GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 31, 2022

Michael Dyki
Blossom Springs
3215 Silverbell Rd.
Oakland Twp, MI 48306

RE: License #: AH630396969
Investigation #: 2022A0585042
Blossom Springs

Dear Mr. Dyki:

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 #:	AH630396969
Investigation #:	2022A0585042
Complaint Receipt Date:	03/28/2022
Investigation Initiation Date:	03/28/2022
Report Due Date:	05/27/2022
Licensee Name:	Blossom Ridge, LLC
Licensee Address:	3005 University Dr Auburn Hills, MI 48326
Licensee Telephone #:	(248) 884-1404
Authorized Representative/Administrator:	Michael Dyki
Name of Facility:	Blossom Springs
Facility Address:	3215 Silverbell Rd. Oakland Twp, MI 48306
Facility Telephone #:	(248) 340-9400
Original Issuance Date:	11/23/2020
License Status:	REGULAR
Effective Date:	05/23/2022
Expiration Date:	05/22/2023
Capacity:	56
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident suffered from hypothermia due to inadequate supervision.	Yes
Additional Findings	No

III. METHODOLOGY

03/28/2022	Special Investigation Intake 2022A0585042
03/28/2022	Special Investigation Initiated - Letter Emailed referral to Adult Protective Services (APS).
04/05/2022	Inspection Completed On-site Completed with observation, interview, and record review.
04/20/2022	Contact - Telephone call made Called staff Meghan Houston to discuss incident.
05/27/2022	Exit conference Conducted with authorized representative Michael Dyki by telephone.

ALLEGATION:

Resident suffered from hypothermia due to inadequate supervision.

INVESTIGATION:

Facility administrator and authorized representative Michael Dyki submitted an incident report pertaining to Resident A on 3/28/2022 that read, “While walking down hallway during wellness checks, medication technician, Employee A, heard resident yelling. Employee A observed Resident A sitting next to the door outside within the enclosed courtyard. Employee A immediately assisted Resident A inside and called 911.” The incident report read in the section *Corrective Measures Taken to Remedy and/or Prevent Recurrence*, “Maintenance and director will lock interior courtyard doors in the Assisted Living area to prevent access by residents. The incident report also notes that physician, Resident A’s authorized representative and the State was called. The physician diagnosis listed on the incident report, is hypothermia and new

onset of afib.

On 3/28/2022, I made a referral to Adult Protective Services (APS) Centralized intake unit.

On 4/5/2022, I completed an onsite at the facility. I interviewed administrator Michael Dyki at the facility. Mr. Dyki stated, Resident A is no longer ambulatory. He stated that Resident A never left the facility but inside the courtyard. He stated Resident A was sleeping at midnight when staff looked in at her. Mr. Dyki explained that when staff was walking through the facility, she heard Resident A yelling. Mr. Dyki stated that the door was not locked because it is inside the courtyard but stated that it is locked now. He stated care staff consists of one medication technician and two caregivers on the first and second shift, and the third shift consists of two caregivers.

On 4/5/2022, I interviewed director of nursing Allisha Kovacs at the facility. Ms. Kovacs stated that it was around 12:00 a.m. when Resident A was last monitored by the staff. She stated that they did not know how long Resident A had been outside. She stated that all residents are monitored every two hours. Ms. Kovacs stated, Resident A is very mobile and like to walk around. She stated that this is the first time that Resident A has displayed this type of behavior

On 4/20/2022, I interviewed Employee A by telephone. Employee A stated that on the night of Resident A's incident, she was working the assisted living side of the building by herself. She stated that there were two agency staff on the other side of the building. She stated that there were 21 residents on the assisted living side. Employee A explained that she was in another room and at some point, she was walking down the hall and she heard yelling. She stated that she looked at the door and that is when she saw Resident A. She stated that the last time she saw her was at 12:00 a.m. She stated that it was around 4:00 a.m. when she found her outside in the courtyard. She stated that they usually check on Resident A to make sure that she is in bed because when she is awake is she exit seeking. She stated that she was the only staff working that hallway and did not complete the two hour check. She stated that there are 21 residents in the assisted living of the facility.

During the onsite, I observed the courtyard door. The door was locked during that time.

The service plan for Resident A, read, resident was admitted to the facility on 5/2/21 with diagnosis that included dementia, major depressive disorder, hypertension, trigger finger and repeated falls. In the section marked, *Behaviors* it read, "resident does not move about the building with purposeful direction. There are many times that resident is exit seeking and looking for someone to pick her up and take her back home." In the section, *Elopement risk*, it reads, attempt redirection when wandering near doors; whereabout checks; and with changes in behavior monitor for increased wandering.

Staffing schedule was reviewed. The staff schedule was consistent to staff on duty during the time of the incident.

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: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
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 supervisor 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.
	(22) "Supervision" means guidance of a resident in the activities of daily living, and includes all of the following: (d) Being aware of a resident's general whereabouts as indicated in the resident's service plan, even though the resident may travel independently about the community.
ANALYSIS:	Resident A was known to be exit seeking. Resident A's service plan did not reflect her increasing need for supervision. Specifically, it lacked the frequency of safety checks. Due to this insufficiently developed plan, she was able to get out of the door. It is unknown how long she was outside in the cold. However, Resident A was outside for enough time to develop hypothermia. The facility lacked an organized program of supervision and reasonable protective measures to keep her safe.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 5/27/2022, I conducted an exit conference with licensee authorized representative Michael Dyki by telephone.

IV. RECOMMENDATION

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

05/31/2022

Brender Howard — Date
Licensing Staff

Approved By:

05/27/2022

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