

GRETCHEN WHITMER GOVERNOR

STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

ORLENE HAWKS DIRECTOR

February 8, 2023

Amy Borzymowski Brookdale Delta MC (MI) 7235 Delta Commerce Dr. Lansing, MI 48917

> RE: License #: AH230236932 Investigation #: 2023A1021022

> > Brookdale Delta MC (MI)

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. 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,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems

611 W. Ottawa Street Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH230236932
Investigation #:	2023A1021022
	40/45/0000
Complaint Receipt Date:	12/15/2022
Investigation Initiation Date:	12/16/2022
Investigation Initiation Date:	12/10/2022
Report Due Date:	02/14/2023
Report Due Duter	GET 172020
Licensee Name:	Brookdale Senior Living Communities, Inc.
Licensee Address:	Suite 2300
	6737 West Washington St.
	Milwaukee, WI 53214
Licenses Telephone #	(444) 040 5000
Licensee Telephone #:	(414) 918-5000
Administrator:	Michael Kegley
Administrator:	Wildridgi Regiey
Authorized Representative:	Amy Borzymowski
•	
Name of Facility:	Brookdale Delta MC (MI)
Facility Address:	7235 Delta Commerce Dr.
	Lansing, MI 48917
Essility Tolonhone #:	(517) 996 5200
Facility Telephone #:	(517) 886-5200
Original Issuance Date:	07/01/1999
Original localito Dato	0170171000
License Status:	REGULAR
Effective Date:	05/07/2022
	05/00/0000
Expiration Date:	05/06/2023
Canacity	38
Capacity:	30
Program Type:	AGED
	ALZHEIMERS

II. ALLEGATION(S)

Violation
Established?

Caregivers not properly trained in Hoyer Lifts	Yes
Additional Findings	Yes

III. METHODOLOGY

12/15/2022	Special Investigation Intake 2023A1021022
12/16/2022	Special Investigation Initiated - Letter referral was placed under AFC and then transferred to HFA. Licensing staff reached out to AFC staff for notes on investigation
12/16/2022	Contact - Telephone call made interviewed administrator
12/19/2022	Contact - Document Received received documents
12/21/2022	Contact - Telephone call made interviewed SP1
01/25/2023	Contact - Telephone call made interviewed health and wellness director
02/08/2023	Exit Conference

ALLEGATION:

Caregivers not properly trained in Hoyer Lifts

INVESTIGATION:

On 12/15/2022, the licensing department received a complaint with allegations Resident A was dropped from the Hoyer Lift during a transfer. The complainant alleged the caregivers were not properly trained.

On 12/16/2022, I interviewed administrator Michael Kegley by telephone. Mr. Kegley reported the incident occurred under different manager and he was not present when the incident occurred. Mr. Kegley reported an incident report was completed

and submitted to the licensing department. Mr. Kegley reported to his knowledge, there were two caregivers involved in the incident. Mr. Kegley reported one caregiver was a temporary agency worker. Mr. Kegley reported the caregivers reported the Hoyer lift tipped over with Resident A in the sling. Mr. Kegley reported the wheels on the lift were locked and the transfer was done correctly. Mr. Kegley reported with the change in management team, the facility is unable to locate training records for SP1 and SP2.

On 12/21/2022, I interviewed staff person 1 (SP1) by telephone. SP1 reported she was assisting SP2 with the Hoyer Lift transfer when the incident occurred. SP1 reported herself and SP2 responded to Resident A. SP1 reported Resident A was sitting in his chair and requested to use the restroom. SP1 reported SP2 questioned how Resident A was transferred and she went through the process. SP1 reported they put the sling under Resident A and got him into the Hoyer Lift. SP1 reported SP2 was operating the Hoyer Lift. SP1 reported SP2 attempted to move the Hoyer Life sideways to get it lined up with the bed and that is when the Hoyer Lift tipped over with Resident A in the sling. SP1 reported the incident happened very quickly. SP1 reported Resident A fell on the floor and reported he felt like he broke his back. SP1 reported Resident A was transferred to the hospital. SP1 reported she was trained in Hoyer Lift transfers.

On 01/05/2023, I interviewed health and wellness director Kimberly Messenger by telephone. Ms. Messenger reported she was not the health and wellness director when this incident occurred. Ms. Messenger reported facility caregivers are trained in Hoyer Lift transfers on the floor by the resident service coordinator. Ms. Messenger reported there is then a competency checkoff on the use of the Hoyer Lift. Ms. Messenger reported with agency workers, the agency provides a copy of their training to the facility. Ms. Messenger reported the agency worker than completes a short facility orientation. Ms. Messenger reported the facility does not have an employee record for SP2.

I reviewed facility incident report that was submitted to the department. The incident report read,

"(Resident A) was being transferred from his chair to his bed by Hoyer lift with two staff members. The Hoyer tipped close to the bed, and (Resident A) fell to the ground; he landed on his back. Re-education of staff are Hoyer use to prevent further accidents."

APPLICABLE R	RULE
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:

	(d) Summary of experience, education, and training.
ANALYSIS:	While the facility attested the caregivers were trained in Hoyer life transfers, the facility was unable to produce record of Hoyer lift training.
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

Resident A's service plan read,

"Requires a mechanical lift for transferring during: all transfers. Hoyer lift ordered, but therapy and staff report 1-person assist."

APPLICABLE RUI	LE
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:	Resident A required two person assist transfer using a Hoyer Lift. Review of Resident A's service plan revealed the service plan was not correctly updated to reflect the current care needs of Resident A.
CONCLUSION:	VIOLATION ESTABLISHED

On 2/8/2023, I conducted an exit conference with authorized representative Amy Borzymowski by telephone.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

Kinveryttoot	1/31/2023
Kimberly Horst	Date
Licensing Staff	
Approved By:	
(moheg)Maore	02/06/2023
Andrea L. Moore, Manager	Date
Long-Term-Care State Licensing Section	