GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 8, 2022

Sunil Bhattad
Bolton Brook Manor Inc
4554 Thomas
Metamora, MI 48455

RE: License #: AL440063943
Investigation #: 2022A0569021
Bolton Brook Manor

Dear Mr. Bhattad:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On March 8, 2022, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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,

Kent W Gieselman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 931-1092

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL440063943
Investigation #:	2022A0569021
Complaint Receipt Date:	02/09/2022
Investigation Initiation Date:	02/09/2022
Report Due Date:	04/10/2022
Licensee Name:	Bolton Brook Manor Inc
Licensee Address:	4554 Thomas Metamora, MI 48455
Licensee Telephone #:	(810) 678-2087
Administrator:	Sunil Bhattad
Licensee Designee:	Sunil Bhattad
Name of Facility:	Bolton Brook Manor
Facility Address:	4554 Thomas Rd Metamora, MI 48455
Facility Telephone #:	(810) 678-2087
Original Issuance Date:	04/11/1995
License Status:	REGULAR
Effective Date:	03/25/2020
Expiration Date:	03/24/2022
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED

II. ALLEGATION(S)

	Violation Established?
• **There is not enough staff to provide appropriate care to the residents.**	Yes
• **Residents pay for cable in their room but do not have it.**	No
• **Staples in the carpet that are popping out causing foot hazard.**	Yes

III. METHODOLOGY

02/09/2022	Special Investigation Intake 2022A0569021
02/09/2022	APS Referral
02/09/2022	Special Investigation Initiated - Telephone Contact with Lisa Jolly, RRO.
03/08/2022	Inspection Completed On-site
03/08/2022	Inspection Completed-BCAL Sub. Compliance
03/08/2022	Exit Conference exit conference conducted with Sunil Bhattad, licensee designee.
03/08/2022	Corrective Action Plan Requested and Due on 03/08/2022
03/08/2022	Corrective Action Plan Received
03/08/2022	Corrective Action Plan Approved

ALLEGATION:

There is not enough staff to provide appropriate care to the residents.

INVESTIGATION:

This complaint was received via the on-line complaint portal. The complainant reported that there are not enough staff working at this facility to ensure the residents' needs are being met in a timely manner.

Lisa Jolly, recipient rights officer, stated on 2/9/22 that she is concerned that there are not enough staff working at this facility to provide appropriate care for the residents. Ms. Jolly stated that staff have reported to her that they are working multiple shifts consecutively because there are not enough staff to cover all three shifts in a 24-hour period. Ms. Jolly stated that she is concerned that the staff that are at this facility are working unreasonable hours making them fatigued when they are assisting the residents. Ms. Jolly stated that Sunil Bhattad, licensee designee, is aware of the problem but is not hiring new staff.

An unannounced inspection of this facility was conducted on 3/8/22. The resident files were reviewed. The resident register documents that there are currently nine (9) residents residing in this facility. The resident written assessment were reviewed during the inspection. Eight (8) of the residents currently residing in this facility require staff prompting or verbal reminders for self-care, but do not require staff assistance with completing daily self-care. One resident ambulates with the assistance of a walker and requires minimum staff assistance with daily self-care tasks. The staff schedule for January and February 2022 were reviewed during the inspection. The staff schedule documents that from 1/1/22 to 1/23/22 there was one staff person scheduled to work from 7:00am to 7:00pm, and then one staff scheduled from 7:00pm to 7:00am. The staff schedule documents that a new staff person was hired and began training on 1/24/22. The staff schedule documents that beginning 1/29/22, two staff were scheduled to work from 9:00am to 9:00pm and then one staff was assigned to work 9:00pm to 9:00am. The staff schedule for February 2022 documents that additional staff were added to the schedule and averaged two staff working from 7:00am to 3:00pm with one staff working from 3:00pm to 11:00pm and then one staff from 11:00pm to 7:00am.

Staff 1 stated on 3/8/22 that they do not feel there are enough staff to cover each shift and complete all the tasks that need to be completed during a shift. Staff 1 stated that for the past four to five months, several staff have been hired to add to the schedule but that they have either called in sick, not showed up for a shift, or have quit soon after being hired. Staff 1 stated that when that happens, the staff person working simply has to stay until another staff person can report to work. Staff 1 stated that there are nine residents, and they all can complete daily living tasks with no or very little staff assistance. Staff 1 stated that the staff that are still working at this facility are doing

everything they can, and always meet the residents' needs, but more staff need to be hired.

Staff 2 stated that the staff working at this facility are dedicated to providing the best care that they can to the residents, but that there are not enough staff currently working at this facility. Staff 2 stated that for several months, there was only one staff person working 12-hour shifts, and there were times that Staff 2 had to work numerous shifts consecutively because a staff person would simply not show up for their shift. Staff 2 stated that there have been times that she has had to tell a resident to wait for assistance with something until she had finished assisting another resident. Staff 2 stated that staff never have a break and are going "all the time" and that it becomes exhausting.

Sunil Bhattad, licensee designee, stated on 3/8/22 that he has had a problem keeping staff after he has hired them. Mr. Bhattad stated that there have been times that a single staff person has had to work multiple consecutive shifts because newly hired staff simply don't show up for their shift or quit. Mr. Bhattad stated that he tries to schedule 2 staff for first shift, and then one staff person for second and one for third. Mr. Bhattad stated that he anticipates adding several staff to the schedule by 4/1/22 and is in the process of making some staffing changes.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	The complainant reported that there are not enough staff working at this facility to meet the residents' needs. Ms. Jolly stated that she has concerns regarding the number of staff working at this facility as well, and that staff have reported to her that they are being made to work multiple shifts consecutively and are very fatigued. The staff schedule documents that for January and part of February, there was one staff person scheduled to work from 9:00am to 9:00pm, and then one from 9:00pm to 9:00am. Staff 1 and staff 2 stated that there are not enough staff working at this facility, and that staff have not reported for their shift, or simply quit shortly after being hired, leaving the staff person on duty to have to work multiple

	consecutive shifts. Staff 1 and Staff 2 stated that this staffing issue has been a problem for four to five months, and there need to be more staff added to the schedule. Mr. Bhattad stated that he has had a problem keeping staff hired and admitted that staff have had to work multiple shifts consecutively until they can be relieved. All of the statements given indicate that there are not enough staff currently to schedule to ensure that staff will not be compelled to work multiple consecutive shifts, causing staff to be fatigued and compromising their ability to meet the residents' needs. Based on the documentation reviewed and statements given, it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents pay for cable in their room but do not have it.

INVESTIGATION:

The complainant reported that the residents pay for cable television in their rooms. The complainant reported that there are residents that do not have cable television in their bedrooms.

All of the resident care agreements were reviewed during the inspection on 3/8/22. None of the resident care agreements document that the residents are being charged for cable television as part of their monthly fee. The resident funds and valuables part II forms were reviewed. The only amount being charged on the part II form is the same amount documented on the care agreements for the monthly cost of care.
Mr. Bhattad stated on 3/8/22 that cable television is "complimentary" and that none of the residents are charged for it. Mr. Bhattad stated that the residents can watch the televisions in their rooms, or the television in the main living room area of the facility. Mr. Bhattad stated that the cost of the cable television is paid for by Bolton Brook Manor Inc.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care

	agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following: (c) A description of additional costs in addition to the basic fee that is charged.
ANALYSIS:	The complainant reported that the residents pay for cable television in their rooms, but some of the residents don't have cable in their rooms. The resident care agreements document that the residents are only charged for monthly cost of care and cable television is not listed as an additional fee. The resident funds part II forms matched the amount documented on the care agreements for monthly cost of care. Mr. Bhattad stated that cable television is "complimentary" and there are several televisions that residents can use in the facility. Based on the documentation reviewed and statements given, it is determined that there has been no violation of this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staples in the carpet that are popping out causing foot hazard.

INVESTIGATION:

The complainant reported that there are staples "popping" out of the carpet. The complainant reported that the residents have to wear shoes while walking around the facility to keep them from puncturing their feet on the exposed staples.

The carpet and flooring were observed throughout this facility during the inspection on 3/8/22. The threshold covering the transition of carpeting in the living room to the vinyl flooring in the dining room was observed to be broken and missing. The missing threshold was observed to expose torn carpeting and tacks fastening the carpet to the floor. Mr. Bhattad stated that he is aware of the damage and the threat it poses. Mr. Bhattad stated that he is replacing the carpeting. Mr. Bhattad stated that the damage was caused by a resident accidentally.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	The threshold covering the transition of carpeting in the living room to vinyl flooring in the dining room was observed to be broken on 3/8/22. The broken threshold exposes flooring staples that could cause foot injuries to the residents. Based on the observation made, it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

An exit conference was conducted with Mr. Bhattad on 3/8/22. The findings in this report were reviewed. Mr. Bhattad submitted an acceptable corrective action plan to address the rule violations cited in this report.

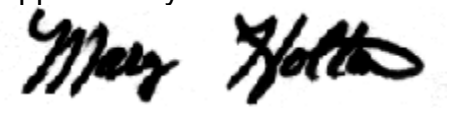
IV. RECOMMENDATION

Sunil Bhattad, licensee designee, submitted an acceptable corrective action plan on 3/8/22. I recommend that the status of this license remain unchanged, and this investigation be closed.

3/8/22

Kent W Gieselman Date
Licensing Consultant

Approved By:



3/8/22

Mary E Holton Date
Area Manager