GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 6th, 2023

James Salamon
Blueberry Hill Assisted Living Inc.
PO Box 480762
Los Angeles, CA 90048

RE: License #: AH800398973
Investigation #: 2023A1021084
Blueberry Hill Assisted Living

Dear Mr. Salamon:

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.

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,
Kimberly Horst

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH800398973
Investigation #:	2023A1021084
Complaint Receipt Date:	08/29/2023
Investigation Initiation Date:	08/30/2023
Report Due Date:	10/28/2023
Licensee Name:	Blueberry Hill Assisted Living Inc.
Licensee Address:	99 Walker Street Lawton, MI 49065
Licensee Telephone #:	(323) 620-4968
Administrator:	Dana Dewitt
Authorized Representative:	James Salamon
Name of Facility:	Blueberry Hill Assisted Living
Facility Address:	99 Walker Street Lawton, MI 49065
Facility Telephone #:	(269) 299-6007
Original Issuance Date:	01/24/2023
License Status:	TEMPORARY
Effective Date:	01/24/2023
Expiration Date:	07/23/2023
Capacity:	66
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident B was locked out of the facility for multiple hours.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/29/2023	Special Investigation Intake 2023A1021084
08/30/2023	Inspection Completed On-site
09/06/2023	Exit Conference

ALLEGATION:

Resident B was locked out of the facility for multiple hours.

INVESTIGATION:

On 08/29/2023, the licensing department received a complaint from Adult Protective Services (APS) with allegations Resident B was locked out of the facility for four hours. APS dismissed the case for investigation.

On 08/30/2023, I interviewed Resident B at the facility. Resident B reported that he goes outside to smoke cigarettes. Resident B reported approximately one week ago, he left the facility to smoke a cigarette and was locked out of the facility for about four hours. Resident B reported all the doors were locked. Resident B reported he had no cell phone to call for help. Resident B reported a care staff member finally came to the facility and let him back inside.

On 08/30/2023, I interviewed staff person 1 (SP1) at the facility. SP1 reported she reported to the facility around 6:30am on 08/22/2023 and observed Resident B outside. SP1 reported she asked Resident B what he was doing, and he reported he was locked out of the facility. SP1 reported she brought Resident B back to his room and made sure he was not injured. SP1 reported SP2 fell asleep at the facility on the midnight shift and did not know Resident B was locked outside. SP1 reported she has observed SP2 to be sleeping multiple times while on duty.

On 08/30/2023, I interviewed SP3 at the facility. and on 08/22/2023, there was one staff member working which was SP2. SP3 reported Resident B will go outside at

night to smoke and the caregiver is to go with the resident. SP3 reported she viewed camera footage and observed Resident B to leave the facility to smoke at approximately 3:30am and was brought back inside three hours later by SP1. SP3 reported the camera footage showed SP2 sleeping in a recliner chair. SP3 reported SP2 is no longer employed at the facility.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	Interviews conducted revealed Resident B was locked outside the facility for multiple hours because the staff member was sleeping.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Observations made revealed Resident B had two ½ bedrails attached to his bed. Review of Resident B's service plan and record revealed lack of physician order for the bedrails and lack of detail in the service plan for the use of the bedrails.

APPLICABLE RULE	
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:	**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:	Upon my inspection, Resident B had bedside assistive devices attached to their bed. I reviewed records and found no physician order for the bedside assistive devices for the use and purpose of the devices. In addition, the service plan for the resident lacked information about the devices related to purpose of use, staff responsibility to ensure devices were safe, and ongoing maintenance schedules. For instance, instruction regarding whether the resident could summon staff independently for help or require monitoring on a predetermined frequency was not defined. In addition, it lacked what staff were responsible for, and what methods were to be used in determining if the device posed a risk.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

SP3 reported she recently took over in management and is in the process of updating service plans. SP3 reported there are four residents in the facility and the residents do not have service plans.

SP1 reported no knowledge of service plans for the residents. SP1 reported caregivers are to treat the residents with respect.

I reviewed Resident A, Resident B, Resident C, and Resident D's records. The review revealed there was no service plans for the residents.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(2) The admission policy shall specify all of the following: (a) That at the time of admission, the home shall document the needs of each individual seeking admission. The documented needs shall be used to develop the resident's service plan.
ANALYSIS:	Review of resident records revealed Resident A, Resident B, Resident C, and Resident D did not have a service plan. **REPEAT VIOLATION ESTABLISHED:** **Licensing study report:**

	AH800398973_RNWL_20230626 dated 06/27/2023 and corrective action plan dated 07/11/2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Review of Resident B's records revealed Resident B did not have a tuberculosis screening prior to admission.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(7) An individual admitted to residence in the home shall have evidence of tuberculosis screening on record in the home that was performed within 12 months before admission. Initial screening may consist of an intradermal skin test, a blood test, a chest x-ray, or other methods recommended by the public health authority. The screening type and frequency of routine tuberculosis (TB) testing shall be determined by a risk assessment as described in the 2005 MMWR ?Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005? (http://www.cdc.gov/mmwr/pdf/rr/rr5417.pdf) , Appendices B and C, and any subsequent guidelines as published by the centers for disease control and prevention. A home, and each location or venue of care, if a home provides care at multiple locations, shall complete a risk assessment annually. Homes that are low risk do not have to conduct annual TB testing for residents.
ANALYSIS:	Resident B did not have a tuberculosis screening prior to admission. **REPEAT VIOLATION ESTABLISHED:** **Licensing study report:** **AH800398973_RNWL_20230626 dated 06/27/2023 and corrective action plan dated 07/11/2023.**
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Review of Resident B's July 2023 medication administration record (MAR) revealed Resident B was prescribed Creon 6000unit capsule with instruction to administer

one capsule by mouth three times daily. The MAR revealed Resident B did not receive this medication on 08/10-8/28 because the facility did not have the medication.

APPLICABLE RULE	
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.
ANALYSIS:	Resident B did not receive Creon medication as ordered by the licensed health care professional.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Review of Resident D's MAR revealed Resident D had an order for Alprazolam 1mg tablet with instruction to administer one tablet at bedtime as needed for insomnia/anxiety. Review of Resident D's MAR revealed Resident D received this medication 08/01-08/29.

APPLICABLE RULE	
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.
ANALYSIS:	Resident D was administered Alprazolam medication every day for 29 days. However, the order was written to administer the medication on an as needed basis. The facility did not ensure the medication was administered as written by the prescribing health care professional.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

08/31/2023

Kimberly Horst Date
Licensing Staff

Approved By:

08/31/2023

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