GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 6, 2023

Amy Borzymowski
Brookdale Troy AL
4850 Northfield Parkway
Troy, MI 48098

RE: License #: AH630236943

Dear Ms. Borzymowski:

Attached is the Renewal Licensing Study Report for the facility referenced above. The violations cited in the report require the submission of a written corrective action plan. 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 dates 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 home for the aged 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 feel free to 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
RENEWAL INSPECTION REPORT

I. IDENTIFYING INFORMATION

License #:	AH630236943
Licensee Name:	Brookdale Senior Living Communities, Inc.
Licensee Address:	Suite 2300 6737 West Washington St. Milwaukee, WI 53214
Licensee Telephone #:	(414) 918-5000
Authorized Representative:	Amy Borzymowski
Administrator:	Gary Kosten
Name of Facility:	Brookdale Troy AL
Facility Address:	4850 Northfield Parkway Troy, MI 48098
Facility Telephone #:	(248) 952-5533
Original Issuance Date:	10/01/1999
Capacity:	78
Program Type:	AGED

II. METHODS OF INSPECTION

Date of On-site Inspection(s): 01/30/2023

Date of Bureau of Fire Services Inspection if applicable: 01/20/2023

Inspection Type: ☐ Interview and Observation ☒ Worksheet ☐ Combination

Date of Exit Conference: 02/06/2023

No. of staff interviewed and/or observed 13
No. of residents interviewed and/or observed 18
No. of others interviewed 0 Role

- Medication pass / simulated pass observed? Yes ☒ No ☐ If no, explain.

- Medication(s) and medication records(s) reviewed? Yes ☒ No ☐ If no, explain.
- Resident funds and associated documents reviewed for at least one resident? Yes ☐ No ☒ If no, explain. The facility does not hold resident funds in trust.
- Meal preparation / service observed? Yes ☒ No ☐ If no, explain.

- Fire drills reviewed? Yes ☐ No ☒ If no, explain.
  The Bureau of Fire Services reviews fire drills, however facility disaster planning procedures were reviewed.
- Water temperatures checked? Yes ☒ No ☐ If no, explain.

- Incident report follow-up? Yes ☐ IR date/s: N/A ☒
- Corrective action plan compliance verified? Yes ☐ CAP date/s and rule/s: SIR2021A1019009, CAP dated 12/21/20, R 325.1932 (5)
- Number of excluded employees followed up? 1 N/A ☐

III. DESCRIPTION OF FINDINGS & CONCLUSIONS

This facility was found to be in non-compliance with the following administrative rules regulating home for the aged facilities:	
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.**
The facility lacked a formalized medication program to ensure medications are reordered timely before a prescription runs out. When asked about the facility's protocol, Employee A stated that "we use more of a reactive approach". When asked to clarify, Employee A reported that medication refills are typically ordered once the medication has already run out, leaving the potential for a resident to miss one or more doses of scheduled medication because the facility failed to proactively reorder the medication prior to it being gone.	
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.
Employee A reported that Resident A began self-administering all of his medication this month. Review of Resident A's service plan reveals that it indicates he only self-administers one medication, and that facility staff are responsible for administering the rest.	
R 325.1922	**Admission and retention of residents.**
	(7) An individual admitted to residence in the home shall have evidence of tuberculosis screening on record in the home which consists of an intradermal skin test, chest x-ray, or other methods recommended by the local health authority performed within 12 months before admission.

The facility was unable to produce evidence of a TB screen prior to admission for Residents B and C. Resident B moved into the facility on 1/24/22 and her TB screen was dated for 1/27/22. Resident C moved into the facility on 2/22/22 and her TB screen was dated 3/9/22.	
R 325.1923	**Employee's health.**
	(2) A home shall provide initial tuberculosis screening at no cost for its employees. New employees shall be screened within 10 days of hire and before occupational exposure. The screening type and frequency of routine tuberculosis (TB) testing shall be determined by a risk assessment as described in the 2005 MMWR Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005? (http://www.cdc.gov/mmwr/pdf/rr/rr5417.pdf), Appendices B and C, and any subsequent guidelines as published by the centers for disease control and prevention. Each home, and each location or venue of care, if a home provides care at multiple locations, shall complete a risk assessment annually. Homes that are low risk do not need to conduct annual TB testing for employees.
Employee B was hired on 11/21/22 and Employee C was hired on 9/25/22. The facility could not provide evidence that either employee received a TB screen within 10 days of hire. **REPEAT VIOLATION ESTABLISHED [for reference, see renewal licensing study report (LSR) for the inspection dated 1/15/2020]**	
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.
Medication administration records (MAR) were reviewed for Residents A, B, C, D and E for the timeframe of 12/1/22-1/30/23 (date of onsite inspection) and the following observations were made: Resident A missed a scheduled dose of Lipitor on 12/18/22. Staff documented the reason for the missed dose as “other/ see nurse note” however Employee A was	

unable to locate a note to accompany the entry. It is unknown why Resident A did not receive this scheduled medication.

Resident B missed one scheduled dose of Atenolol on 12/18/22. Staff documented the reason for the missed dose as “other/ see nurse note” however Employee A was unable to locate a note to accompany the entry. It is unknown why Resident B did not receive this scheduled medication. Resident B missed one scheduled dose of Celecoxib on 12/18/22. Staff documented the reason for the missed dose as “other/ see nurse note” however Employee A was unable to locate a note to accompany the entry. It is unknown why Resident B did not receive this scheduled medication. Resident B missed one scheduled dose of Gabapentin on 12/18/22 and two doses on 12/19/22. Staff documented the reason for the missed doses as “other/ see nurse note” and “pharmacy action required” however Employee A was unable to locate a note to accompany the entry and was unclear what the action required by pharmacy was. It is unknown why Resident B did not receive this scheduled medication. Resident B missed scheduled doses of Aspirin on 12/17/22-12/20/22. Staff documented the reason for the missed doses as “other/ see nurse note” and “pharmacy action required” however Employee A was unable to locate a note to accompany the entries and was unclear what the action required by pharmacy was. It is unknown why Resident B did not receive these scheduled medications. Resident B missed one scheduled dose of Omeprazole on 12/18/22. Staff documented the reason for the missed dose as “pharmacy action required” however Employee A was unclear what the action required by pharmacy was. It is unknown why Resident B did not receive this scheduled medication. Resident B missed scheduled doses of Livalo on 1/4/23, 1/5/23, 1/6/23, 1/7/23, 1/8/23, 1/10/23, 1/11/23, 1/14/23, 1/15/23, 1/16/23, 1/18/23, 1/2023, 1/21/23, 1/22/23, 1/24/23 and 1/25/23. Staff documented the reason for the missed dose as “other/ see nurse note” and “pharmacy action required” however Employee A was unable to locate a note to accompany the entries and was unclear what the action required by pharmacy was. It is unknown why Resident B did not receive these scheduled medications. Resident B missed scheduled doses of Cyclobenzaprine on 1/28/23, 1/29/23 and 1/30/23. Staff documented the reason for the missed dose as “pharmacy action required” however Employee A was unclear what the action required by pharmacy was. It is unknown why Resident B did not receive this scheduled medication.

Resident C missed scheduled doses of Escitalopram on 12/1/22-12/4/22, 12/6/22-12/8/22, 12/27/22, 1/13/23-1/16/23 and 1/18/23. Staff documented the reason for the missed doses as “other/ see nurse note” and “pharmacy action required”. Employee A provided nursing notes dated 12/27/22, 1/16/23 and 1/18/23 that read “medication not in cart” but did not provide evidence that the medication was reordered prior to it running out. There wasn’t any documentation pertaining to the other missed doses and it is unknown why Resident C did not receive this scheduled medication. Staff also documented that the Escitalopram was administered on 12/5/22 and 1/17/23, in between dates staff notated that the medication was not administered. This is likely the result of a documentation error. Resident C missed scheduled doses of Levothyroxine on 12/1/22-12/4/22, 12/6/22-12/12/22, 1/13/23 and 1/22/23. Staff

documented the reason for the missed doses as “other/ see nurse note” and “pharmacy action required”. Employee A provided a nursing note dated 1/13/23 that read “no med” and a note dated 1/22/23 that read “third shift passed during downtime”. There wasn’t any documentation pertaining to the other missed doses and it is unknown why Resident C did not receive this scheduled medication. Staff also documented that the Levothyroxine was administered on 12/5/22, in between dates staff notated that the medication was not administered. This is likely the result of a documentation error. Resident C missed scheduled doses of Seroquel on 12/2/22, 12/3/22, 12/5/22-12/10/22, 12/12/22-12/14/22, 12/16/22-12/18/22, 12/20/22, 12/21/22, 12/23/22-12/25/22, 12/28/22, 1/16/23-1/18/23, 1/20/23, 1/23/23, 1/25/23 and 1/27/23-1/29/23. Staff documented the reason for the missed doses as “other/ see nurse note” and “pharmacy action required”. Employee A provided nursing notes dated 12/20/22, 12/23/22 and 1/27/23 that read “not in cart” and a note dated 12/25/22 that read “not in medication cart” but did not provide evidence that the medication was reordered prior to it running out. There wasn’t any documentation pertaining to the other missed doses and it is unknown why Resident C did not receive this scheduled medication. Staff also documented that the Seroquel was administered on 12/4/22, 12/11/22, 12/15/22, 12/19/22, 12/22/22, 12/26/22, 1/19/23, 1/21/23, 1/22/23, 1/24/23 and 1/26/23, in between dates staff notated that the medication was not in the cart/ not administered. This is likely the result of a documentation error. Resident C missed scheduled doses of Trazodone on 12/6/22-12/8/22, 12/10/22, 12/12/22-12/14/22, 12/16/22-12/18/22, 12/20/22, 12/21/22, 1/11/23, 1/13/23, 1/16/23-1/18/23, 1/20/23, 1/21/23, 1/23/23, 1/25/23 and 1/27/23-1/29/23. Staff documented the reason for the missed doses as “other/ see nurse note” and “pharmacy action required”. Employee A provided a nursing note dated 12/20/22 but it did not indicate why the medication was not given and only listed the administration instructions and a note dated 1/27/23 that read “not in cart”. There wasn’t any documentation pertaining to the other missed doses and it is unknown why Resident C did not receive this scheduled medication. Staff also documented that the Trazodone was administered 12/9/22, 12/11/22, 12/15/22, 12/19/22, 1/10/23, 1/14/23, 1/15/23, 1/19/23, 1/22/23, 1/24/23 and 1/26/23, in between dates staff notated that the medication was not administered. This is likely the result of a documentation error. Resident C missed a dose of Vitamin D3 on 12/17/22. Staff documented the reason for the missed dose as “pharmacy action required” however Employee A was unclear what the action required by pharmacy was. It is unknown why Resident C did not receive this scheduled medication. Resident C missed scheduled doses of Metoprolol on 12/17/22, 12/22/22, 1/7/23, 1/8/23, and 1/24/23. Staff documented the reason for the missed doses as “pharmacy action required”. Employee A provided nursing notes dated 1/7/23 and 1/24/23 that read “med not in cart”. There wasn’t any documentation pertaining to the other missed doses, nor was there evidence that the medication was reordered prior to it running out. Resident C missed a scheduled dose of Donepezil on 12/17/22. Staff documented the reason for the missed dose as “pharmacy action required” however Employee A was unclear what the action required by pharmacy was. It is unknown why Resident C did not receive this scheduled medication. Resident C missed scheduled doses of Senna Plus on 12/17/22, 12/22/22, 1/7/23 and 1/8/23. Employee A provided nursing

notes dated 1/7/23 and 1/8/23 that read “med not in cart”. There wasn’t any documentation pertaining to the other missed doses, nor was there evidence that the medication was reordered prior to it running out. Staff documented the reason for the missed dose as “pharmacy action required” however Employee A was unclear what the action required by pharmacy was. It is unknown why Resident C did not receive this scheduled medication. Resident C missed scheduled doses of Cozaar on 12/19/22, 12/22/22, 1/7/23, 1/8/23 and 1/10/23. Staff documented the reason for the missed dose as “other/ see nurse note” and “pharmacy action required”. Employee A provided a nursing note dated 12/19/22 but it did not indicate why the medication was not given and only listed the administration instructions and nursing notes dated 1/7/23 and 1/10/23 that read “med not in cart”. There wasn’t any documentation pertaining to the other missed doses, nor was there evidence that the medication was reordered prior to it running out. Staff also documented that the Cozaar was administered on 1/9/23, in between dates staff notated that the medication was not in the cart. This is likely the result of a documentation error. Resident C missed scheduled doses of Multivitamin on 12/19/22 and 12/22/22. Staff documented the reason for the missed doses as “pharmacy action required” however Employee A was unclear what the action required by pharmacy was. It is unknown why Resident C did not receive this scheduled medication. Employee A provided a nursing note dated 12/19/22 but it did not indicate why the medication was not given and only listed the administration instructions. It is unknown what action was required by the pharmacy and why Resident C did not receive this scheduled medication. Resident C missed scheduled doses of Amlodipine on 12/23/22, 12/24/22, 12/25/22, 12/27/22, 1/13/23-1/16/23 and 1/18/23. Staff documented the reason for the missed doses as “pharmacy action required”. Employee A provided nursing notes dated 12/24/22, 12/25/22, 12/27/22 and 1/16/23 that read “medication not in cart” but did not provide evidence that the medication was reordered prior to it running out. Staff also documented that the Amlodipine was administered on 12/26/22 and 1/17/23, in between dates staff notated that the medication was not in the cart. This is likely the result of a documentation error. Resident C missed scheduled doses of Tramadol on 1/1/23-1/4/23, 1/8/23 and 1/10/23. Staff documented the reason for the missed doses as “other/ see nurse note” and “pharmacy action required”. Employee A provided nursing notes dated 1/4/23, 1/8/23 and 1/10/23 that read “not in cart” but did not provide evidence that the medication was reordered prior to it running out. Staff also documented that the Tramadol was administered on 1/5/23-1/7/23 and 1/9/23, in between dates that staff notated that the medication was not in the cart. This is likely the result of a documentation error. Resident C missed scheduled doses of Donepezil on 1/7/23 and 1/8/23. Staff documented the reason for the missed doses as “pharmacy action required”. Employee A provided nursing notes for both dates that read “med not in cart” but did not provide evidence that the medication was reordered prior to running out. Resident C missed scheduled doses of Melatonin on 1/9/23-1/13/23, 1/15/23-1/29/23. Staff documented the reason for the missed doses as “other/ see nurse note” and “pharmacy action required”. Employee A provided nursing notes dated 1/10/23, 1/12/23, 1/15/23, 1/19/23, 1/22/23, 1/24/23, 1/26/23 that read “not in cart” but did not provide evidence that the medication was reordered prior to it running out. Staff also documented that the

Melatonin was administered on 1/14/23, in between dates staff notated that the medication was not in the cart. This is likely the result of a documentation error. Resident C was scheduled to receive Keflex every six hours and missed between scheduled doses daily from 1/13/23-1/28/23. Staff documented the reason for the missed doses as “other/ see nurse note” and “pharmacy action required”. Employee A provided nursing notes dated 1/14/23, 1/15/23, 1/16/23, 1/17/23, 1/18/23, 1/20/23, 1/21/23, 1/23/23, 1/24/23, 1/25/23, 1/26/23, 1/27/23 and 1/28/23 that repeatedly read “out of med”, “not in cart” and “med finished”, despite the medication not being discontinued until 1/29/23. Employee A provided no evidence that the medication was reordered prior to it running out, nor was evidence provided that the facility attempted to obtain the medication during this timeframe. Staff also documented that Resident C was administered the Keflex for only one out of four doses on 1/15/23, 1/16/23, 1/19/23, 1/20/23, 1/22/23, 1/24/23, 1/26/23 and 1/27/23, in between doses that staff notated that the medication was not available. This is likely the result of a documentation error.

Resident D missed a scheduled dose of Atorvastatin on 12/13/22. Staff documented the reason for the missed dose as “other/see nurse note” however Employee A was unable to locate a note to accompany the entry. It is unknown why Resident D did not receive this scheduled medication. Resident D missed scheduled doses of Trazodone on 12/12/22 and 12/13/22. Staff documented the reason for the missed doses as “other/see nurse note” however Employee A was unable to locate a note to accompany the entries. It is unknown why Resident D did not receive this scheduled medication. Resident D missed two scheduled doses of Carbidopa-Levodopa on 12/13/22 and 1/28/23. Staff documented the reason for the missed doses as “pharmacy action required”. Employee A provided nursing notes for the medication on the dates in question, but they did not indicate why the medication was not given and only listed the administration instructions. It is unknown what action was required by the pharmacy and why Resident D did not receive this scheduled medication. Resident D missed two scheduled doses of Mucinex on 1/1/23 and one dose on 1/2/23. Staff documented the reason for the missed doses as “other/ see nurse note” and “pharmacy action required”. Employee A provided a note dated 1/1/23 that read “med not in cart” and a note dated 1/2/23 that read “med finished”. Resident D missed a scheduled dose of Seroquel on 1/9/23. Staff documented the reason for the missed dose as “pharmacy action required”. Employee A provided a note dated 1/9/23 that read “not in cart” but did not provide evidence that the medication was reordered prior to it running out. Resident D missed a scheduled dose of Eliquis on 1/10/23. Staff documented the reason for the missed dose as “pharmacy action required”. Employee A provided a note dated 1/10/23 that read “med not in cart” but did not provide evidence that the medication was reordered prior to it running out. Resident D missed ten scheduled doses of Cephalexin from 1/26/23-1/1/30/23. Staff documented the reason for the missed doses as “other/ see nurse note” and “pharmacy action required” however Employee A was unable to locate a note to accompany the entries and was unclear what the action required by pharmacy was. It is unknown why Resident D did not receive these scheduled medications.

Resident E missed a scheduled dose of Levothyroxine on 12/16/22. Staff documented the reason for the missed dose as “other/see nurse note” however Employee A was unable to locate a note to accompany the entry. It is unknown why Resident E did not receive this scheduled medication.	
R 325.1944	**Employee records and work schedules.**
	(1) A home shall maintain a record for each employee which shall include all of the following: **(g) Results of initial TB screening as required by R 325.1923(2).**
Records for Employees B and C did not contain initial TB screening results.	
R 325.1953	**Menus.**
	(2) A home shall maintain a copy of all menus as actually served to residents for the preceding 3 months.
Employee D reported that the facility only keeps copies of menus for one month.	
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.
The facility could not produce any meal census records. Employee D did not know what a meal census was. **REPEAT VIOLATION ESTABLISHED [for reference, see renewal licensing study report (LSR) for the inspection dated 1/15/2020]**	
R 325.1968	**Toilet and bathing facilities.**
	(4) A resident toilet room or bathroom shall not be used for storage or housekeeping functions.

Three separate communal bathing/ shower rooms in resident occupied areas were being used as storage. Items observed in these areas include but are not limited to extra personal protective equipment, mattresses, walkers and other durable medical equipment.	
R 325.1972	**Solid wastes.**
	All garbage and rubbish shall be kept in leakproof, nonabsorbent containers. The containers shall be kept covered with tight-fitting lids and shall be removed from the home daily and from the premises at least weekly.
Multiple garbage cans throughout the facility were observed without lids. Those areas include but are not limited to the facility kitchen, first and second floor kitchenettes, communal bathrooms and resident apartments. **REPEAT VIOLATION ESTABLISHED [for reference, see renewal licensing study report (LSR) for the inspection dated 1/15/2020]**	
R 325.1976	**Kitchen and dietary**
	(5) The kitchen and dietary area, as well as all food being stored, prepared, served, or transported, shall be protected against potential contamination from dust, flies, insects, vermin, overhead sewer lines, and other sources.
Multiple perishable food items in the commercial kitchen's walk in refrigerator and freezer were left uncovered and out in the open air without proper sealing. These items include but are not limited to lunch meat, raw bacon, pork sausage patties, ground beef patties, hard boiled eggs, hot dogs, produce (raw and frozen), chicken tenders, a tomato based sauce and several other unidentifiable items.	
R 325.1976	**Kitchen and dietary.**
	(6) Food and drink used in the home shall be clean and wholesome and shall be manufactured, handled, stored, prepared, transported, and served so as to be safe for human consumption.
As with R 325.1976 (5), perishable food items were not being stored in a manner that is safe for human consumption (noted above). Along with the above items, several containers of dry goods such as cereal, flour and sugar lacked any labeling	

as to when they were delivered, opened or prepared. Many items also lacked a proper seal and were left uncovered in their original packaging after being opened. This was observed throughout both the refrigerator and the freezer despite a large sign directly on the walk-in refrigerator door that read:

STOP
Did you remember to label & date the product?
Remember:
Product Name
Date Opened/ Made
Use by Date
Your Name

When asked about the procedure of labeling and dating items, Employee D reported that typically they do not label or date items. Employee D explained that the facility receives food deliveries twice weekly and items are rotated at that time.

REPEAT VIOLATION ESTABLISHED [for reference, see renewal licensing study report (LSR) for the inspection dated 1/15/2020]

R 325.1976	**Kitchen and dietary.**
	(8) A reliable thermometer shall be provided for each refrigerator and freezer.

The refrigerator and freezer located in the first floor kitchenette did not contain a thermometer. Perishable food and drink items for residents were kept in both areas.

REPEAT VIOLATION ESTABLISHED [for reference, see renewal licensing study report (LSR) for the inspection dated 1/15/2020]

R 325.1976	**Kitchen and dietary.**
	(13) A multi-use utensil used in food storage, preparation, transport, or serving shall be thoroughly cleaned and sanitized after each use and shall be handled and stored in a manner which will protect it from contamination.

Employee D reported that the dish washing machine in the commercial kitchen uses chemicals to sanitize the dishes. When asked how often the chemical levels are tested and by what means they are tested, Employee D did not know. He was unable to locate any test strips and did not have any record of when the chemical levels were last tested.

I also observed several containers of dry goods such a flour, sugar, lentils and cereal that had a scoop like device that was kept inside of the container. It was clear that the “scoops” were left in the containers permanently and were not being sanitized or replaced after each use. **REPEAT VIOLATION ESTABLISHED [for reference, see renewal licensing study report (LSR) for the inspection dated 1/15/2020]**	
R 325.1979	**General maintenance and storage.**
	(3) Hazardous and toxic materials shall be stored in a safe manner.
A “vape” pen was found on top of the medication cart located in the “B” hall. Additionally, hazardous and toxic materials (various cleaning agents and detergents) were found unsecured in the activity room, both kitchenettes and a housekeeping closet on the first floor. These items are an unnecessary ingestion and subsequent poisoning risk to those residents that lack safety awareness. **REPEAT VIOLATION ESTABLISHED [for reference, see renewal licensing study report (LSR) for the inspection dated 1/15/2020]**	

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, renewal of the license is recommended.

02/06/2023

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Elizabeth Gregory-Weil Date
Licensing Consultant