GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 6, 2023

Mary North
Brookdale Northville
40405 Six Mile Road
Northville, MI 48167

RE: License #: AH820236941
Investigation #: 2023A1027084
Brookdale Northville

Dear Licensee:

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 877-458-2757.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820236941
Investigation #:	2023A1027084
Complaint Receipt Date:	07/27/2023
Investigation Initiation Date:	07/28/2023
Report Due Date:	09/26/2023
Licensee Name:	Brookdale Senior Living Communities, Inc.
Licensee Address:	Suite 2300 6737 West Washington St. Milwaukee, WI 53214
Licensee Telephone #:	(414) 918-5000
Administrator:	Leslie Aneed
Authorized Representative:	Mary North
Name of Facility:	Brookdale Northville
Facility Address:	40405 Six Mile Road Northville, MI 48167
Facility Telephone #:	(734) 420-6104
Original Issuance Date:	10/10/1996
License Status:	REGULAR
Effective Date:	10/29/2022
Expiration Date:	10/28/2023
Capacity:	72
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A lacked care.	Yes
Resident A's care conference was not held with his son/durable power of attorney.	No
There was not an appointed shift supervisor on duty.	Yes
Additional Findings	No

III. METHODOLOGY

07/27/2023	Special Investigation Intake 2023A1027084
07/28/2023	Special Investigation Initiated - Telephone Voicemail left for complainant
07/29/2023	Contact - Telephone call received Complainant left a voicemail.
08/01/2023	Contact - Telephone call received Complainant left a voicemail.
08/07/2023	Contact - Telephone call made Voicemail left with complainant requesting additional information by telephone or email
08/11/2023	Contact - Telephone call made Telephone interview conducted with complainant
08/11/2023	Contact - Document Sent Email sent to Leslie Aneed and Mary North requesting documentation pertaining to Resident A
08/15/2023	Contact - Document Received Two emails received from Mary North and Leslie Aneed with requested documentation
08/21/2023	Contact - Document Sent Email sent to Mary North and Leslie Aneed requesting additional documentation

08/29/2023	Contact - Document Received Email received from Mary North with requested documentation and information
09/06/2023	Contact - Telephone call made Conducted with Employee #2
09/06/2023	Inspection Completed-BCAL Sub. Compliance
09/18/2023	Exit Conference Conducted with authorized representative Mary North by telephone

ALLEGATION:

Resident A lacked care.

INVESTIGATION:

On 7/27/2023, the Department received a complaint through the online complaint system which read Resident A did not receive proper care before and after his eye surgery. The complaint read Resident A did not receive his eye drops after surgery.

On 8/11/2023, I conducted a telephone interview with the complainant. The complainant stated Resident A had right eye surgery earlier this year in which he required eye drops before and after the procedure. The complainant stated the facility followed the physician's orders before and after that procedure on the right eye. The complainant stated Resident A's left eye surgery was performed on 7/24/2023 in which he required eye drops before and after the procedure again. The complainant stated Resident A's family friend provided the facility with notification of the scheduled procedure on 7/24/2023, along with the prescription for the pre-surgical eye drops. The complainant stated Resident A's pre-surgery eye drops were administered as prescribed. The complainant stated upon return from the procedure on 07/24/2023, Resident A's family friend provided the prescription for the post-surgery eye drops to a staff member who placed it in Employee #1's mailbox since she was not there that day. The complainant stated Resident A had not received the post-surgery eye drops on 7/25/2023 or 7/26/2023. The complainant stated Resident A's son visited the facility on 7/27/2023 in which the prescription for the post-surgical eye drops remained Employee #1's mailbox. The complainant stated a picture of the prescription was texted to Employee #1 and the eye drops were administered to Resident A in the evening on 7/27/2023. The complainant stated Employee #1 was familiar with Resident A's eye procedures and corresponding physician orders. The complainant stated Employee #1 was supposed to be available to facilitate resident's needs.

Additionally, the complainant stated when Resident A's son visited the facility on 07/27/2023, he was informed by Employee #2 that Resident A fell and hit his head four days prior to his surgery which was 7/21/2023. The complainant stated staff observed him on the floor in the facility's exercise room. The complainant stated Resident A's son was not informed of the fall.

On 8/11/2023, I reviewed a copy of the prescription for the post-surgery eye drops which read in part there were three eye drop medications ordered and to be administered in the left eye twice daily, as well as patch to be worn at bedtime.

On 8/29/2023, I received email correspondence from authorized representative Mary North which read in part there were no reportable event incident reports from July 2023.

I reviewed Resident A's face sheet which read in part he admitted to the facility on 5/4/2021 and his son was his durable power of attorney for medical care and finances.

I reviewed Resident A's service plan updated on 6/27/2023 which read in part the facility was to "*order and coordinate medications between family, health care providers and pharmacy*." The plan read in part Resident A required staff assistance with his medications. The plan read in part Resident A had fallen in the past twelve months, was a fall risk and provided fall risk interventions for staff.

I reviewed Resident A's medication administration records (MARs) for July 2023 which read consistent with the prescription for the post-surgical eye drops. The MARs read in part the three post-surgical eye drops were started on 7/27/2023.

I reviewed Resident A's July 2023 progress notes. The notes read in part on 7/27/2023 Employee #1 was informed Resident A had not received his post-surgical eye drops and she contacted the pharmacy to have them delivered that day. The notes read in part Employee #1 contacted Resident A's surgical physician in which they were informed he had not received his post-surgical eye drops and there were no additional orders received. The notes read in part a physician assistant evaluated Resident A on 7/31/2023 and there were no signs of infection noted in his eye.

I reviewed an incident report dated 7/27/2023 which read consistent with the progress notes. The report read in part, under the corrective measures, staff were instructed and in-serviced again on the proper procedures for when a medication was not available or not in the medication cart. The report read in part Employee #1 received written coaching.

I reviewed the staff schedule for 7/21/2023 which read in part Employee #2 worked dayshift.

On 9/7/2023, I conducted a telephone interview with Employee #2 who stated she did not recall Resident A falling on 7/21/2023 nor having a fall on her shifts.

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.**
ANALYSIS:	Review of A's medical records revealed he had a history of falls and was at risk for falls. Staff interviews and review of documentation could not confirm a fall occurred on 7/21/2023. Review Resident A's medical records revealed the facility was responsible for administration of his medications. The complainant's interview was consistent with facility records. There was a lack of an organized program to ensure Resident A's post-surgical medications were ordered and administered as prescribed, thus this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A's care conference was not held with his son/durable power of attorney.

INVESTIGATION:

On 8/11/2023, during the telephone interview with the complainant, it was alleged Employee #1 conducted a care meeting with Resident A's family friend and not his son, who was his durable power of attorney.

On 8/11/2023, I received email correspondences forwarded from the complainant which read in part there was care conference with Resident A's family friend and Employee #1 on 1/17/2023 at 1:00 PM. The email correspondence read in part the email invite for Resident's care conference from Employee #1 on 1/13/2023 had an incorrect email address for Resident A's son.

On 8/29/2023, I received email correspondence from Mary North which read in part: *"[Resident A] is in Assisted Living, most of our residents in AL are still their own decision maker and fully cognitive. [Resident A] does have this DPOA paperwork in his chart but there are not two doctors signatures deeming him incompetent to make his own medical and financial decisions."*

I reviewed Resident A's face sheet which read in part his son was his first emergency contact, as well as financial and medical care durable power of attorney. The face sheet read in part Resident A's family friend was his second emergency contact.

I reviewed Resident A's Durable Power of Attorney Paperwork (DPOA) which read consistent with email correspondence from Mary North.

I reviewed Resident A's admission contract signed by Resident A's son on 4/28/2021 which read in part:

> ***"Resident Assessment and Care Planning***
> *The Community Assessment Tool is used to determine the level of care that a potential resident requires. The result of the assessment will determine if additional care charges will be necessary. Residents will be reassessed at least every six months or upon a significant change of condition. The assessment will be used to update the Service Plan and the results will be shared with the resident's family members during the Service Plan review."*
>
> ***"Involvement of Families***
> *The Community welcomes the input of family members and resident representatives in preparing the resident's Service Plan and reviewing and modifying the Service Plan as needed. Residents and family members play a key role in helping to develop the Life Skills program for the resident by providing our Life Enrichment Coordinator with completed Social History and Interest Profiles to give an insight into the life of the resident."*
>
> ***"Services and Fees***
> *The Resident Assessment Tool/Summary is used to determine the additional costs and fees for the special care provided beyond what is included in the Basic Service Rate. Each resident's Service Plan is reviewed approximately quarterly by the residence's interdisciplinary team and modified if necessary. Reviews are conducted more frequently if dictated by changes in the resident's condition or other circumstances. At the time of the review, information is gathered from the resident and numerous others involved with the resident, including family members, the Health & Wellness Director, the Executive Director, the Life Enrichment Coordinator, the Dining Service Manager, and the Resident Assistants. In some cases the resident's personal physician is consulted. If the combined input of these individuals suggests the need for modifications to the*

resident's Service Plan, the proposed modifications are written and discussed with the resident and his or her representative."

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	Review of documentation revealed a care conference occurred in January 2023 without Resident A's son; however, no changes were reflected in Resident A's service plan, and it was emailed afterward to his son in which appeared to be an isolated incident. Based on this information, this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

There was not an appointed shift supervisor on duty.

INVESTIGATION:

On 8/11/2023, during the telephone interview with the complainant, it was alleged that Employee #3 did not know who the shift supervisor was on 7/27/2023.

On 8/29/2023, email correspondence with Mary North read in part "*Our med techs are always the "lead supervisor" on the floor and we always have a med tech on each shift. Even if there are not routine meds on midnights, we still have med tech around the clock."*

On 9/6/2023, I conducted a telephone interview with Employee #2 who stated the medication technician was the shift supervisor on duty for each shift.

I reviewed the staff schedule dated 7/27/2023. The schedule read two medication technicians worked first and third shifts, and the medication technician that was the supervisor was not noted.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(3) The home shall designate 1 person on each shift to be supervisor of resident care during that shift. The supervisor of resident care shall be fully dressed, awake, and on the premises when on duty.
ANALYSIS:	Review of the staffing schedule revealed there was more than one medication technician on duty. Email communication revealed the medication technician was also the "lead supervisor," thus the facility was not incompliance with this rule in appointing one designated shift supervisor of resident care and a violation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

09/06/2023

_____

Jessica Rogers Date
Licensing Staff

Approved By:

09/18/2023

_____

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