GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 3, 2021

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

RE: License #: AH630381578
Investigation #: 2022A1019013

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 (517) 284-9730.

Sincerely,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(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 #:** | 2022A1019013 |
| | |
| **Complaint Receipt Date:** | 11/10/2021 |
| | |
| **Investigation Initiation Date:** | 11/12/2021 |
| | |
| **Report Due Date:** | 01/10/2022 |
| | |
| **Licensee Name:** | CA Senior Birmingham Operator, LLC |
| | |
| **Licensee Address:** | Suite 4900<br>161 N. Clark<br>Chicago, IL 60601 |
| | |
| **Licensee Telephone #:** | (312) 673-4387 |
| | |
| **Administrator:** | Jordan Houston |
| | |
| **Authorized Representative:** | Stephen Levy |
| | |
| **Name of Facility:** | The Sheridan at Birmingham |
| | |
| **Facility Address:** | 2400 E. Lincoln Street<br>Birmingham, MI 48009 |
| | |
| **Facility Telephone #:** | (248) 940-2050 |
| | |
| **Original Issuance Date:** | 03/29/2018 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 09/27/2020 |
| | |
| **Expiration Date:** | 09/26/2021 |
| | |
| **Capacity:** | 128 |
| | |
| **Program Type:** | AGED<br>ALZHEIMERS |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Timely care is not being provided. | Yes |
| Additional Findings | No |

## III. METHODOLOGY

| | |
|---|---|
| 11/10/2021 | Special Investigation Intake<br>2022A1019013 |
| 11/12/2021 | Special Investigation Initiated - Letter<br>Notified APS of the allegations via email referral template. |
| 11/12/2021 | APS Referral |
| 11/23/2021 | Inspection Completed On-site |
| 11/23/2021 | Inspection Completed BCAL Sub. Compliance |
| 11/24/2021 | Contact - Telephone call made<br>Called complainant, interview conducted. |
| 12/03/2021 | Exit Conference |

**ALLEGATION:**

**Timely care is not being provided.**

**INVESTIGATION:**

On 11/10/21, the department received a complaint alleging that staff do not respond to Resident A's call pendant or if they do respond, the responses are delayed. The complainant stated that a week prior, Resident A had to wait 70 minutes for staff to respond. The complainant is concerned that the delays or lack of response will cause Resident A's husband (Resident B) to perform care related tasks for her that staff should be taking care of and that the residents are rightfully paying for.

On 11/23/21, I conducted an onsite inspection. I interviewed administrator Jordan Houston at the facility. Mr. Houston stated that Resident A and Resident B have resided at the facility together since March 2021. Mr. Houston stated that Resident B is fully independent and does not require staff assistance with any care related

tasks, including medication administration, however Resident A has some physical limitations from a stroke that require some additional assistance with transfers and activities of daily living. Mr. Houston stated that both residents make their needs known but that Resident B will often speak on behalf of Resident A. Mr. Houston stated that both residents have call pendants, along with a pull cord in their bathroom to notify staff when assistance is needed. When the pendant is pressed or the cord is pulled, it sends an alert to staff phones which are carried on their person. When staff respond, they are supposed to hover the phone over the Resident's pendant, which signals to the pendant that the alert has been answered and will then reset the pendant. Mr. Houston stated that Residents A and B use their pendants frequently and that when Resident B uses his pendant, it is because he is trying to get assistance for Resident A. Mr. Houston stated that Resident A, Resident B and their family have voiced concerns over call light response times previously and they recently had a care conference on 11/11/21 to address their care. Mr. Houston acknowledged the poor response times but reported that the facility is sufficiently staffed and that they have made adjustments in their procedures with Resident A to ensure timely service. Mr. Houston stated that following the care conference, the facility began to assign a specific staff member each shift to Residents A and B to help with consistency and have had in-services and reminders about call light response times. Mr. Houston stated he reviews call light reports frequently and addresses any excessive wait times, which he considers 15+ minutes. Mr. Houston stated that there have been some extenuating circumstances, including an isolated malfunction in the call light system itself or staff not properly resetting the pendants, but overall response times are faster. Mr. Houston stated that since the meeting on 11/11/21, he has not received any complaints pertaining to Residents A and B.

On 11/23/21, I interviewed health and wellness director Brittany Wilcox at the facility. Her statements were consistent with that of Mr. Houston.

On 11/23/21, I interviewed Residents A and B at the facility. To summarize, Residents A and B both verbalized past issues with staff response times and reported that staff have been more attentive since the care conference. Resident A stated that lately staff have responded within ten minutes and Resident B stated "They've been trying".

While onsite, I obtained a report that outlined the response times of Resident A and B's call pendants, along with their bathroom pull cord. I reviewed response times from 10/1/21-11/23/21 (the date of my onsite). For October 2021, there were 181 total alerts, with 49 responses exceeding fifteen minutes. For November 2021, there were 130 total alerts, with 32 responses exceeding fifteen minutes (sixteen of the alerts came after the 11/11/21 care conference took place).

On 1/24/21, I conducted a phone interview with the complainant. The complainant affirmed that there have been improvements in response times and experienced "excellent service" within the last week. The complainant did not express any care related concerns and stated that for the moment, the issues have been resolved.

| 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:**<br>**(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:** | Resident A experienced repeated excessive call pendant and pull cord response wait times during the timeframe reviewed, which are not consistent with facility benchmarks or Resident and B's expectations. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

On 12/3/21, I shared the findings of this report with authorized representative Stephen Levy. Mr. Levy verbalized understanding of the citation and did not have any additional questions at this time.

## IV. RECOMMENDATION

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

12/3/21

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Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

12/02/2021

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Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section