



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 6, 2023

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

RE: License #: AH630338700
Investigation #: 2023A1027019
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 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, 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 #:	AH630338700
Investigation #:	2023A1027019
Complaint Receipt Date:	11/28/2022
Investigation Initiation Date:	11/29/2022
Report Due Date:	1/28/2023
Licensee Name:	Pomkal Rochester Assisted, LLC
Licensee Address:	Suite 130 5480 Corporate Drive Troy, MI 48098
Licensee Telephone #:	(248) 354-7200
Administrator:	Fatou Ceesay
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:	08/07/2022
Expiration Date:	08/06/2023
Capacity:	84
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The facility was understaffed.	No
Residents had not received their medications as prescribed.	Yes
Residents were neglected and had falls daily.	No
The facility lacked an executive director. Staff were sleeping, smoking, and drinking on the job.	No
Additional Findings	No

III. METHODOLOGY

11/28/2022	Special Investigation Intake 2023A1027019
11/29/2022	Special Investigation Initiated - Letter Email sent to AR Manda Ayoub requesting a resident census and employee list
11/29/2022	Contact - Document Received Emails received from Ms. Ayoub with requested documentation
12/21/2022	Inspection Completed On-site
01/06/2023	Inspection Completed-BCAL Sub. Compliance
01/26/2023	Exit Conference Conducted by telephone with authorized representative Manda Ayoub

ALLEGATION:

The facility was understaffed.

INVESTIGATION:

On 11/28/2022, the department received a complaint through the online complaint system which read the facility was understaffed. The complaint read most residents required two-person assist. The complaint read on night shift there was one medication technician and two caregivers, one in memory care and one in assisted living, assigned.

On 12/21/2022, I conducted an on-site inspection at the facility. I interviewed Employee #1 who stated the facility was supplementing with agency staff to assist with resident care. Employee #1 stated the facility tried to overstaff on holidays and weekends in anticipation that some staff would call off duty. Employee #1 stated staff worked three shifts: 7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM, 11:00 PM to 7:00 AM. Employee #1 stated the medication technicians arrived to each shift 15 minutes prior to complete a shift report and conduct the narcotic counting with the previous staff person on duty. Employee #1 stated the day and afternoon shifts were usually staffed with two medication technicians, two caregivers in memory care and four caregivers in the assisted living. Employee #1 stated on nights there was one medication technician on duty, as well as two caregivers in memory care and the assisted living. Employee #1 provided a resident census in which she identified there were three assisted living residents who required two-person assist, one of which required a Hoyer lift for transfers. Employee #1 stated two staff were required to utilize a Hoyer lift. Employee #1 stated there was one resident in the memory care unit who required a Hoyer lift.

While on-site, I interviewed Employee #2 whose statements were consistent with Employee #1.

While on-site, I reviewed the resident roster dated 12/19/2022 which read there were 33 assisted living and ten memory care residents.

While on-site, I reviewed the daily staff schedules dated from 11/2/2022 through 12/14/2022 which read consistent with statements from Employee #1.

While on-site, I observed three staff in the assisted living escorting residents to lunch and two staff assisting residents in the memory care unit.

I reviewed Resident C and D's service plan which read consistent with statements from Employee #1.

APPLICABLE RULE	
R 325.1931	Employees; general provisions.
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.

ANALYSIS:	Staff attestations and review of facility documentation revealed there were four residents who required two-person assistance for care. Review of staff schedules revealed there were minimally two staff on duty to meet the needs consistent with resident's service plans. Based on this information, this allegation was unsubstantiated.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Residents were neglected and had falls daily.

INVESTIGATION:

On 11/28/2022, the department received a complaint through the online complaint system which read residents were neglected and fell daily.

On 12/21/2022, I conducted an on-site inspection at the facility. I interviewed Employee #1 who stated some residents received hospice services in which they received additional assistance with bathing. Employee #1 stated staff documented resident's bathing on the facility's shower sheets. Employee #1 stated residents had falls in which measures were implemented to try to prevent them. Employee #1 stated the facility's fall protocol for staff was to assess and obtain the resident's vital signs, call Employee #1, implement interventions and/or send the resident to the hospital, notify the resident's authorized representative, notify the resident's physician, complete an incident report, then submit the report to the department as appropriate.

While on-site, I interviewed Visitor #1 who stated resident's care was okay. Visitor #1 stated she had not received complaints from residents or their family regarding their care.

While on-site, I interviewed Resident A who stated, "the staff are wonderful."

While on-site, I interviewed Resident B who stated, "care is good."

While on-site, I observed 19 assisted living residents during lunch, who appeared groomed and dressed in clean clothing. I observed six memory care residents who appeared groomed and dressed in clean clothing.

While on-site, I reviewed the facility's incident report binder with reports dated 11/2/2022 through 12/14/2022, in which there had not been a fall from 12/14/2022 to 12/21/2022. The reports read there were 17 falls in November 2022 and eight falls in December 2022 thus far.

I reviewed Resident C, D, E, and F's service plans in which read consistent with statements from Employee #1 and with the resident's December 2022 shower sheets.

APPLICABLE RULE	
R 325.1931	Employees; general provisions.
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	Staff attestations, review of documentation and the Department's facility file revealed residents had falls in which the facility implemented actions to prevent recurrence, notified the resident's authorized representative and healthcare professional as well as the department appropriately. Additionally, resident interviews along with review shower sheets revealed care was provided consistent with their service plans. Based on this information, this allegation was not substantiated.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Residents had not received their medications as prescribed.

INVESTIGATION:

On 11/28/2022, the department received a complaint through the online complaint system which read residents had not received their medications.

On 12/21/2022, I conducted an on-site inspection at the facility. I interviewed Employee #1 who stated residents had received their medications as prescribed, however there were third shift staff members terminated one month prior for not passing medications.

While on-site, I interviewed Employee #2 who stated she passed medications as prescribed. Employee #2 stated staff were trained to document reasons if a medication was not administered such as if the resident refused or was sleeping.

While on-site, I interviewed Resident B who stated she received her medications as prescribed.

I reviewed November and December 2022 medication administration records (MARs) for Residents C, D, E and F.

Resident C's MAR read medication Levetiracetam was left blank on 11/4/2022 for the 2100 [9:00] dose.

Resident D's MAR read one or more doses of medications were left blank on the following dates 11/11/2022, 11/12/2022, 11/14/2022, 11/15/2022, 11/18/2022, 11/22/2022, 11/26/2022, 11/27/2022, 12/4/2022, 12/9/2022, 12/10/2022, 12/12/2022, and 12/15/2022.

Resident E's MAR read staff initialed her medications as prescribed.

Resident F's MAR read medication Divalproex Sodium was left blank on 12/5/2022 for the 2100 [9:00] dose.

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 medication administration records for four residents revealed medications were not always initialed as administered or lacked documentation to justify the missed doses. Based on this information, this violation was substantiated.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

The facility lacked an executive director. Staff were sleeping, smoking, and drinking on the job, as well as had complaints against them.

INVESTIGATION:

On 11/28/2022, the department received a complaint through the online complaint system which read the facility did not have an executive director. The complaint read facility staff were sleeping, smoking, and drinking on the job. Additionally, the complaint read Employees #3 and #4 have had resident and family complaints against them.

On 12/21/2022, I conducted an on-site inspection at the facility. I interviewed the current administrator Teresa Harnos who stated that the new administrator Fatou Ceesay had started her position that day. Ms. Harnos stated there were three employees terminated one month ago for sleeping in the theater room and not passing medications on their shifts. Ms. Harnos stated Employee #4 had “a good rapport” with residents and their families. Ms. Harnos stated the substance abuse and testing drug policy was in the employee handbook in which all staff received and signed upon hire. Ms. Harnos stated the facility could implement drug and alcohol testing as per the policy. Ms. Harnos stated the smoking policy was also located in the employee handbook. Ms. Harnos stated smoking was not allowed on the facility’s campus except staff could smoke in their cars in which she was not notified of someone violating the policy.

While on-site, I interviewed Employee #1 who stated Employee #3 was immediately terminated once she received notification and evidence that she was sleeping during her shift. Employee #1 stated Employee #4 was currently on medical leave in which there were no concerns from residents, their families, or other staff regarding her care nor disciplinary actions in her employee file. Employee #1 stated residents had falls. Employee #1 stated the facility’s protocol for a fall was for the staff to obtain the resident’s vital signs, call her, implement interventions and/or send the resident to the hospital, notify the resident’s authorized representative, notify the resident’s physician, complete an incident report, then submit the report to the department as appropriate.

While on-site, I reviewed the employee handbook, Appendix C, *Substance Abuse & Testing Policy* in which staff were to acknowledge receipt and consent to the terms. The policy read consistent with statements from Ms. Harnos. Additionally, I reviewed the Smoking policy which read in part “*Smoking is not permitted inside or outside of the facility unless the employee smokes in their own personal vehicle in the parking lot.*”

While on-site, I reviewed the facility’s incident report binder with incident reports dated 11/2/2022 through 12/14/2022. Employee #1 stated there had not been a fall from 12/14/2022 to 12/21/2022 the date of the inspection. The reports read there were 17 falls in November 2022 and eight falls in December 2022 thus far.

I reviewed the facility’s file which read Ms. Harnos was appointed as the administrator at the time of inspection. The file read the authorized representative appointed Ms. Ceesay as the administrator on 12/21/2022.

APPLICABLE RULE	
R 325.1921	Governing bodies, administrators, and supervisors.
	(1) The owner, operator, and governing body of a home shall do all of the following:

	<p>(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.</p> <p>(d) Appoint a competent administrator who is responsible for operating the home in accordance with the established policies of the home.</p>
ANALYSIS:	Review of the Department's facility file revealed an administrator was appointed. Review of the employee handbook revealed there was policy for smoking and drinking in which would be followed if required. Additionally, staff attestations revealed when staff had not completed their duties as outlined in their job description, they were terminated. Based on the above information, these allegations were not substantiated.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

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



01/06/2023

Jessica Rogers
Licensing Staff

Date

Approved By:



01/25/2023

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

Date