GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 9, 2023

Drita Aliatim
56565 Senior Care Solutions LLC
2498 Tranquil Dr.
Troy, MI 48098

RE: License #: AS630398556
Investigation #: 2023A0602022
Blossom Hill #1-AS

Dear Ms. Aliatim:

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 (248) 975-5053.

Sincerely,

Cindy Berry, Licensing Consultant
Bureau of Community and Health Systems
3026 West Grand Blvd
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 860-4475

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630398556
Investigation #:	2023A0602022
Complaint Receipt Date:	04/25/2023
Investigation Initiation Date:	04/25/2023
Report Due Date:	06/24/2023
Licensee Name:	56565 Senior Care Solutions LLC
Licensee Address:	56565 10 Mile Rd South Lyon, MI 48178
Licensee Telephone #:	(248) 264-6497
Administrator:	Drita Aliatim
Licensee Designee:	Drita Aliatim
Name of Facility:	Blossom Hill #1-AS
Facility Address:	56565 10 Mile Rd South Lyon, MI 48178
Facility Telephone #:	(248) 264-6497
Original Issuance Date:	12/23/2019
License Status:	REGULAR
Effective Date:	02/13/2023
Expiration Date:	02/12/2025
Capacity:	6
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
About a month and a half ago resident, Resident A was burned by a heating pad that was left on her chest too long. She has a severe burn that has not been cared for properly.	Yes
On 04/22/2023, an on-call APS worker made a visit to facility and found a minor child (approximately 15-16 years of age) alone with the residents. The minor lied and said she was 18 years old but when the owner returned, she said it was her minor sister and she was only alone with the residents for 5 minutes.	Yes

III. METHODOLOGY

04/25/2023	Special Investigation Intake 2023A0602022
04/25/2023	APS Referral Adult Protective Services (APS) referral received.
04/25/2023	Special Investigation Initiated - Telephone Call made to APS worker, Tamiesha Williams.
05/02/2023	Contact – Telephone call received Spoke with the assigned APS worker, Tamiesha Williams.
05/19/2023	Contact – Telephone call made Call made to the wound care nurse, Sue McKiddy
06/22/2023	Inspection Completed – On-site Interviewed Resident A and the home manager, Tina Leonard.
06/26/2023	Contact – Telephone call made Call made to staff member Tyler Mims – no answer.
06/26/2023	Exit Conference Held with the licensee designee, Drita Aliatim

ALLEGATION:

About a month and a half ago Resident A was burned by a heating pad that was left on her chest too long. She has a severe burn that has not been cared for properly.

INVESTIGATION:

On 4/25/2023, a complaint was received and assigned for investigation alleging that about a month and a half ago Resident A was burned by a heating pad that was left on her chest too long. Resident A has a severe burn that has not been cared for properly. It was also alleged that on 04/22/2023, an on-call APS worker made a visit to facility and found a minor child (approximately 15-16 years of age) alone with the residents. The minor lied and said she was 18 years old but when the owner returned, she said it was her minor sister and she was only alone with the residents for 5 minutes.

On 5/02/2023, I spoke with the assigned APS worker, Tamiesha Williams by telephone. Ms. Williams stated she made a visit to the home on 4/25/2023 and observed six residents including Resident A. Resident A informed her that she was cold and asked Ms. Leonard for her heating pad. Ms. Leonard gave her the heating pad and it was left on her overnight. As a result, Resident A suffered from a severe burn.

On 5/19/2023, I spoke with the wound care nurse, Sue McKiddy by telephone. Ms. McKiddy stated she was contacted by the nurse practitioner, Karen Birt (exact date unknown) requesting wound care services for Resident A as she suffered from a burn on her right breast caused by a heating pad. Ms. McKiddy stated that Resident A had a 3rd – 4th degree burns on her right breast. The area was not infected but the blister burst and needed to be covered. Resident A continues to receive wound care three times each week and the area is healing up nicely with the use of biofilm blast (a topical that is used to speed the healing of wounds).

On 6/22/2023, I conducted an unannounced on-site investigation at which time I interviewed Resident A and the home manager, Tina Leonard. Resident A stated she has resided in the home for about three years and uses a wheelchair for ambulation as she is unable to walk. Resident A said she has a heating pad that she purchased herself and uses it when she is cold. One evening (exact date unknown) after she was in bed, she was very cold and asked Ms. Leonard to give her the heating pad. Ms. Leonard put the heating pad on the right side of her chest just over her breast and left the room. Resident A stated when she woke up the next morning, she had a black burn on her right breast. The owner was notified and contacted the visiting nurse. The nurse practitioner was sent pictures of the burn and prescribed a cream that was applied to the area. It was at least one or two weeks before the nurse practitioner made a visit to the home and looked at the burn. At that time a wound care doctor/nurse was ordered. Resident A said the wound never became infected, but the wound care nurse visits her

three times each week to change her bandage. Resident A stated that she feels as if it was an accident and does not blame Ms. Leonard for her injury.

On 6/22/2023, I interviewed staff member Tina Leonard while at the home. Ms. Leonard stated Resident A complained about being cold (exact date unknown) and asked for her heating pad. Ms. Leonard placed the heating pad across Resident A's chest for 30 minutes and removed it. The area appeared to be a bit red but Resident A did not complain of any pain or discomfort. The next morning the area looked more like a bruise with a blister. The licensee designee, Drita Aliatim was notified immediately, and the nurse practitioner was notified the next day. A couple of days later, the nurse practitioner made a visit to the home as the blister became filled with fluid. An antibiotic cream was prescribed and applied to the burned area and covered with a bandage. A wound care nurse was also ordered to change the bandage three times each week. Ms. Leonard stated Resident A never suffered from an infection, but an antibiotic cream was prescribed as a precautionary measure.

On 6/26/2023, I spoke with the licensee designee, Drita Aliatim by telephone. Ms. Aliatim stated from what she was told, Resident A requested her heating pad and Ms. Leonard gave it to her. The heating pad was placed on her chest on top of her gown. Resident A went to sleep and the next morning her right breast was red, and a blister started to form. The blister burst over the weekend. The nurse practitioner, Karen Birt was notified and made a visit to see the client on that Monday (exact date unknown). Over the next few days, the area became redder in color, then turned brown and later a charred color. Ms. Birt prescribed an antibiotic cream as a precautionary measure and made a referral to the wound care clinic. The wound care nurse, Sue McKiddy, visits Resident A three times each week to monitor the wound and change the bandage.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on the information obtained during the investigation, there is sufficient information to determine that Ms. Leonard did in fact place a heating pad on Resident A's chest for an unknown amount of time causing a burn on her right breast. Resident A requested the heating pad because she was cold, and Ms. Leonard placed it on her chest before she went to bed. The next morning the heating pad was still on her chest and left a burn on her right breast.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

On 04/22/2023, an on-call APS worker made a visit to facility and found a minor child (approximately 15-16 years of age) alone with the residents. The minor lied and said she was 18 years old but when the owner returned, she said it was her minor sister and she was only alone with the residents for 5 minutes.

INVESTIGATION:

On 5/02/2023, I spoke with the assigned APS worker, Tamiesha Williams by telephone. Ms. Williams stated an on-call APS worker made a visit to the home on Saturday, 4/22/2023 and found six residents alone with a female teenager who said she was 18 years old. The licensee designee, Ms. Aliatim was contacted, returned to the home and stated the teen was her 15-year-old sister and she had only been alone with the residents for about 5 minutes.

On 6/22/2023, I interviewed Resident A and the home manager, Tina Leonard during the unannounced on-site investigation. Resident A and Ms. Leonard both stated they had no information regarding a teenager being left in the home alone with the residents. Ms. Leonard advised that I speak with Ms. Aliatim for further information.

On 6/26/2023, I conducted an exit conference with the licensee designee, Drita Aliatim by telephone. I informed Ms. Aliatim of the investigative findings and recommendation documented in this report. Ms. Aliatim stated on 4/22/2023 she was working the day shift between the hours of 8 am and 4 pm. She left the home to go to the drugstore then called staff member, Tyler Mims who was scheduled to work the afternoon shift between the hours of 4 pm and 9 am. Ms. Mims informed her that she was pulling up to the home. Ms. Aliatim stated her teenage sister remained in the home with the residents and was only there alone for about five minutes. Ms. Aliatim stated she did in fact leave the home before Ms. Mims arrived for her shift.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(1) Direct care staff shall not be less than 18 years of age and shall be able to complete required reports and follow written and oral instructions that are related to the care and supervision of residents.
ANALYSIS:	Based on the information obtained from the assigned APS worker, Tamiesha Williams and the licensee designee, Drita Aliatim, there is sufficient information to determine that the residents were left alone for an unknown amount of time with a minor.

	According to Ms. Aliatim, her teenage sister was left alone with the residents for about 5 minutes. Ms. Aliatim stated she left the home to go to the drugstore but spoke with the oncoming staff member and was informed that she was pulling up to the home. However, Ms. Aliatim left the home before the staff arrived.
CONCLUSION:	**VIOLATION ESTABLISHED**

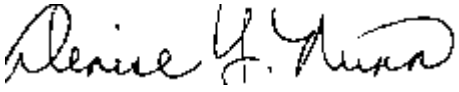
IV. RECOMMENDATION

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

8/09/2023

Cindy Berry Date
Licensing Consultant

Approved By:



08/09/2023

Denise Y. Nunn Date
Area Manager