GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 10, 2022

Kristie Britton
Sunrise of Grosse Pointe Woods
21260 Mack Avenue
Grosse Pointe Woods, MI 48236

RE: License #: AH820391697
Investigation #: 2023A1027001
Sunrise of Grosse Pointe Woods

Dear Ms. Britton:

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 authorized representative 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) 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) 285-7433
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820391697
Investigation #:	2023A1027001
Complaint Receipt Date:	09/28/2022
Investigation Initiation Date:	09/29/2022
Report Due Date:	11/28/2022
Licensee Name:	Welltower OpCo Group LLC
Licensee Address:	4500 Dorr Street Toledo, OH 43615
Licensee Telephone #:	(419) 247-2800
Administrator/ Authorized Representative:	Kristy Britton
Name of Facility:	Sunrise of Grosse Pointe Woods
Facility Address:	21260 Mack Avenue Grosse Pointe Woods, MI 48236
Facility Telephone #:	(313) 343-0600
Original Issuance Date:	12/23/2019
License Status:	REGULAR
Effective Date:	06/23/2022
Expiration Date:	06/22/2023
Capacity:	78
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

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

III. METHODOLOGY

09/28/2022	Special Investigation Intake 2023A1027001
09/29/2022	Special Investigation Initiated - Letter Email sent to administrator Kristy Britton requesting a resident roster
09/29/2022	Contact - Document Received Email received from Ms. Britton with resident roster
10/03/2022	Contact - Telephone call made Voicemail left with complainant
10/04/2022	Contact - Document Received Telephone interview conducted with complainant.
10/04/2022	Contact - Document Sent Email sent to AR/Administrator Ms. Britton requesting documentation pertaining to Resident A
10/04/2022	Contact - Document Received Email received from Ms. Britton with requested information.
11/07/2022	Contact - Telephone call made Voicemail left with Ms. Britton requesting call back
11/07/2022	Contact - Document Sent Email sent to Ms. Britton requesting call to discuss documentation sent on 10/4/202
11/07/2022	Contact - Telephone call received Telephone interview completed with Ms. Britton, who will follow up by telephone or email with additional information/documentation
11/09/2022	Contact - Document Received

	Email received from Ms. Britton with additional documentation
11/10/2022	Inspection Completed-BCAL Sub. Compliance
11/29/2022	Exit Conference Conducted with authorized representative Kristy Britton by voicemail and email

ALLEGATION:

Resident A did not receive her medication as prescribed.

INVESTIGATION:

On 9/28/2022, the department received a complaint by the online complaint system which read Resident A did not receive her Lidoderm patch on 9/19/2022, 9/20/2022, 9/21/2022, and 9/23/2022. Additionally, the complaint read there was no medication technician on duty on 9/16/2022 in which Resident A received her medications at 11:10 AM.

On 10/4/2022, I conducted a telephone interview with the complainant in which I received clarification of Resident A's first and last name. The complainant stated there was a team meeting one week ago with the executive director and director of nursing to address concerns of Resident A's care. The complainant stated she was concerned Resident A had not been receiving her Lidoderm patch as prescribed which was to be applied at "the nape of the neck." The complainant stated Resident A was currently hospitalized in the intensive care unit due to COVID-19.

On 11/7/2022, I conducted a telephone interview with administrator and authorized representative Kristy Britton. Ms. Britton stated Resident A remained in the hospital and her assistant moved out her belongings from the facility. Ms. Britton stated medication technician Employee #1 was on duty from 8:00 AM to 3:00 PM on 9/16/2022.

I reviewed Resident A's face sheet which read she admitted to the facility on 9/1/2022 and she was responsible for herself.

I reviewed Resident A's service plan updated on 10/3/2022 which read the facility was to administer her medications and was diagnosed with COVID-19 on 10/3/2022.

I reviewed Resident A's September 2022 medication administration record (MAR). There were two orders for the Lidoderm patch on the MAR:

> *Lidoderm External Patch (Lidocaine) apply to neck topically one time a day for pain remove after 12 hours at 8:00 PM (2000), start date was 9/2/2022 and*

discontinue date 9/16/2022 in which staff were to initial the 8:00 AM application of the patch.

Lidoderm External Patch (Lidocaine) apply to neck topically one time a day for pain remove after 12 hours at 8:00 PM (2000) and remove per schedule start date was 9/17/2022 in which staff were to initial the 8:00 AM application and 8:00 PM removal of the patch.

The MAR read on 9/21/2022 and 9/22/2022 for the 8:00 AM doses of the Lidoderm patch were marked “medication pending delivery”. The MAR read for the 8:00 PM removal of the Lidoderm patch that staff marked it was completed on 9/21/2022 and 9/22/2022. The MAR read on 9/23/2022 for the 8:00 AM dose of the Lidoderm patch was marked as applied and there was a staff note entered for the removal at 8:00 PM. I reviewed the staff note entered on 9/23/2022 for the Lidoderm patch removal at 8:00 PM which in part read “patch already removed?”

Additional review of Resident A’s MAR revealed she was prescribed Tylenol 325 mg, give two tablets by mouth every six hours for pain dated 9/1/2022 in which there were one or more doses of the medication left blank on the MAR for on the following dates: 9/6/2022, 9/7/2022, 9/8/2022, 9/11/2022, 9/12/2022, 9/23/2022 and 9/26/2022.

I reviewed the facility’s medication delivery receipt dated 9/22/2022 which read one box (five each) Aspercreme Lidocaine 4% patches were delivered.

I reviewed the 9/16/2022 staff schedule which read consistent with Ms. Britton’s statements. Resident A’s MAR on 9/16/2022 read her 8:00 AM medications were administered by Employee #1.

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:	Review of Resident A's records revealed the facility was responsible for her medication administration. Review of Resident A's MAR revealed inconsistent staff documentation pertaining to the administration and removal of the Lidoderm patch. For example, on 9/21/2022 and 9/22/2022 staff documented the 8:00 AM doses of the patch were pending delivery however staff documented the patch was removed at 8:00 PM. Additionally, the MAR read there were various dates and times in which Tylenol doses were left blank and a lack of documentation for the reason why, thus it could not be determined if the medication was administered or not. Based on this information, this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/29/2022, I shared the findings of this report with authorized representative Kristy Britton by voicemail and email.

IV. RECOMMENDATION

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

11/10/2022

Jessica Rogers Date
Licensing Staff

Approved By:

11/28/2022

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