GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 23, 2024

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

RE: License #: AL500402309
Investigation #: 2024A0617025
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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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 #:	2024A0617025
Complaint Receipt Date:	05/31/2024
Investigation Initiation Date:	05/31/2024
Report Due Date:	07/30/2024
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?
On 03/16/2024, Resident A's briefs were not changed, she was not fed and her medications were not passed.	Yes

III. METHODOLOGY

05/31/2024	Special Investigation Intake 2024A0617025
05/31/2024	APS Referral Adult Protective Service Referral received
05/31/2024	Special Investigation Initiated - Telephone TC made to Complainant
05/31/2024	Contact - Telephone call made TC to Resident A's niece
06/04/2024	Inspection Completed On-site I conducted an unannounced investigation of the Sunnydale Assisted Living & Memory Care facility. I interviewed staff Bianca Thorman, Chanice Gilbert, Kayla Barks, Resident A, Resident B, Resident C, Licensee Designee Rita Kumar (via Phone) and Regional Vice President Raenae St. Julian.
06/14/2024	Contact - Telephone call made I conducted an interview with Resident A's daughter.
06/14/2024	Contact - Telephone call made I interviewed staff Shiretta Smith.
06/14/2024	Contact - Telephone call made I interviewed staff Amaria Belcher.
06/14/2024	Exit Conference I conducted an exit conference with Licensee Designee Rita Kumar to discuss the findings of this report.

ALLEGATION:

On 03/16/2024, Resident A's briefs were not changed, she was not fed and her medications were not passed.

INVESTIGATION:

On 05/31/24, I received a complaint on the Sunnydale Assisted Living & Memory Care facility. The complaint stated on 03/16/2024 Resident A fell. She was transported by ambulance to McClaren Hospital, was treated, and returned that same night. There was only one staff member working with 16 memory care patients in a locked ward. The staff member on duty refused to take the care instructions from the hospital. The staff member left the instructions on Resident A's bed. Resident A was put into bed with dirty adult brief. Family members changed Resident A's brief and had to bring her food. Twice that night, two ladies were physically fighting outside Resident A's door. No staff member was present. Family waited 20 minutes for a staff member, and no one was on the floor. Residents were out and about. Family went to the front desk and rang for a supervisor. A supervisor came down and stated the facility was shorthand and there should be more than one staff member in the memory unit. The next day, Resident A's one-on-one nurse Karen arrived. Karen was told by staff that Resident A as not returned and was still at the hospital. Karen had to show staff that Resident A was there and in her bed. Resident A had not been changed or fed. The night staff never logged Resident A as returning. There was still little to no staff on the floor. Resident A is not washed, her briefs are not changed, she is not fed, and her medications are not dispensed. Resident A has had jewelry stolen off her body. She has had beverages and food stolen as well. There are a few women at the facility that fight nonstop. Staff does not intervene. The director is useless to talk to.

On 06/04/24, I conducted an unannounced investigation of the Sunnydale Assisted Living & Memory Care facility. I interviewed staff Bianca Thorman, Chanice Gilbert, Kayla Barks, Resident A, Resident B, Resident C, Licensee Designee Rita Kumar (via Phone) and Regional Vice President Raenae St. Julian.

During the onsite investigation, staff could not provide any resident files. Staff provided me with folders with medical information for each resident but there were no required AFC forms. During the onsite investigation I observed a daily menu posted in the dining area of the facility. The menu posted included options for breakfast (cinnamon muffin, eggs of choice, fresh fruit, 100% juice), lunch (tuna salad on croissant, honeydew, tomatoes with cottage cheese, tomato soup) and dinner (green salad, country fried steak with gravy, fresh mashed potatoes, roasted cauliflower, baked roll, chocolate sour cream cake). staff stated that menus are created daily as the food is brought in from an offsite source. Staff was unable to provide me any menus other than the current one posted for the day. Also, there was not a list of residents or special menus for residents who require an alternate menu. It is unknown if any of the residents require a special

diet. Staff could not provide a staff schedule for my review. Staff stated that they use an app on their phones for the schedule and there is not a printed version of the schedule.

During the onsite investigation, I interviewed Resident A. According to Resident A, her briefs are always changed timely but she doesn't always get to eat or get enough to eat. Resident A stated that she has dementia and has a hard time remembering things but she doesn't remember having any jewelry stolen. I observed Resident A asking for food several times prior to the arrival of the food and after eating all of her food. Staff provided her with a pudding cup after she finished her lunch but that was not enough for her as she was observed begging several other residents for their lunch.

During the onsite investigation, I interviewed Resident B. According to Resident B, she had no issues or concerns to report with regards to her care or the care of any of her housemates. Resident B stated that she loves everything about the facility.

During the onsite investigation, I interviewed Resident C. Resident C had no issues or concerns to report with regards to her care or the care of any of her housemates.

During the onsite investigation, I interviewed staff Chanice Gilbert. According to Ms. Gilbert, residents are changed every two to three hours. Brief changes are not documented unless it is the change of shifts so that the next shift knows when the last time the residents were changed. Ms. Gilbert also stated that the night shift is supposed to log resident brief changes. Staff could not provide brief logs for me to review.

During the onsite investigation, I interviewed medication technician Bionca Thorman. Ms. Thorman stated that she has been employed at the facility since September 2022. Ms. Thorman stated that she was working as the med tech for both Sunnydale and their affiliated AFC facility Riverdale which is next door. Ms. Thorman stated that she has to go between the two facilities to pass meds because management wanted to reduce the amount of staff who had access to the medication carts. The facilities both utilize an electronic medication charting system, and the two facilities were currently sharing one laptop as the other was broken. Ms. Thorman had to take the laptop with her between the two facilities. Ms. Thorman stated that neither facility had printed medication logs or orders. Ms. Thorman could not provide me with paper or electronic medication logs. Ms. Thorman stated that she did not know how to retrieve the requested medication logs.

During the onsite investigation, I contacted Regional Vice President Raenae St. Julian and Licensee Designee Ms. Rita Kumar for assistance. Ms. St. Julian was able to come to the facility to assist with the investigation. When Ms. St. Julian arrived, she stated that staff schedules, menus, and resident files are kept behind the front desk in the lobby. Ms. St. Julian was able to provide menus for the week. Ms. St. Julian provided me with staff schedules for March 2024 and June 1-3, 2024, and resident files. All of the required AFC documents in the resident files were completely blank. Resident A's file did not contain any Incident reports, nor did it have an valuables inventory. The staff schedule for 3/16/24 indicated that staff Shiretta Smith worked the afternoon shift and Amaria Belcher worked the night shift. Both staff are direct care workers and not med

technicians. According to the schedules from March 2024 and June 2024, the facility does not staff med techs during the night shift. Also, there were no staff scheduled for the midnight shift on June 1-3, 2024.

Ms. St. Julian stated that staff should have printed instructions on how to access the medication logs. Ms. St. Julian looked and could not find the printed instructions, nor could she access the logs herself. Ms. St. Julian had to contact someone offsite to have the medication logs emailed over, she then had to leave the facility to go to the lobby to have the logs printed. This process took over an hour before I was provided with medication logs for Resident A and Resident D. Ms. St. Julian stated that they have hired a new head nurse and building manager and they will be starting soon. I reviewed Resident A's March medication logs. According to Resident A's medication logs, all of her medications were administered on 3/16/24.

During the onsite investigation, I completed medication audits with med tech Ms. Thorman and Ms. St. Julian. The following medication errors were found:

Resident A:

- Amlodipine tab 5mg was missing.
- Nitrofurantoin Mono 100mg was not initialed/given on 5/7 to 5/28.

Resident B:

- Acetaminophen 500MG, Bisacodyl SUP 10mg, Calc Antacid CHW 500mg, Haloperidol con 2mg/ml, Lorazepam 0.5mg, Morphine sul sol 100/5ml, and Compazine tab 10mg, were missing.
- The label on Glucosam/chondroitin 750-600mg did not match the medication log.

On 06/14/24, I conducted an interview with Resident A's daughter. According to Resident A's daughter, there were some concerns with the facility and them being short staff previously, but things have become better. With regards to the incident on 3/16/24, Resident A's daughter stated that she was out of the country and does not recall what happened. Resident A's daughter reports that everything is good now and she is satisfied with the care her mother is receiving. Resident A's daughter stated that her mother gets plenty of food and eats well. With regards to the missing jewelry, Resident A's daughter stated that three of Resident A's necklaces with charms were stolen/missing in January of this year. She made a complaint to the former administrator, but nothing happened. Resident A's daughter did not have any contact information for Nurse Karen.

On 06/14/24, I interviewed staff Shiretta Smith. Ms. Smith denied all allegations and stated that nothing happened on her shift that she could remember.

On 06/14/24, I interviewed staff Amaria Belcher. According to Ms. Belcher, on 3/16/24, Resident A was already back in the facility when she arrived at work around 11pm. Ms. Belcher stated that Resident A was changed several times but no meds or food was given. Ms. Belcher stated that food comes from the kitchen, which is outside of the facility and once dinner is done, there is no more food until breakfast. There are

sometimes snacks in the facilities but not always. Ms. Belcher stated that she is not a med tech and does not pass medications.

On 06/14/24, I conducted an exit conference with Licensee Designee Rita Kumar to discuss the findings of this report. Ms. Kumar stated that the facility is working to make adjustments as there have been a lot of staff turnover. The facility just hired a new executive director who will be responsible for the day-to-day operations of the facility.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on the information gathered through my interviews and documentation reviews, the facility has treated Resident A with dignity and her personal needs were attended to accordance with the provisions of the act. Staff denied allegations of not changing Resident A's briefs. According to Resident A's medication logs, all of her medications were administered on 3/16/24.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on the information gathered through my interviews and documentation reviews, the facility does not schedule sufficient staff during the night shift for the supervision, personal care and protection of residents. According to the schedules from March 2024 and June 2024, the facility does not schedule med techs during the night shift. Also, there were no staff scheduled for the midnight shift on June 1-3, 2024. The facility schedules one med tech for both Sunnydale and their affiliated AFC facility Riverdale which is next door. According to Ms. Thorman, she has to go between the two facilities to pass meds because

	management wanted to reduce the number of staff who had access to the medication carts. The one med tech has the only keys to both facility's med carts and medication records. When the med tech leaves to go next door to pass medications, the facility is left without access to medications and medication records.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15210	**Resident register.**
	A licensee shall maintain a chronological register of residents who are admitted to the home. The register shall include all of the following information for each resident: **(a) Date of admission.** **(b) Date of discharge.** **(c) Place and address to which the resident moved, if known.**
ANALYSIS:	During the onsite investigation, the facility was unable to provide a resident register.
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 completed medication audits with med tech Ms. Thorman and Ms. St. Julian. The following medication errors were found: Resident A: • Amlodipine tab 5mg was missing. • Nitrofurantoin Mono 100mg was not initialed/given on 5/7 to 5/28. Resident B: • Acetaminophen 500MG, Bisacodyl SUP 10mg, Calc Antacid CHW 500mg, Haloperidol con 2mg/ml, Lorazepam 0.5mg, Morphine sul sol 100/5ml, and Compazine tab 10mg, were missing.

	• The label on Glucosam/chondroitin 750-600mg did not match the Medication log.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Renewal Inspection dated 06/21/22 and CAP dated 06/30/22 and SIR # 2024A0617016 and dated 4/19/24**

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 completed medication audits with med tech Ms. Thorman and Ms. St. Julian. The following medication errors were found for Resident A: The medication Nitrofurantoin Mono 100mg was not initialed/given on 5/7 to 5/28.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR # 2024A0617016 and dated 4/19/24**

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.
ANALYSIS:	During the onsite investigation I observed a daily menu posted in the dining area of the facility. The menu posted included options for breakfast (cinnamon muffin, eggs of choice, fresh fruit, 100% juice), lunch (tuna salad on croissant, honeydew, tomatoes with cottage cheese, tomato soup) and dinner (green salad, country fried steak with gravy, fresh mashed potatoes, roasted cauliflower, baked roll, chocolate sour cream cake). Staff stated that menus are created daily as the food is brought in from an offsite source. Staff was unable to provide me any

	menus other than the current one posted for the day. Also, there was not a list of residents or special menus for residents who require an alternate menu. It is unknown if any of the residents require a special diet.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: **(a) Identifying information, including, at a minimum, all of the following:** **(i) Name.** **(ii) Social security number, date of birth, case number, and marital status.** **(iii) Former address.** **(iv) Name, address, and telephone number of the next of kin or the designated representative.** **(v) Name, address, and telephone number of the person and agency responsible for the resident's placement in the home.** **(vi) Name, address, and telephone number of the preferred physician and hospital.** **(vii) Medical insurance.** **(viii) Funeral provisions and preferences.** **(ix) Resident's religious preference information.** **(b) Date of admission.** **(c) Date of discharge and the place to which the resident was discharged.** **(d) Health care information, including all of the following:** **(i) Health care appraisals.** **(ii) Medication logs.** **(iii) Statements and instructions for supervising prescribed medication, including dietary supplements and individual special medical procedures.** **(iv) A record of physician contacts.** **(v) Instructions for emergency care and advanced medical directives.**

	(e) Resident care agreement. **(f) Assessment plan.** **(g) Weight record.** **(h) Incident reports and accident records.** **(i) Resident funds and valuables record and resident refund agreement.** **(j) Resident grievances and complaints.**
ANALYSIS:	During the onsite investigation, staff were unable to provide me resident files. Ms. St. Julian stated that resident files are kept behind the front desk in the lobby. Ms. St. Julian was able to provide resident files. However, all of the required AFC documents in the resident files were completely blank. Resident A's file did not contain any Incident reports, nor did it have an valuables inventory.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan I recommend a six-month 1st provisional license. A recommendation for a provisional license is also being made in special investigation report #2024A0617016.

06/14/24

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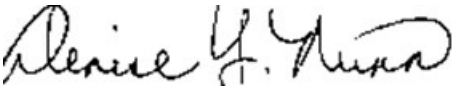
Eric Johnson Date
Licensing Consultant

Approved By:



07/23/2024

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Denise Y. Nunn Date
Area Manager