GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

Amber James
Sunrise Of West Bloomfield
7005 Pontiac Trail
West Bloomfield, MI 48323

December 18, 2023

RE: License #: AH630391473
Investigation #: 2024A1011005
Sunrise Of West Bloomfield

Dear Ms. James:

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 licensee's 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,

Andrea Krausmann, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(586) 256-1632

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630391473
Investigation #:	2024A1011005
Complaint Receipt Date:	11/06/2023
Investigation Initiation Date:	11/06/2023
Report Due Date:	01/06/2024
Licensee Name:	Welltower OpCo Group LLC
Licensee Address:	4500 Dorr Street Toledo, OH 43615
Licensee Telephone #:	(419) 247-2800
Administrator:	Amber James
Authorized Representative:	Amber James
Name of Facility:	Sunrise Of West Bloomfield
Facility Address:	7005 Pontiac Trail West Bloomfield, MI 48323
Facility Telephone #:	(248) 738-8101
Original Issuance Date:	12/23/2019
License **Status:**	REGULAR
Effective Date:	06/23/2023
Expiration Date:	06/22/2024
Capacity:	70
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Visitor and police were unable to enter facility and unable to reach staff inside the home by telephone.	Yes
An elderly male resident came to balcony, undressed from the waist down, and no staff offered to help him.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/06/2023	Special Investigation Intake 2024A1011005
11/06/2023	Special Investigation Initiated - Telephone Called West Bloomfield police officer - left voice mail requesting callback for interview.
11/07/2023	Contact - Telephone call received Police officer returned my call. Interview conducted.
11/08/2023	Inspection Completed On-site Interviews conducted and observations made.
11/08/2023	Contact - Telephone call made Interviewed Staff #1 and Staff #4 separately, by telephone.
11/09/2023	Contact - Telephone call made Interviewed licensee’s authorized representative/administrator Amber James and requested documentation.
11/09/2023	Contact - Document Received Resident A's face sheet and service plan received via email from Amber James.
11/09/2023	Contact - Telephone call made Called Resident A's family member and left voice mail requesting call back.
11/13/2023	Contact - Telephone call made

	Called Resident A's family member again, and left voice mail requesting call back.
12/04/2023	Contact - Telephone call made Called Resident A's family member again, and left voice mail requesting call back.
12/05/2023	Contact - Telephone call made Follow-up call to Amber James.
12/05/2023	Contact - Telephone call received Interviewed Staff #3
12/06/2023	APS Referral – Referral form completed and sent to Adult Protective Services (APS) Centralized Intake.
12/18/2023	Exit Conference – Conducted with licensee authorized representative Amber James by telephone.

ALLEGATION:

Visitor and police were unable to enter facility and unable to reach staff inside the home by telephone.

INVESTIGATION:

On 11/06/2023, the allegations were received via the department's intake unit. On 11/07/2023, I interviewed one of the two responding police officers (PO) by telephone. According to the written allegations and interview with the PO, on 11/01/2023 at 8:00 pm a resident's family member (FM) reported trying to gain entrance into the facility for two hours, from 6 pm to 8 pm. The front doors were locked and required staff to enter a key code to allow entry. FM tried contacting staff inside by repeated telephone calls but received no response. FM reportedly called the facility's corporate office and spoke with someone, who agreed to contact staff and ensure the staff would allow entry, but there was still no response. The FM then called West Bloomfield police department dispatch. The police dispatcher reportedly called the facility in an attempt to reach staff. There was no response. Dispatch then sent two police officers to the facility. The police officers were unable to gain entry at the front door and also were unable to reach staff by telephone. A police officer then walked around the building until she found an unlocked door and entered. Alarms sounded as the police officer walked through the building and then let her partner and the visitor into the building.

The PO said they had been outside the building about 10 minutes trying to gain entry, after dispatch had tried to reach staff by telephone. The PO said about five minutes passed before two staff came out of a room to see why the alarms were

sounding. The PO was told by staff that the front desk phone is re-routed to a cell phone held by another staff person beginning at 6:30pm, after the receptionist leaves. If that staff is busy with care for residents, the phone calls wait to be answered.

On 11/08/2023, I went to the facility. The licensee's authorized representative/administrator Amber James was not present on this date. Activity director Patrick Pantloni filled in for her during her absence. Mr. Pantloni was not present the evening of the incident and staff involved in the incident were not working at the facility while I was in the home.

On 11/08/2023, I interviewed Staff #1 by telephone. Staff #1 recalled the 11/01/2023 incident of police arrival. Staff #1 explained that at 6:30 pm the receptionist leaves her shift and incoming telephone calls are re-routed to a phone in the memory care area of the building for the evening. Staff #1 said there was one staff person working in the memory care area of the building, and if she is busy providing care to residents, she cannot answer the phone. Staff #1 also explained that the doorbell can only be heard by the staff in the memory care unit. Staff #1 said she and Staff #2 were working in the assisted living area of the building and could not hear the phone or the doorbell. Only Staff #3 was working in the memory care unit. Staff #1 said she did not know where the supervisor Staff #4 was working.

Staff #1 said "it was about 7 or 8 o'clock", after she and Staff #2 had already put residents to bed, that she and Staff #2 were seated in the break room documenting their work. Staff #1 said Staff #3 told them that the phone kept ringing, but Staff #3 was difficult to understand due to a language barrier. Staff #1 said she believed it to be Resident A repeatedly calling the facility. Staff #1 then explained that Resident A frequently calls the facility's phone at night to ask if there are any staff in the building. Staff #1 said Resident A often says there is nobody here, but she sees us walking through the hallway. We cannot provide one-to-one staffing to her. Staff #1 said Resident A wants everyone to sit with her. Staff #1 said it was her plan to finish documenting and then to go sit at the front desk with Resident A. Staff #1 then said that she heard the alarms started going off. She and Staff #2 exited the break room and saw an officer in the building. Staff #1 said she did not know how the officer got into the building because she believed all doors are locked in the evening.

On 11/08/2023, I interviewed Staff #4, the supervisor of shift on 11/01/2023, by telephone. Staff #4 said she was taking care of residents on B side of the building in the assisted living area, when she heard the alarm sounding. Staff #4 said she dropped everything, ran downstairs, and saw that police were in the building. Staff #4 also said she thought all doors were locked. Staff #4 said the concierge leaves at 6:30 and if the doorbell rings "when we're doing showers, we can't hear it". Staff #4 also said she did not hear the phone ringing nor the door bell. Staff #4 explained that both are routed to the memory care area, and if staff there are busy, they don't answer it. Staff #4 said there are no specific visiting hours and resident family members can visit at any time.

On 11/09 and 12/05/2023, I interviewed the licensee's authorized representative/administrator, Amber James, by telephone. Ms. James said staff called her when the 11/01/2023 incident occurred and was told that Resident A called the police, and that she often calls the police and EMS. Ms. James said staff reported the police must have achieved entry into the building by punching in the key code and unlocking a door because the alarm was not sounding. I informed Ms. James that staff reported to me that the alarms were sounding.

On 12/05/2023, I interviewed Staff #3 by telephone. Staff #3 said she recalled the 11/01/2023 evening when she was working in "REM" which stands for reminiscence, the memory care area of the building. Staff #3 said that evening Resident A called her for either her television or heat needing staff assistance, she could not recall specifically which. Staff #3 said she told Resident A that she would have Staff #4 come to her room, and Staff #3 immediately told Staff #4. Staff #3 said she is certain that Staff #4 would have immediately went to Resident A's room to address the issue. Staff #3 said Resident A then proceeded to call "every five minutes, 20 or 30 times" that evening. Staff #3 said she answered the phone each time and would ask Resident A what she needed. Staff #3 said "[Resident A] did not even know what she needed". Staff #3 said Resident A also called her daughter and the police. Staff #3 said Resident A often calls the police, for any reason, "even if [the facility] has run out of Coke". When asked what methods staff are to implement when Resident A calls the facility repeatedly, Staff #3 said staff answer the phone and ask what she wants. Staff #3 affirmed that she answered the phone every time that evening.

Staff #3 also said that the facility's doorbell rings in the memory care area. Staff #3 recalled hearing the front doorbell ring that evening, before the police arrived at the facility. However, Staff #3 said she was very busy cleaning a resident who had soiled himself. Staff #3 said she was unable to answer the doorbell, but she did hear the alarms and she went to talk with the police when they came into the building.

On 11/09, 11/13, and 12/04/2023, I called Resident A's family member and left voice mail messages requesting call back, but none were returned.

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:	After the facility's concierge leaves the building, the doorbell and the telephone are re-routed to the REM memory care area, where on 11/01/2023 only one staff was working. This process results in the one memory care staff having to respond to the needs of the residents or attending to phone calls and visitors. Consequently, this is not an organized program of protection, supervision, and assistance for the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

An elderly male resident came to balcony, undressed from the waist down, and no staff offered to help him.

INVESTIGATION:

During my telephone interview, the police officer (PO) said while they were in the facility on 11/01/2023 interviewing staff, an elderly male resident came to 2nd floor balcony, undressed from the waist down, asking for help. The PO said Staff #4 and another staff present (name unknown) ignored the resident and offered no help. The PO officer said the two staff did not even acknowledge the resident.

During my telephone interview, Staff #1 said, "I did not see anyone come out nude. I think I went [elsewhere], I'm not sure."

During my telephone interview, Staff #3 denied having seen any resident come out to the balcony while the police were present.

During my telephone interview, Staff #4 recalled specifically and said that it was Resident B that came out to the balcony and said, "We couldn't stop and attend to him. We let him sit down for a minute. It was strange. He never does that. He heard the police and alarm worried him. All of us told him we'd be with him after the police [were finished]".

On 11/09/2023, I reviewed Resident B's service plan. It reads, "Observe for and report any changes in my cognitive function, specifically changes in my memory recall and general awareness, level of alertness and mental status."

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:	Staff #4 affirmed that Resident B came out to the balcony and said that it was strange. Staff #4 said Resident B heard the police and alarm worried him. Yet, staff did not treat Resident B with dignity, including his protection and safety, by immediately attending to him.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 11/09/2023, I reviewed Resident A's service plan for identification of behaviors. There is no mention of Resident A calling the facility to know if staff are in the building and no mention of Resident A calling the police or EMS to the building. There are no methods of how staff are to address this behavior.

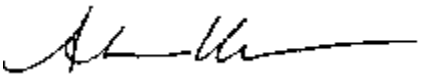
APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
For reference: R 325.1901	**Definitions.**
	(1)(t) "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 each 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:	Resident A's service plan was not updated to address her repeated phone calls to staff, police, and EMS.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/18/2023, I conducted an exit conference with licensee authorized representative Amber James by telephone.

IV. RECOMMENDATION

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



12/06/2023

Andrea Krausmann Date
Licensing Staff

Approved By:

12/18/2023

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