GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 11, 2024

Janet Mazzetti
Lake Orion Assisted Living, LLC
PO Box 564
Oxford, MI 48371

RE: License #: AM630378604
Investigation #: 2024A0605022
Orion Manor

Dear Janet Mazzetti:

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,

Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
3026 W. Grand Blvd
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM630378604
Investigation #:	2024A0605022
Complaint Receipt Date:	03/25/2024
Investigation Initiation Date:	03/25/2024
Report Due Date:	05/24/2024
Licensee Name:	Lake Orion Assisted Living, LLC
Licensee Address:	1814 S Lapeer Lake Orion, MI 48360
Licensee Telephone #:	(248) 814-6714
Administrator:	Loraine Lee
Licensee Designee:	Janet Mazzetti
Name of Facility:	Orion Manor
Facility Address:	1814 S. Lapeer Road Lake Orion, MI 48360
Facility Telephone #:	(248) 814-6713
Original Issuance Date:	06/09/2016
License Status:	REGULAR
Effective Date:	12/09/2022
Expiration Date:	12/08/2024
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED AGED/TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A falls daily, sometimes multiple times a day. For the past two months, there have been urgent care visits. He has gauges on his knees from multiple falls. The left knee is very deep. There are concerns that Resident A needs a higher level of care than his current arrangement is providing.	Yes

III. METHODOLOGY

03/25/2024	Special Investigation Intake 2024A0605022
03/25/2024	Special Investigation Initiated - Letter Email to APS worker Tiffany Pitts
03/25/2024	APS Referral Adult Protective Services (APS) made referral
03/25/2024	Contact - Telephone call received Discussed allegations with APS worker Tiffany Pitts
03/26/2024	Inspection Completed On-site Conducted unannounced on-site investigation
03/28/2024	Contact - Telephone call received Message left by area director Lori Lee
04/01/2024	Contact - Telephone call made Discussed allegations with Lori Lee
04/03/2024	Contact - Document Received Documents received
05/01/2024	Contact - Telephone call made Discussed allegations with direct care staff (DCS) Rosa Bermudez, DCS Alena Martinez, DCS Jasmine Lewis, and DCS Cristiani Spencer
05/16/2024	Exit Conference Conducted exit conference with licensee designee Janet Mazzetti with my findings.

ALLEGATION:

Resident A falls daily, sometimes multiple times a day. For the past two months, there have been urgent care visits. He has gauges on his knees from multiple falls. The left knee is very deep. There are concerns that Resident A needs a higher level of care than his current arrangement is providing.

INVESTIGATION:

On 03/25/2024, intake #200169 was referred by Adult Protective Services (APS) regarding Resident A failing daily and may require a higher level of care than what Orion Manor is providing.

On 03/25/2024, I discussed the allegations with APS worker Tiffany Pitts. Ms. Pitts met with Resident A at Orion Manor. She was informed that Resident A has Parkinson's and unsteady gait. Resident A has hardwood floors in his bedroom. He gets out of bed at night and falls to his knees which results in cuts and then scabbing. Resident A picks at his scabs so the wounds open. He is receiving hospice services with Gentiva who has ordered a hospital bed with rails. It was also recommended for staff to use a gait belt on Resident A whenever he tries to get out of his wheelchair. There are 12 residents at this facility with two staff during first and second shift and only one staff during the third shift. There are concerns that Resident A is unsupervised resulting in several falls and urgent care visits.

On 03/26/2024, I conducted an unannounced on-site investigation. Present were the assistant home manager (AHM) Brandy Martinez, DCS Naomi Black and a total of 10 residents.

I attempted to interview Resident A, but he is somewhat nonverbal and cannot carry a conversation. He was showered by the hospice aide. He was in his wheelchair, good hygiene and dressed appropriately for the day. I observed both knees and the scabbing on both knees were healing properly.

I interviewed the AHM Brandy Martinez regarding the allegations. AHM has been with this corporation since 2005; however, she left for about five years and then returned. She works Monday-Friday first shift. There are always two DCS in the first shift, two DCS in the second shift and only one DCS during the third shift. There are 10 residents at this facility. Resident A is one of those residents. He has a diagnosis of Parkinson and moved in 11/2023. He is currently in a wheelchair and receives hospice services with Gentiva. Resident A will try to get out of his wheelchair frequently and when that happens, staff will redirect him to sit back down. He can ambulate but has unsteady gait. He likes staying in his bedroom most of the day but when that happens, he constantly gets out of his wheelchair and tries walking back and forth several times. He fidgets a lot in his bedroom and at night, he slides out of his bed and kneels in a praying position which is resulting in sores on his knees. Then he picks at the scabs and then

the wounds open. There is no wound care nurse however, his wounds are changed by staff and by hospice, but Resident A takes them off and picks at the wounds. It is challenging trying to redirect Resident A because he is constantly trying to pick at his scabs. Regarding the falls, Resident A has not fallen, but because he is stiff, he slides out of bed onto the hardwood floor which causes the sores on his knees. He went to the hospital two months ago because his gout flared up, but not because he fell. However, due to Resident A sliding out of his bed, a mat was placed near his bed so when he slid out, his knees would not hit or rub against the hardwood floors. Staff are required to check on Resident A every hour during third shift. Currently, they are redirecting Resident A when he tries to get out of his wheelchair and/or bed, use the gait belt when needed, have placed alarm pads underneath his mattress to alert staff when he tries to get out of bed. When asked if Resident A was a one or two person assist, the AHM stated that Resident A one person assist but sometimes he is a two person assist when he is weak. There three residents that are a two-person assist: Resident B, Resident C, and Resident D. These residents require two-person assist for all transfers and personal hygiene care. The AHM acknowledged that it is concerning there is only two DCS during first and second shift and only one DCS during third shift when there are three-four residents that require two-person assist with six other residents who reside at Orion Manor.

On 03/26/2024, I interviewed DCS Naomi Black regarding the allegations. Ms. Black has been working for this corporation for over one year. She works first shift but has sometimes filled in for the third shift. There are always two DCS during first and second shift, but only one DCS during third shift. Regarding Resident A, she has never observed him fall. She has observed him on his knees, in a prayer position after sliding out of bed. The wounds on his knees are a result of him sliding out of his bed and his knees hitting the hardwood floor. He has gone to urgent care not due to falls, but due to the wounds on his knees. The wounds begin to heal, but then Resident A will pick at them, then the wounds open and he is back to urgent care. Now his wounds are healing up nicely. Ms. Black has had to redirect Resident A several times from not getting out of his wheelchair, but he continues to do so. He has unsteady gait which is why his is in the wheelchair. He receives hospice services and is in the process of getting a hospital bed with rails. There are four residents that are a two-person assist: Resident A, B, C, and D. Ms. Black does not know if she could evacuate all 10 residents including the two-person residents by herself if she worked third shift alone, because she has not participated in a fire drill during sleep hours. She only fills in for third shift but does not think she can by herself.

On 03/26/2024, I observed Resident B sitting in her wheelchair with her hands on her face asleep. She is non-verbal; therefore, she was not interviewed regarding the allegations. She appeared to have good hygiene and dressed appropriately for the day.

On 03/26/2024, I attempted to interview Resident C who was also sitting in her wheelchair, but Resident C would not respond to any questions. She too appeared to have good hygiene and was dressed appropriately for the day.

On 03/26/2024, I attempted to interview Resident D in her bedroom, but she too would not respond to questions. Resident D had a registered nurse (RN), Kaisee with Residential Home Health Care in her room. The RN stated that Resident D had a urinary tract infection and was receiving intravenous antibiotics. The RN visits weekly for two weeks and then will recertify to continue those visits. The RN stated that Resident D is a two-person assist with transfers and full care.

On 03/26/2024, I reviewed Resident B's and Resident C's assessment plans. Resident B's assessment plan completed on 10/11/2023 and Resident C's assessment plan completed on 01/16/2024 both stated that Resident B and Resident C are "full assist," with their personal hygiene and transferring.

On 04/01/2024, I interviewed the area director/administrator Lori Lee regarding the allegations. Resident A has not fallen. He is a tall man, large in stature and stiff. She has witnessed him trying to get up out of bed and sliding onto the hardwood floor on his knees in a praying position. He would frequently try getting out of bed and onto the floor resulting in wounds on his knees. He was taken to urgent care not for falls, but for the wounds. Once the wounds scab, he would pick at them, then the wounds open again, and he was back at urgent care. Physical therapy recommended to use a walker and standby assist whenever Resident A ambulates, and to redirect him when he tries to get out of his wheelchair and bed. She stated, "we tried a safety belt a couple of times, but we stopped using it because he was getting upset." Ms. Lee stated that the safety belt used was not recommended nor was it prescribed by Resident A's physical therapist (PT) or a medical professional. There is no script for the safety belt. Ms. Lee does not believe there are four residents that are a two-person assist. She will review Resident A's assessment plan and email it to me since it was not available for my review when I was at the facility. She reported that Resident B is a one-person transfer into a wheelchair at night and that Resident C is also a one-person transfer; however, some staff struggle with her because she is aggressive and requires that additional person in the morning to assist in getting her up and out of bed. Ms. Lee stated the only person who is a two-person assist is Resident D who recently moved in. Ms. Lee acknowledged that there must be at a minimum two DCS per shift including third shift when she has at least one resident who is a two-person assist. She will re-review all residents' assessment plans and their needs and discuss with licensee designee Janet Mazzetti regarding staffing. She stated, "I did do a one-on-one transfer training with staff for the two-person assist residents." Ms. Lee will email Resident D's assessment plan and the staff schedule.

On 04/03/2024, Ms. Lee sent Resident A's and Resident D's assessment plans for my review. Resident A's assessment plan was completed on 09/05/2023 and it stated he is a full assist with bathing and can ambulate but recommended by PT to not walk without assistance. I reviewed Resident D's assessment plan completed on 02/08/2024, and it stated that Resident D is a "full assist," with personal hygiene and all transfers. I also received Resident A's discharge papers from Ascension Providence Rochester Hospital dated 03/12/2024 regarding bilateral leg wounds- diagnosis cellulitis.

I reviewed 01/2024-03/2024 staff schedule and there are two DCS during first and second shift, and one DCS during third shift.

On 04/10/2024, I received an email from APS worker Tiffany Pitts. She conducted a wellbeing follow up today with Resident A. Per staff the daughter provided a 30-day notice and is planning to move Resident A to a facility that specializes in Parkinson's care. Wounds appear to be healing on his knees and he has a hospital bed with guard rails. Gait belts were observed on the dresser in his room. Staff reported they are only used when he is engaged in occupational therapy (OT)/PT.

On 05/01/2024, I interviewed DCS Rosa Bermudez via telephone regarding the allegations. Ms. Bermudez has worked for this corporation for 20 years. She works third shift from 11PM-7AM. She only works two days Wednesdays and Thursdays and has been off the last two weeks. There is only one DCS during third shift. Resident A is currently in a hospital bed with rails as recommended by his doctor to prevent him from trying to get out of bed. He is stiff and when he gets out of bed, he slides onto the hardwood floor in a praying position which resulted in the wounds on his knees. He has not fallen during third shift. Since the hospital bed, he has not tried getting out of bed. His wounds are healing properly now that he stopped picking at the scabs. Prior to being off there were eight residents residing at this facility. Out of the eight residents, four were a two-person assist: Resident A, Resident B, Resident C, and Resident D with transfers. There was no need to transfer any resident out of bed at night so she would wait until the morning shift, when the other DCS showed up for first shift to get all residents ready and out of bed, including the two-person assist residents. Ms. Bermudez has not participated in a fire drill during third shift because she only works two days a week and fire drills were not conducted during her shift. However, she stated, "My boss teaches me to do the fire drill. We have books and there are papers we must do. I can evacuate everyone safely, but I've never done it by myself."

On 05/01/2024, I interviewed DCS Alena Martinez via telephone regarding the allegations. Ms. Martinez has been working for this corporation since 06/2023. She works second shift from 3PM-9PM or 3PM-11PM. there are two DCS during first and second shift and only one DCS during third shift. Resident A is moving out of the facility as the family wants to move him closer to them. Recently, he has not had any incidents of sliding out of bed or falling during her shift; however, in the past, he had slid off his bed onto the hardwood floor in a praying position. He had wounds on both knees that he would pick at and open the wounds up. She stated these wounds have healed. Resident A is a two person assist along with Residents B, C, and D. All these residents require two DCS for transfers and all their personal hygiene needs. Ms. Martinez has participated in a fire drill but stated that they are conducted during their monthly staff meetings. The fire drills are conducted with two DCS and they evacuated all the residents under eight minutes.

On 05/01/2024, I interviewed DCS Jasmine Lewis via telephone regarding the allegations. Ms. Lewis has worked for this corporation for two years. She works third shift from 11PM-7AM. There is only one DCS per third shift. Currently, there are nine

residents at this facility. Resident A is moving out 06/01/2024 and there will only be two residents who are a two-person assist. Resident B and Resident C. They require two DCS for all transfers. Resident A had fallen a few times during her shift between the times of 5AM-6AM when he would wake up and wander out of bed. She would catch him when she witnessed him getting out of bed and then almost falling. He also slides out of bed onto the hardwood floor resulting in the wounds on both knees. Since, the hospital bed, he has not gotten up, fallen, or slid out of bed. Ms. Lewis has never participated in a fire drill as the fire drills are conducted at 9PM-10PM prior to her shift. The last fire drill she participated in was winter of last year. She stated, “No, I cannot evacuate all nine residents including the residents who are a two-person assist by myself in less than eight minutes.”

On 05/01/2024, I attempted to interview DCS Christiani Spencer via telephone, but she stated she was on her way to work and would need to talk to her supervisor Lori Lee before she could speak with me. She stated she will call me later. Ms. Spencer never called.

On 05/16/2024, I conducted the exit conference with licensee designee Janet Mazzetti regarding my findings. Ms. Mazzetti requested a recommendation regarding the violations. I advised her that my recommendation is that she either increases staffing or discharges the two-person assist residents since she has insufficient staffing per shift, especially during third shift with only one DCS.

On 05/20/2024, I received an email from APS worker Tiffany Pitts stating that she is substantiating her case for neglect due to insufficient staffing at this facility.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on my investigation and information gathered, there is insufficient staff during third shift to provide for the supervision, personal care, and protection of all 10 residents. The staffing pattern at this facility is two DCS during first and second shift and only one DCS during third shift. There are at least four residents that are a two-person assist: Resident A, Resident B, Resident C, and Resident D. According to assistant HM Brandy Martinez, DCS Naomi Black, Alena Martinez, and Jasmine Lewis these residents require two DCS to assist with transfers and personal hygiene. I reviewed the staff schedule for 01/2024-

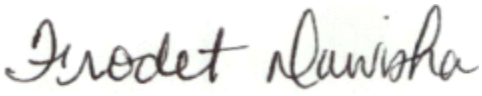
	03/2024 and there is only one DCS during third shift. I also reviewed Residents A, B, C, and D and their assessment plans stated that they require full assist with their care.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on my investigation and review of Residents A, B, C, and D's assessment plans, these residents require "full assist," with their transfers and personal care. However, there is only one DCS during third shift which is insufficient to provide the supervision, protection, and personal care of these residents and the other residents residing at this facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on my investigation and information gathered, there is insufficient staff to provide for the personal needs including protection and safety at all times for 10 residents residing at this facility. Out of the 10 residents, there are four residents who are a two-person assist. Residents A, B, C, and D. There is only one DCS working third shift according to staff schedule from 01/2024-03/2024. Therefore, these residents require two-person with transfers; so, if there is an emergency during third shift, one DCS cannot safety evacuate all 10 residents out of the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

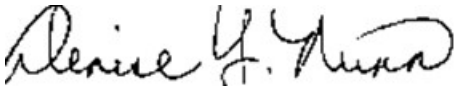
Contingent upon receiving an acceptable corrective action plan, I recommend no change to the status of the license.



05/20/2024

Frodet Dawisha — Date
Licensing Consultant

Approved By:



06/11/2024

Denise Y. Nunn — Date
Area Manager