GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

Bracha Drissman
Lake (Auburn Hills) TRS LLC
6688N.Central Expressway
Dallas, TX 75206

January 4, 2024

RE: License #: AH630409728
Investigation #: 2024A1022003
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.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the authorized representative and a date.
- 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.

Sincerely,

Barbara P. Zabitz, R.D.N., M.Ed.
Health Care Surveyor
Health Facility Licensing, Permits, and Support Division
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Mobile Phone: 313-296-5731
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enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630409728
Investigation #:	2024A1022003
Complaint Receipt Date:	10/05/2023
Investigation Initiation Date:	10/05/2023
Report Due Date:	12/04/2023
Licensee Name:	Lake (Auburn Hills) TRS LLC
Licensee Address:	Suite 1600 6688N.CentralExpressway Dallas, TX 75206
Licensee Telephone #:	Unknown
Administrator/Authorized Rep	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?
Resident care suffers due to short staffing.	No
The facility is understaffed, and the wellness director is unable to assist as she smells of alcohol.	No
Medications are administered late.	Yes
The facility does not have provide adequate food service to their residents.	No
Additional Findings	Yes

III. METHODOLOGY

10/05/2023	Special Investigation Intake 2024A1022003
10/05/2023	Special Investigation Initiated - Letter Request for information sent to facility.
10/24/2023	APS Referral
10/24/2023	Inspection Completed On-site
12/14/2023	Contact - Telephone call made. Interview with AR and HSD via videoconference.
12/26/2023	Contact - Telephone call received. Information exchanged with the facility via email.
01/04/2024	Exit Conference

ALLEGATION:

Resident care suffers due to short staffing.

INVESTIGATION:

On 10/04/2023, the Bureau of Community and Health Systems (BCHS) received an anonymous complaint that in part read, “A resident [name of Resident A] had eloped out and made it down the street to Dairy Queen and found by paramedics. This was because of short staffing and wellness director giving direction to all staff on what’s app to bring an exit seeking resident to AL (assisted living) instead of stay on MC (memory care) when we were short staff she was able to elope. There is constantly no staff to assist with care. We are always short staff and no managers will help us out. The schedule will show ppl (people) scheduled but it’s not right. I (anonymous complainant) come in and have 2 ppl for AL. Call lights go off for over an hour on both floors and I have no help and residents are falling and left on toilet… This happens daily. The past 3 months this happens. No staff, no help and call lights are going off for hours… Because of short staffing and care plans not being followed a resident fell and broke her hip resulting in her death her name is [name of Resident B] there is an increase in falls care plans are not updated or followed showers are not being done.”

On 10/24/2023, a referral was sent to Adult Protective Services.

On 10/24/2023, at the time of the onsite visit, I interviewed the administrator/ authorized representative (AR) and the health services director (HSD). The AR stated that she had only been the administrator/AR at this facility for less than 30 days, and that the HSD had been in her position for about 90 days. The AR went on to explain that the management company overseeing the facility had changed in April 2023, and that the new management company had determined that the facility was not being managed well. The AR went on to describe “poor leadership” in multiple departments including the food service as well as “poor attitude” in the care staff in response to the residents’ needs. As a result, even after performance coaching had been instituted, there had been a number of employees who were terminated.

At the time of the onsite visit, accompanied by the AR and the HSD, I toured the three floors of the facility. There was no evidence of “call lights go (going) off for over an hour” or “residents…falling and left on (the toilet).”

When asked about Resident A, the AR explained that Resident A and her spouse, Resident C, had shared a room in the AL portion of the facility for close to a year when Resident C became very ill and passed away. According to the AR, Resident C had better cognitive abilities than Resident A, however, both residents had been deemed as appropriate to reside on one of the AL floors. Resident A had never

previously exhibited exit seeking behaviors until the day Resident C died. Family members had taken Resident A earlier in the day to the hospital where Resident C was receiving care, so she knew he was dying, but it was unknown if Resident C's death had been the factor that prompted Resident A to leave the building. After Resident C's death, and Resident A's elopement, Resident A was moved to the MC floor.

The AR was asked to provide all documentation regarding Resident A's elopement from the building, but review of documents provided revealed that the only reference to this incident consisted of a nursing note that read, "Resident has moved to memory care today due to altered mental status and confusion. Resident left the community night of 8/16/23 confused, looking for her husband. Resident went to the hospital after this occurrence and returned with no changes or new orders from the ER (emergency room) …" During a videoconference held on with AR and HSD on 12/14/2023 to clarify the documentation provided, the AR acknowledged the incident had not been documented in Resident A's health record. The AR went on to say that until that day, Resident A had been deemed as being able to leave the community on her own, so it truly was not an elopement. The AR went on to say that any information she had was given to her by the interim administrator who had preceded her. According to his notes, on 08/16/2023, at 8:52 pm, Resident A waited for the caregiver who had escorted her to her room and at that time, "walked out of the building. At 9 pm, [name of Resident A] knocked on the car window of the (local) Fire Chief who was sitting at (the) DQ (Dairy Queen restaurant). Fire Chief brought [name of Resident A] back (to the facility) at 9:20 pm…Police were notified by Fire Chief… Fire Chief and police took [name of Resident A] to hospital." According to the AR, it was her understanding that the captain of the local fire department was coincidently at the Dairy Queen restaurant and was concerned that Resident A seemed too confused to have walked to the restaurant by herself. It was not clear how the Fire Chief knew to bring Resident A to the facility, but, according to the AR, The Avalon at Auburn Hills was the closest facility to the restaurant.

When asked about Resident B, the AR stated that Resident B was had relatively good cognition and was able to make her needs known but was at risk for falling. Resident B sustained a fall on 09/27/2023, but her post-fall assessment did not find any injuries. Resident B told the HSD that she had "slid out" of bed at the end of September 2023, but could not recall the actual date. Although a caregiver assisted Resident B back to bed, there was no documentation of this incident, and the caregiver did not report to the HSD or anyone else. Several days later, Resident B made a call from her personal phone to 911, asking to be taken to the local hospital because she was experiencing a generalized pain. According to the HSD, Resident B was not able to pinpoint where the pain originated, and because she had a history of cardiac problems, she asked to go to the local emergency room. She had previously visited the local ER on 09/25/2023 with left sided chest and arm but returned back to the facility on the same day with no changes. The HSD went on to say Resident B was admitted and that subsequent x-rays revealed that she had "acute fractures to her left scapula, lower back and right pelvis." Resident B was

scheduled to be discharged from acute care into subacute rehab when she apparently suffered a cardiac arrest and died.

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:	There was no evidence that residents were not being provided with adequate care.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility is understaffed, and the wellness director is unable to assist as she smells of alcohol.

INVESTIGATION:

According to the anonymous compliant, “The schedule is never right. It will show 5 people on but only 1 or 2 show up because the scheduler is scheduling people who can no work on certain days. Pull an actual clock in report and you will show how short we are forced to work… The wellness director comes in smelling like alcohol and stays in her office…”

At the time of the onsite visit, the HSD did not appear to be inebriated in any way. Both the AR and the HSD denied that this allegation could be true.

According to the AR, to determine staffing needs, the facility used a combination of a staffing ratio, supplemented by an acuity score that was objectively determined by assessment. The HSD went on to explain that there was some subjectivity to assigning staff, for example, how many showers were scheduled for any given day, or extra time required for any given resident who needed additional attention. Generally, the facility was staffed both for the day and the afternoon shifts with 3 caregivers for the two AL floors and 2 caregivers for the MC floor. Additionally, for the day and the afternoon shifts, there would be 2 medication techs, who were available for care when it did not interfere with the administration of medication. For

the overnight shift, there would be 1 caregiver on the MC unit and 1 caregiver for the two AL floors, plus a medication tech, who could “float” between floors.

The facility provided the staffing schedule and the time-punch record for the dates 10/01/2023 through 10/07/2023. The staffing schedule indicated that adequate numbers of caregivers were scheduled, and time-punch records reconciled with the staffing schedule.

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:	There was no evidence that the facility was understaffed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Medications are administered late.

INVESTIGATION:

According to the anonymous compliant, “Passing meds is always late because the med tech has to help with care so meds are 4+ hours late.”

The facility provided medication administration records (MARs) for Resident A, Resident D and Resident E for the month of October 2023. Review of the MARs revealed that the records did indicate the time that the medication was to be administered, it did not show the actual time that the medication technician actually administered the medication to the resident.

On 12/26/2023, via an email exchange with the AR, the administrator was asked to explain why the MARs did not document the actual time that the resident was administered each medication. The administrator responded, “The signature verifies that the medications were administered at the prescribed times.”

All three residents, Resident A, Resident D and Resident E were scheduled medications for 8 am on Sunday 10/01/2023. The MARs for the three residents were documented and signed-off by medication technician #1 as having been administered at 8 am. According to the MAR for Sunday 10/01/2023, Resident A

was administered 5 medications at 8 am, Resident D was administered 10 medications at 8 am, and Resident E was administered 15 medications at 8 am.

APPLICABLE RULE	
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: **(b) Complete an individual medication log that contains all of the following information:** **(iv) The time when the prescribed medication is to be administered and when the medication was administered.**
ANALYSIS:	The allegation was that medications were not being given in a timely manner. The facility's MARs lacked the detail necessary to make this determination. While the allegation could not be determined, the facility lacks the required aspects of documentation on the MAR. The violation is founded on this lack of documentation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility does not have provide adequate food service to their residents.

INVESTIGATION:

According to the anonymous complaint, "The kitchen is always out of food and never has anything for the residents. There's no staff in the kitchen and it's filthy with expired food."

At the time of the onsite visit, I toured the facility kitchen. The kitchen appeared to be adequately supplied with food, both canned/packaged food items in the dry storage room as well as perishable food items in the freezer/walk-in refrigerator. No expired food items were found. I was not able to make an assessment of "cleanliness," as kitchen employees were in the middle of lunch preparations. Food service employee #1 explained that the kitchen had "failed" a county health department kitchen inspection, however, they had implemented corrections and passed the follow-up inspection.

The AR explained that the position of food service manager was vacant, and that the department was one that needed a strong leader to improve.

APPLICABLE RULE	
R 325.1976	**Kitchen and dietary.**
	(1) A home shall have a kitchen and dietary area of adequate size to meet food service needs of residents. It shall be arranged and equipped for the refrigeration, storage, preparation, and serving of food, as well as for dish and utensil cleaning and refuse storage and removal.
ANALYSIS:	There was no evidence that the facility had inadequate food or lacked food service staff, and the kitchen was found to be in acceptable condition.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

When the AR and the HSD were asked to provide documentation that described the observations made on 08/16/2023, when Resident A left the facility by herself. The fire chief brought Resident A back to the facility. Facility staff found Resident A to be very confused and not safe to have walked to the restaurant by herself. Resident A was then transferred to the hospital for evaluation.

According to both the AR and the HSD, this was a new and unexpected behavior for Resident A, but they both acknowledged that there was no charting in Resident A's health record to document this change in her status other than the notation that she was being moved to the memory care unit.

APPLICABLE RULE	
MCL 333.20175	**Maintaining record for each patient**
	(1) A health facility or agency shall keep and maintain a record for each patient including a full and complete record of tests and examinations performed, observations made, treatments provided, and in the case of a hospital, the purpose of hospitalization.

ANALYSIS:	The facility did not document observations made of changes in Resident A's behavior in her health record.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the authorized representative (AR) on 01/04/2024. When asked if there were any comments or concerns with the investigation, the AR stated that there were none.

IV. RECOMMENDATION

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

01/04/2024

Barbara Zabitz Date
Licensing Staff

Approved By:

12/27/2023

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