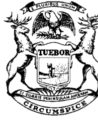

GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 31, 2023

Surindar Jolly
Brownstown Forest View Assisted Living
19341 Allen Rd.
Brownstown, MI 48183

RE: License #: AH820238949
Investigation #: 2023A0784090
Brownstown Forest View Assisted Living

Dear Surindar Jolly:

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. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Aaron L. Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820238949
Investigation #:	2023A0784090
Complaint Receipt Date:	09/07/2023
Investigation Initiation Date:	09/08/2023
Report Due Date:	11/06/2023
Licensee Name:	Brownstown Assisted Living Center LLC
Licensee Address:	19335 Allen Road Brownstown, MI 48183
Licensee Telephone #:	(734) 658-4308
Administrator/Authorized Representative:	Surindar Jolly
Name of Facility:	Brownstown Forest View Assisted Living
Facility Address:	19341 Allen Rd. Brownstown, MI 48183
Facility Telephone #:	(734) 675-2700
Original Issuance Date:	08/14/2002
License Status:	REGULAR
Effective Date:	12/17/2022
Expiration Date:	12/16/2023
Capacity:	76
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Staff passed medications without training.	Yes
Resident A did not receive showers.	No
Staff did not follow physicians orders.	No
Narcotics are stored improperly.	No
Additional Findings	No

III. METHODOLOGY

09/07/2023	Special Investigation Intake 2023A0784090
09/08/2023	Special Investigation Initiated - On Site
09/08/2023	Inspection Completed On-site
09/18/2023	Contact - Document Sent Email sent to resident care director Jaqueline Elayyan requesting additional information/documentation
10/19/2023	Contact - Document Received Additional investigative documents received from Ms. Elayyan
10/19/2023	Contact - Telephone call made Interview with Ms. Elayyan
10/19/2023	Exit Conference Conducted with Ms. Elayyan

ALLEGATION:

Staff passed medications without training.

INVESTIGATION:

On 9/07/2023, The department received this online complaint from adult protective services (APS). According to information provided on the complaint, the referral source to APS was anonymous.

According to the complaint, staff are not adequately trained.

On 9/08/2023, the department intake unit received additional information regarding this complaint. According to the additional information, Associates 1 passed medications on 8/08/2023 without having been trained yet. Additionally, Associates 2 and 3 pass medications though they have not been trained to do so.

On 9/08/2023, I interviewed resident care manager Jackie Elayyan at the facility. Ms. Elayyan stated she creates the staff schedule for the facility and does not schedule staff to perform duties that they are not yet trained for. Ms. Elayyan stated Associates 1, 2 are currently trained to pass medications. Ms. Elayyan stated Associate 3 is not a medication technician (med tech) and has not been placed on the schedule to pass medications. Ms. Elayyan stated she is not aware of Associate 1 having passed medications without being trained first. Ms. Elayyan stated that from what she could recall, Associate 1 was still in training for medication administration on 8/08/2023 and was being trained by Associate 4 Ms. Elayyan stated that on that day, 8/08/2023, she received a call from Associate 1 as Associate 4 had apparently went on break and not yet passed medications for a resident. Ms. Elayyan stated Associate 1 asked if he was supposed to pass the medications while Associate 4 was gone and Ms. Elayyan stated she instructed him not to as he had not been fully trained yet. Ms. Elayyan stated that to her knowledge, Associate 1 did not pass the medications. Ms. Elayyan stated staff who are trained to be medication technicians (med techs) receive “Lead Training” which includes training for med passing policies and procedures and related med tracking documentation. Ms. Elayyan stated once staff have completed this training, it must be signed off on by the trainer who is themselves either a lead worker or supervisor. Ms. Elayyan stated she is often the training person.

I reviewed the “as worked” staff schedule, provided by Ms. Elayyan, for August 2023. According to the schedule, Associate 1 was designated as a first floor “Lead/R.A.” on 8/08/2023.

I reviewed Associate 1’s *Lead Training Check off list*, provided by Ms. Elayyan. The list indicated several areas of training specific to medications. According to the list, Associate 1 was trained by Associate 4 on all aspects of lead training on 8/24/2023, 8/26/2023, 8/27/2023 and 8/31/2023 with the final med pass observational review done on 9/04/2023 by Ms. Elayyan.

I reviewed Associate 2's Lead Training Check off list, provided by Ms. Elayyan, which indicated Associate 2 completed this training on 8/19/2023 and was consistent with Ms. Elayyan's statements.

On 10/19/2023, I Interviewed Ms. Elayyan by telephone. Ms. Elayyan stated when the schedule designates someone as the "Lead/R.A." that means they are the supervisor and a med medication technician (med tech) on that shift. Ms. Elayyan stated she could not explain the discrepancy between Associate 1's lead training dates, noted as being completed on 9/04/2023, and his designation on the calendar as a "Lead/R.A." on 8/08/2023. Ms. Elayyan stated she may have mixed up the date she believed she had been contacted by Associate 1, but that she was certain Associate 1 was still in training during that time. Ms. Elayyan stated she did not have further explanation as to the contradiction between the dates she thought Associate 1 was still in training and the dates he was on the schedule as a fully trained Lead.

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.**
R 325.1932	**Resident medications.**
	(3) If a home or the home's administrator or direct care staff member supervises the taking of medication by a resident, then the home shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.**

ANALYSIS:	The complaint alleged Associate's 1, 2 were not trained to pass medications but expected to and that Associate 3 had passed medications prior to being trained to do so. Review of training documents for Associates 1 and 2 revealed both were trained to pass medications. Review of Associate 3's training documentation revealed he had not completed med training until 9/04/2023, while review of the staff schedule revealed he was scheduled on 8/08/2023 as a "Lead/R.A." which indicates a staff person who is fully trained to pass medications. Ms. Elayyan originally reported Associate 1 was still being trained to pass medications on 8/08/2023 and did not do so upon her directive, however, this is a contradiction which Ms. Elayyan was unable to explain. Based on the findings, the facilities own documentation indicates that not only was Associate 1 in appropriately scheduled, in part, as a med tech prior to completion of his training, but that, given the scheduling, it is reasonable to believe that he would have passed medications on 8/08/2023 having been scheduled as a lead with the duty to do so which lacks adequate protection for residents being administered medications by an untrained staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A did not receive showers.

INVESTIGATION:

According to the complaint, Resident A did not receive showers.

When interviewed, Ms. Elayyan stated she is not aware of any issues with Resident A receiving showers. Ms. Elayyan stated shower activity is tracked for residents on "shower sheets" as well as within resident activities of daily living (ADLs) logs within the facilities computer system. Ms. Elayyan stated Resident A not only received regularly scheduled bathing at least once per week, but also received additional bathing, as needed, due to issues with incontinence.

I reviewed July and August 2023 ADL and shower specific, or *Bed bath/Shower Sheet*, tracking documentation for Resident A, provided by Ms. Elayyan, which read consistently with statements provided by Ms. Elayyan indicated that on most weeks, Resident A received bathing multiple times a week.

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.
ANALYSIS:	The complaint alleged Resident A was not bathed. Evidence reviewed did not support the allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff did not follow physicians orders.

INVESTIGATION:

According to the complaint, medications are not being given and blood sugars are not being taken. No staff or resident names, dates or times were provided specific to this complaint.

According to the additional information, Resident B did not have her blood sugars checked. Resident C was not administered her coumadin for the first week she was living at the facility. Resident D is out of his narcotic medications. Residents are often administered medications late or not at all.

On 9/08/2023, I interviewed resident care manager Jackie Elayyan at the facility. Ms. Elayyan stated she was not aware of any issues related to Resident B, C and D’s physicians orders not being followed correctly pertaining to blood sugars being checked or medications being administered. Ms. Elayyan stated Resident B has her blood sugars checked each day “more than once” and that as far as she is aware, staff have been consistent to do so. Ms. Elayyan stated Resident C had an order for Warfarin (Coumadin generic) upon admission to the facility and received it as ordered. Ms. Elayyan stated that Resident D is prescribed Oxycodone, and she is unaware of Resident D running out of this medication. Ms. Elayyan stated that because narcotic medication is regulated very tightly, the medications do get low each month before they can be refilled, but that the facility has been able to keep the medications filled.

I reviewed July and August 2023 *Blood Sugar Summary records* for Resident B, provided by Ms. Elayyan, which read consistently with her statements.

I reviewed Resident C's ADMISSION RECORD, provided by Ms. Elayyan, which indicated Resident C moved to the facility on 7/18/2023. I reviewed Resident C's medication administration record (MAR) for July 2023 which read consistently with Ms. Elayyan's statements.

During the onsite, I observed Resident D's medications within the facilities medication cart. Resident D had a prescription for OXYCODONE with two pills left in the bubbler pack that contained them. Ms. Elayyan stated the facility is receiving a new order of the medication today. Following the onsite, Ms. Elayyan provided pictures, via email, of the newly ordered OXYCODONE dated 9/08/2023. Review of Resident D's MAR for August and September 2023 revealed Resident D had been administered his OXYCODONE as prescribed.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.
ANALYSIS:	The complaint alleged physician orders were not followed in that Resident B did not have blood sugars taken, Resident C did not receive prescribed Warfarin the first week after her admission and Resident D's narcotic medications were not available to be administered. The investigation did not find sufficient evidence to support these allegations.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Narcotics are stored improperly.

INVESTIGATION:

According to the complaint, narcotics have been stored in Ms. Elayyan's office which is accessible to other staff.

During the onsite inspection, I observed Ms. Elayyan's office. In order to get into the office, Ms. Elayyan had to unlock the door as it was locked at the time. Ms. Elayyan stated that if she is not planning to come immediately back to the office, she leaves it locked. I did not observe any unused narcotics in the office at that time.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(5) A home shall take reasonable precautions to ensure or assure that prescription medication is not used by a person other than the resident for whom the medication is prescribed.
ANALYSIS:	The investigation did not result in sufficient evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

Aaron L. Clum 10/23/2023

Aaron Clum Date
Licensing Staff

Approved By:

Andrea Moore 10/31/2023

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