-ray yet. Ms. Caldwell informed Ms. Vader that Resident A had not received an X-ray as of yet. Ms. Caldwell was advised to contact Resident A's daughter. Resident A's daughter arrived to the AFC group home. Ms. Caldwell stated Resident A was given a Tylenol. Ms. Caldwell stated at that time, Resident A was not complaining of pain. Resident A's daughter told Ms. Caldwell to wait for the results of the X-ray but if her condition worsens send her to the hospital. Ms. Caldwell stated when Resident A received an X-ray it was discovered that her hip was fractured therefore; she was sent to the hospital.

On 10/26/22, I received a return phone call from former staff member, Jessica Hang. Regarding the allegations, Ms. Hang stated on 08/04/22 she noticed that Resident A was not acting like herself as she couldn't transfer, she couldn't move her left leg, nor could she raise her arm. Ms. Hang was informed by staff that Resident A fell on 08/01/22. Ms. Hang informed Ms. Vader between 8:30am and 9:00am that Resident A needs an X-ray. Ms. Vader obtained an order for an X-ray. Ms. Hang contacted Resident A's son and informed him that Resident A was acting out of character and that she fell on 08/01/22. Resident A's son stated that he was not notified on 08/01/22 regarding Resident A falling. Resident A's son stated if they needed anything to contact his sister as he has COVID-19. Ms. Hang stated Ms. Vader looked at the incident report and confirmed that Resident A's son was notified concerning the fall.

On 10/26/22, I completed an exit conference with the licensee designee, Trina Watson. Ms. Watson was informed that a corrective action plan will be required based on the fact the AFC group home did not seek immediate medical attention when Resident A complained of hip pain. Ms. Watson stated the reason why the home manager waited 12 hours to seek medical attention for Resident A is because she was waiting for the family to take Resident A to the hospital. However, the family chose to wait for an X-ray. Ms. Watson stated it is out of the AFC group home control as to how long it took the independent contractor to arrive to the AFC group home to complete an X-ray.

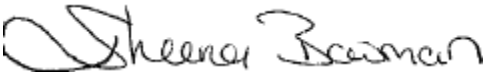
APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Based on my findings and the information gathered, there is sufficient information to substantiate the allegation as Resident A did not receive immediate medical care on 08/04/22, when she complained to staff that she was in pain and was observed to have a sudden adverse change in her physical condition as she could not bear weight. The incident report dated 08/04/22 indicates that Resident A had been complaining of hip pain all day and she was unable to bear weight. An order for a portable X-ray was made around 10:00am on 08/04/22. However, Resident A did not receive an X-ray until around 10:00pm. Therefore, Resident A remained in pain for approximately 12 hours until the results from her X-ray indicated that she had a fractured hip. At that time, Resident A was then sent to the hospital where she received a hip replacement.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(a) The death of a resident.** **(b) Any accident or illness that requires hospitalization.** **(c) Incidents that involve any of the following:** **(i) Displays of serious hostility.** **(ii) Hospitalization.** **(iii) Attempts at self-inflicted harm or harm to others.**

ANALYSIS:	Based on my findings and the information gathered, there is not sufficient information to confirm the allegation as Resident A's son confirmed that he was notified about Resident A falling on 08/01/22 the following morning on 08/02/22. The incident report dated 08/01/22, indicates that Resident A's son was notified about Resident A falling on 08/02/22 at 9:00 am.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

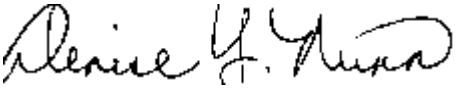
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



10/28/22

Sheena Bowman — Date
Licensing Consultant

Approved By:



10/28/2022

Denise Y. Nunn — Date
Area Manager