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GOVERNOR

## STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

ORLENE HAWKS DIRECTOR

June 21, 2021

Kristie Nagle Sunrise Assisted Living of Northville 16100 North Haggerty Road Plymouth, MI 48170

> RE: License #: AH820400126 Investigation #: 2021A0585033

> > Sunrise Assisted Living of Northville

Dear Ms. Nagle:

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 Howard, Licensing Staff

render J. Howard

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 #:	AH820400126	
Investigation #:	2021A0585033	
Complaint Receipt Date:	06/09/2021	
Investigation Initiation Date:	06/09/2021	
ga	06/06/2021	
Report Due Date:	08/09/2021	
Licensee Name:	SZR Northville Assisted Living Opco, L.L.C.	
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Licensee Address:	Suite 200	
	500 N. Hurstbourne pkwy	
	Louisville, KY 40222	
Licensee Telephone #:	(502) 357-9380	
·		
Administrator/Authorized	Kristie Nagle	
Representative:		
Name of Facility:	Sunrise Assisted Living of Northville	
Facility Address:	16100 North Haggerty Road	
	Plymouth, MI 48170	
Facility Telephone #:	(734) 420-4000	
-		
Original Issuance Date:	01/01/2020	
License Status:	REGULAR	
Lioundo Giatas.	11202/111	
Effective Date:	07/01/2020	
Expiration Date:	06/30/2021	
Expiration Date:	00/30/2021	
Capacity:	118	
Program Type:	AGED ALZHEIMERS	
	ALZHEHVIERO	

### II. ALLEGATION(S)

## Violation Established?

Resident was left on the toilet for 30 minutes.	Yes
The food is nasty.	No
Additional Findings	No

#### III. METHODOLOGY

06/09/2021	Special Investigation Intake 2021A0585033
06/09/2021	Special Investigation Initiated - Telephone Called to request a resident roster.
06/09/2021	APS Referral
	Made a referral to Adult Protective Services (APS).
06/10/2021	Inspection Completed On-site
	Completed with observation, interview, and record review.
06/17/2021	Contact document sent.
	Emailed administrator Kristie Nagle to request additional information.
06/23/2021	Exit Conference.
	Conducted with authorized representative Kristie Nagle.

#### **ALLEGATION:**

Resident was left on the toilet for 30 minutes.

#### **INVESTIGATION:**

On 6/9/21, the department received the allegations via the BCAL Online complaint website.

On 6/10/21, I conducted an onsite inspection. I interviewed the complainant at the facility. She stated that she was left on the toilet for thirty minutes. She stated that she pressed the call pendant, and the aide came in her room. She stated that the aide told her that she would be back because she was in the middle of helping someone else. She stated that eventually the nurse and the medication technician came in to help her. She stated that they put her on the toilet and left her. She stated that when she was finished, she pressed the pendant and was calling for help. She stated that she was beating the wall and calling for help. She stated that the staff that was delivering food finally came in. She stated that there is one person for seventeen people.

While on site, I interviewed the administrator Kristie Nagle at the facility. She stated that Resident A pressed the pendant, and the caregiver went in her room to let her know that she was taking care of another resident and will be back. She stated that the nurse on duty Shereen Janissee and medication technician Dnesi Bonner went in to assist Resident A. She stated that Ms. Janissee and Ms. Bonner assisted Resident A to the bathroom. She stated that after taking Resident A to the bathroom, Ms. Janissee and Ms. Bonner walked out to give her privacy. She stated that when Resident A finished toileting, she called for assistance to get off the toilet. She stated that Resident A is the most frequent user of the pendant and staff response to Resident A's call pendant as quickly as possible. She stated that if the caregivers are busy, the nurse will assist with her and the nurse cannot reset the call pendant after providing the care. She stated that the caregiver will clear the pendant once they get a chance. Ms. Nagle stated that she is in the process of ordering additional pendants for nurses so that when they provide care, they could also clear the pendants. Ms. Nagle stated that the expected response time for staff to response to call light pendant is 10-12 minutes. She stated that the census for the facility is 38. She stated that the staff consists of two caregivers, two medication technicians and two nurses on the day and evening shift. She stated that there are two staff on the midnight shift. She stated that medication technicians assist with care when they are not passing medication.

On 6/10/21, I interviewed Ms. Bonner at the facility. She stated that she went in to give Resident A her medication. She stated that her and the nurse on duty, assisted Resident A to the bathroom. She stated they left out of the bathroom to give Resident A her privacy. She stated that they went back 20 minutes later to assist her off the toilet. She stated that because the pager went to the first aide who responded to the call pendant, her or Ms. Janissee was not able to reset the call pendant.

On 6/10/21, I interviewed Resident B at the facility. She stated that there are no issues with the staff. She stated that she uses her pendant and staff are always coming to assist her with her needs.

On 6/10/21, I interviewed Resident C at the facility. She stated that there is never a long wait when she uses her pendant. She stated that staff is wonderful to her and there are no concerns.

On 6/15/21, I interviewed Ms. Janissee by telephone. She stated Resident A called for a care manager. She stated that Resident A's care manager was busy helping another resident, so she and another manager went in to assist Resident A. She stated that they assisted Resident A to the bathroom. She stated that Resident A do not like anyone to stay there when she is in the restroom, and they left her to give her privacy. She stated that she told Resident A to put her call light back on when she is done in the bathroom. Ms. Janissee stated that she got called away to do something else. She stated that she does not have the same system as the care mangers and did not know that Resident A was still on the toilet. She stated that when she got back to Resident A's room to check on her, Resident A started yelling at her and calling her names because she was left on the toilet. She stated that Resident A's care managers were assisting another resident that requires a Hoyer lift. She stated that she did not stay with Resident A in the bathroom because she gets mad if you stand there.

Staff observed on duty during my onsite was consistent to Ms. Nagle's statement.

The service plan for Resident A read, able to make needs known clearly and precisely. The plan read, wants things done in a certain way and is not always accommodating to new ideals. She is frequently awake during the night, often to be assisted with toileting. The plan read, mood state for resident is easily frustrated when things are not done her way, and then get angry. The plan read, provide with assistance as needed or requested to the bathroom so that she can maintain her continence. The plan read, resident is a fall risk and is to be reminded to call for assistance for transfers and care managers are to check on resident 2 to 4 times per shift and as needed.

APPLICABLE RULE		
R 325.1931	Employees; general provisions.	
	(2) The 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 was left on the toilet for at least 30 minutes which was not consistent to the expected respond time of 10-12 minutes or consistent to resident's service plan. Therefore, the facility did not comply with this rule.
CONCLUSION:	VIOLATION ESTABLISHED

#### **ALLEGATION:**

The food is nasty.

#### **INVESTIGATION:**

Complainant stated that she receives three meals a day, but the food is awful, and she do not like it. She stated that hotdogs and sandwiches are served every day.

Ms. Nagle stated that residents are given three meals a day. She stated that the meals are served in accordance with the posted menu. She stated that alternative meals are served if the resident desire something different.

Resident B and Resident C stated that they are given three meals a day and if something is served that they do not want, that they are able to request something different. Resident B stated that sandwiches are always available. Resident C and Resident B stated that the food is good, and they do not have any issues with the food.

During my observance of lunch being served, the food was consistent to the posted menu.

APPLICABLE RULE		
R 325.1952	Meals and special diets.	
	(5) A home shall prepare and serve meals in an appetizing manner.	
ANALYSIS:	Based on observation, interview and record review, this claim could not be substantiated.	
CONCLUSION:	VIOLATION NOT ESTABLISHED	

On 6/23/21, I shared the findings of this report with authorized representative Kristie Nagle. Ms. Nagle did not have any questions regarding the citations included in this report.

#### IV. RECOMMENDATION

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

Grender J. Howard	6/23/21
Brender Howard Licensing Staff	Date
Approved By:	C/00/04
	6/22/21
Russell B. Misiak Area Manager	Date