GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 19, 2023

Rowan Farber
SJV 2 N Farmington OpCo LLC
7902 Westpark Drive
McLean, VA 22102

RE: License #: AH630407346
Investigation #: 2022A0585063
Sunrise of North Farmington Hills

Dear Ms. Farber:

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.

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 L. 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 #:	AH630407346
Investigation #:	2022A0585063
Complaint Receipt Date:	06/02/2022
Investigation Initiation Date:	06/03/2022
Report Due Date:	08/02/2022
Licensee Name:	SJV 2 N Farmington OpCo LLC
Licensee Address:	250 Vesey St., 15th Floor New York, NY 10281
Licensee Telephone #:	(248) 538-9200
Authorized Representative:	Rowan Farber
Administrator:	Dorothy Harold
Name of Facility:	Sunrise of North Farmington Hills
Facility Address:	29681 Middlebelt Road Farmington Hills, MI 48334
Facility Telephone #:	(248) 538-9200
Original Issuance Date:	06/07/2021
License Status:	REGULAR
Effective Date:	12/07/2021
Expiration Date:	12/06/2022
Capacity:	75
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A's catheter was tied in a knot.	Yes
Staff did not get in-serviced on catheter.	No
Additional Findings	No

III. METHODOLOGY

06/02/2022	Special Investigation Intake 2022A0585063
06/03/2022	Special Investigation Initiated - Telephone Contacted the complainant listed on APS referral to discuss allegations.
06/07/2022	Inspection Completed On-site Completed with observation, interview and record review.
05/19/2023	Exit Emailed special investigation report to the email on file.

ALLEGATION:

Resident A's catheter was tied in a knot.

INVESTIGATION:

On 6/2/2022, the department received the allegations from Adult Protective Services (APS) via the BCHS Online Complaint website. The complaint alleges that resident's catheter was tied in a knot.

On 6/3/2022, I contacted the complainant to discuss the allegations. The complainant stated that she received a call and was told that Resident A's catheter was found tied in a knot which was the second time it has happened. She stated that it is unknown who keeps tying the catheter in a knot, but she knows that Resident A is not able to do it himself.

On 6/6/2022, I interviewed Resident A's private caregiver Lakesha Stones by telephone. Ms. Stones stated that she didn't know how it happened that his catheter was tied in a knot. She stated that when she got ready to change Resident A she

noticed that there was no output. She stated that she informed staff to help her untie it. She stated that it is not known how long the catheter was tied in a knot.

On 6/6/2022, an onsite was completed at the facility. During the onsite, I interviewed the administrator at that time, Mary Ostrowski at the facility. Ms. Ostrowski stated that Resident A is dementia, and he pulls on his catheter. She stated that Resident A has a private duty caregiver from midnight to morning. Ms. Ostrowski stated that the private caregiver came in that day and the catheter was tied in a knot.

On 6/6/2022, I interviewed resident care director Natalie Luko at the facility. Ms. Luko stated that staff have watched Resident A wrap his catheter in a knot. She stated that he is a two person assist and they monitor Resident A throughout the day.

On 6/6/2022, I interviewed resident care coordinator Donna Howell at the facility. Ms. Howell stated that Resident A wrap the catheter cord around. She stated that Resident A often throws himself on the floor and they monitored him more frequently.

On 6/6/2022, I interviewed lead care manager Bianca Blake at the facility. Ms. Blake stated, Resident A throws himself out of the bed and constantly pulls at this catheter. She stated that Resident A is monitored throughout each shift. She stated that they only found out during lunch that Resident A had pulled the catheter out.

Progress notes for Resident A read, 5/27/22, private duty care giver reported that she noted a knotted catheter upon her arrival this morning. Nurse informed her about the upcoming in service with midnight care managers this evening about proper foley care; she insisted on calling POA to relay the information while writer was in the room. Writer spoke with POA, discussed upcoming in-service with care managers and resident's POC.

During the onsite, I observed Resident A in his room, lying on the bed. He was constantly pulling on the covers on the bed. Resident A was not able to be interviewed.

The service plan for Resident A read, "assist with catheter care empty foley at the end of every shift. Notify wellness staff and hospice if there is no urine output. While providing care, report any redness, odor, or drainage on or around the catheter dressing site, or if there are any changes in mental status, behavior or wandering" The plan read, "fall risk factors behavior of throwing himself out of bed. Check on frequently to ensure needs are met. At times, may require 1x1 time with care manager to ease agitation. Turn and reposition at least 3-4x per shift. Have a pressure ulcer to coccyx which becomes very painful when not repositioned, causing agitation/behaviors."

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.**
ANALYSIS:	The complaint alleges Resident A was found with the catheter tied in a knot. Interview and documentation revealed that Resident A has a history of restlessness and is to be monitored throughout the shifts. It is not known when the last time he was monitored or how long the catheter was tied in a knot preventing the output of urine. Therefore, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff did not get in serviced on catheter.

INVESTIGATION:

The complainant alleges that she was told that staff will be in-serviced on the proper use and monitoring of a catheter.

Ms. Ostrowki stated that the nurse completed a retraining with staff regarding proper care and monitoring someone with a catheter.

Ms. Blakes stated that all staff was retrained on how to monitor residents who has a catheter.

Ms. Howell stated that she was trained on the proper use of catheter and recently was retrained on using and monitoring the catheter.

Document shows that in service for using catheters was conducted on 5/27/2022.

R 325.1931	**Employees; general provisions.**
	(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following: **(a) Reporting requirements and documentation.** **(b) First aid and/or medication, if any.** **(c) Personal care.** **(d) Resident rights and responsibilities.** **(e) Safety and fire prevention.** **(f) Containment of infectious disease and standard precautions.** **(g) Medication administration, if applicable.**
ANALYSIS:	Based on documentation and interviews, staff had in-service on how to provide care for the catheter and how to monitor residents for any issues with the catheter. The facility reasonably complied with this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

RECOMMENDATION

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

Brender L. Howard 05/19/2023

Brender Howard Date
Licensing Staff

Approved By:

Andrea L. Moore 05/18/2023

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