GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 14, 2022

Lance Davis
Sunrise Assisted Living Of Bloomfield Hills
6790 Telegraph Rd.
Bloomfield Hills, MI 48301

RE: License #: AH630391696
Investigation #: 2022A1027034
Sunrise Assisted Living Of Bloomfield Hills

Dear Mr. Davis:

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 authorized representative and dated.

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) 241-1970.

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 #:	AH630391696
Investigation #:	2022A1027034
Complaint Receipt Date:	01/25/2022
Investigation Initiation Date:	01/26/2022
Report Due Date:	03/24/2022
Licensee Name:	Welltower OpCo Group LLC
Licensee Address:	4500 Dorr Street Toledo, OH 43615
Licensee Telephone #:	(703) 854-0322
Administrator/Authorized Representative:	Lance Davis
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 lacked care and had falls.	No
Resident A did not receive his medications.	Yes
The memory care was short staffed.	No
Additional Findings	Yes

III. METHODOLOGY

01/25/2022	Special Investigation Intake 2022A1027034
01/26/2022	Special Investigation Initiated - Telephone Telephone interview conducted with complainant to obtain clarification regarding complaint
02/07/2022	Inspection Completed On-site
02/08/2022	Contact - Telephone call made Telephone interview conducted with medication care manager Emily Matas
02/14/2022	Inspection Completed-BCAL Sub. Compliance
02/25/2022	Exit Conference Conducted with authorized representative Lance Davis

ALLEGATION:

Resident A lacked care and had falls.

INVESTIGATION:

On 1/25/22, the department received a complaint which alleged Resident A lacked care and had falls.

On 1/26/22, I conducted a telephone interview with the complainant to obtain Resident A's name.

On 2/7/22, I conducted an on-site inspection at the facility. I interviewed interim administrator and authorized representative Lance Davis. Mr. Davis stated Resident A admitted to the facility in the assisted living then transitioned to the memory care approximately a week later. Mr. Davis stated Resident A had frequent falls. I interviewed Assisted Living Care Coordinator Pam Rush. Ms. Rush stated she was the care coordinator for both the memory care and assisted living while Resident A resided in the facility. Ms. Rush stated Resident A had moved into the facility from out of state and stayed there approximately one month. Ms. Rush stated Resident A had Parkinson's and a history of falls, but unknown as to how many falls. Ms. Rush stated Resident A utilized a walker and wheelchair at times, but sometimes would forget to use equipment for ambulation. Ms. Rush stated initially Resident A moved into the assisted living, but then he started to become more forgetful as well as went into other resident rooms. Ms. Rush stated Resident A transitioned into the memory care unit. Ms. Rush stated facility staff continued to work to know Resident A better. Ms. Rush stated the facility team and Resident A's family collaborated in which it was decided Resident A would benefit from a private duty caregiver at night. I interviewed caregiver Norma Ready whose statements were consistent with Ms. Rush. Ms. Ready stated care was provided per Resident A's service plan. Ms. Ready stated she did not recall Resident A having falls on her shift, however stated he was "shaky." Ms. Ready stated Resident A had a calm demeanor at first then became more active within both the assisted living and memory care once he was accustomed to each unit.

I reviewed Resident A's face sheet which read consistent with statements from staff interviews. The face sheet read Resident A admitted to the facility on 12/13/21 and discharged on 1/19/22.

I reviewed facility documentation for Resident A's level of care which read consistent with staff interviews. The documentation read Resident A admitted to the facility on 12/13/21, transferred to memory care on 12/24/21, was hospitalized on 1/15/22 and moved out on 1/19/22.

I reviewed Resident A's service plan which read consistent with the complaint and staff interviews.

I reviewed Resident A's activities of daily living documentation which read consistent with staff interviews and Resident A's service plan.

I reviewed Resident A's progress notes which read consistent with staff interviews.

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.

ANALYSIS:	Staff interviews along with review of facility documentation revealed staff provided care consistent with Resident A's service plan. Documentation revealed staff communicated Resident A's falls and the need to transition to the memory care unit with Resident A's family.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A did not receive his medications.

INVESTIGATION:

On 1/25/22, the department received a complaint which alleged Resident A did not receive his medications.

On 1/26/22, I conducted a telephone interview with the complainant to obtain Resident A's name.

On 2/7/22, I conducted an on-site inspection at the facility. I interviewed Assisted Living Care Coordinator Pam Rush who stated medication technicians were trained to stay with residents while administering their pills to ensure they took them. I conducted an interview with care manager Norma Ready who stated she had not observed Resident A's pills on the floor.

On 2/8/22, I conducted a telephone interview medication care manager Emily Matas. Ms. Matas stated initially Resident A took his medications without difficulty. Ms. Matas stated Resident A's family informed staff a pill was found on the floor. Ms. Matas stated after notification of finding the pill on the floor, Resident A's medications were administered crushed.

I reviewed Resident A's service plan which read consistent with staff interviews.

I reviewed Resident A's medication administration records (MARs) which revealed the following doses of medications were left blank: Rytary on 12/19/22 at 10:00 PM, 1/15/22 at 10:00 PM, 1/16/22 at 10:00 PM, Midodrine Hcl tablet on 1/9/22 at 1:00 PM and 1/10/22 at 1:00 PM.

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:	Staff interviews along with review of facility documentation revealed staff failed to mark all Resident A's medications as given or any reason for the missed doses and the MARs were left blank, therefore it cannot be confirmed why the medication administration was not completed as scheduled.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The memory care was short staffed.

INVESTIGATION:

On 1/25/22, the department received a complaint which alleged the facility's memory care was short staffed.

On 2/7/22, I conducted an on-site inspection at the facility. I interviewed interim administrator and authorized representative Lance Davis. Mr. Davis stated the facility staffs three shifts 6:00 AM to 2:00 PM, 2:00 PM to 10:00 PM and 10:00 PM to 6:00 PM. Mr. Davis stated the memory care usually has four staff scheduled for first shift, four staff for second shift and two staff scheduled for third shift. Mr. Davis stated the memory care has additional staff such as the medication care manager, life enrichment manager, and memory care coordinator. Mr. Davis stated the memory care located on third floor has a capacity for 36 residents, in which there were currently 33 residents. Mr. Davis stated there were approximately three memory care residents who required two person assist and provided a spreadsheet with showing the levels of care for memory care. Mr. Davis stated the number of residents requiring two person assist had remained consistent throughout December and January. Mr. Davis stated the memory care unit has two neighborhoods in which there are two caregivers assigned to each neighborhood. I interviewed Assisted Living Care Coordinator Pam Rush whose statements were consistent with Mr. Davis. Ms. Rush stated she was both the memory care and assisted living coordinator when Resident A resided in the facility. Ms. Rush stated she scheduled the facility's memory care and the facility's staffing was met with additional agency based on resident needs. Ms. Rush stated the facility had been utilizing agency staff from Clipboard Health for approximately three months in which most of the agency staff were consistent and familiar with their residents. Ms. Rush stated the facility's

staffing is determined by resident needs and calculated automatically using their "On-shift" scheduling system by the level of care assigned to each resident. Ms. Rush demonstrated how the "On-Shift" scheduling system worked on her computer.

I reviewed the facility's memory care staffing schedule for December 2021 and January 2022 which read consist with staff interviews.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	Staff interviews along with review of facility documentation revealed the facility was staffed consistent with resident needs as per their service plans.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

I reviewed the facility's chart notes for Resident A. Chart note from 12/14/21 at 10:27 AM read "Staff was alerted that (Resident A) was sitting on the toilet, and was trying to wipe himself while leaning forward, he fell off the toilet." The note read "Staff assisted (Resident A) off of the floor and onto a chair, (Resident A) head has an abrasion on forehead right side that was bleeding, bleeding was stopped, abrasion was cleaned and covered." Chart note from 1/15/22 at 12:17 PM read "On 1/14/21 Satff (sp) was walking past room and observed resident in his wheelchair pushing another chair. Staff went to assist resident, resident fell out of wheelchair onto the floor." Chart note from 1/15/22 at 12:36 PM read Resident A was transferred to Beaumont Royal Oak Hospital. Chart note from 1/17/22 at 2:08 PM read Resident A's family informed staff he admitted to St. Joseph's hospital. Chart note from 2/1/22 at 5:06 PM read "on 12/29/21 Resident was walking without equipment in room, and fell."

I reviewed the facility's file which revealed the facility had not reported Resident A's falls nor hospitalization to the department.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(2) 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.
ANALYSIS:	Review of facility charting revealed Resident A had one fall with injury as well as required hospitalization which were not reported to the department.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 2/25/2022, I shared the findings of this report with authorized representative Lance Davis. Mr. Davis verbalized understanding of the citations.

IV. RECOMMENDATION

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

2/14/2022

_____

Jessica Rogers Date
Licensing Staff

Approved By:

02/24/2022

_____

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