GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 11, 2024

Kristy Britton
Sunrise Of West Bloomfield
7005 Pontiac Trail
West Bloomfield, MI 48323

RE: License #: AH630391473
Investigation #: 2024A0585024
Sunrise Of West Bloomfield

Dear Ms. Britton:

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

Sincerely,

Brender L. Howard

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street, P.O. Box 30664
Lansing, MI 48909
(313) 268-1788
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630391473
Investigation #:	2024A0585024
Complaint Receipt Date:	02/12/2024
Investigation Initiation Date:	02/13/2024
Report Due Date:	04/13/2024
Licensee Name:	Welltower OpCo Group LLC
Licensee Address:	4500 Dorr Street Toledo, OH 43615
Licensee Telephone #:	(419) 247-2800
Administrator/Authorized Representative:	Kristy Britton
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:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A sustained injuries and no one knows how it happened.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/12/2024	Special Investigation Intake 2024A0585024
02/13/2024	Special Investigation Initiated - Telephone
02/13/2024	APS Referral A referral sent to Adult Protective Services (APS).
02/14/2024	Inspection Completed On-site Completed with observation, interview and record review.
03/01/2024	Contact - Document Received Received call from Relative A1 regarding the allegations and to add additional information.
03/05/2024	Contact - Telephone call received. Received call from Officer from the West Bloomfield Police Department regarding the incident.
	Exit Conference

ALLEGATION:

Resident A sustained injuries and no one knows how it happened.

INVESTIGATION:

On 2/09/2024, a complaint was received via the BCHS Online Complaint. The complaint read in part, "[Resident A] needs a 2 person assist for transfers. On 2/6, staff was in the process of transferring Norma and she had a fall. The fall was not documented, and [Resident A] sustained injuries, bleeding. It was unknown to staff that she was injured, and she did not receive medical attention until being sent to the hospital on 2/7 and passed away on 2/8".

On 2/13/2024, a referral was made to Adul Protective Services (APS).

On 2/14/2024, an onsite was completed at the facility. During the onsite, I interviewed the administrator at that time, Amber James who stated that they did an investigation, and no one said that Resident A had a fall. She stated that Resident A was checked on at midnight and she was okay. She said the last time Resident A was changed at 5:00 a.m. everything was fine but when the caregiver went in around 8:00 a.m., get her up, she noticed that Resident A made a noise. She said the caregiver asked Resident A was she in pain. She said the caregiver went to get the med passer. She said the med passer told the nurse when she came in at 8:30 to take a look at Resident A. She said at that time, the nurse noticed that Resident A's leg was swollen. She said that hospice was called. Ms. James said that when hospice came, they ordered an X-Ray and discovered that Resident A's femur was broken. She explained that nobody reported a fall. She said they asked Resident A did she have a fall and she said yes but somebody got her up and she didn't know who it was. She stated that she interviewed all the staff on duty, and no one knew about Resident A having a fall. Ms. James said that all staff was trained on resident's rights, dementia care, reporting and documentation. She said that they have regular in-service.

I interviewed Employee #1 the facility. Employee #1 stated that it is still a mystery what happened to Resident A. She stated that no one reported a fall. She said that Resident A was found in pain, and they have no idea what happened. She explained that Resident A is not physically able to get herself up.

On 3/1/2024, I interviewed Relative A1 by telephone. Relative A1 stated that Resident A was in bed in the evening of the 6th. He said that morning staff said they checked on Resident A and realized that her leg was not right, and they called hospice. Relative A1 said that hospice called him at 9:30 a.m. and he never received a call from the facility. He said that a mobile X-Ray was completed, and it revealed that Resident A had a broken femur. Relative A1 stated that hospice recommended that Resident A go to the hospital. He said that the hospital gave Resident A another X-Ray and the doctor informed him that Resident A had a severe break, with internal bleeding. He said that Resident A was given morphine. He stated that the doctor said that if Resident A had surgery, it will not be a guarantee and advise us just to keep her comfortable.

On 3/5/2024, I received a call from Officer Conapalis from the West Bloomfield Police Department. He stated that he is the process of doing an investigation and it is still open at this time.

On 3/6/2024, I interviewed Employee #2 by telephone, who stated that she was working on the other side when the incident with Resident A happened. Employee #2 stated that she didn't see or hear anything that night. She said that she usually goes over to that side to see Resident A but on that night, she didn't see her.

On 3/6/2024, I interviewed Employee #3. She stated that she worked the night shift and there were no falls. She said that Resident A did not have any pain and did not show any signs of pain. She said that Resident A can does not get herself up and that if she fell somebody had to get her up. She said they call her from the facility at 10 or 11 that morning and asked her if Resident had a fall.

On 3/6/2024, I interviewed Employee #4 by telephone. Employee #4 stated that she did not see Resident A that day. She said that another staff [Employee #5] went to get Resident A for breakfast and the next thing they knew, they said Resident A was bleeding but no one knew what happened.

On 3/6/2024 and 3/7/2024, attempts were made to contact Employee #5. As of the date of this report, no contact has been made.

A review of Resident A's progress notes revealed:

> On 2/7/2024, writer informed by staff that resident's left leg was red and swollen. Writer assessed resident and resident seemed to be in pain stating that she had fallen but doesn't remember who dropped her. Resident's right leg red, swollen, and painful to touch. Writer contacted hospice spoken with nurse who stated she had arrived to the facility around 9:30 a.m. to assess resident. Writer instructed med tech to administer PRN pain medication, Will continue to monitor.
>
> On 2/7/2024, writer was informed this morning by staff that resident was observed in her bed with her left leg swollen. Resident in pain when the leg is moved. Staff contacted hospice team and nurse came out. Scheduled morphine was ordered for the resident. Writer observed hospice nurse take photos of resident's leg and send to doctor who did not order an X-Ray. Hospice nurse contacted by RCD (resident care director) who then sent a technician for a STAT X-Ray. EMS was called for resident this afternoon. Family informed; resident is getting sent out by RCD.

A review of documentation showed that staff was trained on dementia care, resident's right, abuse, documentation and reporting.

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 the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**

R 325.1901	**Definitions.**
	(p) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	Based on interview with employees and Relative A1, it was revealed that Resident A is not physically able to get herself up without assistance. A fall was not documented or reported for Resident A. It is not known when Resident A had the fall or how she sustained the injury. However, it was revealed that Resident cannot get herself up from a fall. Although, no staff admitted to knowing about Resident A falling, she was in the care of the facility during that time, therefore the facility did not protect Resident A while under their care.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

Relative A1 stated that Resident A is immobile and uses a Hoyer lift. He stated that two people are required to take care of Resident A.

Employee #3 stated that Resident A has a Hoyer lift that requires two people to assist.

Employee #4 stated that Resident is a two person assist but that doesn't always happen. She stated that Resident A use a Hoyer lift for transfers, and she never use it unless another person is there.

Service plan for Resident A, read, "I need a walker to assist with mobility for longer. distances outside of my suite. I need a Broda Chair to assist with mobility. I need physical assistance of one person with mobility. I am at risk for potential fall due to

my unsteady gait. Observe me for any change. Observe me for and report any change in my range of motion. Observe me for any complaint of pain or altered comfort during care and mobility."

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.
R 325.1901	**Definitions.**
	(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 the 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:	Based on interview with Relative A1 and employees of the facility, two staff are required to be use for transferring Resident A. The staff also reveal that a Hoyer lift is used to help transfer Resident A. The service plan does not have information pertaining to using a Hoyer lift. The service plan indicated that Resident A should have assistance of one person for mobility and transfers. The service plan does not have adequate information for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

Ms. James is no longer the administrator as of this report. The facility has a newly appointed administrator/authorized representative Kristy Britton.

IV. RECOMMENDATION

03/11/2024

Brender Howard Date
Licensing Staff

Approved By:

03/11/2024

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