



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 1, 2023

Stephen Levy
The Sheridan at Birmingham
2400 E. Lincoln Street
Birmingham, MI 48009

RE: License #: AH630381578
Investigation #: 2023A0585051
The Sheridan at Birmingham

Dear Mr. Levy:

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,

A handwritten signature in cursive script that reads "Brender Howard".

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

License #:	AH630381578
Investigation #:	2023A0585051
Complaint Receipt Date:	04/12/2023
Investigation Initiation Date:	04/12/2023
Report Due Date:	06/12/2023
Licensee Name:	CA Senior Birmingham Operator, LLC
Licensee Address:	Suite 4900 161 N. Clark Chicago, IL 60601
Licensee Telephone #:	(312) 673-4387
Administrator:	Margaret Canny
Authorized Representative:	Stephen Levy
Name of Facility:	The Sheridan at Birmingham
Facility Address:	2400 E. Lincoln Street Birmingham, MI 48009
Facility Telephone #:	(248) 940-2050
Original Issuance Date:	03/29/2018
License Status:	REGULAR
Effective Date:	09/27/2022
Expiration Date:	09/26/2023
Capacity:	128
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was missing from her room and was found hours later in another room.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/12/2023	Special Investigation Intake 2023A0585051
04/12/2023	Special Investigation Initiated - Telephone Contacted APS to discuss allegations. Allegations sent by APS assigned to worker Tina Edens.
04/18/2023	Inspection Completed On-site Completed with observation, interview and record review.

ALLEGATION:

Resident A was missing from her room and was found hours later in another room.

INVESTIGATION:

On 4/11/2023, the department received the allegations from Adult Protective Services (APS) via the BCHS Online Complaint website. The complaint alleged that Resident A wandered out of her room. The complaint alleged that Resident A was missing from around midnight until about 5:30am to when she was located by the police. The complaint alleged that Resident A was locked in a vacant room and on her back. The complaint alleged that Resident was located in a storage room.

On 4/12/2023, I spoke to APS worker Tina Edens by telephone. Ms. Edens stated that she will be substantiating the claim due to Resident A being missing out of the sight of the staff for an extended period.

On 4/18/2023, an onsite was completed at the facility. I interviewed wellness director Darnisha Katon at the facility. Ms. Katon stated that staff went to search for Resident A. She stated that Resident A was on checks every two hours. She stated that when staff saw that Resident A was missing, they called the supervisor and immediately started searching for her in the building. She stated that staff searched every room. Ms. Katon stated that staff called the family and called 911. She stated that 911 came and assisted with the search of Resident A.

During the onsite, I interviewed Employee #1 at the facility. Employee #1 stated that Resident A went missing and no one could find her. Employee #1 stated that the police found Resident A in an empty room of the facility. She explained that the room door was not latched, and Resident A was able to get in. She stated that Resident A was last seen wandering at midnight and when staff went back at 2:30 a.m. she was missing.

APPLICABLE RULE	
R 325.1921	Governing bodies, administrators, and supervisors.
	<p>(1) The owner, operator, and governing body of a home shall do all of the following:</p> <p>(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.</p>
R 325.1901	Definitions.
	<p>“Protections” 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.</p>
ANALYSIS:	<p>Resident A was missing from her room and was missing for three hours before she was found. She was found in another room that should have been locked. Although, Resident A was found without injury, there was a threat that she could have been harmed due to her whereabouts being unknown. Therefore, the facility did not comply with this rule.</p>
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS

INVESTIGATION:

Resident A’s service plan read, “fall potential, monitor resident for falls and report to appropriate team members. Monitor resident for episodes of disorientation. Nighttime care needs will be met with staff checks, staff to check on resident every 2

hours during the night. The service plan read, “has current or history of frequent difficulty communicating and receiving information; cannot follow instructions; has frequent difficulty following instructions with using the telephone and other communication devices. [Resident A] has current or history of occasional disorientation to person, place, time, or situation even in familiar surroundings and requires supervision and oversight for safety. Requires supervision due to inability to discern and avoid situations in which she may be abused, neglected, or exploited.”

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.
R 325.1901	Definitions.
	"Service plan" means a written statement prepared by the home in cooperation with a resident, the resident's authorized representative, or the agency responsible for a resident's placement, if any, that identifies the specific care and maintenance, services, and resident activities appropriate for the individual resident's physical, social, and behavioral needs and well-being, and the methods of providing the care and services while taking into account the preferences and competency of the resident.
ANALYSIS:	Documents show that Resident was supposed to be monitored every two hours. Resident A was last seen at 12:00 a.m. wandering in the facility, and was not found to be missing until 2:30 a.m. Therefore, the facility did not reasonably comply with this rule.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remains unchanged.

Brender d. Howard

08/01/2023

Brender Howard
Licensing Staff

Date

Approved By:

Andrea L. Moore

08/01/2023

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

Date