GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

Lance Davis
Sunrise Assisted Living of Bloomfield
2080 S. Telegraph Rd
Bloomfield Hills, MI 48302

July 27, 2023

RE: License #: AH630399613
Investigation #: 2023A1022030
Sunrise Assisted Living of Bloomfield

Dear Lance Davis:

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.

Please review the enclosed documentation for accuracy and contact me with any questions.

Sincerely,

Barbara P. Zabitz, R.D.N., M.Ed.
Health Care Surveyor
Health Facility Licensing, Permits, and Support Division
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Mobile Phone: 313-296-5731
Email: zabitzb@michigan.gov

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630399613
Investigation #:	2023A1022030
Complaint Receipt Date:	06/02/2023
Investigation Initiation Date:	06/07/2023
Report Due Date:	08/02/2023
Licensee Name:	SZR Bloomfield Senior Living Opco, LLC
Licensee Address:	Suite 200 500 N. Hurstbourne Pkwy Louisville, KY 40222-3301
Licensee Telephone #:	(502) 357-9029
Administrator/Authorized Representative	Lance Davis
Name of Facility:	Sunrise Assisted Living of Bloomfield
Facility Address:	2080 S. Telegraph Rd Bloomfield Hills, MI 48302
Facility Telephone #:	(248) 972-0800
Original Issuance Date:	01/08/2020
License **Status:**	REGULAR
Effective Date:	06/29/2023
Expiration Date:	06/28/2024
Capacity:	114
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was subjected to sexual abuse.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/02/2023	Special Investigation Intake 2023A1022030
06/07/2023	Special Investigation Initiated - Telephone Complainant interviewed by phone.
06/12/2023	APS Referral
06/12/2023	Inspection Completed On-site
07/27/2023	Exit Conference Conducted via email.

ALLEGATION:

Resident A was subjected to sexual abuse.

INVESTIGATION:

On 5/10/2023, the Bureau of Community and Health Systems received a complaint that read “On Monday, 4/24/23 I (the complainant) received a call from the Care Coordinator [name of assisted living coordinator] of Sunrise Senior Living Bloomfield Twp location wherein she stated, "I wish that I were calling under better circumstances. I'm calling to inform you that your Father (Resident A) was assaulted last night." I (complainant) asked the question of "What do you mean? Can you elaborate on what that means?" She (assisted living coordinator) responded, "you want me to tell you in exact words what happened" and I replied, "yes". The Care Coordinator then stated, "While Dad (Resident A) was in bed asleep a woman entered his room and began performing oral sex on him as he slept. He was heard screaming and when the staff entered the room they (referring to the staff) said that Dad looked mortified." I then asked if my father was alright and she replied, Yes. I asked, "does this person have any health issues that I now need to be concerned about concerning my father and any health risks"? She replied no.”

On 06/07/2023, I interviewed the complainant by phone. The complainant stated that the facility had failed in their obligation to keep her father, Resident A, safe from being sexually abused. She further elaborated that when she spoke to the administrator, he did not identify the assailant but inferred that the individual was a male, when the employee who called her at the time of the incident said that it had been a female. Furthermore, the administrator implied that the sex act had been consensual. The complainant went on to say that Resident A was unable to consent to that kind of activity due to his dementia. According to the complainant, Resident A had been moved to another facility.

On 06/12/2023, a referral was made to Adult Protective Services.

On 06/12/2023, at the time of the onsite visit, I interviewed the administrator/authorized representative (AR) and the assisted living coordinator. The AR stated that when he arrived at the facility on the morning of 4/24/2023, he was informed that there had been an incident of a sexual nature between Resident A and Resident B. The AR acknowledged that Resident B had at times displayed behaviors of a sexual nature, for example, exposing himself to others, masturbating when in his room and not stopping when caregivers entered, making requests to other residents both male and female of a sexual nature, as well as groping care givers as they passed by him. The AR went on to say that the incident had been reported to the assisted living coordinator by caregiver #1, who was on duty for the overnight shift of 4/23/2023. Caregiver #1 entered Resident A’s room when she heard “moans

of pleasure," coming from the room and found the two residents, Resident A sitting on the side of his bed with his pajama bottoms down around his feet and Resident B in front of him. The AR then asserted that this activity was consensual, because Resident A was sitting up and had pushed his pants down, signaling cooperation. When the AR was informed that the complainant had alleged that Resident A was not able to consent, the AR stated that was an "agist" attitude towards a perfectly normal behavior between two adults.

The AR went on to say that after he had been informed of this incident, he met with the assisted living coordinator and determined that they needed to inform the families of both residents, but additional action was not needed because they considered the event to be consensual.

At the time of the onsite visit, I met with Resident B in his room. Resident B was seated in a wheelchair. While he was able to respond appropriately to simple questions (What day is it?), when asked if he had visitors, he replied that his mother and his father came to visit him and that he saw his mother the previous week.

When I asked the assisted living coordinator about Resident B, she confirmed that while he was cooperative with the care staff, he was incapable of making independent choices, even when it came to what clothes to wear or what to order from a menu in a restaurant. The assisted living coordinator stated that Resident A was very similar in his decision-making processes.

As I was leaving Resident B's room, I was approached by Resident C. Resident C stated that Resident B "touched" him and gestured at his crotch. When I asked Resident C if he had been groped by Resident B, Resident C replied that he had been and that he (Resident C) did not like to be touched like that. I asked Resident C if he had reported this behavior to the staff, and he replied that he did not because "they (staff) were too busy."

The AR was asked to provide documentation regarding this incident including an incident report, any resulting investigation documentation as well as health record charting for both Resident A and Resident B for that general time period (end of April 2023). No documentation was provided.

The AR was asked to provide any documentation that would back up his assertion that the sexual activity between these two residents was consensual. No documentation was provided.

The AR provided Brief Interview Mental Status (BIMS) testing results for both Resident A and Resident B. Neither of the residents' testing results were dated, so it was not clear what time period the testing represented. Resident A had a BIMS score of 9, indicating he had moderately impaired cognition. Resident B's score was 1, indicating severely impaired cognition.

Review of Resident A's service plan revealed that he was receiving an anti-psychotic medication "due to my (Resident A's) diagnosis of Dementia with behavioral disturbances," but the service plan did specify what those behaviors disturbances were.

Review of Resident B's service plan revealed that Resident B was also receiving an anti-psychotic medication due to a diagnosis of Dementia with behavioral disturbances. Resident B's service plan addressed his "need for self physical intimacy…" and his "behavioral expression," including groping others. The service plan directed caregivers to verbally redirect Resident B ([name of Resident B], please don't do that) in response to groping, and to "steer his wheel chair clear of any person in the hallway…remove me (Resident B) from the situation…Report findings to the nurse/med care manager/supervisor."

Additionally, the AR was asked to provide any written policy/procedure/guideline/protocol used by the facility to ensure that residents were protected from sustaining sexual abuse. The AR did not respond to this request.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(l) A patient or resident is entitled to be free from mental and physical abuse**
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.**
For Reference: R325.1901	**Definitions.**

	(16) "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.
ANALYSIS:	The facility did not protect Resident A from being sexually assaulted by Resident B. Further, Resident B posed on ongoing threat to additional residents, including Resident C. Although his service plan acknowledged Resident B's sexual behaviors, it seemed to assume that verbal redirection would be an effective intervention.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

At the time of the onsite visit, the AR stated that on 04/24/2023, right after he had been informed of the incident involving Residents A and B, he met with the assisted living coordinator, as they together made up the interdisciplinary team, and discussed how to proceed with this matter. According to the AR, the assisted living coordinator called both families to inform them of the incident and increased the amount of supervision provided in the first-floor common area, but that no further interventions were called for. The AR went on to say that no they had not created an incident report, because they considered the situation as consensual sexual activity between adults.

According to the complainant, Resident A walked away (eloped) from the facility the week after Resident B was found in his room because he was upset that he had been subjected to a sexual assault. In her initial written narrative, the complainant wrote, "When asked of him (Resident A) following the (elopement) incident, why did you walk away from the facility? My Father (Resident A) responded saying, cause I (Resident A) had to get away from those freaky people, they do things that ain't supposed to be done. When I (complainant) asked him, what are you talking about and why do you call them freaky people? My Father then responded, cause that's what they are freaky people". I asked why do you say that Pop? He replied, cause they do things that ain't supposed to be done, like oral sex and everything else." Resident A's elopement was investigated separately.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(5) Records must be maintained that demonstrate incident reporting to the team, analyses, outcomes, corrective action taken, and evaluation to ensure that the expected outcome is achieved. These records must be maintained for 2 years.
For Reference: R325.1901	**Definitions.**
	(k) "Incident" means an intentional or unintentional event including, but not limited to, elopements and medication errors, where a resident suffers physical or emotional harm.
ANALYSIS:	Resident A was not physically harmed but was emotionally distressed to the point he felt as though he needed to walk out of the facility, thereby warranting creation of an incident report.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

At the time of the onsite visit, the AR acknowledged that the facility had not recorded the sexual activity that occurred between Resident A and Resident B in an incident report. The AR was asked to provide charting notes that had been written in the health records for Resident A and Resident B, respectively. This documentation was not provided.

APPLICABLE RULE	
MCL 333.20175	**Maintaining record for each patient; wrongfully altering or destroying records; noncompliance; fine; licensing and certification records as public records; confidentiality; disclosure; report or notice of disciplinary action; information provided in report; nature and use of certain records, data, and knowledge.**
	(1) A health facility or agency shall keep and maintain a record for each patient including a full and complete record of tests and examinations performed, observations made, treatments provided, and in the case of a hospital, the purpose of hospitalization.

ANALYSIS:	The facility did not document the occurrence of this incident.
CONCLUSION:	**VIOLATION ESTABLISHED**

The authorized representative did not make himself available for an exit conference.

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend no change to the status of the license.

07/27/2023

Barbara Zabitz Date
Licensing Staff

Approved By:

07/24/2023

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