GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 8, 2021

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

RE: License #: AH630381578
Investigation #: 2021A1019023
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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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. 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,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630381578
Investigation #:	2021A1019023
Complaint Receipt Date:	03/03/2021
Investigation Initiation Date:	03/03/2021
Report Due Date:	05/02/2021
Licensee Name:	CA Senior Birmingham Operator, LLC
Licensee Address:	Suite 4900 161 N. Clark Chicago, IL 60601
Licensee Telephone #:	(312) 673-4387
Administrator:	Melissa Bell
Authorized Representative:	Stephen Levy
Name of Facility:	The Sheridan at Birmingham
Facility Address:	2400 E. Lincoln Street Birmingham, MI 48009
Facility Telephone #:	(248) 940-2050
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?
Staff are not checking on Resident A throughout the night.	No
Additional Findings	Yes

III. METHODOLOGY

03/03/2021	Special Investigation Intake 2021A1019023
03/03/2021	Special Investigation Initiated - Letter Emailed APS worker Tina Edens for additional information.
03/09/2021	Contact - Document Sent Emailed APS worker for additional information, second attempt. At this time LARA has not received a response to the first email attempt on 3/3/21.
03/09/2021	Contact - Document Received Email received from APS worker Tina Edens indicating that the case is now assigned to APS worker Candid Jamerson.
03/10/2021	Contact - Document Sent Email sent to APS worker Candid Jamerson to obtain additional information.
03/10/2021	Contact - Document Received Email received from APS worker Candid Jamerson.
03/10/2021	Inspection Completed On-site
03/10/2021	Contact- Document Sent Additional information and supporting documentation requested from administrator Missy Bell, correspondence is ongoing.
03/16/2021	Contact - Telephone call made Called Relative A to conduct interview, left voicemail requesting return phone call.
03/16/2021	Contact - Telephone call made Called former caregiver G. Cottingham, left voicemail requesting return phone call.

03/16/2021	Contact - Telephone call received Call received from Relative A, interview conducted.
03/17/2021	Inspection Completed- BCAL Sub. Compliance
04/08/2021	Exit Conference

ALLEGATION:

Staff are not checking on Resident A throughout the night.

INVESTIGATION:

On 3/3/21, the department received a complaint alleging that the facility staff were not checking on Resident A throughout the night. The complaint alleged that Resident A had a fall sometime during the night on 2/22/21 going into the morning of 2/23/21 and alleged that Resident A is left in soiled briefs overnight. The complaint was forwarded to LARA from Adult Protective Services (APS), however did not contain the original referral source's contact information. Because the referral source was not provided, I was unable to obtain additional information.

On 3/10/21, I conducted an onsite inspection. I interviewed administrator Missy Bell at the facility. Ms. Bell stated that Resident A has resided at the facility since June 2018. Ms. Bell stated that Resident A is on hospice, is wheelchair bound, incontinent, has dementia and requires total assistance with activities of daily living (ADLs). Ms. Bell stated that Resident A has a private duty care giver that has been with her since before she moved into the facility. Ms. Bell stated that Resident A's private duty caregiver is with her 5-6 days per week during most of first shift and into second shift. Ms. Bell stated that Resident A's private duty caregiver has expressed that while she is with Resident A, she does not like for the facility staff to come in to provide care to Resident A and that the private duty caregiver "handles everything". Ms. Bell stated that there have been some personality conflicts between the private duty caregiver and facility staff which resulted in many staff wanting to avoid the private duty caregiver as much as possible. Ms. Bell stated that Resident A's private duty caregiver attempts to dictate Resident A's care and requests that staff do tasks that they do not have orders to complete. Ms. Bell stated that these issues have been addressed between facility staff, the private duty caregiver and Relative A but issues continue to occur. Ms. Bell stated that staff conduct safety checks on Resident A every two hours throughout the night and will change her whenever they notice that her brief is wet or soiled. Ms. Bell stated that staff are not expected to document the safety checks or brief changes. Ms. Bell also acknowledged that Resident A had a fall in the early morning on 2/23/21. Ms. Bell stated that the fall was unwitnessed, and hospice came out to assess her that morning but did not require that she be sent to the hospital.

On 3/10/21, I interviewed Resident A's private duty caregiver Tamara Blue. Ms. Blue stated that she is employed through Assured Home Nursing Services, Inc. and has worked with Resident A for five years. Ms. Blue confirmed that Resident A is wheelchair bound, is a one person transfer and needs assistance with all care related tasks. Ms. Blue stated that she works with Resident A six days per week from about 9am-6pm. Ms. Blue acknowledged that she does not expect facility staff to complete any care tasks with Resident A while she is present and stated that while she is there, staff typically come in to give Resident A medications and take out her garbage only. Ms. Blue stated that there are times when she will ask facility staff to assist her but most of the time she does not want or need their assistance. Ms. Blue stated that she does not believe facility staff are checking on her during the night because there are times in the morning that she has had to immediately change her briefs because they were wet and had concerns over a fall, questioning how long Resident A was on the floor before staff discovered her.

On 3/17/21, I interviewed Relative A by telephone. Relative A stated that she is Resident A's medical and financial power of attorney for the last six years. Relative A stated that prior to the COVID-19 pandemic she would visit Relative A at the facility weekly, but it is now monthly and stated that she has not gone into Resident A's apartment since the pandemic began. Relative A stated that Resident A requires a lot of assistance with care and believes that the facility is meeting her needs. Relative A stated that she has not observed anything that she is concerned over and stated "If I really had concerns she wouldn't live there." Relative A stated that Ms. Blue has voiced some concerns over the facility and their lack of supervision with Resident A but attributes it to Ms. Blue having unrealistic expectations. Relative A stated "This is assisted living, staff are not going to be at her side every minute." Relative A stated "It's a push and pull between the aide and the facility staff. The aide creates a lot of drama and staff don't want to deal with her. I don't blame them." Relative A stated she believes Ms. Blue is "blowing things out of proportion" and "overreacting".

Resident A's service plan dated 2/26/21 outlines that she requires staff assistance with mobility, transfers, ambulation, bathing, grooming, dressing and toileting. The service plan reads that Resident A is incontinent and wears adult briefs.

A progress note from nurse Nahima Chowdhury dated 2/23/21 read "Resident had a fall early this morning, med tech found her next to resident bed on her round [sic], her vitals was [sic] stable, she had a bump and redness on her right side of forehead. I called hospice nurse, and she will be here later this morning. Notified ED and POA." Ms. Chowdhury also attested that Resident A was discovered around 4:30am, was not complaining of any pain but an x-ray was completed, and the results were normal.

Med tech Vashawna Jones attested the following:

On 2/22/2020, I checked on [Resident A] every 2 hours. I just walk by and look into her room. I change her as needed throughout the night. She is not a heavy wetter. She usually sleeps well. She was fine throughout the night.

On 2/23/2020, I found [Resident A] laying on her right side of her bed on the floor about 5:30 a.m. I took her vitals and they were normal. I observed a bump on her face and a scrape on her knee. I gave her some ice. She did not complain of any pain. She did not push her pendant. When Nahima, Wellness LPN came she took over and was going to call hospice.

Care staff Bianca Johnson attested the following:

On 2/23/2020, I found Shirley Fawcett laying on her right side of her bed on the floor and I don't remember the time. It was in the morning. I heard, "help me, help me." Vashawna took her vitals and they were normal. I observed a bump on her face and a scrape on her knee. Vashawna gave her some ice and PRN Tylenol. [Resident A] did not complain of any pain. She did not push her pendant. Vashawna called Nahima ahead of time and when Nahima, Wellness LPN came she took over and was going to call hospice.

Shift supervisor Tiffany Rodgers attested the following:

I walk the whole building every two hours give or take the things that are happening. During midnights the staff are expected to provide wellness checks on the residents every two hours, this would include placing your eyes on them and making sure they are safe and alive. [Resident A] gets the same care as well as changing her brief and repositioning as needed. We physically go in her room every 2-3 hours and check her brief and change as needed.

Care staff Britain Jarema attested the following:

[*Resident A's] care on midnights consists of checking on her 3 to 4 times a night, repositioning her, making sure she has a wedge along side her and mat on the floor to assure her safety. We make sure she is warm and comfortable, dry & clean. We also do her laundry, and empty trash and put new garbage bags in. also we elevate her legs with a pillow to help circulation.*

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(1) A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the

	health facility or agency. Except for a licensed health maintenance organization, which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.
For Reference MCL 333.20201	**(2) (e) A patient or resident is entitled to receive adequate and appropriate care, and to receive, from the appropriate individual within the health facility or agency, information about his or her medical condition, proposed course of treatment, and prospects for recovery, in terms that the patient or resident can understand, unless medically contraindicated as documented by the attending physician in the medical record.**
ANALYSIS:	Attestations from facility staff combined with Relative A's interview do not suggest that Relative A isn't being checked on or toileted throughout the night. A fall was confirmed to have occurred on 2/23/21, however staff consistently attested that Resident A was regularly checked on overnight and there is no way to determine how long Resident A was on the floor before she was discovered. Based on this information, the allegation is not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Current emergency pandemic orders outline face covering mandates within the confines of the facility. Ms. Bell stated that it is facility policy that all staff and visitors wear a mask or face covering for the entire time they are in the facility and they encourage mask wearing by residents as well. While onsite, I observed that Resident A's private duty caregiver Tamara Blue was not wearing any type of mask or face covering while in close contact and providing direct care to Resident A. Ms. Bell was present for the duration of my interview and observation with Ms. Blue and did not remind her of this mandate.

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.**
For Reference R 325.1901	**Definitions.**
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	The facility outlines expectations of residents, staff, and visitors regarding face coverings. During my inspection I witnessed noncompliance of this expectation and no reasonable effort to ensure the safety of others.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Resident A had a fall on the morning on 2/23/21 which was believed to have occurred around 4:30 or 5:30am. She was observed on the ground near her bed and it is believed she rolled out of bed and onto the floor. A progress note written by Ms. Chowdhury on 2/23/21 at 9:53am following the fall read “Resident complaining her right hip is hurting now from the fall. I called her dr and he wants her to go the hospital, but her POA and hospice nurse were refusing to sent [sic] her to the hospital.” Resident A’s injuries were described by staff as “bump on forehead”, “scrape on knee”, “bump and redness on forehead” and prompted x-rays to be ordered to verify if more severe injuries were present. Ms. Bell stated that an incident report was not completed for the fall and did not report it to the department, as she did not feel it met criteria.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(1) The home shall complete a report of all reportable incidents, accidents, and elopements. The incident/accident report shall contain all of the following information: **(a) The name of the person or persons involved in the incident/accident.** **(b) The date, hour, location, and a narrative description of the facts about the incident/accident which indicates its cause, if known.** **(c) The effect of the incident/accident on the person who was involved, the extent of the injuries, if known, and if medical treatment was sought from a qualified health care professional.** **(d) Written documentation of the individuals notified of the incident/accident, along with the time and date.** **(e) The corrective measures taken to prevent future incidents/accidents from occurring.** **(2) The original incident/accident report shall be maintained in the home for not less than 2 years.** **(3) 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:	Resident A's fall was not reported to the department and an incident report was never completed. Sustaining injuries (even minor) meets the definition of a reportable incident as outlined in this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Regarding toileting, Resident A's service plan read "Resident requires physical assistance with all tasks related to toileting." The service plan read that Resident A is incontinent of bladder and bowel, wear adults briefs and identifies that Resident A requires assistance with incontinence care. The service plan does not provide instruction or guidance to staff on the expected frequency of the toileting tasks.

Resident A's service plan does not provide instruction or guidance regarding the frequency of overnight safety or wellness checks but read "Resident is unable to utilize emergency response system; may have frequent monitoring in place".

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.
For Reference: R 325.1901	**Definitions.**
	(21) "Service plan" means a written statement prepared by the home in cooperation with a resident and/or the resident's authorized representative or agency responsible for a resident's placement, if any, and that identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical, social, and behavioral needs and well-being and the methods of providing the care and services while taking into account the preferences and competency of the resident.
ANALYSIS:	Resident A's service plan did not contain pertinent information about the need for monitoring or the frequency of care she required by facility staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Resident A's medication administration records (MAR) were provided onsite. The MAR was left blank for one or more doses of scheduled medication on the following dates during the timeframe reviewed: 1/4/21, 1/18/21, 2/2/21, 2/14/21, 2/21/21 and

2/22/21. Facility staff did not document a reason for the missed medication administrations.

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:	Review of Resident A's MAR reveals that she did not receive all her prescribed medications as ordered.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 4/8/21, I shared the findings of this report with authorized representative Stephen Levy. Mr. Levy verbalized understanding of the citations listed above.

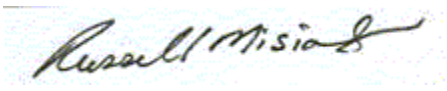
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no changes to the status of the license at this time.

3/18/21

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:



4/6/21

Russell B. Misiak Date
Area Manager