GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 8, 2023

Michael Dyki
Blossom Springs
3215 Silverbell Rd.
Oakland Twp, MI 48306

RE: License #: AH630396969
Investigation #: 2023A0784025
Blossom Springs

Dear Mr. Dyki:

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 responsible party 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. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630396969
Investigation #:	2023A0784025
Complaint Receipt Date:	01/20/2023
Investigation Initiation Date:	01/23/2023
Report Due Date:	03/24/2023
Licensee Name:	Blossom Ridge, LLC
Licensee Address:	3005 University Drive Auburn Hills, MI 48326
Licensee Telephone #:	(248) 340-9400
Administrator/Authorized Representative:	Michael Dyki
Name of Facility:	Blossom Springs
Facility Address:	3215 Silverbell Rd. Oakland Twp, MI 48306
Facility Telephone #:	(248) 601-0505
Original Issuance Date:	11/23/2020
License Status:	REGULAR
Effective Date:	05/23/2022
Expiration Date:	05/22/2023
Capacity:	56
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Inadequate incident reporting	Yes
Additional Findings	No

III. METHODOLOGY

01/20/2023	Special Investigation Intake 2023A0784025
01/23/2023	Special Investigation Initiated - On Site
01/23/2023	Inspection Completed On-site
01/23/2023	Exit Conference Conducted with administrator/authorized representative Michael Dyki at the facility

ALLEGATION:

Inadequate incident reporting

INVESTIGATION:

On 1/23/2023, the department received this complaint. According to the complaint, Resident A had an unwitnessed fall on 12/22/2022 in the early morning which resulted in him bleeding from a head wound. It is unknown if the facility reported this incident, timely or at all, to the department.

Review of the facility licensing file revealed that on 1/02/2023, the department received an incident report, with an incident date of 12/22/2023, via email from administrator and authorized representative Mike Dyki regarding the incident noted in the complaint. The email read, in part, “Please find attached a state report from a fall in MC [memory care resident, Resident A]. My nurse [Associate 1] and I though each other had sent this back on 12-23, unfortunately with the holiday’s we did not confirm with each other that it was sent. Sorry for the delay”. Under a section titled *Explain What Happened/Describe Injury*, the report read, in part, “Resident observed laying on floor in room on his left side. Resident alert but unable to state what happened. Discoloration observed to left arm and top of left hand. Laceration approximately 3.5cm long observed above left eyebrow bleeding bright red”.

On 1/23/23, I interviewed administrator and authorized representative Michael Dyki. Mr. Dyki stated Resident A had moved to the facility on 12/09/2023. Mr. Dyki stated that, prior to the fall, Resident A was scheduled for safety checks every two hours based on his assessment moving into the facility. Mr. Dyki stated that Resident A had been prescribed psychiatric medication at a rehab facility prior to moving to the facility which may have contributed to his fall. Mr. Dyki stated Associate 1 was reportedly with Resident A approximately 18 minutes prior to him falling.

On 1/23/2023, I interviewed Associate 1 at the facility. Associate 1 provided statements consistent with those of Mr. Dyki regarding being with Resident A prior to his fall. Associate 1 stated she went into Resident A's room to assist him with getting up for the day. Associate 1 stated Resident A did appear to be ready to get up, and that after she sat with him for a few moments, he "drifted back to sleep". Associate 1 stated she then went to assist another resident, Resident A's neighbor, with plans to come back and check on Resident A when she was done. Associate 1 stated that while assisting the other resident, she heard a noise from Resident A's room and went to check on him and found him on his floor. Associate 1 stated she was not certain what happened but assumed he attempted to get up on his own. Associate 1 stated the situation was unexpected, especially since Resident A had just fallen back asleep a few minutes prior.

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.
For Reference: R 325.1901	**Definitions**
	(17) "Reportable incident/accident" means an intentional or unintentional event in which a resident suffers harm or is at risk of more than minimal harm, such as, but not limited to, abuse, neglect, exploitation, or unnatural death.

ANALYSIS:	The complaint alleged Resident A had a fall which resulted in an injury which was not reported to the department. Review of the facility file revealed the facility did report the incident; however, the report was not received until ten days after the incident took place. Based on the findings, the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

3/01/2023

_____

Aaron Clum Date
Licensing Staff

Approved By:

03/08/2023

_____

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