GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 8, 2023

Steven Tyshka
Waltonwood at Lakeside
14650 Lakeside Circle
Sterling Heights, MI 48313

RE: License #: AH500285320
Investigation #: 2023A1027035
Waltonwood at Lakeside

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.
- 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 #:	AH500285320
Investigation #:	2023A1027035
Complaint Receipt Date:	01/26/2023
Investigation Initiation Date:	01/30/2023
Report Due Date:	03/25/2023
Licensee Name:	Waltonwood At Lakeside I, L.L.C.
Licensee Address:	Suite #200 7125 Orchard Lake Rd. West Bloomfield, MI 48325
Licensee Telephone #:	(248) 865-1600
Administrator:	Gina Steigerwald
Authorized Representative/	Steven Tyshka
Name of Facility:	Waltonwood at Lakeside
Facility Address:	14650 Lakeside Circle Sterling Heights, MI 48313
Facility Telephone #:	(586) 532-7601
Original Issuance Date:	07/16/2007
License Status:	REGULAR
Effective Date:	01/14/2022
Expiration Date:	01/13/2023
Capacity:	90
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A and B lacked protection and care.	No
The facility was dirty.	No
Additional Findings	Yes

III. METHODOLOGY

01/26/2023	Special Investigation Intake 2023A1027035
01/30/2023	Special Investigation Initiated - Letter Email sent to APS worker informing her an investigation was opened pertaining to the allegations submitted to the Department
03/01/2023	Inspection Completed On-site Administrator Ms. Conway to provide follow up documentation by email
03/06/2023	Contact - Document Received Email received from Ms. Conway with documentation requested at on-site inspection
03/07/2023	Inspection Completed-BCAL Sub. Compliance
03/14/2023	Exit Conference Conducted by voicemail with authorized representative Mr. Tyshka

ALLEGATION:

Resident A and B lacked protection and care.

INVESTIGATION:

On 1/26/2023, the department received a complaint forwarded from Adult Protective Services (APS) which read Resident A had seven falls since January 2023 and some falls required hospital transport. The complaint read Resident B had five falls. The complaint alleged Resident A and B had not received adequate care.

On 3/1/2023, I conducted an on-site inspection at the facility. I interviewed Employee #1 who stated Resident A and B had admitted to the facility in the assisted living in

December 2022. Employee #1 stated Resident A admitted to the facility from a skilled rehabilitation facility in which he falls at home prior to going to the rehabilitation facility. Employee #1 stated Resident B admitted directly from home. Employee #1 stated Resident A and B were married and both had dementia. Employee #1 stated Resident B would try to assist Resident A instead of asking staff for assistance. Employee #1 stated both Resident A and B had several falls in January 2023 in which Resident A was transported to the hospital for evaluation but did not stay overnight. Employee #1 stated Resident A and B's daughters were their emergency contacts and authorized representatives. Employee #1 stated the facility had a meeting with Resident A and B's daughters in which it was agreed upon that both residents would benefit from transferring to the facility's memory care in separate rooms. Employee #1 stated Resident A and B were adjusting well to the memory care unit, however Resident B was anxious when she is not able to visit with Resident A.

While on-site, I interviewed Employee #2 whose statements were consistent with Employee #1. Employee #2 stated Resident A was a one person assist for personal care and required more assistance than Resident B. Employee #2 stated Resident B required a standby assist for personal care with cueing and reminding. Employee #2 stated Resident B would get anxious when she was not with Resident A however staff provided redirection and encouraged her to participate in activities in which helped relieve her anxiety. Additionally, Employee #2 stated all memory care residents were one-hour checks and received showers twice weekly. Employee #2 stated the memory care unit had activities throughout the day as well as meals in the common area in which most residents remained in that area.

While on-site, I observed Resident A in his apartment sleeping on top of his blankets on his bed in which he appeared well groomed and dressed in clean clothing.

While on-site, I observed Resident B in her wheelchair in her apartment in which she appeared well groomed and dressed in clean clothing. Resident A stated she could not remember what she was doing.

While on-site, I observed the third-floor shower schedule which read Resident A had received showers in the afternoon every Sunday and Wednesday. The schedule read Resident B received showers in the mornings every Sunday and Thursday.

I reviewed Resident A and B's face sheets which read consistent with statements from Employee #1. Resident A and B's face sheets read they admitted to the facility 12/21/2022.

I reviewed Resident A's service plan updated on 1/23/2023 which read in part he had history of occasional disorientation to person, place, time, or situation as well as occasional difficulty remembering information in which he required reminding. The plan read in part Resident A had 12-15 falls since January 2022 in which he was

unable to ambulate without assistance. The plan read in part he required assistance with all activities of daily living.

I reviewed Resident B's service plan updated on 2/15/2023 which read in part she had history of occasional disorientation to person, place, time, or situation as well as occasional difficulty remembering information in which she required reminding. The plan read in part she had occasional anxiety. The plan read in part Resident B was a fall risk due to her forgetfulness using her walker. The plan read in part she required stand by assistance with reminding for her activities of daily living.

I reviewed Resident A and B's progress notes which read in part a care conference was held with their daughters on 1/27/2023 which discussed moving both residents into memory care in separate rooms. The notes read in part Resident A and B's daughters would let the facility know their decision on 1/30/2023. The notes read in part both Resident A and B moved into the memory care unit on 2/1/2023 into separate rooms.

I reviewed an incident report for Resident A dated 12/27/2022 for a fall in the bathroom. The report read Resident A had "a knot the size of a nickel on the crown of the head that was bleeding." The report read Resident A was sent to the hospital for evaluation. The report read it was emailed to the Department on 12/29/2022.

I reviewed the facility's incident report log for Resident A which read in part he had falls with injury on 1/18/2023, twice on 1/25/2023, 1/28/2023, and 1/30/2023. The log read Resident A was observed on the floor on 1/26/2023 and no injury noted.

I reviewed Resident B's incident report log which read in part she had fallen on 1/10/2023 and no injury noted.

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:	Review of Resident A and B's medical records revealed both residents had moved into the facility in December 2022 in which Resident A had a history of falls. Resident A's medical records revealed he required staff assistance for his activities of daily living and had six falls in January 2023. Review of Resident B's medical records revealed she required stand by assistance for her activities of daily living and had one fall in January 2023. Review of Resident A and B's medical records revealed the facility worked in collaboration with their licensed healthcare professional and daughters to transition them from assisted living to memory care. Observations and staff attestations revealed Resident A and B received care consistent with their service plans. Based on this information, there was lack of evidence to support Resident A and B lacked protection and care.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility was dirty.

INVESTIGATION:

On 1/26/2023, the department received a complaint forwarded from Adult Protective Services (APS) which alleged the facility was dirty.

On 3/1/2023, I conducted an on-site inspection at the facility. I interviewed Employee #1 who stated residents' apartments were cleaned once weekly by housekeeping staff, then picked up daily by caregivers. Additionally, Employee #1 stated housekeeping staff cleaned the common areas daily as well as the memory care.

While on-site, I interviewed Employee #3 who stated there were three housekeepers on duty Monday through Friday. Employee #3 stated the housekeepers worked staggered shifts from 6:00 AM to 2:30 PM, 7:00 AM to 3:30 PM and 8:00 AM to 4:30 PM. Employee #3 stated the housekeepers rotated working one or two days on the weekends. Employee #3 stated the housekeepers all shared the responsibility of cleaning the common areas daily then their assigned resident apartments for that day. Employee #3 stated each housekeeper cleaned four to six apartments daily in which they vacuumed, dusted, wiped down bathrooms and kitchenettes, as well as removed any soiled laundry. Employee #3 stated there was person assigned to complete laundry daily.

While on-site, I observed two housekeepers with their cleaning carts. I observed facility's entryway, assisted living dining area, common areas throughout the facility,

the first-floor public restroom, the hallways on all three floors, including the memory care area along with three memory care resident rooms, and three assisted living resident rooms which appeared clean.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	Staff attestations and observations revealed the facility maintained housekeeping staff who ensured the facility was maintained, thus there was lack of evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of the facility's incident report log for Resident A read he had falls with injury in January 2023. The report read he fell on 1/18/2023 in which he sustained a skin tear on his left arm and first aid was provided. The report read he fell twice on 1/25/2023 in which he sustained a right finger skin tear and cut to his head requiring direct pressure to be applied. The report read he was observed on the floor on 1/26/2023 and no injury noted. The report read he fell on 1/28/2023 in which he sustained a laceration to his head. The report read he fell on 1/30/2023 and sustained a right arm skin tear.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(2) 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.
For Reference: R 325.1901	**Definitions.**
	(17) "Reportable incident/accident" means an intentional or unintentional event in which a resident suffers harm or is at

	risk of more than minimal harm, such as, but not limited to, abuse, neglect, exploitation, or unnatural death.
ANALYSIS:	Review of the Department's facility file revealed one fall with injury on 12/27/2022 occurred and was reported for Resident A which was consistent with the one incident report received from the facility. Review of facility's incident report log for Resident A revealed he had five falls with injuries in January 2023 and one without injury. Thus, Resident A was at risk for more than minimal harm in which it would be expected to be reported to the Department. Based on this information, a violation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

03/09/2023

Jessica Rogers Date
Licensing Staff

Approved By:

03/13/2023

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