GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 22, 2021

Taylor Darby
Providence Park Senior Living, L.L.C.
38525 Woodward Avenue
Bloomfield Hills, MI 48304

RE: License #: AH630361856
Investigation #: 2022A0784012
Rose Senior Living at Providence Park

Dear Ms. Darby:

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.

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 (517) 284-9730.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630361856
Investigation #:	2022A0784012
Complaint Receipt Date:	11/08/2021
Investigation Initiation Date:	11/12/2021
Report Due Date:	01/07/2022
Licensee Name:	Providence Park Senior Living, L.L.C.
Licensee Address:	38525 Woodward Avenue Bloomfield Hills, MI 48304
Licensee Telephone #:	(248) 686-5500
Administrator/Authorized Representative:	Taylor Darby
Name of Facility:	Rose Senior Living at Providence Park
Facility Address:	47400 Heritage Drive Novi, MI 48374
Facility Telephone #:	(248) 513-8900
Original Issuance Date:	02/15/2018
License Status:	REGULAR
Effective Date:	08/14/2021
Expiration Date:	08/13/2022
Capacity:	172
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Facility is short staffed	No
Additional Findings	Yes

III. METHODOLOGY

11/08/2021	Special Investigation Intake 2022A0784012
11/12/2021	Special Investigation Initiated - On Site
11/12/2021	Inspection Completed On-site
11/15/2021	Contact - Document Received Investigative documents recieved by email
11/17/2021	Contact - Telephone call made Interview with administrator Taylor Darby and regional director of health services Brad Dinsmore
11/17/2021	Exit Conference - Telephone Conducted with authorized representative Taylor Darby. Regional director of health services Brad Dinsmore was present on the call

ALLEGATION:

The facility is short staffed

INVESTIGATION:

On 11/8/21, the department received this online complaint. Due to the anonymous nature of the complaint, additional information could not be obtained.

According to the complaint, the facility is short staff as evidenced by a resident recently having fell in her room (Rm. 265) overnight and was not discovered until the morning, another resident who fell and broke her leg after a fall and was dragged across the room and on 11/7/21, only two staff were scheduled to work with between 70 and 75 residents.

Review of the facility licensing file revealed no reporting regarding resident falls or injuries.

On 11/12/21, I interviewed administrator Taylor Darby at the facility. Ms. Dardy stated that the referenced room 265 was most recently lived in by Resident A. Ms. Darby stated Resident A was taken to the hospital several days ago and has not returned to the facility. Ms. Darby stated Resident A did have a fall prior to going to the hospital, on approximately 11/6/21, but that Resident A did not present with injury either verbally or physically at the time of the fall. Ms. Darby stated Resident A was a very independent person and was able to transfer and ambulate on her own. Ms. Darby stated Resident A did not require specific safety checks based on her abilities and health condition, but that staff conduct regular visual checks for all residents throughout their shifts. Ms. Darby stated Resident A was discovered by a staff member during a visual check in the morning and that she is not aware of Resident A having been on her floor for an extended period of time. Ms. Darby stated Resident A did not have her pendent on her at the time of the fall, which, she stated, Resident A generally did and would use it to summons staff for assistance. Ms. Darby stated she was not aware of any other residents having fallen and sustained injuries. Ms. Darby stated the facility has memory care residents on the first floor and assisted living residents on the second and third floor with approximately 30 first floor memory care residents, 21 second floor assisted living residents and 25 third floor assisted living residents. Ms. Darby stated the facility staffs two associates per assisted living floor and four to five on the memory care floor for first and second shift, “depending on the census” and one associate for the two assisted living floors with two to three associates on the memory care floor on third shift. Ms. Darby stated that as far as she is aware, the facility was not short staffed on 11/6/21 and has been able to maintain consistent staffing. Ms. Darby stated licensing staff Brendar Howard completed an onsite inspection on 10/27/21 and reviewed staffing levels noting no issues.

I reviewed facility Progress Notes, pertaining to Resident A which were consistent with statements provided by Ms. Darby. The notes were dated 11/6/21, noting a time of 7:50am, and indicated Resident A was discovered on her floor with no noted or reported injuries and was assisted to her bed at the time. Additional notes indicated that at approximately 1pm on 11/6 staff was summons to Resident A’s room and that

Resident A was “not responding as resident usually does” and taken to the ER [Emergency Room].

I reviewed the resident census, provided by Ms. Darby, which was consistent with statements provided by Ms. Darby.

I reviewed the facilities “as worked” schedule from 10/27/21 to 11/12/21 which was consistent with statements provided by Ms. Darby.

I reviewed Resident A’s service plan which was consistent with statements provided by Ms. Darby.

On 11/17/21, I interviewed Ms. Darby and regional director of health services Brad Dinsmore by telephone. Mr. Dinsmore stated that Resident A did not return to the facility because she was discovered to have cancer which had metastasized. Mr. Dinsmore stated Resident A has been placed on hospice and will not be returning to the facility.

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:	The complaint alleged the facility was short staffed on 11/7/21 as evidenced by only two staff being scheduled to work with up to 75 residents, Resident A having been left on her floor for an extended period of time after a fall and another resident having fallen suffered injury. The investigation revealed insufficient evidence to support the allegations.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

Review of facility progress notes indicated Resident A went to the ER on 11/6/21.

When interviewed Ms. Darby stated Resident A did not return to the facility after going to the ER on 11/6/21.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(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 was noted to have a change in health condition on 11/6/21 and was taken to the ER related to this change in condition. Review of the facility licensing file revealed no reporting regarding Resident A being taken to the ER. Based on the findings the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/17/21 I discussed the findings with authorized representative Taylor Darby and regional director of health services Brad Dinsmore.

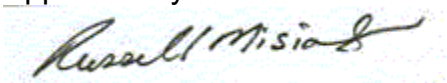
IV. RECOMMENDATION

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

11/17/21

Aaron Clum — Date
Licensing Staff

Approved By:



11/19/21

Russell B. Misiak — Date
Area Manager