GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 10, 2024

Karen Pleaugh
Sunrise Of West Bloomfield
7005 Pontiac Trail
West Bloomfield, MI 48323

RE: License #: AH630391473
Investigation #: 2024A1019060
Sunrise 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.

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,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AH630391473 |
| | |
| **Investigation #:** | 2024A1019060 |
| | |
| **Complaint Receipt Date:** | 08/06/2024 |
| | |
| **Investigation Initiation Date:** | 08/07/2024 |
| | |
| **Report Due Date:** | 09/05/2024 |
| | |
| **Licensee Name:** | Welltower OpCo Group LLC |
| | |
| **Licensee Address:** | 4500 Dorr Street<br>Toledo, OH 43615 |
| | |
| **Licensee Telephone #:** | (419) 247-2800 |
| | |
| **Administrator and Authorized Representative:** | Karen Pleaugh |
| | |
| **Name of Facility:** | Sunrise Of West Bloomfield |
| | |
| **Facility Address:** | 7005 Pontiac Trail<br>West Bloomfield, MI 48323 |
| | |
| **Facility Telephone #:** | (248) 738-8101 |
| | |
| **Original Issuance Date:** | 12/23/2019 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 08/01/2024 |
| | |
| **Expiration Date:** | 07/31/2025 |
| | |
| **Capacity:** | 70 |
| | |
| **Program Type:** | AGED<br>ALZHEIMERS |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Residents are being emotionally abused by staff. | Yes |
| Additional Findings | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 08/06/2024 | Special Investigation Intake<br>2024A1019060 |
| 08/07/2024 | Special Investigation Initiated - Letter<br>Notified APS of the allegations. |
| 08/07/2024 | APS Referral |
| 08/21/2024 | Inspection Completed On-site |
| 08/21/2024 | Inspection Completed-BCAL Sub. Compliance |

**ALLEGATION:**

Residents are being emotionally abused by staff.

**INVESTIGATION:**

On 8/6/24, the department received a complaint alleging Resident A was teased by staff and alleging Resident B was emotionally abused. The complaint read that “abt 3 months ago”, staff were observed laughing in Resident A’s face and making her cry and read that on 7/8/24, administrator Karen Pleaugh emotionally abused Resident B by not allowing her to socialize with a staff member she was attached to. Due to the anonymous nature of the complaint, additional information could not be obtained.

On 8/21/24, I conducted an onsite inspection. I interviewed administrator and authorized representative Karen Pleaugh at the facility. Regarding Resident A, Ms. Pleaugh confirmed that there was an incident in which three staff members (Employees 3, 4, and 5) were observed making fun of her. Ms. Pleaugh provided staff statements that were collected following the event, however reported that two of the staff members (Employees 4 and 5) directly involved were not interviewed and were no longer employed at the facility due to unrelated circumstances.

Ms. Pleaugh's statement read:

> *On 4/27/24 at 3:20pm, myself & [Employee 1] approached [Resident A] about anything that happened to her involving care managers. [Resident A] stated that a dark complexion girl "antagonized her" and was talking behind her back. It upset her and made her mad. [Resident A] could not recall the date or the name of the care manager. She resides in the reminiscence neighborhood. She stated she is happy we are talking to this person.*

A second statement by Ms. Pleaugh read:

> *On 4/28/24, I spoke with [Employee 2]. She stated that she witnessed [Employee 3], [Employee 4] & [Employee 5] teasing [Resident A] and it made [Resident A] upset. The 3 care managers were talking and teasing and laughing at [Resident A] in front of her. [Employee 2] went in to calm [Resident A] down. [Resident A] had closed her door and put a chair in front of it. [Employee 2] got in and was able to calm [Resident A] down by listening and talking calmly.*

Employee 3's statement read:

> *It was me and [Employee 2] and [Employee 5] where [sic] in rem and [Employee 5] didn't believe that [Resident A] will get mad and started cussing so I said bow [sic] [Resident A] then I said you did that so she started cussing so [Employee 2] started calming her down that's when I started [sic] how sorry I am for doing that and also telling her I will not do that again cause [sic] it's not right I kept telling her I'm sorry so she can heel [sic] and know that I was just playing.*

Employee 6's statement read:

> *It was Saturday evening, (April 20, 2024), I was by the med cart in reminiscence, then I head a commotion outside of [Resident A's] room. [Resident A] was very upset, screaming & banging her door & her walker. She was also "bitching" & "swearing" and she said "she will call a police". I saw two care managers who were laughing. [Employee 2] said that the 2 care managers mocked [Resident A].*
>
> *I approached [Resident A] and tried to calm her down. I told her that "I'm going to report it to the management", so I called [Employee 2] that night.*

Regarding Resident B, Ms. Pleaugh confirmed that there was an incident on 7/8/24 involving Employee 7 that upset the resident. Ms. Pleaugh reported that Employee 7 had worked the midnight shift on 7/7/24 going into the morning of 7/8/24 and that her shift was scheduled to end at 6am, however she had stayed around for a few additional hours "tending to personal business". Ms. Pleaugh reported that during this time Employee 7 had stayed over past her shift, Resident B had asked her to provide some care to her. Ms. Pleaugh stated that she intervened and told

Employee 7 that she could not tend to Resident B because she was off the clock and should not still be in the building. Ms. Pleaugh stated that Employee 1 took care of Resident B's needs while she attempted to get Employee 7 to leave. Ms. Pleaugh stated that Resident B was upset, as she thought she had caused a conflict. Ms. Pleaugh stated that she and Employee 1 reassured the resident that she had not and explained that it was a liability for Employee 7 to help her when she was not technically working. Ms. Pleaugh stated that Resident B verbalized that she understood but acknowledged that she was a bit emotional. Ms. Pleaugh went on to state that Employee 7 was causing a scene and refused to leave the building, eventually having to be escorted out by the police.

Ms. Pleaugh provided staff statements that were collected following the event.

Employee 1's statement read:

> *I was in the wellness office when I saw [Employee 7] and Karen talking. I came out to assist a resident back into her room via w/c as she was propelling self in the hallway and was talking to [Employee 7]. I heard Karen ask [Employee 7] to leave the building if she was not currently working. [Employee 7] said that she was leaving but was just saying hi to above resident. After I took the resident back to her room, I saw [Employee 7] by the stairs telling me that she will not leave until Karen calls the police and she will not allow anyone to disrespect her. Karen called the police.*

Ms. Pleaugh's statement read:

> *On 7/8/24, around 9:15am, I witnessed [Employee 7] in the wellness area, talking on the landline phone. It sounded like a personal call to me. Her shift ended at 6am. In my mind, I questioned why she was still here. A resident approached her for help. I asked [Employee 7] to leave the building because her shift was over 3 hours ago. [Employee 7] asked why and what about the policy. I stated she was not on the clock and calmly asked her to leave. She stated she was going but then stood there. Again, she agreed with me as I asked her calmly please leave. She said she was not leaving & I should call the police. I went to my office and did that. [Employee 8] stayed with her as I called. [Officer 1] arrived. I explained the situation and that I want her out of the building. I sat downstairs with the officer (and 2 more arrived) talked with [Employee 7] after about 20 minutes, she was escorted out.*

Employee 6's statement read:

> *After giving a medication to a resident on the first floor, I went upstairs and found our ED & RCD talking to [Employee 7]. I heard [Employee 7] saying "Don't disrespect me because I respect you". After a few minutes, I saw 1 policeman came. When I passed by again, I saw 2 more policemen came. The next time I've seen [Employee 7] was already by the front porch with the police.*

Employee 8's statement read:

> *I [Employee 8] walked up the stairs on Jul 8th and heard Karen Pleaugh asking [Employee 7] to please leave the community. [Employee 7] became very upset and state I am not going anywhere, call the police. [Employee 7] then stated I will not fall into this trap you are creating. [Employee 7] also stated show me a policy. A resident was present during this altercation. I stayed in the area of employee until police arrived.*

| **APPLICABLE RULE** | |
|---|---|
| **MCL 333.20201** | **Policy describing rights and responsibilities of patients or residents;** |
| | **(1) A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization, which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.** |
| **ANALYSIS:** | Facility staff failed to treat Resident A with dignity and respect consistent with the provisions of care outlined in public health code statute by intentionally antagonizing her, causing her to become visibly upset 4/20/24. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

During her interview onsite, Ms. Pleaugh reported that an incident report was not completed on the event pertaining to Resident A and the emotional distress caused by staff antagonizing her.

| APPLICABLE RULE | |
|---|---|
| **R 325.1924** | **Reporting of incidents, accidents, elopement.** |
| | **(5) Records must be maintained that demonstrate incident reporting to the team, analyses, outcomes, corrective action taken, and evaluation to ensure that the expected outcome is achieved. These records must be maintained for 2 years.** |
| **For Reference R 325.1901** | **(k) "Incident" means an intentional or unintentional event including, but not limited to, elopements and medication errors, where a resident suffers physical or emotional harm.** |
| **ANALYSIS:** | The licensee could not demonstrate that an incident report was completed on the 4/20/24 incident involving Resident A. Corrective measures pertaining to the incident could not be confirmed or evaluated. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no changes to the status of the license at this time.

09/03/2024

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

09/10/2024

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