GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 07, 2024

Vera Gjolaj
Sunrise Assisted Living Of Bloomfield Hills
6790 Telegraph Rd.
Bloomfield Hills, MI 48301

RE: License #: AH630391696
Investigation #: 2024A1027023
Sunrise Assisted Living Of Bloomfield Hills

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 #:	AH630391696
Investigation #:	2024A1027023
Complaint Receipt Date:	01/10/2024
Investigation Initiation Date:	01/11/2024
Report Due Date:	03/09/2024
Licensee Name:	Welltower OpCo Group LLC
Licensee Address:	4500 Dorr Street Toledo, OH 43615
Licensee Telephone #:	(419) 247-2800
Authorized Representative/ Administrator:	Vera Gjolaj
Name of Facility:	Sunrise Assisted Living Of Bloomfield Hills
Facility Address:	6790 Telegraph Rd. Bloomfield Hills, MI 48301
Facility Telephone #:	(248) 858-7200
Original Issuance Date:	12/23/2019
License Status:	REGULAR
Effective Date:	06/23/2023
Expiration Date:	06/22/2024
Capacity:	132
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
The facility failed to order COVID-19 medications for residents. Resident A went three days without insulin which resulted in hospitalization, and his medications were not ordered. Staff were not trained to manage Resident A and he was not a good fit for the facility.	No
There were medication errors, no record of medications, expired medications left on the cart, and medication cart keys were left unsecured.	Yes
Old narcotics were not disposed of.	No
Additional Findings	No

III. METHODOLOGY

01/10/2024	Special Investigation Intake 2024A1027023
01/11/2024	Special Investigation Initiated - On Site
01/16/2024	Contact - Telephone call made Voicemail left with Complainant #1
01/16/2024	Contact - Telephone call made Telephone interview conducted with Employee #4
01/18/2024	Contact - Document Sent Email sent to Vera Gjolaj requesting additional documentation
01/23/2024	Contact - Document Received Email received from Vera Gjolaj with requested documentation
01/24/2024	Inspection Completed-BCAL Sub. Compliance
02/07/2024	Exit Conference Conducted with Vera Gjolaj by email

ALLEGATION:

The facility failed to order COVID-19 medications for residents. Resident A went three days without insulin which resulted in hospitalization, and his medications were not ordered. Staff were not trained to manage Resident A and he was not a good fit for the facility.

INVESTIGATION:

On 1/10/2024, the Department received allegations through the online complaint system which read a resident went without medication for COVID. The allegations read a resident went without his insulin for three days. The allegations lacked resident's names.

On 1/10/2024, additional allegations were forwarded by Adult Protective Services (APS) which read consistent with the previous allegations regarding the resident without his insulin for three days. The allegations Resident A had diagnoses of dementia and diabetes. The allegations read Resident A moved into the facility on 12/21/2023 and Employee #1 did not enter his medications orders, so he went without his diabetes medications until 12/23/2023 which resulted in his hospitalization on 12/24/2023. The allegations read Resident A returned to the facility and on 12/30/2023, and his hospice nurse administered morphine in which the facility did not have an order. Additionally, the allegations noted staff were not trained in managing residents with dementia who were violent and refused medications like Resident A. The allegations read Resident A was "*not a good fit for the facility.*"

On 1/11/2024, I conducted an on-site inspection at the facility. I interviewed administrator and authorized representative Vera Gjolaj who stated there was an outbreak of COVID-19 in the memory care unit in December 2023. Ms. Gjolaj stated Dr. Rojas' nurse practitioner evaluated all the memory care residents in which those who were diagnosed with COVID-19 were asymptomatic. Ms. Gjolaj stated the nurse practitioner ordered COVID-19 medication for positive residents; however there were two residents who were unable to have the medication because it was not covered by their insurance.

Ms. Gjolaj stated Resident A moved into the assisted living with his spouse in December 2023. Ms. Gjolaj stated Resident A was a veteran and came to the facility with no medications or orders for medications. Ms. Gjolaj stated Resident A's family stated they would bring in his medications; however, they did not. Ms. Gjolaj stated Resident A's physician declined to provide the facility with medication orders due to needing to evaluate him. Ms. Gjolaj stated she contacted Dr. Rojas, a physician who visited the facility, and he accepted Resident A as a patient in which his medications were ordered from a local pharmacy due to difficulty with insurance coverage through the Veteran's Administration. Ms. Gjolaj stated around the same time Resident A had dizziness, and was sent to the hospital, then returned with no new

medication orders. Ms. Gjolaj stated Resident A was acclimating well at the facility and would transition to the secured memory care when his dementia advanced.

Ms. Gjolaj stated all staff were trained to manage residents with a diagnosis of dementia during their new hire orientation, then annually through a training titled "*Behavioral Expressions*."

On 1/16/2024, I left a voicemail with the Complainant #1 with no return call.

On 1/16/2024, I conducted a telephone interview with the assigned APS worker who stated she spoke with Resident A's granddaughter in which she relayed it was difficult to obtain Resident A's medications initially upon admission due to being a veteran; however, the facility had administered them as ordered since that time. The APS worker stated Resident A's granddaughter relayed she had no concerns regarding his care at the facility.

On 1/16/2024, I conducted a telephone interview with Employee #4 who stated she conducted dementia intervention training with staff in which she taught validation. Employee #4 stated staff were trained on dementia and managing dementia both in-person and on-line through "*Behavior Expressions*."

I reviewed Residents B, C, D, E, F, G, H, and I's physician orders which read they were prescribed Molnupiravir 200 mg, give four capsules by mouth two times a day for five days for COVID-19.

I reviewed Residents J and K's physician orders from Dr. Rojas, the rounding physician at the facility, were dated 12/11/2023 which read they were prescribed Molnupiravir 800 mg two times daily by mouth for five days for COVID-19; however, correspondence with the pharmacy dated 12/15/2023 read the pharmacy staff attempted to transfer the prescription to Walgreens, Walmart, and Meijer pharmacies but the pharmacies could not bill the patient's assistance program. Residents J and K's MARs read staff documented all other prescribed medication as administered or provided a reason why they were not administered.

I reviewed Residents B, C, D, E, F, G, H, I, J and K's December 2023 medication administration records (MARs) which read consistent with their physician orders in which staff initialed the medication Molnupiravir for COVID-19 as administered or documented the reason why it was not administered.

I reviewed Resident A's face sheet which read in part he moved into the facility on 12/21/2023 and his granddaughter was his primary contact. The face sheet read in part Dr. Rojas was his primary care doctor.

I reviewed Resident A's service plan which read in part Resident A shared the apartment with his spouse. The plan read in part he was diabetic and received and insulin. The plan read in part he was one person assist with his activities of daily

living. The plan read in part he had edema in both legs. The plan read in part Resident A utilized a walker for ambulation and wheelchair for long distances. The plan read in part Resident A often used profanity to express himself. The plan read in part Resident A made threats to strike his spouse in which if staff witnessed this or it was reported by his spouse of being physical or threatening to report it to nursing, coordinator, family, and hospice. The plan read in part he received Harmony hospice services.

I reviewed Resident A's progress notes from December 21, 2023, to current.

Note dated 12/21/2023 at 17:25 [5:25 PM] read in part Resident A moved into the facility accompanied by his granddaughter.

Note dated 12/21/2023 at 17:40 [5:40 PM] read in part Resident A's granddaughter was to bring in Resident A's medications at move-in since he utilized the Veteran pharmacy; however, the medications did not arrive, and the granddaughter stated she would bring them in.

Note dated 12/22/2023 at 08:30 [8:30 AM] read in part Resident A's medications were brought in by his granddaughter and reviewed but did not match his physician orders. The note read in part Resident A's physician was contacted and staff were waiting for a call back from the physician.

Note dated 12/22/2023 at 08:45 [8:45 AM] read in part Resident A's granddaughter provided his Lantus pen; however not his Novolog.

Note dated 12/22/2023 at 10:00 [10:00 AM] read in part Resident A's physician Dr. Reddy called and stated he had not seen Resident A within the last 30 days. The note read in part Dr. Reddy requested Resident A utilize an alternate physician to manage care.

Note dated 12/22/2023 at 10:30 [10:30 AM] read in part Resident A, his spouse and granddaughter agreed to have Dr. Rojas take over as his primary care physician.

Note dated 12/22/2023 at 11:45 [11:45 AM] read in part Dr. Rojas agreed to take over as Resident A's primary physician and provided verbal orders.

Note dated 12/22/2023 at 14:00 [2:00 PM] read in part Resident A's medication orders were sent to guardian pharmacy with urgent delivery request.

Note dated 12/24/2023 at 21:24 [9:24 PM] read in part Resident A had a horrible headache and felt dizzy when standing so he was transferred to the hospital.

Note dated 12/25/2023 at 13:20 [1:20 PM] read in part Resident A returned from the hospital with no new orders.

Note dated 12/31/2023 at 14:55 [2:55 PM] read in part Resident A's hospital nurse left a comfort kit in the wellness nurse office; however, there were not written orders for staff to administer the medications. The note read in part the comfort kit medications could not be administered by staff without the written orders.

I reviewed Resident A's December 2023 medication administration records (MAR) which read consistent with the progress notes. The MAR read in part some of Resident A's medications were administered starting 12/22/2023 in evening. The MAR read in part Resident A's diabetic medications Lantus and Novolog were administered starting 12/23/2023 in the morning.

I reviewed Resident A's order summary report which read consistent with statements from Ms. Gjolaj.

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:	Memory care residents' physician orders read consistent with their December 2023 MARs which revealed they received medication for COVID-19. Additionally, review of pharmacy and facility documentation revealed two residents lacked prescription coverage for the COVID-19 medication. Review of Resident A's medical records revealed the facility lacked his medication orders initially when he moved in; however, review of facility documentation revealed staff initiated a new licensed health care professional for him to obtain medication orders which supported staff attestations and the APS worker's interview with his granddaughter. Staff attestations and review of Resident A's medical records revealed there was lack of evidence to support staff were not trained to manage his dementia nor improper admission to the facility. Therefore, these allegations were not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

There were medication errors, no record of medications, expired medications left on the cart, and medication cart keys were left unsecured.

INVESTIGATION:

On 1/10/2024, the Department received allegations through the online complaint system which read there were multiple medication errors. The allegations read there was no record kept of medications. The allegations read expired medications were left on the medication carts. The allegations read medication cart keys were placed next to where the medications were locked up.

On 1/11/2024, I conducted an on-site inspection at the facility. I interviewed Employee #2 who stated she had not observed medication errors. Employee #2 stated medications were recorded as they were administered in the computer charting system. Employee #2 stated when administering medications, she conducted the following:

1. checked the medication card with the medication order on the computer
2. checked the six rights of medication administration
3. locked the computer screen, then administered the medication to the resident
4. saved the medication as administered in the computer

Employee #2 stated the facility recently changed from Omni to Guardian pharmacy. Employee #2 stated every quarter Omni pharmacy conducted audits on staffs' administration of medications and expired medications were removed from the medication carts. Employee #2 stated staff also conducted medication cart audits in which expired medications were removed from the cart.

Employee #2 stated each staff member assigned to a medication cart carried the medication cart keys on their body while working. Employee #2 stated only medication technicians and nurses could administer medications and enter the medication carts. Employee #2 stated there were two sets of spare keys located in the locked wellness coordinator's office.

Employee #2 stated there were seven medication carts, four carts for the assisted living and three carts for the memory care. Employee #2 stated there were usually two medication technicians on duty for day and afternoon shifts.

While on-site, I interviewed Employees #1 and #3 whose statements were consistent with Employee #2.

While on-site, I observed Employee #2 and the medication technician for the memory care unit both maintained their medication cart keys on their body.

While on-site, Employee #2 and I reviewed all expiration dates on medications located in medication carts A and B in which there were no expired medications observed.

On 1/16/2024, I left a voicemail with the Complainant #1 with no return call.

On 1/16/2024, I conducted a telephone interview with Employee #4 who stated she observed residents received their medications as prescribed.

I reviewed Residents A, B, C, D, E, F, G, H, and I's December 2023 MARs December 2023 MARs.

> Residents A, B, D, G, H, and I MARs read staff documented their medications as administered and lacked errors.
>
> Resident C's MARs read staff documented her medications as administered except for medication Insulin Aspart on 12/11/2024 and 12/30/2024 at 2100 [9:00 PM] in which those two doses were left blank.
>
> Resident E's MARs read staff documented her medications as administered; however, for medications Cefuroxime Axetil and Molnupiravir, staff documented reasons the medications were not administered were "*MD*" which meant "*medication pending delivery*" and "*17*" which meant "*course completed*." For example, from 12/6/2023 to 12/26/2023 staff documented the reason Cefuroxime

Axetil was not administered was "*course completed*" or "*medication pending delivery*" in which it was not clear why the medication was not administered. Additionally, staff documented the medication Molnupiravir as administered, then for the evening dose on 12/17/2023 documented "*course completed*" and afterward on 12/18/2023 to 12/20/2023, staff documented the medication as administered.

Resident F's MARs read staff documented her medications as administered; however, staff documented the reason the medication Molnupiravir was not administered for three doses on 12/17/2023 and 12/18/2023 was "*course completed*," then afterward on 12/19/2023 to 12/20/2023, documented the medication as administered. Additionally, the MAR was left blank for medication Acetaminophen on 12/19/2023 at 0000 [12:00 AM] and 12/29/2023 at 12:00 PM.

I reviewed the facility's policy titled "*Controlled Drug Security and Reconciliation*" which read in part the facility stored controlled drugs in a safe and secure manner in accordance with all Federal Drug Enforcement Agency (DEA) requirements. The policy read in part the keys to locked controlled drug storage areas were in the personal custody of an authorized team member at all times. The policy read in part controlled drugs were counted at the beginning and end of each shift or when there was a transfer of the custody of the keys by two authorized team members at the same time.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(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:	Review of a random sample of residents' MARs revealed there were some medication doses with blank spaces in which it could not be determined the reason why the medication was not administered. Additionally, there was a lack of consistency in reasons staff documented medications were not administered, such as when staff documented "*course completed*," but the medication was documented as administered after that time. Review of residents' MARs revealed there were records demonstrating administration of medications. Observation of the medication carts, along with two full medication cart audits, revealed there was lack of evidence to support expired medications were left on the carts. Staff attestations and observations revealed the medication cart keys were located on the staff person assigned to the medication cart. Nonetheless, a violation was substantiated for medications not always being administered per the orders of the licensed healthcare professional.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Old narcotics were not disposed of.

INVESTIGATION:

On 1/10/2024, the Department received allegations through the online complaint system which read old narcotics were not disposed of.

On 1/11/2024, I conducted an on-site inspection at the facility and interviewed Employee #1 who stated the facility utilized drug buster to dispose of narcotics. Employee #1 stated two nurses were required to dispose of narcotics while utilizing the drug buster. Employee #1 stated a binder maintained the narcotic medication sheets for each medication destroyed. Employee #1 stated the facility was in the process of changing over pharmacies in which the previous pharmacy Guardian needed to pick up medications that were in the locked wellness coordinator office so residents' accounts could be refunded accordingly for those medications.

While on-site, I interviewed Employee #2 who stated she would dispose of an individual narcotic with another medication technician if it was dropped on the floor, otherwise, the nurses would dispose of expired narcotics per the policy.

While on-site, I interviewed Employee #3 who statements were consistent with Employees #1 and #3.

While on-site, I observed the drug buster located under the sink in the wellness coordinator's office.

While on-site, I reviewed the binder that maintained the narcotic count sheets for medications destroyed which read consistent with staff statements.

While on-site, Employee #2 and I conducted narcotic counts on Medication carts A, B, C, D, E, F and G which were accurate and lacked no additional narcotic medications.

On 1/16/2024, I left a voicemail with the Complainant #1 with no return call.

I reviewed the facility's policy titled "*Controlled Drug Security and Reconciliation*" which read in part the facility did not store more than a 30-day supply of each controlled drug.

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:	Staff attestations and observations were consistent with the facility's policy, therefore there was lack of evidence to support old narcotic medications were not destroyed consistent with that policy.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

01/24/2024

Jessica Rogers Date
Licensing Staff

Approved By:

01/31/2024

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