GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

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

April 1, 2024

RE: License #: AH500394648
Investigation #: 2024A1022017
Oakleigh of Macomb

Dear Eric Simcox:

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.

Please review the enclosed documentation for accuracy and contact me with any questions.

Sincerely,

Barbara P. Zabitz, R.D.N., M.Ed.
Health Care Surveyor
Health Facility Licensing, Permits, and Support Division
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Mobile Phone: 313-296-5731
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enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500394648
Investigation #:	2024A1022017
Complaint Receipt Date:	02/06/2024
Investigation Initiation Date:	02/06/2024
Report Due Date:	04/07/2024
Licensee Name:	Oakleigh Macomb Operations, LLC
Licensee Address:	Suiet 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:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility mishandled the indwelling urinary catheter used by the Resident of Concern (ROC).	No
Additional Findings	Yes

III. METHODOLOGY

02/06/2024	Special Investigation Intake 2024A1022017
02/06/2024	Special Investigation Initiated - Telephone Complainant interviewed by phone.
02/13/2024	APS Referral
02/13/2024	Inspection Completed On-site
03/04/2024	Contact - Document Sent Information exchanged with the facility via email.
04/01/2024	Exit Conference

ALLEGATION:

The facility mishandled the indwelling urinary catheter used by the Resident of Concern (ROC).

INVESTIGATION:

On 02/05/2024, the complainant called the Bureau of Community and Health Systems (BCHS) complainant hotline with allegations regarding her mother, the Resident of Concern (ROC). According to the intake unit's interview, "Mother resides at this home 10/23-12/23 she passed away due to the facilities negligence. The staff was not doing the medical orders as requested. They were not taking the residents issues seriously. Resident had a drastic decline in health very quickly. There was a catheter that the resident used, and they were not correctly tending to it. The facility was underplaying caller's mother's health. Her health declined in 1 day and ½ from the date the daughter called the facility to deal with the incorrect catheter. The facility did not address the catheter issue when the resident's daughter addressed them about this. The facility should have sent resident to the hospital earlier than they did. Since they did not this caused her health to decline and ultimately lead to her death. The director told caller that she would never put her mother in a home, they would take care of them at their own home. There is no accountability at this facility."

On 02/06/2024, I interviewed the complainant by phone. The complainant explained that her mother, the Resident of Concern (ROC) was to use an indwelling urinary catheter to address urinary retention. When the ROC moved into the facility, the facility assured the family that they would be able to provide appropriate care to the ROC including the care necessary for a properly functioning indwelling urinary catheter. According to the complainant, proper care was not provided. The complainant stated that the caregivers at the facility would not notice when the tubing that led from the catheter to the urinary collection bag was dragging on the floor and it would be "run over" by the wheelchair. The complainant stated that in the last days of her life, no urine output was observed in the urine collection bag.

According to medical records supplied by the complainant, the ROC was admitted to a local hospital on 12/14/2023 and died on the following day. The ROC's primary diagnosis was septic shock, secondary to urosepsis (the condition where the bacteria that causes a urinary tract infection, spreads to the bloodstream). In the hospital emergency room (ER), the ROC's indwelling catheter was noted to be in place, but without any urine in the collection bag. ER notes then documented that a computed tomography (CT) scan indicated a "misplaced Foley (catheter)." When the ROC's catheter was replaced by hospital personnel, blood was noticed in the collection bag.

According to an email exchange with the complainant summarizing her recollection of the events leading up to the ROC being sent to a local emergency room (ER), “On December 13 at 1PM Michigan time, I (complainant) received a call from Mom's (the ROC) (private) caregiver, [name of the private caregiver]. She said Mom was very swollen, disoriented and not feeling at all well. Also noticed that there was urine leaking on her pant leg. Couldn't see the foley catheter. I asked her to get the nurse, [name of the director of nursing] at Oakleigh to take a look at Mom and make sure everything was ok. She said she got her - but [name of director of nursing] wouldn't let [name of private caregiver] go into the room with her to check on the catheter. Nurse [name of the director of nursing] came out - very shortly after - and told [name of private caregiver] everything was fine. [Name of private caregiver] then called me a little later and said Mom was slumped over in her wheelchair - this would have been around 2PM Michigan time on December 13. She tried to get someone to help - and they just pushed Mom back up in her wheelchair and said she was fine... (On) December 14 - 3AM Michigan time - I (complaint) receive a call from Oakleigh saying they are rushing Mom to the hospital because she is very thirsty, is throwing up and has diarrhea, and there is no output in her catheter. I asked how long there hadn't been output - they said they didn't know... (On) December 14 - 8AM Michigan time - I receive a call from ER doctor - says catheter was "malpositioned"... Doctor says possible it got yanked out - entirely possible since Oakleigh ran over the hose many times and broke their bag ... Michigan VNA (the ROC’s contracted home care provider) inserted catheter on December 12 and said there was output and everything was proper then… I have texts from Michigan VNA telling me well before any of this happened, that Oakleigh had been running over the hose and not taking care of the catheter properly. I even have photos of the bag being tied up with a shoestring...”

In additional email exchanges with the complainant, the complainant explained that the ROC’s urinary catheter had been inserted at a local hospital on 10/14/2023. The contracted home care provider, Michigan VNA, was engaged to change out the catheter and check on the ROC on a monthly basis, starting on 11/03/2023. The complainant went on to say that on 11/07/2023, she had been informed by a family member that that the ROC’s “pee bag,” that is the urine collection bag, had been ripped and placed into a plastic bag. The complainant then relayed that information to the contracted home health provider who was able to replace the collection bag by 11/08/2023. On 12/11/2023, the urine collection bag was ripped a second time. The home health provider informed the complainant that it ripped because “someone (on the facility staff) let the (wheel) chair down on it…”

On 02/13/2024, a referral was sent to Adult Protective Services.

On 02/13/2024, at the time of the onsite visit, I interviewed the administrator and the director of nursing (DON). According to the administrator, the ROC moved into the facility in October 2023 after being hospitalized for sepsis due to an unknown cause. The administrator went on to say that the ROC’s health care provider called the family because the hospital had obtained some late laboratory testing that indicated

the ROC needed further hospital care. When the ROC returned to the facility on 10/17/2023, she was using the indwelling urinary catheter.

According to the administrator and the DON, the facility's staff were only responsible for managing the urinary collection bag. The home care contracted provider handled everything else. Caregivers emptied the bag when full, and manipulated the bag and tubing when transferring, dressing, or repositioning the resident. Caregivers were instructed to report any changes in the characteristics of the resident's urine to facility nursing staff or to call the home care provider directly.

When the administrator and the DON were asked to provide their version of what happened to the ROC, the DON stated that up until December 2023, no abnormal findings had been reported to her, but on 12/11/2023, when she arrived at the facility, she was informed that the ROC's home care contractor was in the building because an overnight shift caregiver had called the home care company reporting that the collection bag had "ripped." The DON acknowledged that she had not followed up with this report, did not know how or why the collection bag "ripped," and had not documented the occurrence. The DON did provide an updated service plan for the ROC, developed on 12/11/2023, that included the instruction to caregivers "to make sure catheter bag is not caught in wheel (of wheelchair when transferring)." The DON went on to say that on the day before the ROC was sent to the local hospital, 12/13/2023, she and the resident care coordinator had assisted the ROC to the toilet. According to the DON, at approximately 4:00 pm, the ROC and her private caregiver were sitting in the facility lobby when the ROC said she needed to use the toilet and the private caregiver requested assistance. The DON stated that in the process of undressing the ROC in the toilet room to use the toilet, she had the opportunity to see what was in the urinary collection bag and there was "nothing unusual" about the ROC's urine at that time. The DON went on to say that later, during the overnight shift, the ROC's caregiver called to report that the ROC was having loose stools, vomiting and that there was no urine in the collection bag. The ROC was sent out to the local ER.

The facility provided statements written by caregiver #1 and caregiver #2, both describing interactions with the ROC and her private caregiver around 2 pm on 12/13/2023. According to Caregiver #1's statement, the ROC's private caregiver requested assistance repositioning the ROC in her chair. Caregiver #1's statement went on to say that the ROC possessed the ability to reposition herself and with some prompting, "when [name of the ROC] did push herself back, her companion said, oh yes she can (reposition herself)." Caregiver #2's statement indicated that the private caregiver requested assistance with adjusting the footrests on the ROC wheelchair. Neither statement indicated that the ROC was unable to sit upright or maintain her positioning.

Further, the facility provided the hair salon's appointment schedule and invoice log for 12/13/2023, that indicated the ROC was seen for a "Wash and Style" appointment on 12/13/2023 at approximately 1:15 pm.

At the time of the onsite visit, caregiver #3 was identified as having provided care to the ROC while she was living at the facility. Caregiver #3 stated that the ROC had been very vocal about not wanting the catheter. According to caregiver #3, the ROC frequently told her that she (the ROC) was going to pull the catheter out. Caregiver #3 stated that whenever the ROC told her (caregiver #3) of her plans, caregiver #3 would tell her that was not a good idea, because doing that would land her (the ROC) in the emergency room. Caregiver #3 stated that her responsibility was to empty the collection bag when full and to position the bag when transferring the ROC. Caregiver #3 stated that she personally did not have knowledge of whatever kind of care required by the ROC on 12/13/2023 or any knowledge of a damaged urinary collection bag, but on one occasion the clip used to attach the collection bag to the frame of the bed or chair was missing. Caregiver #3 stated that she placed a call to the home care contractor to arrange for a replacement. Caregiver #3 denied any knowledge of the wheelchair running over the catheter tubing but did say that early in the ROC's stay at the facility, the form of the collection bag changed from a square boxy shape to a round shape. Caregiver #3 stated that she had been instructed to report any change in the ROC's urine color or quantity to the nurse.

At the time of the onsite visit, the DON identified two current residents with indwelling urinary catheters. Resident A was observed in his room, sitting in a wheelchair. The urinary collection bag was attached to the bottom of Resident A's wheelchair. The tubing that connected the collection bag with the catheter cleared the floor and was filled with light colored urine. Resident A's family member was visiting at the time. According to Resident A's family member, Resident A's home care contractor came into the facility once a month to change the catheter and every other week to flush the catheter. Resident A's family member stated that all issues related to catheter use were referred to the home care contractor and that facility staff were not involved.

Resident B was observed seated in his room, in an armchair with his wheelchair positioned in front of him. A urine collection bag was hanging on the frame of the wheelchair with the tubing extending out of Resident B's pant leg. Resident B was not able to describe how his home care contractor provided services to him regarding the catheter use.

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:	There was no evidence to link the care provided to the ROC by caregivers to the ROC's need for emergency medical care.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

At the time of the onsite visit, the DON stated that on 12/11/2023, she received report that the ROC's home care contractor was in the building because the ROC's urine collection bag had "ripped." The DON acknowledged that she had not followed up with this report, did not know how or why the collection bag "ripped," and had not documented the occurrence. The DON did provide an updated service plan for the ROC, developed on 12/11/2023, that included the instruction to caregivers "to make sure catheter bag is not caught in wheel (of wheelchair when transferring)."

Review of the charting notes for the ROC revealed that there were no notations referring to the fact that the ROC had an indwelling urinary catheter, or that the caregivers were responsible for emptying the bag, or that the bag had been ripped or otherwise damaged. On 03/04/2023 via an email exchange with the administrator, the administrator was asked to explain why there were no documented observations related to the ROC's urinary catheter. The administrator replied, "When a resident has a catheter, a skilled nurse (contracted home care provider) is utilized as a case manager for the catheter. Our staff is still providing care for that resident with the catheter by emptying it and cleaning around it. If there is an issue related to anything to the catheter, we call the skilled nurse and they come out immediately or as soon as possible. The skilled nurse is then responsible for charting and communication with family members."

APPLICABLE RULE	
MCL 333.20175	**Maintaining record for each patient; wrongfully altering or destroying records; noncompliance; fine; licensing and certification records as public records; confidentiality; disclosure; report or notice of disciplinary action; information provided in report; nature and use of certain records, data, and knowledge.**
	(1) A health facility or agency shall keep and maintain a record for each patient, including a full and complete

	record of tests and examinations performed, observations made, treatments provided, and in the case of a hospital, the purpose of hospitalization.
ANALYSIS:	The facility did not document their observations of the ROC that arose from their responsibilities for urinary catheter care.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the authorized representative (AR) on 04/01/2024. When asked if there were any comments or concerns with the investigation, the AR stated that there were none.

IV. RECOMMENDATION

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

04/01/2024

_____

Barbara Zabitz Date
Licensing Staff

Approved By:

03/25/2024

_____

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