



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

ORLENE HAWKS  
DIRECTOR

May 31, 2023

Hemant Shah  
Cranberry Park West Bloomfield LLC  
Suite 230, 25500 Meadowbrook Rd  
Novi, MI 48375

RE: License #: AH630402042  
Investigation #: 2023A0585036  
Cranberry Park of West Bloomfield

Dear Mr. Shah:

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. 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) 284-9730.

Sincerely,

Brender Howard, Licensing Staff  
Bureau of Community and Health Systems  
611 W. Ottawa Street, P.O. Box 30664  
Lansing, MI 48909  
(313) 268-1788  
enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AH630402042
<b>Investigation #:</b>	2023A0585036
<b>Complaint Receipt Date:</b>	02/20/2023
<b>Investigation Initiation Date:</b>	02/22/2023
<b>Report Due Date:</b>	04/22/2023
<b>Licensee Name:</b>	Cranberry Park West Bloomfield LLC
<b>Licensee Address:</b>	Suite 230 25500 Meadowbrook Rd Novi, MI 48375
<b>Licensee Telephone #:</b>	(248) 692-4355
<b>Administrator:</b>	Tyler May
<b>Authorized Representative:</b>	Hemant Shah
<b>Name of Facility:</b>	Cranberry Park of West Bloomfield
<b>Facility Address:</b>	2450 Haggerty Rd West Bloomfield, MI 48323
<b>Facility Telephone #:</b>	(248) 671-4204
<b>Original Issuance Date:</b>	03/10/2022
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	09/10/2022
<b>Expiration Date:</b>	09/09/2023
<b>Capacity:</b>	53
<b>Program Type:</b>	AGED ALZHEIMERS

## II. ALLEGATION(S)

	<b>Violation Established?</b>
Resident A left the facility from the sliding door that is inside her room.	Yes
Additional Findings	Yes

## III. METHODOLOGY

02/20/2023	Special Investigation Intake 2023A0585036
02/22/2023	APS Referral Allegations were referred by Adult Protective Services (APS).
02/22/2023	Special Investigation Initiated - Telephone Attempts were made to contact Officer Sefa of the West Bloomfield Police Department regarding their investigation and their report.
02/28/2023	Inspection Completed On-site Completed with observation, interview and record review.
05/31/2023	Exit Email report to authorized representative Shah Hemant with details about cites.

### **ALLEGATION:**

**Resident A left the facility from the sliding door that is inside her room.**

### **INVESTIGATION:**

On 2/21/2023 the department received the complaint from Adult Protective Services (APS) via the BCHS Online Complaint website. The complaint alleged that on 2/19/23 at 10:00 p.m., Resident A left the facility from the sliding door that is inside her bedroom. The complaint alleged that Resident A was gone for approximately three hours before staff members were aware that she left. The complaint alleged that there was an alarm on the door that is supposed to sound when it is opened, but it didn't. The complaint alleged that Resident was located within 1000ft from the facility inside the lobby of a building.

On 2/22/2023, attempts were made to contact the listed referral source Officer Blerim Sefa from the West Bloomfield Police Department. No return call was received; however, an email was sent from Officer Sefa. The email read, "Upon arrival to the facility, I made contact with one of the caregivers (Employee #1) who advised that one of their patients, [Resident A] went missing. Employee #1 advised that Resident A was admitted to the facility on 2/19/2023, and she was able to leave the facility through a sliding door. Resident A was staying in the room which was equipped with a sliding door that led to a ground-level patio. The sliding door was equipped with a normal lock mechanism without a key or keypad. Per staff members, the sliding door were part of an audible alarm system that is supposed to go off if the door is opened. No one from the staff members heard the alarm go off. Every time the sliding door is opened there is a timestamp on the alarm system. The sliding door was opened at 2157 hours (9:57 p.m.) on 2/19/2023 which is when Resident A left her room. Employee #1 noticed that Resident A went missing when he went to conduct a regular check at 0100 hours (1:00 a.m.) on 2/20/2023. Resident A went missing for three hours before staff members noticed that she went missing."

On 2/28/2023, an onsite was completed at the facility. I interviewed administrator Suzy Mulka at the facility. Ms. Mulka stated that Resident A was a respite resident and family failed to let them know her condition. She stated that Resident A was admitted on 2/17/2023 and discharged on 2/20/23. She stated that Resident A had a room with a patio, and she was able to get out of the door. She stated that the door dinged but staff did not hear it. She stated that Resident has dementia, but she is high functioning and was able to wait for the door to open and get out quickly. She stated that Resident A is supposed to be checked on every two hours. She stated that once staff realized that Resident A was gone, they searched and 911 was called. Ms Mulka stated that Resident A's authorized representative was able to track her phone and she was found safe by the police.

<b>APPLICABLE RULE</b>	
<b>R 325.1921</b>	<b>Governing bodies, administrators, and supervisors.</b>
	<p><b>(1) The owner, operator, and governing body of a home shall do all of the following:</b></p> <p style="padding-left: 40px;"><b>(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.</b></p>

<b>R 325.1901</b>	<b>Definitions.</b>
	<b>"Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.</b>
<b>ANALYSIS:</b>	Resident A was able to get out the facility without staff knowing that she was gone. Resident A was gone from the facility for three hours without anyone knowing where she was. Resident A's room door opened at 9:57 p.m. and regular room check was completed at 1:00 a.m. revealing that it was three hours since she was last checked on. Therefore, the facility did not comply with this rule.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

## **ADDITIONAL FINDINGS**

### **INVESTIGATION**

On 5/18/2023, when calling the facility, it was revealed that the facility has a new administrator, Tyler May. Mr. May started as the administrator on 4/10/2023 and the former administrator, Suzy Mulka last day was 4/6/2023 without notifying the department.

<b>R 325.1913</b>	<b>Licenses and permits, general provisions.</b>
	<b>(2) The applicant or authorized representative shall give written notice to the department within 5 business days of any changes in information as submitted in the application pursuant to which a license, provisional license, or temporary nonrenewable permit.</b>
<b>ANALYSIS:</b>	The facility did not notify the department regarding the administrator change within five days. Therefore, the facility did not comply with this rule.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

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

*Brender d. Howard*

05/31/2023

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Brender Howard  
Licensing Staff

\_\_\_\_\_  
Date

Approved By:

*Andrea L. Moore*

05/30/2023

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

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Date