GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 25, 2022

Michelle Bojaj
Sunrise Assisted Living of Bloomfield Hills
6790 Telegraph Rd.
Bloomfield Hills, MI 48301

RE: License #: AH630391696
Investigation #: 2022A0585013
Sunrise Assisted Living of Bloomfield Hills

Dear Ms. Bojaj:

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 (517) 284-9730.

Sincerely,

Brender L. Howard

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(313) 268-1788
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630391696
Investigation #:	2022A0585013
Complaint Receipt Date:	12/03/2021
Investigation Initiation Date:	12/03/2021
Report Due Date:	02/02/2022
Licensee Name:	Welltower OpCo Group LLC
Licensee Address:	4500 Dorr Street Toledo, OH 43615
Licensee Telephone #:	(703) 854-0322
Authorized Representative/Administrator	Michelle Bojaj
Name of Facility:	Sunrise Assisted Living Of Bloomfield Hills
Facility Address:	6790 Telegraph Rd. Bloomfield Hills, MI 48301
Facility Telephone #:	(248) 858-7200
Original Issuance Date:	12/23/2019
License Status:	REGULAR
Effective Date:	06/23/2021
Expiration Date:	06/22/2022
Capacity:	132
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive his medication as prescribed.	Yes
Additional Findings	No

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

12/03/2021	Special Investigation Intake 2022A0585013
12/03/2021	Special Investigation Initiated - Letter Emailed referral to Adult Protective Services (APS).
12/14/2021	Inspection Completed On-site Completed with observation, interview and record review.
12/20/2021	Contact - Document Sent Emailed administrator Michelle Bojaj to request additional documents.
12/21/2021	Contact – Document received. Requested documents received.
01/26/2022	Exit conference Conducted with authorized representative Michelle Bojaj.

ALLEGATION:

Resident A did not receive his medication as prescribed.

INVESTIGATION:

On 12/2/21, the department received the allegations from a complainant via the BCHS Online Complaint website. The complainant alleges that resident did not get his last dose of medication on several occasions at night.

On 12/3/21, a referral was made to Adult Protective Services (APS). A letter was

received from APS Oakland County Services stating that investigation was not assigned for investigation.

On 12/14/21, an onsite was completed at the facility. The administrator Michelle Bojaj was not at the facility during the onsite. I interviewed nurse Judith Gafa. She stated that Resident A would get upset if his medicine is not administered at the exact time. She stated that he can make his needs known. She stated that Resident A missed one dosage of medication, but she did not remember the reason why the dosage was missed.

On 12/20/21, I interviewed administrator Michelle Bojaj by telephone. She stated that she didn't know if Resident A had any refusals of medication. She stated that if a resident refuse medication, staff are to make several attempts. She stated that if staff is not successful in getting resident to take medication, then they are to contact the doctor for further instructions. Ms. Bojaj emailed me copies of Resident A's medication administration record (MAR) and staff schedule.

Resident A' service plan read, admitted to the facility on 4/9/21 with diagnoses of displaced fracture of left tibial spine, sequela, traumatic rupture of lumbar intervertebral disc, subsequent encounter, anemia and essential hypertension. The plan read that Resident A is able to communicate verbally. The plan read, unable to self-administer his medication.

A review of Resident A's October medication administration record (MAR) read, 10/14, 10/19-10/20 medication (hydrocodone-acetaminophen) was not administered at 12:00 a.m. and on 10/11, 10/16-10/17, and 10/25 – 10/26 medication (Gabapentin) was not administered at 11:00 p.m. The MAR notes that Hydrocodone – acetaminophen is a controlled drug - give 1 tablet by mouth every 6 hours for pain. Gabapentin 1 tablet by mouth every 8 hours for pain.

The staff schedule/sign in shows that there was enough staff to care for the needs of the residents.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.

ANALYSIS:	Observation of the MAR shows several missed times of administering doses of medication to Resident A. Staff did not administer medication to Resident A as prescribed. Therefore, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 1/26/2022, I shared the findings of this report with authorized representative Michelle Bojaj.

IV. RECOMMENDATION

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

_____________________________________1/26/2022_
Brender Howard   Date
Licensing Staff

Approved By:

01/25/2022
____
Andrea L. Moore, Manager   Date
Long-Term-Care State Licensing Section