GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 10, 2020

Stephen Levy
The Sheridan at Birmingham
2400 E. Lincoln Street
Birmingham, MI 48009

RE: License #: AH630381578
Investigation #: 2020A0585047
The Sheridan at Birmingham

Dear Mr Levy:

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.

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,

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(313) 268-1788

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630381578
Investigation #:	2020A0585047
Complaint Receipt Date:	05/26/2020
Investigation Initiation Date:	05/28/2020
Report Due Date:	07/25/2020
Licensee Name:	CA Senior Birmingham Operator, LLC
Licensee Address:	Suite 4900 161 N. Clark Chicago, IL 60601
Licensee Telephone #:	(248) 864-2491
Administrator:	Russ Conrad
Authorized Representative:	Stephen Levy
Name of Facility:	The Sheridan at Birmingham
Facility Address:	2400 E. Lincoln Street Birmingham, MI 48009
Facility Telephone #:	(248) 864-2491
Original Issuance Date:	03/29/2018
License Status:	REGULAR
Effective Date:	09/27/2019
Expiration Date:	09/26/2020
Capacity:	128
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
• There were many COVID cases and deaths at the facility. • Falls happen at the facility and they are not getting properly recorded.	No
Residents are not getting their medication	No
Boxes of paper plates, cutlery and napkins are being stored in a bathroom.	Yes
Additional Findings	No

III. METHODOLOGY

05/26/2020	Special Investigation Intake 2020A0585047
05/28/2020	Special Investigation Initiated - Letter Made a referral to Adult Protective Services regarding the allegations.
05/28/2020	APS Referral Sent referral to APS.
06/02/2020	Contact - Telephone call made Interviewed the administrator Missy Bell by telephone. Documents were requested.
06/03/2020	Contact - Document Received Received requested documents from the administrator.
08/14/2020	Exit Conference Completed with authorized representative Stephen Levy.

ALLEGATION:

- **There were many COVID cases and deaths at the facility.**
- **Falls happen at the facility and they are not getting properly recorded.**

INVESTIGATION:

On 5/23/20, the department received the allegations from an anonymous complainant via the BCHS Online Complaint website.

The complaint read that there were 28 residents in memory care but due to COVID deaths there are only 18. The complaint noted that residents fall, and it does not get recorded properly.

On 5/28/20, I made a referral to adult protective services (APS).

On 6/2/20, I interviewed the administrator Melissa Bell by telephone. She stated that there was 18 positive COVID cases in memory care. She stated there was a total of seven deaths as result of COVID. She stated that all residents and staff were tested. She stated they will do COVID retesting if they have the test kits available after 14 days of the initial testing. She stated that all falls are recorded and noted on the service plan of the residents. She stated that she has submitted all reportable incidents to the state. Ms. Bell submitted copies of Resident B, Resident C, and Resident D's incident reports, medication administration records (MAR) and service plans.

On 6/10/20, I interviewed care staff Jennifer Sobral by telephone. Ms. Sobral stated that all residents and staff were tested. She stated that they are tested every two weeks and at the present time there are only six COVID cases for memory care residents and no staff was positive at the time. She stated that if a resident has a fall, it is recorded, and it is reported to the physician and the family. She stated that incident reports are also completed on all residents that have falls.

COVID cases were reported on incident reports. The incident reports read, COVID cases reported to the State and health department. It also read; CDC guidelines were followed.

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:	Documents revealed that all COVID cases were reported to the health department as well as following guidelines of the CDC. Documents also notes that falls were recorded. This claim could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents are not getting their medication.

INVESTIGATION:

Ms. Bell stated that there have not been any complaints regarding medication not being given. She stated that if a resident refused medication, staff are to make several attempts and if there is a continual refusal, then staff should contact the doctor, as well as the family. Ms. Bell shared copies of the service plan and medication administration record (MAR) for Resident B, Resident C, and Resident D.

Ms. Sobral stated that she administers medication. She stated that after three attempts to administer resident medication, staff chart refusal and inform the charge nurse of the refusal. She stated that all residents are getting their medication as ordered.

Ms. Quick stated that she helps administer medication but that is typically the responsibility of the medication technician. She stated that there have been no medication errors to her knowledge. Her statement was consistent with Ms. Bell and Ms. Sobral regarding the residents' medication refusal.

A review of the MAR for Resident B, Resident C, and Resident D read that all residents were administered medication as prescribed.

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:	Interviews with staff along with review of the MAR for Resident B, C and D revealed that all medication was administered as prescribed. The MAR revealed that all refusals were documented.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Boxes of paper plates, cutlery and napkins are being stored in a bathroom.

INVESTIGATION:

On 5/23/20, pictures of the facility were received of a resident's bathroom that contained boxes of paper plates, paper napkins and cutleries.

Ms. Bell stated that once the governor's executive order came out, staff immediately threw out all the paper kitchen supplies because they did not want to cross contaminate the new supplies with the old supplies. She said staff took the older paper products and stored them in one of the empty rooms to be trashed. Ms. Bell stated that they could not get another dumpster at that time to put all the old paper products in and they kept them in the bathroom of an empty room.

APPLICABLE RULE	
R 325.1968	**Toilet and bathing facilities.**
	(4) A resident toilet room or bathroom shall not be used for storage or housekeeping functions.
ANALYSIS:	The bathroom in a resident's room was used as storage.
CONCLUSION:	**VIOLATION ESTABLISHED**

At the time of the investigation, Melissa Bell was the administrator.

On 8/14/20, I conducted an exit conference with licensee authorized representative Stephen Levy by telephone.

IV. RECOMMENDATION

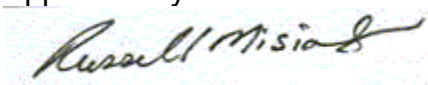
Contingent upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

8/12/20

Brender Howard
Licensing Staff

Date

Approved By:



8/12/20

Russell B. Misiak
Area Manager

Date