GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 19, 2023

Eric Simcox
Oakleigh Macomb Operations, LLC
8025 Forsyth Blvd.
St. Louis, MO 63105

RE: License #: AH500394648
Investigation #: 2023A1027093
Oakleigh of Macomb

Dear Licensee:

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 877-458-2757.

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 #:	2023A1027093
Complaint Receipt Date:	09/13/2023
Investigation Initiation Date:	09/15/2023
Report Due Date:	11/12/2023
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:	Eric Simcox
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:	08/07/2023
Expiration Date:	08/06/2024
Capacity:	101
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Residents were mentally abused.	No
Residents lacked care.	No
Resident E was injured by staff. Resident F was discharged. Staff were intoxicated and did drugs. Staff forged documentation. There were medication errors.	Yes
Resident C had feces on her wall.	No
Resident A had ants crawling on him.	No
Additional Findings	No

On 9/13/2023, allegations were submitted to the Department anonymously which read there were no staff working on 8/21/2023; however, similar allegations were investigated in Special Investigation Report (SIR) 2023A1019071 in which licensing staff reviewed five weeks of schedules including date 8/21/2023. There was no violation substantiated for staffing in SIR 2023A1019071.

III. METHODOLOGY

09/13/2023	Special Investigation Intake 2023A1027093
09/15/2023	Special Investigation Initiated - Letter Referral emailed to Adult Protective Services
09/15/2023	APS Referral by email
10/05/2023	Inspection Completed On-site
10/19/2023	Inspection Completed-BCAL Sub. Compliance
10/23/2023	Exit Conference Conducted with authorized representative Eric Simcox and Helen Bisbikis by email

ALLEGATION:

Residents were mentally abused.

INVESTIGATION:

On 9/13/2023, allegations were submitted to the Department anonymously which read the executive director abused residents. The allegation read Resident D moved out of the facility due to mental abuse. Due to the anonymous nature of the complaint, I was unable to obtain additional information from the complainant.

On 9/15/2023, the Department referred the allegations by email to Adult Protective Services (APS).

On 10/5/2023, I conducted an on-site inspection at the facility. I interviewed administrator Helen (Eleni) Bisbikis who stated she never mentally abused residents and was an advocate for them. Ms. Bisbikis stated she enjoyed working with the residents and they gave her hugs. Ms. Bisbikis stated Resident D's family sought an alternative living arrangement and she moved out early.

While on-site, I interviewed Employees #2 and #3 who stated they had never observed any staff mentally abuse residents.

While on-site, I interviewed Resident E who stated Ms. Bisbikis and all the staff were all very kind, easy to work with and helpful. Resident E stated, "I plan to stay here until I die."

While on-site, I observed ten memory care residents who positivity interacting with two staff members in which they did not appear to be mentally abused.

I reviewed a hand-written note dated 7/11/2023 and signed by Resident D's authorized representative which read in part that it was informing the facility Resident D's last day there would be 7/17/2023.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(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:	Staff attestations, observation and Resident E's interview revealed there was insufficient evidence to support residents were mentally abused, thus this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents lacked care.

INVESTIGATION:

On 9/13/2023, allegations were submitted to the Department anonymously which read Residents A and B had not received showers. The allegations read Resident C had not received showers or food. Due to the anonymous nature of the complaint, I was unable to obtain additional information from the complainant.

On 9/15/2023, the Department referred the allegations by email to APS.

On 10/5/2023, I conducted an on-site inspection at the facility. I interviewed administrator Ms. Bisbikis who stated residents received care consistent with their service plans. Ms. Bisbikis stated residents received showers twice weekly and as needed. Ms. Bisbikis stated Resident A had a diagnosis of bipolar and schizophrenia in which sometimes he declined care. Ms. Bisbikis stated Resident C had behaviors in which she would become combative and remove her clothing; however, she had recently declined and now received hospice services in which her hospice aide provided showers.

While on-site, I interviewed Employee #1 whose statements were consistent with Ms. Bisbikis. Employee #1 stated there was shower aide who worked five days per week to bathe residents and could provide additional care if necessary. Employee

#1 stated Resident A received showers from his hospice agency aide; however, staff provided them as needed. Employee #1 stated Resident B received showers twice weekly and as needed. Employee #1 stated Resident C was actively passing away on hospice services in which she was bedbound.

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

While on-site, I observed Resident B eating lunch in which he appeared clean and finished his lunch meal. I observed Resident C in her bed, and she appeared clean. Additionally, I observed ten memory care residents who appeared to be well groomed.

I reviewed Residents A, B and C's service plans.

Resident A's service plan dated 6/28/2023 which read in part he dependent for bathing and received hospice services.

Resident B's service plan dated 3/4/2023 which read in part he was minimal physical assist for bathing. I reviewed Resident B's September 2023 shower logs which read consistent with staff interviews and his plan.

Resident C's service plan dated 9/12/2023 which read in part she was dependent for bathing and received hospice services.

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 were consistent with review of medical records and observations; thus, this allegation could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident E was injured by staff. Resident F was discharged. Staff were intoxicated and did drugs. Staff forged documentation. There were medication errors.

INVESTIGATION:

On 9/13/2023, allegations were submitted to the Department anonymously which read staff injured Resident E with a wheelchair and went to the hospital. The allegations read Resident F was discharged. The allegations read Employee #4 was intoxicated in the kitchen. The allegations read the executive director did drugs. The allegations read Employee #1 forged documentation. The allegations read there were medication errors. Due to the anonymous nature of the complaint, I was unable to obtain additional information from the complainant.

On 9/15/2023, the Department referred the allegations by email to APS.

On 10/5/2023, I conducted an on-site inspection at the facility.

I interviewed Ms. Bisbikis who stated Resident E's leg was injured by a staff member unintentionally in which the staff member was re-educated. Ms. Bisbikis stated the facility sought treatment for Resident E immediately, and the wound was healing.

Ms. Bisbikis stated Resident F chose to move to another facility in January 2023.

Ms. Bisbikis stated Employee #4 was terminated for sleeping on the job. Ms. Bisbikis stated Employee #4 was "*really good with the residents*" and had no prior disciplinary actions in her file. Additionally, Ms. Bisbikis stated Employee #4 was not intoxicated nor on drugs.

Ms. Bisbikis stated there were no staff currently employed who were intoxicated or took drugs including herself.

Ms. Bisbikis stated her team monitored when staff entered a medication exemption, which meant that a medication was not given. Ms. Bisbikis stated she maintained a binder with medication exemption logs since the medication exemptions were reviewed daily for errors. Ms. Bisbikis stated the facility maintained a policy and procedure for medication technician training and administration in which if there was a medication error, the staff member was removed from administering medications, re-educated and was required to go through re-training. Additionally, Ms. Bisbikis stated random audits were conducted monthly on the narcotic logbooks.

While on-site, I observed six staff positively interacting with both memory care and assisted living residents in which they did not appear intoxicated nor under the influence of drugs.

While on-site, I observed two medication carts with Employee #1 and reviewed narcotic logbooks. Employee #1 stated staff would count the total number of narcotics, then each resident's narcotic medications at every shift change. Employee

#1 stated the narcotic count was written in the narcotic count logbook in which each staff member would sign it confirming that the count was correct. I reviewed the memory care north and south narcotic count logbooks in which staff did not always sign the narcotic count logbook. For example, the narcotic logbooks were not signed by staff on one or more shifts on the following dates 10/3/2023, 10/2/2023, 9/30/2023, 9/29/2023, 9/25/2023, 9/24/2023, 9/23/2023, 9/21/2023, 9/20/2023, 9/19/2023, 9/16/2023, and 9/15/2023.

While on-site, I interviewed Resident E whose statements were consistent with the allegations. Resident E stated she was sitting next to a resident in a wheelchair and a staff member moved the resident's wheelchair too quickly in which the foot pedal accidentally scraped her leg. Resident E stated she received treatment for the injury and this week was her last nursing visit because her wound was healed.

I reviewed Resident F's 30-day discharge notification addressed to the facility, dated 1/27/2023, and signed by the resident's authorized representative. The notification read in part that it was a formal 30-day notice, and Resident F would be moved out of the facility on or before 2/28/2023.

I reviewed Employee #4's separation notice which read in part her separation date was 8/14/2023. The notice read in part Employee #4 slept for four hours in a resident's room on 8/5/2023.

I reviewed Residents A, B, C and D's service plans which read consistent with staff attestations.

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: **(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:	Although Resident E was unintentionally injured by staff, the facility ensured protection and sought medical services for treatment, as well as home health care for continuation of treatment for her wound until it was healed. Additionally, interview with Resident E revealed no additional complaints regarding her care from staff. The complaint alleged documentation was forged in which it lacked specificity regarding the types of documentation forged, therefore there was insufficient information to investigate this allegation and inability to obtain clarification due to the anonymity of the complainant. Additionally, the complaint alleged there were medication errors however lacked specific information in relation to the resident(s), staff, and timeframe. Observations of memory care logbooks revealed they were not consistent with the facility's narcotic count procedure, thus there was a violation. Therefore, a violation was substantiated for lack of organized program to ensure staff completed narcotic counts and documentation consistent with the facility's policy and procedure.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident C had feces on her wall.

INVESTIGATION:

On 9/13/2023, allegations were submitted to the Department anonymously which read Resident C had feces on her wall. Due to the anonymous nature of the complaint, I was unable to obtain additional information from the complainant.

On 10/5/2023, I conducted an on-site inspection at the facility. Ms. Bisbikis stated prior to Resident C starting on hospice services, she had behaviors in which she would become combative and remove her brief, so stool would be on the floor and/or wall. Ms. Bisbikis stated anytime stool was observed, it was cleaned by staff or housekeeping.

While on-site, I observed Resident C's apartment in which her walls and floor both appeared clean. Additionally, Resident C's apartment lacked foul odors.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	Observations revealed Resident C's apartment lacked evidence of stool on the wall, therefore this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A had ants crawling on him.

INVESTIGATION:

On 9/13/2023, allegations were submitted to the Department anonymously which read Resident A had ants crawling on him. Due to the anonymous nature of the complaint, I was unable to obtain additional information from the complainant.

On 9/15/2023, the Department referred the allegations by email to APS.

On 10/5/2023, I conducted an on-site inspection at the facility. I interviewed Ms. Bisbikis who stated there were no ants in the facility. Ms. Bisbikis stated Resident A had a diagnosis of schizophrenia in which he may have believed there were ants on him.

While on-site, I interviewed Employees #1 and #2 whose statements were consistent with Ms. Bisbikis.

While on-site, I interviewed Employee #3 who stated the facility had a contract with pest company Rose Pest Solutions in which they treated the facility monthly and as needed. Employee #3 stated Rose Pest Solutions externally sprayed the facility every spring and fall. Employee #3 stated Rose Pest Solutions treated the external grounds, as well as internally in the kitchens, maintained rodent traps, treated specific complaints, and as needed if necessary. Employee #3 stated they had not observed ants recently, but if identified, he cleaned the area first, then called Rose Pest Solutions if needed. Employee #3 stated Rose Pest Solutions would conduct services not only monthly, but anytime he called them.

While on-site, I observed three kitchen areas, the assisted living and memory care dining areas, as well as Resident A's apartment in which ants were not observed.

I reviewed *Rose Pest Solutions* invoices for August through October 2023.

Invoice dated 8/1/2023 read in part the technician inspected and treated for occasional invaders as well as the yellow jackets nest on the patio.

Invoice dated 9/5/2023 read in part the technician inspected and serviced the interior areas for general pests in which there was no activity at the time of service.

Invoice dated 9/8/2023 read in part the technician treated the exterior perimeter as appropriate for overwintering pests.

Invoice dated 10/3/2023 read in part the technician inspected and serviced the interior areas for general pests in which there was no activity at the time of service.

APPLICABLE RULE	
R 325.1978	**Insect and vermin control.**
	(1) A home shall be kept free from insects and vermin.
ANALYSIS:	Staff attestations and observations revealed there was not a current pest infestation. Review of the Rose Pest Solutions invoices revealed the facility maintained an organized plan for pest control, thus this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

Jessica Rogers 10/19/2023

Jessica Rogers Date
Licensing Staff

Approved By:

Andrea L Moore 10/22/2023

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