GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 22, 2022

Amy Borzymowski
Brookdale Grand Blanc AL
5080 Baldwin Road
Holly, MI 48442

RE: License #: AH250236939
Investigation #: 2023A1027018
Brookdale Grand Blanc AL

Dear Ms. Borzymowski:

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 #:	AH250236939
Investigation #:	2023A1027018
Complaint Receipt Date:	11/22/2022
Investigation Initiation Date:	11/23/2022
Report Due Date:	1/22/2022
Licensee Name:	Brookdale Senior Living Communities, Inc.
Licensee Address:	Suite 2300 6737 West Washington St. Milwaukee, WI 53214
Licensee Telephone #:	(414) 918-5000
Administrator:	Heather Vahlbusch
Authorized Representative:	Amy Borzymowski
Name of Facility:	Brookdale Grand Blanc AL
Facility Address:	5080 Baldwin Road Holly, MI 48442
Facility Telephone #:	(810) 953-7111
Original Issuance Date:	10/01/1998
License Status:	REGULAR
Effective Date:	05/07/2022
Expiration Date:	05/06/2023
Capacity:	78
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
The facility was understaffed.	No
Resident A was neglected.	Yes
Resident A had not received his medications as prescribed.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/22/2022	Special Investigation Intake 2023A1027018
11/23/2022	Special Investigation Initiated - Letter Referral emailed to APS for review
11/23/2022	APS Referral Sent by email
12/12/2022	Inspection Completed On-site
12/19/2022	Contact - Document Sent Email sent to Absolute Hospice requesting information and documentation pertaining to Resident A
12/20/2022	Contact - Document Received Email received from Absolute Hospice with requested documentation and information
12/21/2022	Contact - Document Sent Email sent to Ms. Vahlbusch requesting the nurse notes for the MARs
12/21/2022	Contact - Telephone call made Telephone interview with Absolute Hospice staff member
12/22/2022	Contact - Document Received Emails received from Ms. Vahlbusch with requested documentation
12/22/2022	Inspection Completed-BCAL Sub. Compliance

01/26/2023	Exit Conference Conducted with authorized representative Amy Borzymowski by telephone

ALLEGATION:

The facility was understaffed.

INVESTIGATION:

On 11/22/2022, the department received a complaint in which read the facility was understaffed.

On 12/12/2022, I conducted an on-site inspection at the facility. I interviewed administrator Heather Vahlbusch who stated the resident census during November 2022 was 50 to 60 residents. Ms. Vahlbusch stated the number of staff scheduled for resident care was based on the needs in the resident's service plans in which was six staff for first and second shifts, then four staff for third shift. Ms. Vahlbusch stated there were three shifts: 6:00 AM to 2:00 PM, 2:00 PM to 10:00 PM and 10:00 PM to 6:00 AM in which sometimes additional shorter shifts were added during busy hours such as mealtimes.

While on-site, I interviewed Employee #1 whose statements were consistent with Ms. Vahlbusch. Employee #1 stated each shift was staffed by resident acuity. Employee #1 stated there were approximately seven residents who required two-person assist with care.

While on-site, I interviewed Employee #2 who statements were consistent with Ms. Vahlbusch and Employee #1. Employee #2 stated the facility was fully staff and had not utilized agency staff since the end of October 2022.

While on-site, I interviewed Employee #3 who stated staffing was "good."

While on-site, I observed approximately 20 residents who appeared groomed and dressed in clean clothing.

While on-site, I interviewed Resident B who stated, "sometimes I have to wait for staff but overall, they are good."

While on-site, I interviewed Resident C who stated staff care was "very good."

I reviewed the resident roster which read there were 61 residents.

I reviewed the staff schedules from 10/30/2022 through 12/10/2022 which read consistent 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:	Review of facility documentation, as well as resident and staff attestations, revealed the facility was staffed sufficiently to meet the needs of residents consistent with their service plans. Based on this information, this allegation was unsubstantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was neglected.

INVESTIGATION:

On 11/22/2022, the department received a complaint in which read Resident A's needs were neglected, as well as staff's response to his call light and his nutritional needs. The complaint read residents' call lights were being ignored or they must wait 30 minutes to one hour for assistance. The complaint read Resident A had a bed sore in which worsened due to lack of care and being left in soiled briefs. The complaint read Resident A required two-person assist for care. The complaint read Resident A's meals had been forgotten or incorrect repeatedly.

On 11/23/2022, I referred the allegations to Adult Protective Services (APS) for review.

On 12/12/2022, I conducted an on-site inspection at the facility. I interviewed the administrator Heather Vahlbusch who stated Resident A moved into the facility in June 2022 and received hospice services. Ms. Vahlbusch stated Resident A had required two-person assistance for care in which he would transfer to his wheelchair and attend meals in the dining room. Ms. Vahlbusch stated Resident A had a wound on his bottom area on admission to the facility. Ms. Vahlbusch stated Resident A had declined since moving into the facility.

While on-site, I interviewed Employee #2 who stated Resident A had a condom catheter in which kept urine from touching his wound, however Resident A would

have confusion intermittently and state he felt wet. Employee #2 stated staff would check Resident A's when he "felt wet" but it was dry. Employee #2 stated staff documented when residents would refuse showers in the shift log. Employee #2 stated Resident A had not refused showers and that his showers were completed by his hospice agency or the facility staff. Employee #2 stated the hospice agency's communication was poor initially but had improved.

While on-site, I interviewed Employee #3 who stated Resident A's wound had "on/off improvements" since his admission to the facility. Employee #3 stated she had observed his wound approximately one week prior in which at that time it was not open. Employee #3 stated staff assisted Resident A with meals in his room in which he usually ate five or six bites of each meal.

While on-site, I observed the facility's menus and interviewed Employee #5, who stated staff documented when residents refused meals. Employee #5 stated Resident A had received his meals as prescribed. Employee #5 stated the facility maintained a meal census for a seven period in which she had only the current week.

While on-site, I observed Resident A in sitting up in his bed watching television. Resident A appeared groomed and dressed in clean clothing. Resident A declined to be interviewed without his family present.

While on-site, I reviewed the facility's November 2022 shift logs which read consistent with statements from Employee #2 and had not recorded Resident A had missed or refused showers.

On 12/21/2022, I interviewed Resident A's Absolute hospice staff who stated Resident A's wound was closed however it had worsened and become "macerated" since his admission to the facility. The hospice staff stated Resident A was observed sitting in his own feces, or his condom catheter would come off in which urine would be on his wound. The hospice staff stated Resident A's wound area was painful in which there were medications prescribed to control his pain. The hospice staff stated Resident A had declined since his admission to the facility in which he was total care and bed bound. The hospice staff stated the hospice team had increased their visits to five days per week to accommodate Resident A's decline.

I reviewed Resident A's face sheet which read he admitted to the facility on 6/29/2022 and Relative A1 was his durable power of attorney. The face sheet read Relative A2 was his co-durable power of attorney.

I reviewed Resident A's service plan dated 11/17/2022 which read consistent with staff interviews. The plan read in part Resident A had Parkinson's Disease along with Multiple Sclerosis and left sided weakness. The plan read in part Resident A was two-person Hoyer lift with all transfers and care. The plan read in part Resident A was deaf in his left ear, and it was better to speak in his right ear. The plan read in

part Resident A was prescribed a regular diet; however, he had trouble swallowing so his meat would need to be cut up in the kitchen. The plan read in part Resident A wore a condom catheter in which staff would need to monitor and empty the foley bag once per shift and as needed. The plan read in part Resident A wore briefs for bowel incontinence and required checks every two to three hours. The plan read Resident A had a stage 2 pressure ulcer on his buttocks in which Absolute Hospice cleaned and dressed.

I reviewed Resident A's Medication Administration Records (MARs) which read in part at 2100 [9:00 PM] staff were to change his catheter every night at bed time and as needed at bedtime. The MAR read staff were to mark the task completed with their initials and a check mark. On 12/8/2022, staff marked "09" on the MAR which referred to "other/see Nurses Notes." I reviewed the nurse note for 12/8/2022 which read "looks intact."

I reviewed Resident A's facility progress notes dated 7/8/2022 through 12/9/2022:

> Note dated 9/14/2022 and completed by Employee #2 read: "*Care conference held @4:15 PM with resident's wife, and two daughters, HWD, RCC and 2 shift leads. Will look to move resident to another table in dining room where his feet will fit under the table while in his wheelchair. All concerns by family addressed and family agreeable to solution*."
>
> Note dated 11/12/2022 and completed by Employee #1 read in part: *"staff had already placed him in his chair. i had him push his pendant to see if he could push it. he pushed it and I had a staff member verify that the page went through. The page went through on the pager and the monitor."*
>
> Note dated 11/14/2022 and completed by Employee #2 read in part: *"On Monday Nov 14 maintenance moved the pull cord closer to the resident so if he is having difficulty with the button he can just pull the cord."*
>
> Note dated 11/15/2022 and completed by Employee #1 read in part: "call lights were pulled. he had no long wait times."
>
> Note dated 11/17/2022 and completed by Employee #1 read: *"sat in on care conference. Family wants more communication between hospice and staff. they also added feeding assistance to his care plan. they asked that he be given prn meds 30 minutes before any care is done to him. (norco and morphine) i gave my number to family to call or text anytime."*
>
> Note dated 11/23/2022 and completed by Employee #2 read in part: *"Family stated things were going much better. Discussed pain management and needing orders from hospice to d/c medications. Discussed staff communicating with hospice and hospice communicating with staff and ways to improve it."*

Note dated 11/30/2022 and completed by Ms. Vahlbusch read: *"Family placed a move out notice due to increased care needs and (Resident A) wanting to be home."*

I reviewed Resident A's call light response logs from 11/12/2022 to 12/1/2022 which read in part his shortest wait time was five seconds on 11/22/2022 and longest wait time was 58 minutes 59 seconds on 11/20/2022. Additionally, the logs read in part on 11/18/2022, Resident A waited 34 minutes and 27 seconds and 45 minutes and 45 seconds at two separate times. The logs read in part on 11/19/2022, Resident A waited 31 minutes and 32 seconds and on 11/22/2022, he waited 52 minutes.

I reviewed the facility's policy titled *Resident Call System and Door Alarm Response* which read in part:

B. Responding to resident call system alerts.

1. *When responding to resident call systems alerts:*
   a. *When an associate receives a resident call system alert, he or she should respond within a timely manner.*
   b. *If the associate is unable to respond in a timely manner, he or she should request assistance from another associate.*

I reviewed the November 2022 Absolute hospice nurse and home health aide notes:

Nurse note dated 11/1/2022 read in part Resident A's pain level was "8" in his coccyx and the right buttock wound measurements were Length: 2.5 centimeters (cm) and width: 2.5 cm. The note read in part patient's coccyx and buttocks were excoriated with small open area on right buttocks. The note read in part educated staff on wound care, updated home health aide on wound care. The note read in part extensive education with staff and patient about pressure relief. The note read in part the patient was to be turned every couple of hours to promote healing, wound care to be performed twice a day and when soiled. The note read in part Resident A was eating 25-50% of meals, sometimes skipping meals.

Nurse note dated 11/8/2022 read in part Resident A's buttock wound measurements were length: 3 cm and width: 3 cm. The note read in part staff were educated on the importance of skin integrity; turns, cleansing, use of ordered creams. The notes read in part Resident A was eating 75% of meals, sometimes skipping meals.

Aide note dated 11/9/2022 read in part Resident A had diarrhea for three days non-stop.

Nurse note dated 11/15/2022 read in part Resident A stated he had been waiting for his as needed pain medications for a long time.

Aide note dated 11/16/2022 read in part Resident A reported still having diarrhea and requested a bed bath, instead of shower.

Nurse note dated 11/17/2022 read in part Resident A was under better pain control, but the medication passers continue to make him wait long periods. The note read in part that Resident A reported a 30-minute wait.

Nurse note dated 11/18/2022 read in part Resident A's call light had not been answered after an hour and he was needing pain medications.

Nurse note dated 11/23/2022 read in part Resident A's coccyx wound measurements were length: 8 cm and width: 8 cm.

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.
For Reference: 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 supervision 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.
For Reference: R 325.1922	**Admission and retention of residents.**
	5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.

ANALYSIS:	Review of Resident A's medical records revealed he had received hospice services in which he had declined since his admission to the facility. Additionally review of Resident A's medical records revealed his nutrition had decreased and he had diarrhea for days consecutively in which his wound had increased after that time. Thus, there was lack of substantial evidence his wound increased from lack of care, nor could it be substantiated that he lacked meals. However, review of Resident A's hospice nurse notes revealed staff were educated to complete his wound care after every bowel movement and as needed, however his service plan read Absolute Hospice cleaned and dressed his buttock wound. Resident A's service plan lacked specific instructions for staff to provide wound care. Additionally, review of Resident A's December 2022 MARs revealed staff did not always follow written instructions for changing his condom catheter and the service plan lacked specific instructions for staff to change Resident A's condom catheter every night at bedtime. Furthermore, review of Resident A's call light response times revealed times that were inconsistent with the facility's policy of "timely" in which staff were unable to always provide Resident A safety and protection. Based on the above information, this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A had not received his medications as prescribed.

INVESTIGATION:

On 11/22/2022, the department received a complaint in which read Resident A's medications were documented as given but had run out in the medication cart and were not re-ordered.

On 12/12/2022, I conducted an on-site inspection at the facility. I interviewed Employee #3 who stated Resident A had received his medications as prescribed. Employee #3 stated the facility pharmacy sent 15 days of medications at one time for residents who received hospice services.

While on-site, Employee #3 and I compared Resident A's December 2022 Medication Administration Records (MARs) with the medications in the medication cart. I observed the MARs read consistent with the medications located in the cart and there was sufficient supply of all medications except Senna 8.6 mg and

Tamsulosin 0.4 mg, which did not have any tablets or capsules for staff to administer. Employee #3 stated she would need to look at having them re-ordered.

I reviewed Resident A's service plan dated 11/17/2022 which read in part Resident A required his medications crushed and put into pudding, applesauce or yogurt followed by a full glass of water. The plan read for staff to ensure he swallowed all medications prior to leaving.

I reviewed Resident A's November and December 2022 MARs. The November 2022 MAR read Resident A had received his medications as prescribed. The December 2022 MAR read in part: Senna Tablet 8.6 mg, give one tablet by mouth one time a day every two days in which on 12/7/2022 and 12/11/2022 staff documented "09" which refers to "other/see Nurses Notes." The notes for 12/7/2022 and 12/11/2022 read "not in cart," however on 12/9/2022 staff documented the medication was administered. The December 2022 MAR read in part: Tamsulosin HCL Capsule 0.4 mg, give one capsule by mouth in the morning in which on 12/7/2022, 12/8/2022, and12/10/2022 through 12/12/2022 staff documented a "09." The notes that corresponded to the above dates read "not in cart," however on 12/9/2022, staff documented the medication was administered.

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 attestations and review of facility documentation revealed staff were responsible for Resident A's medication administration. Review of Resident A's November and December 2022 MARs read consistent with the complaint. Based on this information, this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

Additional Finding:

On 12/12/2022, interview with Employee #5 revealed the kitchen staff maintained a meal census for only a seven-day period.

APPLICABLE RULE	
R 325.1954	**Meal and food records.**
	The home shall maintain a record of the meal census, to include residents, personnel, and visitors, and a record of the kind and amount of food used for the preceding 3-month period.
ANALYSIS:	Staff interviews revealed the facility maintained a meal census for seven days which was not in compliance with this rule, thus a violation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

12/27/2022

Jessica Rogers Date
Licensing Staff

Approved By:

01/25/2023

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