GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 23, 2021

Beth Mell
Brookdale Ann Arbor
2190 Ann Arbor-Saline Rd.
Ann Arbor, MI 48103

RE: License #: AH810305217
Investigation #: 2022A1027009
Brookdale Ann Arbor

Dear Ms. Mell:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed by the licensee authorized representative and dated.

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) 284-9727.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 241-1970
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH810305217
Investigation #:	2022A1027009
Complaint Receipt Date:	11/03/2021
Investigation Initiation Date:	11/03/2021
Report Due Date:	01/03/2022
Licensee Name:	Brookdale Place of Ann Arbor, LLC
Licensee Address:	Suite 2300 6737 W. Washington St. Milwaukee, WI 53214
Licensee Telephone #:	(414) 918-5000
Administrator:	Jena Wisely
Authorized Representative/	Beth Mell
Name of Facility:	Brookdale Ann Arbor
Facility Address:	2190 Ann Arbor-Saline Rd. Ann Arbor, MI 48103
Facility Telephone #:	(734) 327-1350
Original Issuance Date:	10/19/2010
License Status:	REGULAR
Effective Date:	03/13/2021
Expiration Date:	03/12/2022
Capacity:	82
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A left the facility without signing out.	Yes
Additional Findings	No

III. METHODOLOGY

11/03/2021	Special Investigation Intake 2022A1027009
11/03/2021	Special Investigation Initiated - Letter Administrator Jena Wisely emailed requesting updated service plan, nurses notes and physician notes.
11/04/2021	Contact - Document Received Requested documentation received from Administrator Jena Wisely
11/23/2021	Contact - Document Sent Email sent to administrator Jena Wisely requesting LOA policy
11/23/2021	Contact - Document Received Email received with requested documentation from administrator Jena Wisely
11/23/2021	Inspection Completed-BCAL Sub. Compliance
12/13/2021	Exit Conference Conducted with authorized representative Beth Mell

ALLEGATION:

Resident A left the facility without signing out.

INVESTIGATION:

On 10/31/21 the department received an incident report dated 10/30 which read "Resident (A) left community to get jelly beans from the grocery store across the street. Resident did not sign out and self reported tripping on the side walk." The report read the extent of injuries were "swollen abrasion to lower left eye, blood from nose and discoloration around right eye." The report read medical treatment was necessary and "HVA was contacted by a passing civilian, HVA recommended to take

resident to the ED for treatment and evaluation which was refused by the resident. The resident is his own person." The report read corrective measures taken to prevent recurrence were "the resident has been re-educated on LOA policies and management will also be re-educating staff on LOA policies for residents. The resident will be re-assessed by physician and psych for appropriate AL placement."

On 11/3/21, I conducted a telephone interview with administrator Jena Wisely. Ms. Wisely stated Resident A did not sign out of the facility per their policy, exited at approximately 6:30 pm on 10/30 and returned by ambulance at approximately 7:22 pm. Ms. Wisely stated Resident A purchased his jelly beans and snickers as he intended and fell walking back to the facility. Ms. Wisely stated Resident A told her that he tripped on the sidewalk. Ms. Wisely stated a pedestrian called the ambulance which returned Resident A to the community. Ms. Wisely stated a 1:1 sitter was implemented on 10/30 to stay with Resident A to ensure his safety until further placement was sought in which family was assisting. Ms. Wisely stated Resident A was evaluated by the psychiatrist on 11/1 and diagnosed him with dementia. Ms. Wisely stated her and Resident A's family felt Resident A would not adapt well to Brookdale's small memory care. Ms. Wisely stated Resident A did not associate well the residents when they had group events. Ms. Wisely stated Resident A's family was working to find alternative placement for Resident A, possibly at an Adult Foster Care home within the next week. Ms. Wisely stated she has also assisted the family with some alternative living options. Ms. Wisely stated Resident A will continue to have a 1:1 sitter until alternative placement is sought.

I reviewed Resident A's service plan which read under the heading of "Behavior Management" on 10/12/21 that it was recommended by Resident A's physician that Resident A does not leave the community independently until further evaluation related to intermittent confusion. The plan read Resident A verbalized understanding. The plan read the problem that is being addressed by the physician has not occurred prior to this incident (on 10/12/21).

I reviewed Resident A's physician order from 10/12/21 which read consistent with his service plan. The order read Resident A may leave the facility with family or caregivers, not alone, with medications unless otherwise contraindicated.

I reviewed the facility's nurse's notes. The notes read as follows:

> 10/12/21 at 16:06 [4:06 PM]: "After 2:00 PM, resident (A) left the community without signing out. Resident regularly walks to the store to get snacks and exercise. Community received a phone call from a physician's office across the street from the store that (Resident A) was turned around and wanted to go home. (Resident A) was able to tell the physician's office where he lived and they contacted us immediately and staff went picked him up. (Resident A) was interviewed by ED, HWD, and HWC when he returned. VSS, resident denied any pain. Resident (A) did not recall being at the doctor's office. BIMS test completed (Resident A) scored a 12 per baseline. District nurse notified for guidance,

physician contacted and new order for UA, psych eval, and that resident is not permitted LOAs on his own at this time pending UA results. Family notified and in agreement with tx plan, (Resident A) is his own person at this time though. Staff alerted that (Resident A) is unable to go out on his own at this time til further notice. Resident (A) informed that physician wants a UA done on him and that the physician does not wanting him to leave the community on his own at this time until we receive UA results and further evaluation, resident nodded head his head in understanding. Awaiting urine sample. Will continue to monitor for safety."

10/13/21 12:49 PM: "Spoke with resident again about not leaving community unattended r/t safety and that we needed to collect a urine sample to r/o possible UTI, resident verbalized understanding. New urinal and specimen cup placed in room. Resident instructed to let staff know when he voids, resident stated that he would. No attempts to leave the community thus far."

10/15/21 at 16:51 [4:51 PM]: "Urine collected and sent to lab, (Resident A) has made no attempts to leave the building. No changes in mental status, no confusion noted. Safety maintained, will continue to monitor."

10/18/21 at 22:08 [10:08 PM]: "UA results were negative, no new orders at this time."

10/30/21 at 06:02 [6:02 AM}: "Agency Jalisa asked at 6:02 PM if the resident was allowed to leave the facility unsupervised, I stated with it being cold and dark earlier that it is not in his best interest to be allowed to leave the facility unattended."

The nurses note from 10/30/21 at 21:29 [9:29 PM] read consistent with the incident report and statements from Ms. Wisely. The report read "HWC and ED provided education again that it is not safe for him to leave the community and the doctor had ordered that he wasn't permitted to leave the community on his own and resident (A) verbalized understanding."

On 11/5/21 the department received email communication from Ms. Wisely read Resident A transitioned to their memory care unit on 11/4, which was temporary while the family solidified a new residence for him. The email read it would allow Resident A to not have to have a 1:1 caregiver which was privately paid for by his family.

On 11/23/21 email communication with Ms. Wisely read when the facility's psychiatry group prefers medical conditions ruled out and/or addressed prior to treatment. The email read when Resident A's physician was notified on 10/12/21, he requested a urinalysis, but he did not provide any additional orders or referrals since there were no further concerns.

I reviewed the policy regarding resident's signing in and out of the facility which read a binder is kept at the front entrance in which residents should sign out and sign in each time they leave or return to the building.

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.**
	(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:	Interview with the administrator and review of facility documentation revealed Resident A's physician wrote an order for him to not leave the community unaccompanied as of 10/12/21. On 10/30, Resident A left the community alone. Resident A's physician had not rescinded the order from 10/12. Facility staff lacked providing Resident A protection and safety consistent with the physician order and his service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/13/2021, I shared the findings of this report with authorized representative Beth Mell. Ms. Mell verbalized understating of the citation.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend that status of this license remain unchanged.

11/24/21

Jessica Rogers Date
Licensing Staff

Approved By:

12/13/21

Russell B. Misiak Date
Area Manager