GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 14, 2024

Rita Kumar
Sunnydale Assisted Living & Memory Care LLC
Suite 300
28592 Orchard Lake Rd.
Farmington Hills, MI 48334

RE: License #: AL500402309
Investigation #: 2024A0617016
Sunnydale Assisted Living & Memory Care

Dear Ms. Kumar:

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.

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.

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 (248) 975-5053.

Sincerely,

Eric Johnson
Adult Foster Care Licensing Consultant
Department of Licensing and Regulatory Affairs
Bureau of Community and Health Systems
3026 Cadillac Place, Ste 9-100
Detroit, MI 48202 .

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL500402309
Investigation #:	2024A0617016
Complaint Receipt Date:	02/20/2024
Investigation Initiation Date:	02/20/2024
Report Due Date:	04/20/2024
Licensee Name:	Sunnydale Assisted Living & Memory Care LLC
Licensee Address:	Suite 300 - 28592 Orchard Lake Rd. Farmington Hills, MI 48334
Licensee Telephone #:	(313) 269-9437
Administrator:	Rita Kumar
Licensee Designee:	Rita Kumar
Name of Facility:	Sunnydale Assisted Living & Memory Care
Facility Address:	44315 N. Gratiot Clinton Twp., MI 48036
Facility Telephone #:	(586) 493-7300
Original Issuance Date:	12/15/2021
License **Status:**	REGULAR
Effective Date:	06/15/2022
Expiration Date:	06/14/2024
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Staff caught stealing medications. Staff not approved to pass medications.	No
Cleaning supplies are left in areas accessible to the residents.	Yes

III. METHODOLOGY

02/20/2024	Special Investigation Intake 2024A0617016
02/20/2024	Special Investigation Initiated - Telephone TC with Adult Protective Services worker Heather Horan
02/20/2024	APS Referral Adult Protective Services (APS) referral received - assigned worker Heather Horan
02/26/2024	Inspection Completed On-site I conducted an unannounced investigation of the Sunnydale Assisted Living & Memory Care facility. I interviewed staff Rebecca Pfropper, Lakeisha Jenkins, Aliyyah Wells, Tori Karazim facility head nurse Amanda Zanetti, and Administrator Laurie Russell via telephone. I also interviewed Resident A.
02/29/2024	Contact - Document Received Email received from Ms. Russell. I received and reviewed the staff trainings for all medication technicians.
03/05/2024	Contact - Face to Face I interviewed Optimal care Home Nurse Lisa Burdt
04/04/2024	Contact - Telephone call made TC with LD Ms. Rita Kumar
04/19/2024	Exit Conference Exit Conference was held with LD Ms. Rita Kumar

ALLEGATION:

Staff caught stealing medications. Staff not approved to pass medications.

INVESTIGATION:

On 02/20/24, I received a complaint on the Sunnydale Assisted Living & Memory Care facility. The complaint stated that cleaning supplies including bleach are left in areas accessible to the residents, which is particularly concerning as the residents in memory care are known to get into stuff, including one resident that eats dirt off the floor. Additionally, the medication cart has been left open giving access to residents and staff. One employee has already been caught stealing medications. Staff not approved to pass medications have been asked to do so by medication technicians.

On 02/26/24, I conducted an unannounced investigation of the Sunnydale Assisted Living & Memory Care facility. I interviewed staff Rebecca Pfropper, Lakeisha Jenkins, Aliyyah Wells, Tori Karazim facility head nurse Amanda Zanetti, and administrator Laurie Russell via telephone. I also interviewed Resident A. Other residents were unable to answer questions due to cognitive disabilities.

During the onsite investigation I interviewed staff Lakeisha Jenkins. According to Ms. Jenkins, the medication cart is always locked. Ms. Jenkins is unaware of any situations or incidents where the medication cart was left unlocked. Ms. Jenkins is unaware of any medications missing or being stolen by staff. Ms. Jenkins stated that all medication techs are trained to pass medications and she is unaware of any untrained staff passing medications. I observed the medication cart in the nurse room that included a security camera above the cart. I observed the medication cart locked and unlocked with a key.

During the onsite investigation, I interviewed staff Rebecca Pfropper. According to Ms. Pfropper, she is unaware of any medications missing, being stolen or the medication being left unlocked. She stated that only medication techs pass medications, and all are trained to do so.

During the onsite investigation I interviewed staff Aliyyah Wells. According to Ms. Wells, the medication cart is always locked. Ms. Wells is unaware of any situations or incidents were the medication cart was left unlocked. Ms. Wells is unaware of any medications missing or being stolen by staff. Ms. Wells stated that all medication techs are trained to pass medications and she is unaware of any untrained staff passing medications.

During the onsite investigation, I interviewed staff Tori Karazim. According to Ms. Karazim, she is unaware of any medications missing, being stolen or the medication being left unlocked. She stated that only medication techs pass medications, and all are trained to do so.

The facility utilizes an electronic medication charting system. Staff was unable to provide me with requested copies of the residents' medication logs. Staff called for the head nurse Amanda Zanetti to come to the facility and assist. Ms. Jenkins stated that staff were only trained to use the system features to pass medications and she is unaware how to run any reports. Ms. Zanetti reported that medication techs do not have access to run medication log reports.

During the onsite investigation, I observed Ms. Pfropper and Ms. Jenkins struggle to provide care and supervision to the 17 residents. The residents were sitting in the dining and living areas of the facility but due to the residents' cognitive disabilities the residents were very active. I observed two residents almost get into a physical alteration, another resident spilled her drinking water on herself, table and floor, all while Ms. Prfropper was assisting a resident to the couch and Ms. Jenkins was passing medications. Both staff members stated that two worker is not enough to properly care for the residents. Ms. Zanetti agreed and stated that she has mentioned to upper management multiple times that more staff is needed.

During the onsite investigation, I conducted a medication review for Resident A and Resident B.

The following medication errors were found for Resident A:

- The medications Glucosam/chondroitin 750-600MG, Multivitamin tab, and Vitamin E 400 IU Caps, medication containers did not have labels.
- The medications Acetaminophen 500MG, Bisacodyl sup 10MG, Blue-emu Cre (Liniments), Calc antacid chw 500MG (Tums), CBD Hemp Oil 1500MG (100MG/ML), Haloperidol CON 2MG/ML (Haldol), Hydroco/Apap 5-325MG (Norco), Ibuprofen 200MG, Lorazepam 0.5MG (Ativan), Morphine SUL Sol 100/5ML, were missing.
- The medication Hydroco/APAP 5-325MG was not initialed/given on 2/6(8 pm)
- The medication Ibuprofen 200MG was not initialed/given on 2/4, 2/15, 2/16
- The medication Multivitamin Tab was not initialed/given on 2/18/, 2/19
- The medication Senexon plus 8.6-50 MG was not initialed/given on 2/3, 2/4, 2/5

The following medication errors were found for Resident B:

- The medication Celecoxib Cap 200MG was not initialed/given on 2/16
- The medication D3 High Potency 25MCG (1000 UT) Caps was not initialed/given on 2/5, 2/6, 2/7, 2/9, 2/10, 2/11, 2/21, 2/22, 2/24, 2/25
- The medication Donepezil Tab 5MG was not initialed/given on 2/16
- The medication Pravastain Tab 40MG (Pravachol) was not initialed/given on 2/16
- The medication Sertraline Tab 25MG (Zoloft) was not initialed/given on 2/8,2/9, 2/10, 2/11, 2/12, 2/16
- The medication Alendronate Tab 70MG was missing.

During the onsite investigation, staff were unable to provide staff files including staff training. Ms. Zanetti stated that the staff files are in Ms. Russell's office and she was out

sick. Ms. Russell was contacted via telephone and stated that she would email all of the staff trainings. Ms. Russell denied the allegations that staff were stealing medications and stated that all medication techs are properly trained.

On 2/29/24, I received and reviewed the staff trainings for all medication technicians. All medication technicians have proper medication trainings.

On 03/05/24, I interviewed Optimal care Home Nurse Lisa Burdt. According to Ms. Burdt, she comes to the facility three to four times a week and provide care to residents. She believes the facility is severely understaffed. Ms. Burdt stated that due to the resident's needs, more care and supervision is needed.

APPLICABLE RULE	
R 400.15209	**Home records generally.**
	(1) A licensee shall keep, maintain, and make available for department review, all the following home records: **(h) Personnel records, as required in R 400.15208.**
ANALYSIS:	During the onsite investigation, staff were unable to provide me with staff files including staff training. Ms. Zanetti stated that the staff files are in Ms. Russell's office, and she was out sick. Ms. Russell was contacted via telephone and stated that she would email all of the staff trainings. Ms. Russell denied the allegations that staff were stealing medications and stated that all medication techs are properly trained.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.

ANALYSIS:	During the onsite investigation, I conducted a medication review for Resident A and Resident B. The following medication errors were found for Resident A: The medications Acetaminophen 500MG, Bisacodyl sup 10MG, Blue-emu Cre (Liniments), Calc antacid chw 500MG (Tums), CBD Hemp Oil 1500MG (100MG/ML), Haloperidol CON 2MG/ML (Haldol), Hydroco/Apap 5-325MG (Norco), Ibuprofen 200MG, Lorazepam 0.5MG (Ativan), Morphine SUL Sol 100/5ML, were missing. The following medication errors were found for Resident B: The medication Alendronate Tab 70MG was missing.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	During the onsite investigation, I conducted a medication review for Resident A and Resident B. The following medication errors were found for Resident A: • The medications Glucosam/chondroitin 750-600MG, Multivitamin tab, and Vitamin E 400 IU Caps, medication containers did not have labels. • The medications Acetaminophen 500MG, Bisacodyl sup 10MG, Blue-emu Cre (Liniments), Calc antacid chw 500MG (Tums), CBD Hemp Oil 1500MG (100MG/ML), Haloperidol CON 2MG/ML (Haldol), Hydroco/Apap 5-325MG (Norco), Ibuprofen 200MG, Lorazepam 0.5MG (Ativan), Morphine SUL Sol 100/5ML, were missing. • The medication Hydroco/APAP 5-325MG was not initialed/given on 2/6(8 pm) • The medication Ibuprofen 200MG was not initialed/given on 2/4, 2/15, 2/16 • The medication Multivitamin Tab was not initialed/given on 2/18/, 2/19 • The medication Senexon plus 8.6-50 MG was not initialed/given on 2/3, 2/4, 2/5 The following medication errors were found for Resident B: • The medication Celecoxib Cap 200MG was not initialed/ given on 2/16

	• The medication D3 High Potency 25MCG (1000 UT) Caps was not initialed/given on 2/5, 2/6, 2/7, 2/9, 2/10, 2/11, 2/21, 2/22, 2/24, 2/25 • The medication Donepezil Tab 5MG was not initialed/ given on 2/16 • The medication Pravastain Tab 40MG (Pravachol) was not initialed/given on 2/16 • The medication Sertraline Tab 25MG (Zoloft) was not initialed/given on 2/8,2/9, 2/10, 2/11, 2/12, 2/16 • The medication Alendronate Tab 70MG was missing.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Renewal Inspection dated 06/21/22 and CAP dated 06/30/22**

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	During the onsite investigation, I conducted a medication review for Resident A and Resident B. The following medication errors were found for Resident A: • The medication Hydroco/APAP 5-325MG was not initialed on 2/6(8 pm) • The medication Ibuprofen 200MG was not initialed on 2/4, 2/15, 2/16 • The medication Multivitamin Tab was not initialed on 2/18/, 2/19 • The medication Senexon plus 8.6-50 MG was not initialed on 2/3, 2/4, 2/5 The following medication errors were found for Resident B: • The medication Celecoxib Cap 200MG was not initialed on 2/16

	• The medication D3 High Potency 25MCG (1000 UT) Caps was not initialed on 2/5, 2/6, 2/7, 2/9, 2/10, 2/11, 2/21, 2/22, 2/24, 2/25 • The medication Donepezil Tab 5MG was not initialed on 2/16 • The medication Pravastain Tab 40MG (Pravachol) was not initialed on 2/16 • The medication Sertraline Tab 25MG (Zoloft) was not initialed on 2/8,2/9, 2/10, 2/11, 2/12, 2/16
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Cleaning supplies are left in areas accessible to the residents.

INVESTIGATION:

During the onsite investigation, Ms. Jenkins stated that cleaning supplies are kept under the sink and not locked. Ms. Pfropper stated that the main cleaning supplies are kept on the sanitation cart that is kept away from the residents unless it is in use. I observed the cleaning cart in the nurse's office, until Ms. Pfropper took it out to clean spilled water. I observed several cleaning spray bottles under the sink that were not locked up. Ms. Pfropper stated those cleaning bottles are only used to clean surfaces like tables and counters.

On 04/19/24, I conducted an exit conference with licensee designee Rita Kumar to discuss the findings of this report. Ms. Kumar did not answer, a voicemail was left.

APPLICABLE RULE	
R 400.15401	**Environmental health.**
	(6) Poisons, caustics, and other dangerous materials shall be stored and safeguarded in nonresident areas and in non-food preparation storage areas.
ANALYSIS:	During the onsite investigation, Ms. Jenkins stated that cleaning supplies are kept under the sink and not locked. I observed the cleaning cart in the nurse's office, until Ms. Pfropper took it out to clean spilled water. I observed several cleaning spray bottles under the sink that were not locked up. Ms. Pfropper stated those cleaning bottles are only used to clean surfaces like tables and counters.
CONCLUSION:	**VIOLATION ESTABLISHED**

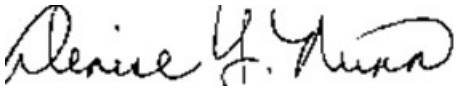
IV. RECOMMENDATION

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

04/19/24

Eric Johnson — Date
Licensing Consultant

Approved By:



06/14/2024

Denise Y. Nunn — Date
Area Manager