GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 17, 2023

Amber James
Sunrise Of West Bloomfield
7005 Pontiac Trail
West Bloomfield, MI 48323

RE: License #: AH630391473

Dear Ms. James:

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 #:	AH630391473
Licensee Name:	Welltower OpCo Group LLC
Licensee Address:	4500 Dorr Street Toledo, OH 43615
Licensee Telephone #:	(419) 247-2800
Authorized Representative and Administrator:	Amber James
Name of Facility:	Sunrise Of West Bloomfield
Facility Address:	7005 Pontiac Trail West Bloomfield, MI 48323
Facility Telephone #:	(248) 738-8101
Original Issuance Date:	12/23/2019
Capacity:	70
Program Type:	AGED ALZHEIMERS

II. METHODS OF INSPECTION

Date of On-site Inspection(s): 05/10/2023

Date of Bureau of Fire Services Inspection if applicable: 03/09/2023

Inspection Type: ☐ Interview and Observation ☒ Worksheet ☐ Combination

Date of Exit Conference: 05/10/2023

No. of staff interviewed and/or observed 17
No. of residents interviewed and/or observed 21
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: N/A-special investigation reports and licensing study report reviewed were full compliance
- 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 325.1922	**Admission and retention of residents.**
	(4) If there is a change in a term or condition in the written resident admission contract, then the home or home's designee shall review the change with the resident and the resident's authorized representative, if any.
The facility underwent a change of ownership that was processed on 12/23/2019, which included a change to the licensee organization. Residents in care before at the facility before this date were not informed of the corporate change of ownership that changed who the resident had contracted with. Neither the former licensee nor current licensee (Welltower OpCo Group LLC) provided notice that the contract condition had been altered from one corporate entity to another as required by this rule.	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan. **(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following:** **(vi) A record if the resident refuses to accept prescribed medication and notification as required in subdivision (c) of this subrule.** **(c) Contact the appropriate licensed health care professional when the prescribed medication has not been administered in accordance with the label instruction, an order from a health care professional, medication log, or a service plan.**
Medication administration records (MAR) were reviewed for Residents A, B, C, D and E for the timeframe of 4/1/23-5/10/23 (date of onsite inspection) and the following observations were made:	

Resident A missed one or more scheduled dose of polyethyl glycol from 4/12/23-4/15/23 and from 4/17/23-4/22/23. For all the above dates except for 4/20/23, staff notated that the medication was waiting on pharmacy delivery. On 4/20/23, staff notated that the resident refused the medication and on 4/16/23, staff documented that the medication was administered to Resident A. The facility did not provide evidence of when the medication was reordered but did report that the medication was coming from outside of their contracted pharmacy. Administrator and authorized representative Amber James reported that the 4/16/23 documented administration was a documentation error and confirmed that the medication was not given to the resident. Resident A also missed A scheduled dose of acetaminophen on 4/29/23. Staff failed to notate any reason for the missed dose and the MAR was left completely blank.

Resident B missed a scheduled dose of cholecalciferol and triamcinolone acetonide cream on 4/4/23. For both medications, staff notated “other/see progress note”. The progress notes for the missed medications read “med missed” and lacked any explanation or justification for why the doses were missed. It is unknown why the resident did not receive his scheduled medication. Additionally, I observed that Resident B refused some or all of his medication every day during the timeframe reviewed. Prior to my onsite inspection, facility staff did not have documentation to support that this was addressed with Resident B’s physician and subsequently lacked instruction or guidance from the physician on this matter.

Resident C missed a scheduled dose of loratadine on 4/3/23 and 4/4/23. Staff notated that the medication was waiting on pharmacy delivery. Pharmacy documentation was reviewed, and it was determined that the medication was not ordered by the facility until 4/4/23, after Resident C had already missed a dose.

Resident D missed one or more scheduled doses of magnesium oxide from 4/29/23-5/2/23. Staff notated that the medication was waiting on pharmacy delivery. Pharmacy documentation was reviewed, and it was determined that the medication was not ordered by the facility until 5/2/23. Staff failed to document a reason or justification for

Resident E missed a scheduled dose of atorvastatin on 4/6/23, 4/7/23, 4/8/23, 4/10/23, 4/11/23 and 4/12/23. For all the above dates except for 4/8/23, staff notated that the medication was waiting on pharmacy delivery. On 4/8/23, staff notated that the resident refused the medication and on 4/9/23, staff documented that the medication was administered to Resident E. It is not reasonable to a resident to refuse a medication and for staff to document a medication administration during a time period that the medication was not at the facility and these instances are considered to be a documentation error. Pharmacy documentation was reviewed, and it was revealed that Resident E’s atorvastatin was ordered on 4/12/23 after several doses were missed. Resident E missed a scheduled dose of gabapentin from 4/6/23-4/25/23. Staff notated that the medication was waiting on pharmacy

delivery. Pharmacy documentation was reviewed, and it revealed that the medication was ordered on 4/4/23 however it was too soon to refill per the payer source and was dispensed to the facility on 4/25/23. Resident E missed a scheduled dose of irbesartan from 4/6/23-4/11/23. Staff notated that the medication was waiting on pharmacy delivery. Documentation provided did not indicate when the medication was ordered or delivered to the facility. Resident E missed a scheduled dose of lexapro on 4/6/23, 4/7/23, 4/8/23, 4/10/23, 4/11/23 and 4/12/23. Staff notated that the medication was waiting on pharmacy delivery. Pharmacy documentation was reviewed, and it was revealed that the medication was ordered on 4/12/23. On 4/9/23, staff documented that the medication was administered to Resident E and is considered to be a documentation error. Resident E missed twelve consecutive scheduled doses of duloxetine from 4/11/23-4/16/23. Staff notated that the medication was waiting on pharmacy delivery. Resident E missed eleven doses of scheduled flecainide from 4/11/23-4/16/23. Staff notated that the medication was waiting on pharmacy delivery. On 4/14/23, staff documented Resident E was administered one dose of this medication, which is a documentation error.	
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.
Perishable food items located in the commercial kitchen's walking fridge and freezer contained items that lacked proper labeling, dating and sealing. These items included but are not limited to produce, pork and beef products.	
R 325.1976	**Kitchen and dietary.**
	(8) A reliable thermometer shall be provided for each refrigerator and freezer.
Thermometers were missing from the fridge and/or freezer in occupied apartment #s 118, 123, 218 and 222.	

IV. RECOMMENDATION

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

05/17/2023

Elizabeth Gregory-Weil Date
Licensing Consultant