GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 17, 2023

Mary North
Brookdale Farmington Hills North I
27950 Drake Road
Farmington Hills, MI 48331

RE: License #: AH630236928
Investigation #: 2023A1027061
Brookdale Farmington Hills North I

Dear Ms. North:

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 #:	AH630236928
Investigation #:	2023A1027061
Complaint Receipt Date:	04/20/2023
Investigation Initiation Date:	04/21/2023
Report Due Date:	06/20/2023
Licensee Name:	Brookdale Senior Living Communities, Inc.
Licensee Address:	Suite 2300 6737 West Washington St. Milwaukee, WI 53214
Licensee Telephone #:	(414) 918-5000
Administrator:	Leslie Rowe
Authorized Representative:	Mary North
Name of Facility:	Brookdale Farmington Hills North I
Facility Address:	27950 Drake Road Farmington Hills, MI 48331
Facility Telephone #:	(248) 489-9362
Original Issuance Date:	07/01/1999
License Status:	REGULAR
Effective Date:	01/07/2023
Expiration Date:	01/06/2024
Capacity:	28
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A lacked care.	Yes
The staff's children were in the facility. Residents received Kool-Aid to drink.	No
Additional Findings	No

III. METHODOLOGY

04/20/2023	Special Investigation Intake 2023A1027061
04/21/2023	Special Investigation Initiated - Letter Email sent to APS worker informing her the allegations submitted to the Department were opened for investigation.
04/21/2023	Contact - Document Received Email received from APS with additional information
04/26/2023	Contact - Document Received Additional information received from the online complaint department
05/11/2023	Inspection Completed On-site
05/16/2023	Contact - Document Received Email received from Ms. Rowe with requested documentation
05/17/2023	Contact - Document Sent Email sent to Ms. Rowe to request additional information/documentation
05/23/2023	Contact – Document Received Email received from Ms. Rowe with requested information
05/23/2023	Inspection Completed - BCAL Sub. Compliance
05/25/2023	Exit Conference Conducted by telephone with authorized representative Mary North

ALLEGATION:

Resident A lacked care.

INVESTIGATION:

On 4/20/2023, the Department received a complaint forwarded from Adult Protective Services (APS) which read Resident A had resided at the facility for two months. The complaint read Resident A had not received a shower for one month and had several “UTIs.” The complaint read Resident A was not receiving her medications properly nor on-time. The complaint read Resident A had falls. The complaint read Resident A’s family wanted her sent to the hospital for lethargy and staff told the family they did not have that right, then called the police. The complaint read Resident A was hospitalized for two days and returned on 3/23/2023. The complaint read on 3/24/2023 at 11:45 AM, Resident A was not out of bed and did not receive her medications at 7:00 AM.

On 4/21/2023, I received an email correspondence from an APS worker which read Resident A no longer resided at the facility.

On 5/11/2023, I conducted on-site inspection at the facility. I interviewed administrator Leslie Rowe. Ms. Rowe stated she was an operations specialist and appointed the interim administrator for approximately one week. Ms. Rowe stated Resident A no longer resided at the facility.

While on-site, I interviewed Employee #1 who stated Resident A ambulated independently, very talkative, and active. Employee #1 stated Resident A required one person assist for her activities of daily living and would sometimes decline showers, so sometimes she required two staff members to assist her with showers. Employee #1 stated Resident A was steady on her feet and had not fallen on her shift.

While on-site, I interviewed Employee #2 whose statements were consistent with Employee #1. Employee #2 stated Resident A required encouragement for showering but allowed staff to provide her care.

While on-site, I interviewed Employee #3 whose statements were consistent with previous staff interviews. Employee #3 stated she observed staff administer Resident A’s medications and provide her showers. Employee #3 stated Resident A was sent to the hospital and after she returned to the facility, her son was “extremely upset” in which staff contacted the police and Resident A discharged shortly afterward.

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

I reviewed Resident A's face sheet which read in part her admission date was 2/1/2023 and her discharge date was 4/15/2023. The face sheet read in part her diagnoses were unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and generalized anxiety disorder.

I reviewed Resident A's service plan updated 3/23/2023. The plan read the facility ordered and coordinated Resident A's medications with family, health care providers and the pharmacy. The plan read Resident A took her medications whole but would take medications with applesauce or coffee. The plan read she was prescribed a regular diet. The plan read Resident A required one person assist with grooming, dressing, bathing, and incontinence care. The plan read Resident A's preferred her shower or bath days every Monday and Friday, between 10:00 AM and 11:00 AM. The plan read she walked independently, and staff needed to monitor her throughout the community for safety. The plan read Resident A wandered throughout the night and day, and to redirect her for safety. The plan read staff needed to provide escort assistance to and from the dining room and/or community activities as needed. The plan read staff followed universal fall precautions. The plan read Resident A would urinate and had bowel movements in inappropriate places in which staff were to monitor her safety, as well as assist with her care.

I reviewed Resident A's February, March and April 2023 Medication Administration Records (MARs). The February 2023 MARs read staff initialed Resident A's medications as administered or documented according to the chart codes if they were not administered. The March 2023 MARs read one or more medication doses were left blank on the following dates 3/4/2023, 3/5/2023 and 3/20/2023. The MAR read staff initialed her medications as administered on 3/24/2023 at 8:00 AM. The April 2023 MARs read staff initialed Resident A's medications as administered or documented according to the chart codes if they were not administered.

I reviewed Resident A's order summary report which read consistent with her service plan and MARs.

I reviewed Resident A's progress notes dated from to April 2023.

> Alert note dated 02/13/2023 15:25 [3:25 PM] written by Employee #4 read:
> "*Writer received updated results for Urine sample, alert physician of results orders for Cipro X3, alert Emergency contact, family wants resident to have water and cranberry juice for each meal, will alert staff and no s/s of distress, no c/o pain, verbal, alert, will continue to monitor for safety and follow care plan.*"
>
> General progress note dated 03/13/2023 16:11 [4:11 PM] written by Employee #5 read:
> *"Due to power outage 3/3/23 to 3/6/23 see resident hard chart under medication tab for paper eMARS for medication documentation."*

General progress note dated 03/21/2023 12:55 PM written by Employee #4 read: "*LATE ENTRY. Writer was alerted by family member and second POA that resident was not at her baseline, vitals were within range 127/58 HR 62, Resp. 20, O2 94% RA, no c/o pain, unsteady gait, writer observed resident Lethargic, eyes rolling, and chewing on something, writer could not see what resident was chewing POA and family member stated "it was gum", writer alerted Physician of patient status change and POA and Family concern, order for Transfer to hospital, writer alerted 911 and resident was transferred by stretcher to hospital, will reach out for updates follow up for patient return.*"

I reviewed an incident report for Resident A dated 3/24/2023 at 10:50 AM which read Resident A's family member/power of attorney (POA) was concerned she had a change in mental status in which he alleged she had received the wrong medication or was over medicated, thus wanted her sent to the hospital. The report read staff reassured Resident A's POA that she received her prescribed medications and called emergency medical services for transport to the hospital. The report read Resident A was evaluated at Beaumont Emergency Room with a diagnosis of advanced dementia and possible dehydration with no new orders, no findings of polypharmacy or being over medicated, and to follow up with her licensed healthcare professional. The report read upon Resident A's return to the facility, her POA came to the facility and demanded to speak with the nurse, who was out of the community at the time. The report read the POA became aggressive and was using profanity in which staff called 911. The report read the nurse spoke with Resident A's POA by telephone however she ended the conversation when he used profanity, demanded to know where she was, and made threats against her and the community. The report read Farmington Police Department arrived at the community and told the POA he would not be able to return to the community for 24 hours. The report read on 3/25/2023, Adult Protective Services (APS) visited the community, met with the executive director, and informed them Resident A's family had made the same allegations at her previous facility. The report read Resident A's POA returned to the community on 3/25/2023 after business hours, then texted the executive director on 3/26/2023 with allegations regarding Resident A's care and staff. The report read the executive director planned to setup a meeting with the POA.

On 5/23/2023, I received an email correspondence from Ms. Rowe which read the facility experienced a three-day power outage due to a winter storm and there were paper medication administration records that could not be located for Resident A.

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 325.1932	**Resident's medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.
ANALYSIS:	Review of Resident A's service plan revealed she required a one person assist with her activities of daily living and staff were to administer her medications. Staff attestations were consistent with Resident A's service plan. Review of Resident A's chart notes revealed she was diagnosed with one urinary tract infection (UTI) however there were no falls documented. Review of the incident report for Resident A revealed she was transferred to the hospital in March 2023 for concerns regarding a change of condition. Comparison of the March and April 2023 MARs, as well as review of the order summary report, revealed there were no new orders around the timeframe of her hospitalization in March 2023. However, review of Resident A's MARs revealed although they read consistent with the order summary report, there were dates left blank and her paper MARs could not be located, so it could not be confirmed if Resident A received her medications as prescribed or not for dates 3/4/2023 and 3/5/2023, as well as on 3/20/2023. Thus, Resident A did not always receive care consistent with her service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The staff's children were in the facility. Residents received Kool-Aid to drink.

INVESTIGATION:

On 4/20/2023, the Department received a complaint forwarded from APS which read "staff's children are running around the building." The complaint read Resident A and other residents were given Kool-Aid to drink.

On 5/11/2023, I conducted on-site inspection at the facility. I interviewed interim administrator Ms. Rowe who stated the corporation's Dementia Specialist was on-site reviewing the facility's menu and drink options. Ms. Rowe stated the facility provided drink options for residents and may have received Kool-Aid prior. Ms. Rowe stated she has not observed staff's children in the facility. Ms. Rowe stated the employee handbook read that staff were not permitted to have visitors at work.

While on-site, I interviewed Employee #1 who stated resident's drink options were water with every meal, juice specifically orange juice and cranberry juice, milk, coffee, and tea. Employee #1 stated she had not observed Kool-Aid served as a drink option unless a family member brought it for a resident. Employee #1 stated she had not observed staff's children in the facility.

While on-site, I interviewed Employee #2 whose statements were consistent with Employee #1.

While on-site, I interviewed Employee #3 whose statements were consistent with previous staff interviews. Employee #3 stated she also observed kitchen staff served pre-packaged drink mixes such as lemonade, fruit punch, or grape flavored, but not Kool-Aid.

While on-site, I did not observe staff's children in the facility.

While on-site, I observed the facility's weekly menu posted and signed by a registered dietician on 5/8/2023. The menu read in part juice was served with breakfast. The menu read in part other juices may be offered as a substitute for orange juice. I observed on a small table near the weekly menu was a water dispenser and plastic glasses next to it for residents and visitors.

APPLICABLE RULE	
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.**
ANALYSIS:	Staff attestations and observations revealed residents were served a variety of drink options and there no children in the facility. Based on this information, this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

05/23/2023

Jessica Rogers Date
Licensing Staff

Approved By:

05/24/2023

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