GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 23, 2022

Vera Gjolaj
Sunrise Assisted Living Of Bloomfield Hills
6790 Telegraph Rd.
Bloomfield Hills, MI 48301

RE: License #: AH630391696
Investigation #: 2022A1019056

Dear Ms. Gjolaj:

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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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 authorized representative and a date.

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,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630391696
Investigation #:	2022A1019056
Complaint Receipt Date:	06/15/2022
Investigation Initiation Date:	06/15/2022
Report Due Date:	08/15/2022
Licensee Name:	Welltower OpCo Group LLC
Licensee Address:	4500 Dorr Street Toledo, OH 43615
Licensee Telephone #:	(703) 854-0322
Administrator and Authorized Representative:	Vera Gjolaj
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:	06/23/2022
Expiration Date:	06/22/2023
Capacity:	132
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Improper treatment of Residents A and B.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/15/2022	Special Investigation Intake 2022A1019056
06/15/2022	Special Investigation Initiated - Telephone Admin/AR called licensing staff to report the incidents on 6/3/22 and 6/12/22. Admin/AR followed up both calls with incident reports on the events.
06/15/2022	Comment Due to the COVID-19 pandemic, investigation is being conducted remotely.
06/15/2022	Contact - Document Sent Ongoing email correspondence with admin/AR.
06/16/2022	APS Referral Notified APS of the allegations via email referral template.
06/16/2022	Inspection Completed-BCAL Sub. Compliance
06/28/2022	Comment SIR submitted to area manager for review.

ALLEGATION:

Improper treatment of Residents A and B.

INVESTIGATION:

Administrator and authorized representative Vera Gjolaj notified licensing staff of two reportable incidents involving Resident A and Resident B. Ms. Gjolaj reported that on 6/3/22, Employee A placed a chair under Resident A's doorknob to prevent her

from being able to open the door and leave her room. The incident report submitted by Ms. Gjolaj read:

> *[Witness A] was walking through the Memory Care neighborhood when she noticed a chair place under the doorknob of a resident's door. [Witness A] questioned Sunrise team member on why a chair was placed against [Resident A's] door, team member responded with she is COVID positive and keeps trying to get out. [Witness A] promptly reported incident to [Employee B] instructed team member to immediately remove the chair.*

Ms. Gjolaj reported that on 6/10/22, Resident B was discovered on the floor and was left there for roughly two hours. The incident report submitted by Ms. Gjolaj read:

> *At approximately 4:30pm [Employee C] entered resident suite and observed her on the floor near her bathroom with her cane. Team member attempted to help resident off the floor but was unable to. At approximately 6:30 pm. [Employee D] observed resident sitting on the floor. [Employee D] requested help and two team members assisted resident off the floor and into bed. Family arrived at the community around 6:45 p.m. and requested resident to be transport to the hospital due to complaints of pain.*

In follow up correspondence, Ms. Gjolaj stated "The first care manger [Employee C] states she told the other care managers that the resident had a fall. Upon investigation, no team member report having a conversation with [Employee C] in regards to the resident having a fall. When [Employee D] observed the resident on the floor at 6:30 pm, the team immediately responded and assisted her off the floor."

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(1) A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization, which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.

ANALYSIS:	Residents A and B were treated in an undignified manner and the provision of care provided to Residents A and B as outlined above are not consistent with the expectations of this statute.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(2)(l) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician, by a physician's assistant with whom the physician has a practice agreement, or by an advanced practice registered nurse, for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician, physician's assistant, or advanced practice registered nurse who authorized the restraint. In case of a chemical restraint, the physician, or the advanced practice registered nurse who authorized the restraint, shall be consulted within 24 hours after the commencement of the chemical restraint.
ANALYSIS:	Staff intentionally locked Resident A in her room by placing a physical restraint on the door, preventing her from exiting.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the course of this investigation, a verbal request was made on 6/22/22 and written requests were made on 6/23/22 and 6/29/22 for additional documentation pertaining to Resident B's incident and action that staff took upon the initial discovery of the fall. Ms. Gjolaj stated that the documentation requested was

“privileged” and at the time of this report, the licensee has failed to comply with this request.

APPLICABLE RULE	
MCL 333.20155	**Visit to health facility or agency; survey and evaluation for purpose of licensure; nursing home surveyor; criminal history check; survey team; composition and membership; waiver; confidentiality of accreditation information; limitation and effect; consultation engineering survey; summary of substantial noncompliance or deficiencies and response; investigations or inspections; prior notice as misdemeanor; record; periodic reports; access to documents; disclosure; delegation of functions; voluntary inspections; forwarding evidence of violation to licensing agency; reports; clarification of terms; quarterly meeting; resident care policies and compliance protocols; nursing home's survey report; posting; other state and federal law; definitions.**
	(17) The department shall require periodic reports and a health facility or agency shall give the department access to books, records, and other documents maintained by a health facility or agency to the extent necessary to carry out the purpose of this article and the rules promulgated under this article. The department shall not divulge or disclose the contents of the patient's clinical records in a manner that identifies an individual except under court order. The department may copy health facility or agency records as required to document findings. Surveyors shall use electronic resident information, whenever available, as a source of survey-related data and shall request facility assistance to access the system to maximize data export.
ANALYSIS:	The licensee has not cooperated with the department as evidenced by their refusal to provide documentation directly pertaining to a licensing investigation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Per the incident report submitted by Ms. Gjolaj, Resident B's fall resulted in a hip fracture. Facility staff failed to identify that medical attention was needed for Resident B upon Employee C's initial discovery of the resident and she was subsequently left on the floor for over two hours before medical attention was sought.

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: **(c) Assure the availability of emergency medical care required by a resident.**
ANALYSIS:	Resident B was not afforded emergency medical care in a timely manner after falling and sustaining a fractured hip. Resident B was left on the floor for at least two hours (from roughly 4:30pm-6:30pm on 6/10/22) before staff assisted her. Facility staff did not seek mediation attention until after Resident B's family arrived to the facility at 6:45pm and requested medical attention.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Resident A was locked in her room by staff on 6/3/22. The incident report submitted by Ms. Gjolaj indicated that the physician was not notified about this incident until 6/7/22. When questioned about the delay, Ms. Gjolaj stated "We did not report to the PCP in the required time frame. Assisted Living Coordinator stated she forgot to inform the doctor."

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) 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:	Resident A's physician was notified four days following the incident instead of immediately.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 8/23/22, I shared the findings of this report with authorized representative Vera Gjolaj.

IV. RECOMMENDATION

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

08/23/2022

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

08/23/2022

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