STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

June 8, 2021

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

RE: License #: AH630381578
Investigation #: 2021A0585023
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.

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,

Brender L. Howard

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 #:	2021A0585023
Complaint Receipt Date:	03/18/2021
Investigation Initiation Date:	03/18/2021
Report Due Date:	05/17/2021
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:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff was found sleeping in another resident's room and there was no other staff on the hall.	Yes
Resident J's care was not consistent to her service plan.	Yes
Residents are not getting their medication and sometimes residents are getting their medication late.	Yes
Additional Findings	Yes

The complainant identified some concerns that were not related to licensing rules and statutes for a home for the aged. Therefore, only specific items pertaining to homes for the aged provisions of care were considered for investigation. The following items were those that could be considered under the scope of licensing.

III. METHODOLOGY

03/18/2021	Special Investigation Intake 2021A0585023
03/18/2021	Special Investigation Initiated - Letter Emailed administrator Missy Bell for additional information.
03/18/2021	APS Referral Made a referral to Adult Protective Services (APS).
04/14/2021	Contact - Document Sent Emailed administrator Missy Bell for documents.
04/14/2021	Contact – Document Sent Emailed the initial complainant to call me back to discuss allegations.
04/15/2021	Contact - Document Received Emailed received from administrator Missy Bell that she was out sick and will send me the requested document when she gets back.
04/26/2021	Contact - Document Received Received documents from administrator.

05/04/2021	Inspection Completed On-site.
06/09/2021	Exit Conference. Conducted with authorized representative Stephen Levy.

ALLEGATION:

Staff was found sleeping in another resident's room and there was no other staff on the hall.

INVESTIGATION:

On 3/18/21, the department received the allegations from a complainant via BCHS Online Complaint website. The complainant had an email address, but no phone number. An emailed was sent to the address, but as of the date of this report, no response has been received. Therefore, no additional information was received.

On 3/17/21, an incident report was emailed to the State from the administrator Melissa Bell. The incident report read, "shift supervisor Raychelle Robinson, went to the 4th floor to answer call lights and did not see resident care giver Tiaerra Crawford. Ms. Crawford was assigned to the 4th floor. Ms. Robinson was met by the Birmingham Fire Department. The fire department shared with Ms. Robinson that Resident [J], called 911 on her own phone. [Resident J] and EMS reported to Ms. Robinson that she was on the floor about an hour and her care staff did not respond to her call light. [Resident J] pushed her call light at 2:34 a.m. The report shows that her call light was not answered. [Resident J] was transported to the hospital within 26 minutes of her fall. [Resident J] was complaining of hip pain. EMS transported [Resident J] to the hospital where she was admitted."

The report read, when resident care aide Britain Jarema, saw the ambulance lights outside while working in memory care. Ms. Jarema went to assisted living to assist and the fire department shared with her that they could not find the staff on the 4th floor. Ms. Jarema assisted Ms. Robinson in looking room to room to locate Ms. Crawford. Ms. Jarema and Ms. Robinson found Ms. Crawford in another room. Ms. Jarema shared that Ms. Crawford was in the living room, in her recliner, covered with a blanket in front of the television. Ms. Crawford told Ms. Jarema that her phone did not work, and she did not know. The report noted that Ms. Crawford was placed on administrator leave pending an investigation.

On 3/18/21, a referral was made to Adult Protective Services (APS).

On 4/14/21, an emailed was sent to administrator Melissa Bell requesting documents to complete investigation.

On 5/3/21, I interviewed Ms. Jarema by telephone. She attested that her and Ms. Robinson went looking for Ms. Crawford and found her in another resident's room

sleep. She stated that there was not a lot of falls, but there have been some but did not know how many.

On 5/5/21, I interviewed Ms. Bell at the facility. She stated that Resident [J]'s pendant went off at 2:30 and EMT was there by 3. She stated that the staff that was working the fourth floor is no longer employed there. She stated that there was one staff working the fourth floor.

Attempts were made to interview Ms. Crawford and Ms. Robinson. As of the date of this report, no return call has been received.

The 3/16/21 staff schedule revealed one staff [Tiaerra Crawford] on the midnight shift for the fourth floor.

Incident reports were reviewed for the facility. The incident reports reviewed for March and April indicates there were nine reportable falls.

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 only staff working on the 4th floor was found sleeping in a resident's room. Resident J was found on the floor after a fall, that resulted in a broken pelvis. The 4th floor had 26 residents at the time of the incident with one person who was a two person assist.

CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident J's care was not consistent with her service plan.

INVESTIGATION:

The service plan for Resident J read that she is a 97-year-old female with diagnoses that includes insomnia, asthenia, depression, hypertension, atrial fibrillation, and cardiac failure. The plan read she has a history fall and staff is to observe resident is embracing safety measures to decrease fall potential, total dependent on staff for all mobility/ambulation needs or requires hands on assistance on routine basis and resident requires frequent hands-on assistance with transfers and/or change in position. The plan read, resident requires physical assistance with parts of toileting tasks.

A review of the call light audit suggests that Resident J summons helps often and some of staff responses took longer than 20 minutes. According to the audit, on 3/16/21 on the date of the incident that sent her to the hospital, Resident J summoned help at 2:41:56 a.m., and response time was 1 hour and 54 minutes.

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 J relies on staff to assist her with transfers, toileting and other personal needs. She summons staff assistance for these needs via her call alert device. Documentation revealed staff's repeated delay in responses to Resident J's call-alert device, examples ranging from 23 minutes to three hours, when she is summoning staff assistance for personal care, confirms Resident J is not treated with dignity and her personal needs are not attended to consistent with her service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents are not getting their medication, sometimes they are getting their medication late and there is not a medication technician on staff during the midnight shifts.

INVESTIGATION:

The complainant alleges that residents are getting their medication late. No other information could be obtained due to the complainant being anonymous.

Ms. Bell stated that staff are getting their medication as prescribed. She stated that medication is given on time to residents. She stated that nurses give out medication when there is no medication technician on duty. She stated that there was no there is no nurse on the midnight shift. Ms. Bell stated that there are some residents that have as needed medication. She stated that residents are usually sleeping at midnight and do not usually need medication.

On 5/6/21, I interviewed staff scheduler Antonia George by telephone. Ms. George stated that she has only been working at the facility for a month. She stated that there are always two medication technicians on each shift. She stated that the midnight supervisor is responsible for passing the medication at night.

Ms. Jarema stated that there is not a medication technician on the midnight shift. She stated that she does not know if a resident has missed medication on the other shifts. She stated that if a resident is on "as needed" medications there is no one to give it to them.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.
ANALYSIS:	Based on interview with administrator Melissa Bell and other care staff, there is no medication technician on the midnight shift. A review of the MAR for residents did not indicate if medication was needed during the midnight shift. However, if a resident were to need medication on the midnight shift, they would be unable to receive it. Therefore, this claim is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

Ms. Bell stated that there is enough staff to care for the needs. She stated that if a staff call in, they make every effort to fill the position. She stated that she has also filled the position herself. Ms. Bell stated that there are no documents to show that residents are getting showers. She stated that they are going to start documenting showers but as of now they don't do it. She stated that they do the honor system when the staff tell them they have done them. She stated that on 3/16, there was only one staff working the fourth floor with 21 residents on that floor. She stated that the fourth floor have one two-person assist. She shared with me copies of the staffing/sign in sheets.

Ms. Bell explained that current staff cover the shifts by working double shifts, coming in early and/or working late. She stated that at times she comes in to cover shifts. Ms. Bell affirmed that at times the schedule is not completely full as expected, and said she is working on contracting with a staffing agency. She stated that it is hard to get staff due to the pandemic. She stated that sometimes one staff must cover two floors, but it is never without coverage.

Ms. Jarema stated that Ms. Crawford was the only staff working on the 4th floor on 3/16/21. She stated that when her and Ms. Robinson saw EMT, they came to the 4th floor to see what was going on and EMT told them that they could not find any staff on the 4th floor. She stated that one staff always work the 4th floor. She stated that

there are about 20 something (did not know the exact number) of residents on that floor with one or two people that needs two people to assist them.

On 5/6/21, I interviewed staff scheduler Antonia George by telephone. She stated that there are three shifts, 6 am – 2 pm, 2 pm – 10 pm and 10 pm -6 am. She stated that every floor has two caregivers.

A random review of response time documentation for Resident J revealed extended response times have occurred as follows:

Date	Alert	Response time
3/4/21	2:17:21 PM	1 hour 14 minutes 29 sec
3/5/21	7:04:43 PM	2 hours 22 minutes 58 sec
3/6/21	9:07:50 AM	1 hour 11 minutes 40 sec
3/10/21	2:43:47 AM	23 minutes 35 sec
3/13/21	12:11:43 AM	2 hours 21 minutes 15 sec
3/14/21	10:02:30 PM	28 minutes 26 sec
3/15/21	12:31:24 AM	46 minutes 52 sec
3/15/21	10:11:02 PM	1 hour 36 minutes 14 sec
3/16/21	2:41:56 AM	1 hour 54 minutes 20 sec
3/16/21	9:07:50 AM	1 hour 11 minutes 40 sec

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.

ANALYSIS:	Resident J needs vary from only needing medication management to requiring “total assistance”. Staff schedules are not filled as expected. In addition, there are excessive response times on all three shifts. There were response times that ranged from 23 minutes to two hours and 21 minutes. The facility did not demonstrate compliance with their own standards nor with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

At the time of the exit for this investigation, Melissa Bell was no longer the administrator.

On 6/9/21, I reviewed the findings of this report with licensee authorized representative Stephen Levy via telephone.

IV. RECOMMENDATION

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

Brender L. Howard 6/9/2021

Brender Howard Date
Licensing Staff

Approved By:

Russell Misiak 6/8/21

Russell B. Misiak Date
Area Manager