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 #: 2024A1019061
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 #:	2024A1019061
Complaint Receipt Date:	08/08/2024
Investigation Initiation Date:	08/08/2024
Report Due Date:	10/07/2024
Licensee Name:	Welltower OpCo Group LLC
Licensee Address:	4500 Dorr Street 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 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 ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident C was neglected, contributing to his death.	Yes
The facility is understaffed.	No
Additional Findings	Yes

III. METHODOLOGY

08/08/2024	Special Investigation Intake 2024A1019061
08/08/2024	Special Investigation Initiated - Letter Notified APS of the allegations.
08/08/2024	APS Referral
08/21/2024	Inspection Completed On-site
08/21/2024	Inspection Completed BCAL Sub. Compliance

The complaint identified some concerns that were already investigated under special investigation report [SIR] 2024A0585024 and will not be addressed in this report.

ALLEGATION:

Resident C was neglected, contributing to his death.

INVESTIGATION:

On 8/8/24, the department received a complaint alleging that Resident C died as a result of staff's negligence towards him. The complaint alleged that Resident C had multiple falls because staff didn't tend to him. After his last fall, the complainant alleged that Resident C didn't survive the surgery needed to repair is injuries. The complaint alleged that staff did not adhere to safety measures put into place to help prevent the falls and did not provide sufficient monitoring to Resident C. 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. Ms. Pleaugh reported that Resident C resided in the memory care unit due to his dementia diagnosis and

cognitive decline. Ms. Pleaugh reported that staff conduct safety checks on memory care residents at least every two hours, but those checks are not documented. Ms. Pleaugh reported that Resident C was ambulatory with a walker and stand by assistance from staff. Ms. Pleaugh reported that Resident C had documented falls on 6/24/24 and 7/9/24 and confirmed that Resident C passed away at the hospital after having surgery following a fall on 7/9/24.

Resident C's service plan was reviewed. The service plan dated 7/1/24 instructed the following:

- *"Check on me at frequent intervals (3-4x a shift) to see if I need any assistance and offer me reassurance."*
- *"I need a walker to assist with mobility. Observe and report any changes in my mobility. I need physical assist of 1 person with mobility.*
- *"I need 1 person physical assistance to the bathroom."*

While onsite, Ms. Pleaugh provided supporting documentation pertaining to the abovementioned falls. On 6/24/24, staff documented *"Resident was yelling this morning in his room. When the RCC arrives resident was observed wrapped up in his blankets laying face down on the floor with blood coming from his nose. Evaluated resident for other injurys [sic] and none was found. Helped the resident sit up against his bed*." The documentation read that 911 was called and he was taken to the emergency room.

On 7/9/24, staff documented "*Found resident on the floor in his bathroom ask [sic] for help. I yelled for another caregiver to assist me. Resident informed me that his right leg and head hurts. We helped resident sit on toilet and asked if he was okay. Resident stated that he fell. I stayed with resident until another caregiver was told how to proceed then I left resident in care of another caregiver."* The documentation read that 911 was called and he was taken to the emergency room; however, he did not return.

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.
For Reference R 325.1901	**(1)(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:	Resident C's service plan was not followed on 7/9/24, as he was not assisted to the bathroom and subsequently sustained a fall with injury.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED**

ALLEGATION:

The facility is understaffed.

INVESTIGATION:

On 8/8/24, the department received a complaint alleging that there is not enough staff at the facility. The complaint alleged that residents are left unattended and are neglected, however did not provide any specific examples of this. No dates or shifts were listed to demonstrate understaffing. Due to the anonymous nature of the complaint, additional information could not be obtained.

Ms. Pleaugh reported that staffing is sufficient to meet the needs of the residents at their current census and acuity level. While onsite, I was provided a resident roster which listed 31 residents (25 in the general assisted living area and 6 in memory care). Ms. Pleaugh reported that 13 of the residents receive their lowest, base level care meaning they do not require staff assistance with completion of activities of daily living (ADLs) or personal care tasks and only one resident who requires two staff persons to assist with transferring. Ms. Pleaugh reported that med passers are scheduled daily from 6am-2pm and from 2pm-10pm. She reported that there is also a lead care manger that is onsite to pass meds as needed. Ms. Pleaugh reported that care staff are scheduled on three shifts (6am-2pm, 2pm-10pm and 10pm-6am). In total, Ms. Pleaugh reported that being fully staffed consists of four staff (med passing and care) on first and second shift and three staff on third shift. Ms. Pleaugh reported that in addition to the care and med passing staff, the resident care coordinator, resident care director and herself are available and on call to assist when needed. While there are no formal coverage procedures such as shift mandates, Ms. Pleaugh explained that there are staff that are frequently willing to pick up shifts if there is an unexpected staffing shortage, that management will ask staff from the previous shift to stay and work over and reported that there is an employee list that management use to contact other staff to come in and provide coverage if needed.

During my onsite, I obtained staff schedules for the previous four weeks. Staffing levels observed were overall consistent with the levels described by Ms. Pleaugh.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	Staff attestation combined with review of staff schedules and employee coverage procedures reveal that staffing levels are sufficient to meet the needs of the residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

While onsite, Ms. Pleaugh reported that the facility schedules are not updated to reflect when changes to the scheduled staff occur, such as when there is a call off or when staff switch shifts. However, in follow up correspondence, Ms. Pleaugh reported that the schedules are updated in real time but confirmed that for three dates (8/3/24, 8/4/24 and 8/17/24), the schedules did not accurately reflect care and/or med passing staff present.

APPLICABLE RULE	
R 325.1944	**Employee records and work schedules.**
	(2) The home shall prepare a work schedule showing the number and type of personnel scheduled to be on duty on a daily basis. The home shall make changes to the planned work schedule to show the staff who actually worked.
ANALYSIS:	Facility schedules were not updated on three occasions during the timeframe reviewed to demonstrate care and med passing staff working.
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.

09/04/2024

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Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

09/10/2024

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