GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 8, 2023

Vera Gjolaj
Sunrise Assisted Living Of Bloomfield Hills
6790 Telegraph Rd.
Bloomfield Hills, MI 48301

RE: License #: AH630391696

Dear Ms. Gjolaj:

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. If you fail to submit an acceptable corrective action plan, disciplinary action will result. 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 #:	AH630391696
Licensee Name:	Welltower OpCo Group LLC
Licensee Address:	4500 Dorr Street Toledo, OH 43615
Licensee Telephone #:	(419) 247-2800
Authorized Representative and Administrator:	Vera Gjolaj
Name of Facility:	Sunrise Assisted Living Of Bloomfield Hills
Facility Address:	6790 Telegraph Rd. Bloomfield Hills, MI 48301
Facility Telephone #:	(248) 858-7200
Original Issuance Date:	12/23/2019
Capacity:	132
Program Type:	AGED

II. METHODS OF INSPECTION

Date of On-site Inspection(s): 06/06/2023

Date of Bureau of Fire Services Inspection if applicable: 05/30/2023

Inspection Type: ☐Interview and Observation ☒Worksheet
☐Combination

Date of Exit Conference: 06/06/2023

No. of staff interviewed and/or observed 19
No. of residents interviewed and/or observed 41
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: CAP dated 4/4/23- R 325.1921(1) (b), CAP dated 2/10/22- R 3251932 (1) *not in compliance and are being cited in this report for similar issues, CAP dated 7/6/21- R 1932 (1)- *not in compliance with this measure and are being cited in this report for similar issues.
- Number of excluded employees followed up? 6 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 325.1932	**Resident 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.

Medication administration records (MAR) were reviewed for the timeframe of 5/1/23-6/6/23 (date of onsite inspection) and the following observations were made:

Resident A missed a scheduled dose of Aricept on 5/23/23 and a scheduled dose of Metoprolol on 6/2/23. For both, staff documented the reason for the missed medication as “sleeping”. Employee 1 stated that staff are expected to wake the resident up to take medication or reapproach at a different time. There is no documentation to support that staff attempted to administer these medications to Resident A later. Resident A missed a scheduled dose of Aricept on 6/3/23, 6/4/23 and 6/5/23. Staff documented the reason for the missed doses as “medication pending delivery” [from pharmacy]. Employee 1 stated that medications should be reordered when there is a seven-day supply left and stated that the pharmacy makes deliveries five days per week (and a STAT delivery can be made for urgent matters). Employee 1 stated that this medication was reordered on 6/1/23. It is unknown why this medication was not ordered or delivered in time to avoid Resident A missing his medication.

Resident B missed a scheduled dose of Melatonin on 5/8/23, 5/9/23 and 5/10/23. Staff documented the reason for the missed doses as “medication pending delivery” [from pharmacy]. Employee 1 stated that this medication was reordered on 5/11/23, which is after the medication ran out. Resident B missed a scheduled dose of Sennoside on 5/9/23 and 5/10/23. Employee 1 stated that this medication was reordered on 5/11/23, which is after the medication ran out. Staff did not proactively reorder these medications to avoid Resident B missing her medication. Resident B missed a scheduled dose of Acetaminophen on 5/1/23, 5/2/23, 5/3/23, 5/4/23, 5/7/23, 5/9/23, 5/10/23, 5/12/23, 5/13/23, 5/14/23, 5/15/23, 5/16/23, 5/17/23, 5/18/23, 5/19/23, 5/20/23, 5/21/23, 5/22/23, 5/23/23, 5/24/23, 5/25/23, 5/26/23, 5/27/23, 5/28/23, 5/29/23, 5/30/23 and 5/31/23. Staff left the MAR completely blank for the administrations on 5/7/23, 5/9/23, 5/10/23, 5/15/23, 5/27/23 and 5/31/23. It cannot be determined why medications were missed on these dates due to lack of documentation. Staff documented the reason for the missed doses on 5/1/23,

5/2/23, 5/3/23, 5/4/23, 5/12/23, 5/13/23, 5/14/23, 5/15/23, 5/16/23, 5/17/23, 5/18/23, 5/19/23, 5/20/23, 5/21/23, 5/22/23, 5/23/23, 5/24/23, 5/25/23, 5/26/23, 5/28/23, 5/29/23 and 5/30/23 as “sleeping”. Resident B is scheduled to receive this medication four times per day and missed the first dose for the entire month of May.

Resident C missed a scheduled dose of Alprazolam on 5/3/23, 5/4/23, 5/6/23, 5/7/23, 5/8/23 and 5/9/23. Staff documented the reason for the missed doses as “medication pending delivery” [from pharmacy]. Employee 1 stated this medication was reordered on 5/3/23 and delivered on 5/4/23. It is unknown why staff did not administer the medication to Resident C after 5/4/23. Additionally, staff documented that Resident C was administered her Alprazolam on 5/5/23, which is in between dates that staff indicated that the medication was not available. The 5/5/23 administration is a documentation error. Resident C missed a scheduled dose of Gabapentin on 5/24/23, 5/25/23 and 5/26/23. Staff documented the reason for the missed doses as “medication pending delivery” [from pharmacy]. Employee 1 stated this medication was reordered on 5/26/23, which is after the medication ran out. Staff did not proactively reorder this medication to avoid Resident C missing her medication.

Resident D missed one or more scheduled doses of Apixaban on 5/4/23, 5/5/23, 5/6/23, 5/7/23, 5/8/23 and 5/11/23. Staff documented the reason for the missed doses as “medication pending delivery” [from pharmacy]. Employee 1 stated that this medication was ordered on 5/4/23 and delivered on 5/20/23. Employee 1 also stated that Resident D’s family brought the medication in from home to administer, so it is unclear why staff did not have it. Additionally, Resident D is scheduled to receive Apixaban twice daily, and on 5/5/23, 5/7/23, 5/8/23, 5/9/23, 5/10/23 and 5/11/23 staff documented that the medication was administered in between shifts that the medication was not available. These administrations are documentation errors. Resident D missed a scheduled dose of Metoprolol on 5/4/23 and 5/5/23. Staff documented the reason for the missed doses as “medication pending delivery” [from pharmacy]. Employee 1 stated that Resident D’s family brought the medication in from home to administer, so it is unclear why staff did not have it.

Resident E missed scheduled doses of Allopurinol, Escitalopram, Melatonin and Omeprazole on 5/17/23, 5/20/23 and 5/25/23. For all four medications, staff documented the reason for the missed medications as “sleeping”. There is no documentation to support that staff attempted to administer these medications to Resident E later.

R 325.1953 Menus.

(1) A home shall prepare and post the menu for regular and therapeutic or special diets for the current week. Changes shall be written on the planned menu to show the menu as actually served.

Posted menus around the facility were not dated for the current week.

R 325.1975 Laundry and linen requirements.

(1) A new construction, addition, major building change, or conversion after November 14, 1969 shall provide all of the following:
(a) A separate soiled linen storage room.
(b) A separate clean linen storage room.

The facility was not utilizing separate clean and soiled linen areas. Soiled items were observed laying directly on the floor and were not in any type of bag or container which greatly increases the risk of cross contamination between soiled items and those items that have already been laundered.

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 walk-in fridge and freezer contained items that lacked proper labeling, dating and sealing. Examples of these items include but are not limited to hot dogs, ribs, sausage links and shrimp.

R 325.1976 Kitchen and dietary.

(8) A reliable thermometer shall be provided for each refrigerator and freezer.

Thermometers were missing from the memory care kitchen refrigerator and freezer along with the refrigerator and freezer in resident room 221.

IV. RECOMMENDATION

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

06/08/2023

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Elizabeth Gregory-Weil Date
Licensing Consultant