GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 8, 2024

Bracha Drissman
Lake (Auburn Hills) TRS LLC Suite 1600
6688N.CentralExpressway
Dallas, TX 75206

RE: License #: AH630409728
Investigation #: 2024A0784018
The Avalon of Auburn Hills

Dear Bracha Drissman:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 #:	AH630409728
Investigation #:	2024A0784018
Complaint Receipt Date:	11/28/2023
Investigation Initiation Date:	11/28/2023
Report Due Date:	01/27/2023
Licensee Name:	Lake (Auburn Hills) TRS LLC
Licensee Address:	Suite 1600 6688N.CentralExpressway Dallas, TX 75206
Administrator/Authorized Representative:	Bracha Drissman
Name of Facility:	The Avalon of Auburn Hills
Facility Address:	3151 E Walton Blvd Auburn Hills, MI 48326
Facility Telephone #:	(248) 282-4094
Original Issuance Date:	09/30/2022
License Status:	REGULAR
Effective Date:	03/31/2023
Expiration Date:	03/30/2024
Capacity:	158
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Inadequate care of Resident A	No
Additional Findings	Yes

III. METHODOLOGY

11/28/2023	Special Investigation Intake 2024A0784018
11/28/2023	Special Investigation Initiated - Telephone Interview with complainant
11/28/2023	Contact - Telephone call made Interview conducted with administrator/authorized representative Bracha Drissman
11/28/2023	Contact - Document Sent Investigative document/information request sent to Ms. Drissman via email
12/15/2023	Exit Conference Conducted with Ms. Drissman
12/01/2024	Contact - Document Received Investigative documents/information received from Ms. Drissman

ALLEGATION:

Inadequate care of Resident A

INVESTIGATION:

On 11/28/2023, I interviewed complainant by telephone. Complainant stated that in April of 2023, the facility contacted emergency medical services (EMS) and had Resident A transported to the hospital related to constipation. Complainant stated that Resident A had a prescription medication, a suppository, that was supposed to be used when she had constipation. Complainant stated it was later discovered that staff should have given Resident A her prescribed suppository, and not sent her to the hospital, but staff working at time apparently did not have a key to the medication cart (med cart) and could not access the suppository.

On 11/28/2023, I interviewed administrator/authorized representative Bracha Drissman and director of health services Nora Sarras by speaker phone. Ms. Drissman state she and Ms. Sarras did not work at the facility when the alleged incident happened. Ms. Drissman stated that none of the staff working on the shift at that time, in April 2023 when the incident was alleged to have happened, currently work for the facility. Ms. Drissman stated she did speak with staff who worked for the facility during that time. Ms. Drissman stated that staff reported Resident A was getting suppositories as needed. Ms. Drissman stated staff reported Resident A had been constipated for several days and that the suppositories were apparently not working. Ms. Sarras stated staff reported calling EMS because they believed Resident A was having a "cardiac event". Ms. Sarras stated Resident A was noted as being constipated at the hospital since she had been so for several days, however staff did not report sending her to the hospital related to constipation. Ms. Drissman stated she was unaware of any issues with staff being able to access the medication cart and has no information to indicate this was an issue. Ms. Drissman stated that "after the fact" Resident A was found to only be constipated, however staff at the time reported they felt she was displaying behaviors that apparently lead them to believe she may have been having a heart attack.

I reviewed Resident A's discharge documentation from *McLaren Oakland*, with a noted discharge date of 4/16/2023, provided by Ms. Drissman. According to the documentation, Resident A presented at the hospital with constipation and abdominal pain.

Review of Resident A's physician's orders revealed Resident A was prescribed *BISACODYL SUP [suppository] 10MG* to be administered "as needed for constipation".

I reviewed Resident A's medication administration record (MAR) for April 2023, provided by Ms. Drissman. The MAR indicated Resident A was administered her regularly scheduled evening medications on the date she went to the hospital, 4/15/2023. According to MAR Resident A was not administered BISACODYL on the evening of 4/15/2023.

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:	The complaint alleged inadequate care of Resident A when she was sent to the hospital in April 2023. The investigation revealed insufficient evidence to support a lack of adequate care based solely on staff sending Resident A to the hospital. While Resident A may have had issues with constipation at the time, there is no evidence to indicate that staff working at the time did not believe Resident A was having additional health issues which required hospitalization. Additionally, the complaint alleged staff did not administer Resident A's suppository due to not being able to get into the med cart, however, review of Resident A's MAR indicated she received her evening regularly scheduled medications on the date she went to the hospital indicating staff were able to access the med cart. While review of the MAR indicated Resident A was not administered prescribed medication for constipation on the evening of 4/15/2023, the medication was prescribed "as needed" and evidence is insufficient to support that staff, based on the available information, should have administered the medication prior to having her go to the hospital as staff apparently believed Resident A was having health issues unrelated to constipation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of Resident A's MAR revealed she was prescribed *BISACODYL* to be administered "retally once daily as needed for CONSTIPATION".

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(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:	While Resident A was reportedly constipated for several days leading up to her hospitalization on 4/15/2023, which confirmed she was constipated, review of the MAR indicated staff did not administer any of the medication prescribed for constipation leading up to her hospitalization. Based on the finding the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

12/15/2023

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Aaron Clum Date
Licensing Staff

Approved By:

01/08/2024

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