GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 8, 2024

Hemant Shah
Cranberry Park West Bloomfield LLC
Suite 230
25500 Meadowbrook Rd
Novi, MI 48375

RE: License #: AH630402042
Investigation #: 2024A1027048
Cranberry Park of West Bloomfield

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 #:	AH630402042
Investigation #:	2024A1027048
Complaint Receipt Date:	04/11/2024
Investigation Initiation Date:	04/12/2024
Report Due Date:	06/10/2024
Licensee Name:	Cranberry Park West Bloomfield LLC
Licensee Address:	Suite 230 25500 Meadowbrook Rd Novi, MI 48375
Licensee Telephone #:	(248) 692-4355
Administrator:	Pamela Skatzka
Authorized Representative:	Hemant Shah
Name of Facility:	Cranberry Park of West Bloomfield
Facility Address:	2450 Haggerty Rd West Bloomfield, MI 48323
Facility Telephone #:	(248) 671-4204
Original Issuance Date:	03/10/2022
License Status:	REGULAR
Effective Date:	09/10/2023
Expiration Date:	09/09/2024
Capacity:	53
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Residents did not receive their meals at posted times.	No
Resident A was fed food he was allergic to, and his personal preferences were not accommodated.	No
Resident A was treated poorly. Resident A's family member was banned from the facility. Staff were on their phones and sleeping on the job.	No
Resident A lacked care consistent with his service plan.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/11/2024	Special Investigation Intake 2024A1027048
04/12/2024	Special Investigation Initiated - Telephone Telephone interview conducted with complainant
04/16/2024	Inspection Completed On-site
04/22/2024	Inspection Completed-BCAL Sub. Compliance
05/08/2024	Exit Conference Conducted by email with Hemant Shah and Pamela Skatzka

ALLEGATION:

Residents did not receive their meals at posted times.

INVESTIGATION:

On 4/11/2024, the Department received allegations through the online complaint system which read residents were not being fed when they were supposed to be.

On 4/12/2024, I conducted a telephone interview with the complainant who stated residents received their meals from a ½ to 1.5 hours past the facility's posted mealtimes. For example, the complainant stated meals were served at 5:45 PM on 4/9/2024. The complainant stated Resident A was served after all other residents.

On 4/17/2024, I conducted an on-site inspection at the facility. I interviewed Employee #2 who stated sometimes meals were served later than posted times due to staff call offs which occurred for a 2–3-week timeframe in February 2024.

Employee #2 stated the facility recently transitioned a staff member with culinary experience into the role as cook and meals were served around the facility's planned mealtimes. Employee #2 stated meals were served around 9:00 AM, 12:00 PM and 5:00 or 5:30 PM.

Employee #2 stated Resident A was served his meal when a caregiver was able to assist him with eating, so the meal did not get cold. Employee #2 stated another resident at Resident A's table sometimes requested to provide Resident A assistance with his meal also.

Employee #2 stated there were three assisted living and memory care residents who currently required one to one assistance with eating in which the facility was able to accommodate.

I observed staff assisting residents to the dining room between 12:00 and 12:30 PM. I observed three staff in the dining room at lunch assisting residents. I observed a staff member assisting Resident A with his lunch meal.

I reviewed Resident A's admission contract which read in part "Cranberry Park will provide three meals daily. Snacks are available 24 hours a day."

I reviewed the facility's weekly menu which read in part three meals were served daily.

APPLICABLE RULE	
R 325.1952	**Meals and special diets.**
	(1) A home shall offer 3 meals daily to be served to a resident at regular meal times. A home shall make snacks and beverages available to residents.
ANALYSIS:	Although meals may have been served later than the facility's planned mealtimes, residents were served three meals per day; therefore, this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was fed food he was allergic to, and his personal preferences were not accommodated.

INVESTIGATION:

On 4/11/2024, the Department received allegations through the online complaint system which read Resident A was served food he was allergic to.

On 4/12/2024, I conducted a telephone interview with the complainant who stated Resident A was served lemon squares after supper on 4/9/2024 in which he was allergic to lemons and nuts. Additionally, the complainant stated the facility was not making accommodations for personal preferences.

On 4/17/2024, I conducted an on-site inspection at the facility. I interviewed the interim administrator LaShawnda Braxton who stated Resident A preferred meat and potatoes. Ms. Braxton stated sometimes Resident A would get agitated if he did not get the food he preferred.

I interviewed Employee #2 who stated if resident requested an alternate meal option, then sometimes it may take time to cook that meal.

Employee #2 stated residents were offered two dessert options in which today dessert options were cookies and cheesecake.

I interviewed Resident A who stated he was not served lemon squares because he was allergic to citrus. Resident A denied being offered any food with peanuts or citrus which were his allergies. Resident A stated he requested ice cream for dessert in which sometimes they did not have it, but other dessert options were available. Resident A stated he was served beef per his request today and not what was on the lunch menu that day.

I reviewed the weekly menu in which offered one meal option. I observed the "*Anytime Alternates*" menu which read grilled cheese, cheeseburger, egg salad plate, tuna plate, and side salad were other options.

I reviewed the menu from 4/9/2024 which read consistent with the complaint.

I reviewed Resident A's service plan updated on 1/1/2024 which read in part he preferred beef over other meats and loved V-8 juice. The plan read in part Resident A did not like rice, liked strawberry jelly and seasoning. The plan read in part his allergies were Aspirin, Peanut-containing Drug Products, Thimerosal, Citrus and Peanuts.

I reviewed Resident A's meal ticket which read in part he had allergies to citrus and peanuts.

I reviewed Resident A's chart notes which read in part on 4/4/2024, Resident A was offered an alternative meal and salad choices.

APPLICABLE RULE	
R 325.1952	**Meals and special diets.**
	(2) A home shall work with residents when feasible to accommodate individual preferences.
ANALYSIS:	There was lack of evidence to support the home did not accommodate Resident A's individual preferences. Resident A denied being offered anything with peanuts or citrus.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was treated poorly. Resident A's family member was banned from the facility. Staff were on their phones and sleeping on the job.

INVESTIGATION:

On 4/11/2024, the Department received allegations through the online complaint system which read staff were rude to Resident A's family. The allegations read police were called on Resident A's family because they refused to leave the resident and the family member was banned from the facility, in which now she cannot take the resident to his doctor's appointment. The allegations read staff at the facility were on their phones and sleeping on the job.

On 4/12/2024, I conducted a telephone interview with the complainant who stated staff treated Resident A poorly. The complainant stated Employee #1 and another employee in which she only knew the first letter of her name was "*T*" treated Resident A poorly. The complainant stated staff "*write up*" Resident A and threaten to provide him a 30-day notice.

The complainant stated on 4/9/2024, facility staff expressed she was creating a hostile environment, asked to leave, and unable to finish assisting with Resident A with eating his meal.

The complainant stated she was currently working to move Resident A to another facility.

On 4/17/2024, I conducted an on-site inspection at the facility. I interviewed interim administrator LaShawnda Braxton who stated the home did not tolerate staff who were "*rude*." Ms. Braxton stated she had been in her role for three weeks in which she had not observed staff acting "*rude*" and if so, they would be terminated. Ms. Braxton stated there were two staff members recently terminated for their behaviors.

Ms. Braxton stated recently in-services were provided to staff regarding phone usage and sleeping. Ms. Braxton stated she was unable to confirm if a staff member was sleeping; nonetheless, it was not tolerated.

I interviewed Employee #2 who stated staff were terminated for rudeness, one staff member was terminated for using cuss words and several staff members were written up for going against the facility's policies. Employee #2 stated more than half of the staff members were new employees. Employee #2 stated the facility maintained a write up process for staff members in violation of the facility's employee handbook.

Employee #2 stated she completed several staff in-services in the past few months which included but was not limited to inappropriate behavior, cell phones, rounding, and caregiver role/responsibilities.

Employee #2 provided a staff list which was reviewed and there were more than one staff member whose first name started with the letter "*T*." Employee #2 stated there had not been disciplinary actions for behaviors from Employee #1, nor Employee #3 in which it could not be confirmed if she was the employee referenced in the allegations or not.

Employee #2 stated Resident A's family member was calling staff "*derogatory*" names in the dining room and displaying disrespectful behavior in which she was asked to stop and did not. Employee #2 stated the police were contacted and the family member is no longer able to visit.

Employee #2 stated a 30-day discharge notice was issued to Resident A and his authorized representative by the administrator on 4/8/2024.

I interviewed Resident A who stated staff assisted him when he asked for help.

While on-site, I did not observe staff members on their phones or sleeping during the inspection.

I reviewed Resident A's admission contract dated 4/27/2022 which read in part:

> "*Visitors – Although we do not have specific visiting hours, we ask that you respect the residents that are living in the community and please be considerate. Visitors are not allowed in the facility under the influence of drugs or alcohol. Visitors can be asked to leave at any time for any reason.*
>
> *Residents may be transferred or discharged for any of the following reasons:*
> - *Medical reasons.*
> - *His or her welfare or that of other residents.*
> - *For nonpayment of his or her stay.*

- *Transfer or discharge sought by resident or authorized representative.*
- *If at any time Cranberry Park cannot adequately provide for the welfare of a resident when resident's current status is not consistent with the Program Statement.*

Cranberry Park shall provide a resident and his or her authorized representative, if any, and the agency responsible for the resident's placement, if any, with a 30-day written notice before discharge from the home. The written notice shall consist of all of the following:

- *The reasons for discharge.*
- *The effective date of the discharge.*
- *A statement notifying the resident of the right to file a complaint with the Department of Human Services."*

I reviewed Resident A's 30-day discharge notification letter which read in part:

"*On April 6th, 2024, Cranberry Park Assisted Living of West Bloomfield is issuing a 30-day notice of contract termination with [Resident A]. Our reasons are as follows, patient is medically inappropriate for our assisted living setting and needs a higher acuity level setting a new assessment has been completed and the physician overseeing [Resident A] agrees with discharge. With the level of care that the resident needs and his behaviors which are not appropriate for are [sic] facility and puts other residents at risk. On more than one occasions [Resident A] has been seen by other staff going into other resident's apartments and being inappropriate with a female resident*."

I reviewed Resident A's chart notes which read in part:

Note dated 3/26/2024 at 2:44 PM: "*Writer was notified that resident was in dining room with female resident the same resident from previous occurrence with hand in female residence [sp] private area while she was sitting in her wheelchair. When caregiver noticed the behavior she asked residentto [sic] not touch the female resident and again separated the resident. ED immediately reach out to [Relative A1] and left a voice message for return call Employee #3 reached out to female residence [sic] family for a return call voice message left for both residents families.*"

Note dated 3/27/2024 12:44 PM read: "*Writer observed resident attempting to go in two female residents rooms. Writer politely asked resident if everything was ok. Resident stated yes that he was going to his room. Writer stood by to ensure the safety of other residents as well as resident himself. Resident then attempted to go into female residents room stating "I am closing her door", writer informed resident that female did not want her room door closed. Resident became very agitated and yelled for writer to go into room and ask female resident if she wanted her door closed. Writer again informed resident that female resident does*

not want her door closed. Resident screamed that he pays for everyone in the building and can do what he wants. Writer redirected resident away from female residents rooms. Incident was observed by another family members family that voiced their concerns after resident was removed from the hallway."

Note dated 4/4/2024 7:55 PM read: "*writer [sic] was in dining hall when resident was observed being combative yelling at the caregiver telling her to "get the effing food away from me before I hit you) [sic] Writer and ED intervened, Caregiver states she was asking resident what else he wouldlike [sp] to eat while he waits on his meal to be served. ED (LaShawnda Braxton) asked resident how she could help and offered to bring resident what he requested. Resident continued to scream at her. Writer asked residents daughter to come to the dining room. [Relative A1] states this is the problem with staff they do not help him and they do not bring him what he likes. Writer and ED expressed the resident consumed a salad twice last week. Once when the writer fed the resident in front of his son and resident did not complain. Resident also requested a salad today which is what was served and then changed his mind. [Relative A1] states "well he wanted a side salad." Writer explained that resident stated he wanted the salad just not with the chicken on it. The caregiver was going to get a salad with no chicken until his alternative meal arrived and resident was still not happy. Another resident in the dining room expressed his discomfort and tried speaking with [Relative A1] and she put her hand on his face and said "[Resident C] please" the ED intervened again and asked her not to speak to the residents that way and pulled her to the side to explain the situation more in depth*."

I reviewed the employee handbook which read in part under the work rules:

"*Refrain from rudeness or unprofessional behavior toward a customer, or anyone in contact with the Company*."

"*Not make or receive personal phone calls or us Company telephones without permission. This includes no cell phone usage in the facility while on Company time*."

"*Employees may not sleep or assume the position of sleep while on duty*."

I reviewed the facility's employee write-up form which read in part reasons for the warning, the details of actions that warranted the warning, and the corrective action that must be taken by the employee.

I reviewed Employee #1's file which read in part she completed "*Caregiver Skills Checklist*" dated 11/29/2023 which included but was not limited to training cell phone and texting while on the job. The file read in part she completed training modules including but not limited to *Resident Rights* and *Reporting Requirements* on

11/30/2023. The file read in part she signed acknowledgement of the Employee Handbook on 12/4/2023 and again on 3/29/2024.

I reviewed Employee #4's file which read in part she completed "*Caregiver Skills Checklist*" dated 12/1/2023 which included but was not limited to training cell phone and texting while on the job. The file read in part she completed training modules including but not limited to *Resident Rights* and *Reporting Requirements* on 12/1/2023. The file read in part she signed acknowledgement of the Employee Handbook on 2/1/2024 and again on 3/29/2024.

I reviewed the facility's staff in-services and sign-in sheets which read consistent with statements from Employee #2.

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 insufficient evidence to support Resident A was treated poorly. Review of Employee #1 and #4's files revealed they were trained on *Resident Rights* and the Employee Handbook, which included the facility's policies on serving residents and the abuse policy. Review of Resident A's admission contract and chart notes revealed the facility followed their policies regarding Resident A's family member. Additionally, the discharge policy in Resident A's admission contract read consistent with the discharge letter and the Administrative Rules, as well as Public Health Code. There was lack of evidence to support staff were on their phones and sleeping on the job. The facility had an organized program of employee rules with disciplinary actions. Therefore, these allegations were not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A lacked care consistent with his service plan.

INVESTIGATION:

On 4/12/2024, I conducted a telephone interview with the complainant who stated Resident A was left in a wet brief. The complainant stated Resident A required 1:1 assistance with his meals and a resident at his table would feed him because there were no staff available to assist.

On 4/17/2024, I conducted an on-site inspection at the facility. I interviewed Employee #2 who stated she was currently updating all residents service plans since they were not an accurate reflection of the care needed and required. Employee #2 stated Resident A was evaluated and she had a paper copy of his updated service plan in her office; however, the plan had not been placed into their charting system for all staff yet. Employee #2 stated staff could review all residents' services in the "PCC" charting system, once uploaded.

I interviewed Resident A who stated that he changed his own clothing and brief. Resident A stated he would get up without asking for assistance; however, if he called staff, they would respond and help.

I reviewed Resident A's face sheet which read in part admitted to the facility on 4/27/2022. The face sheet read in part Relative A1 was his first emergency contact.

I reviewed Resident A's admission contract dated 4/27/2022 which read in part the plan was developed upon admission and updated at least annually, or when significant change in needs occurred. The contract read in part the home would provide activities of daily living services as identified in the service plan such as activities associated with eating, toileting, bathing, grooming, dressing, transferring, mobility, and medication management.

I reviewed Resident A's service plan updated on 1/19/2024 which read in part Resident A had a behavior problem in which he was non-compliant with participation with ADLs (activities of daily living) and care, combative with staff and refused to get out of bed. The plan read in part he utilized a wheelchair for mobility. The plan read in part was a setup/assist, as well as assistance to dining room for meals. The plan read in part Resident A was able to choose his clothing options and dress himself. The plan read in part Resident A utilized pull ups for occasional urinary accidents. The plan read in part Resident A was alert and orientated x3.

I reviewed Employee #2's "*Needs Assessment and Individual Service Plan*" for Resident A which read he was non-ambulatory and required a wheelchair for mobility. The plan read he had repeated falls and required one to two personal transfer or use of a lift. The plan read Resident A totally dependent for bathing, dressing, grooming, and resisted assistance. The plan read Resident A had daily incontinence and used incontinence products, as well as required a toileting schedule. The plan read Resident A had special needs for meals: wanders during meals, must be fed or will not eat if constantly cued, thickened liquids done by staff, and monitoring of intake on 24-hour report. The plan read Resident A had behavioral issues resisting staff assistance, unpredictable behaviors, elopement tendency or attempts; firm of frequent redirection necessary to ensure daily needs are met. The plan read Resident A requires reality orientation, and a psych consult was on file.

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:	Review of Resident A's service plan dated 1/19/2024 lacked specific care and maintenance reflective of his current needs. Although Employee #2 had evaluated and updated a written plan; it was not available for staff to review and follow. Additionally, the plan lacked specific care and maintenance regarding his food preferences like the plan updated 1/19/2024, and his ability to transfer as to whether he could bear weight, required a lift or one or two-person assist was unclear. Therefore, it could not be confirmed if the service plan was followed, and this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 4/17/2024, I reviewed the current diet orders for residents located in a kitchen binder which read some residents were prescribed a diabetic/consistent carb/controlled carb diet. While on-site, the home provided two weeks of regular diet menus.

Interview with Employee #2 revealed there were two weeks of regular menus, and all previous menus were not available, as well as there were no menus for therapeutic or special diets available nor posted.

APPLICABLE RULE	
R 325.1953	**Menus.**
	(1) A home shall prepare and post the menu for regular and therapeutic or special diets for the current week. Changes shall be written on the planned menu to show the menu as actually served. **(2) A home shall maintain a copy of all menus as actually served to residents for the preceding 3 months.**
ANALYSIS:	The facility's menus were not incompliance with this rule; therefore, a violation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

04/25/2024

_____

Jessica Rogers Date
Licensing Staff

Approved By:

05/08/2024

_____

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