GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 20, 2024

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

RE: License #: AL500402309
Investigation #: 2024A0617028
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, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
3026 W Grand Blvd.
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 #:	2024A0617028
Complaint Receipt Date:	07/14/2024
Investigation Initiation Date:	07/14/2024
Report Due Date:	09/12/2024
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:	06/15/2024
Expiration Date:	06/14/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was found on the floor by staff with bruises and blood on her face	Yes

III. METHODOLOGY

07/14/2024	Special Investigation Intake 2024A0617028
07/14/2024	APS Referral Adult Protective Services (APS) referral received - assigned worker Heather Horan
07/14/2024	Special Investigation Initiated - Telephone TC with Ms. Horan
07/16/2024	Inspection Completed On-site I conducted an unannounced investigation of the Sunnydale Assisted Living & Memory Care facility. I interviewed staff Bianca Thorman, Chanice Gilbert, facility head nurse Patricia Conner, executive director Brian Radyko, and Licensee Designee Rita Kumar.
07/16/2024	Contact - Document Received Email received from Mr. Radyko with staff files
08/06/2024	Contact - Telephone call made TC to Tyeisha Houston
08/06/2024	Contact - Telephone call made TC to Taylor Burnett
08/27/2024	Contact - Telephone call made TC to Resident A daughter
08/27/2024	Contact - Telephone call made TC to Resident A son
08/28/2024	Contact - Telephone call received TC from Ms. T. Houston

08/28/2024	Exit Conference I conducted an exit conference with licensee designee Rita Kumar to discuss the findings of this report.

ALLEGATION:

Resident A was found on the floor by staff with bruises and blood on her face.

INVESTIGATION:

On 07/14/24, I received a complaint on the Sunnydale Assisted Living & Memory Care facility. The complaint stated on 06/23/2024 Resident A fell and was left on the floor unattended for several hours.

On 07/14/24, I interviewed Adult Protective Services worker Heather Horan. According to Ms. Horan, Resident A fell during the night shift on 06/22/24 and was left on the floor for several hours without staff noticing. Ms. Horan stated that Resident A was discovered the next morning by staff and was sent to the hospital.

On 07/16/24, I conducted an unannounced investigation of the Sunnydale Assisted Living & Memory Care facility. I interviewed staff Bianca Thorman, Chanice Gilbert, facility head nurse Patricia Conner, executive director Brian Radyko, Resident A and Licensee Designee Rita Kumar.

During the onsite investigation, Head nurse Ms. Patricia Conner came to the facility to assist with the investigation and stated that the resident files were located in her office because she pulled them to work on them and bring them into compliance. We went to her office to review the files and Resident A's file was blank with no required AFC forms completed.

During the onsite investigation, I reviewed an incident report dated 07/02/24 regarding Resident A. According to the incident report, on 06/23/24, Resident A was found laying in the fetal position in the middle of her bedroom floor at 7:20am by Bianca Thorman Med Tech. According to the incident report, Resident A was sent to the hospital and her daughter was contacted. The incident report was completed by Biance Thorman on 07/02/24.

During the onsite investigation, I reviewed the staff schedule for June and July 2024. According to the schedule, on 6/22/24, staff Taylor Burnett worked from 11pm to 7am. According to the schedule, on 06/23/24, staff Bianca Thorman, Tyeisha Houston, and Stephanie Winters worked from 7am to 3pm. The staff schedules also indicated that there were no staff at the Sunnydale facility from 11pm to 7am on the following dates:

- 6/7/24, 6/20/24, 6/24/24, 6/30/24, 7/1/24, 7/2/24, 7/8/24, 7/15/24

During the onsite investigation, I interviewed staff Bianca Thorman. According to Ms. Thorman, on 06/23/24, she was scheduled to work from 7am to 3pm but she was 20 minutes late and arrived at 7:20am. When she arrived the midnight staff told her that Resident B had been up all night and was currently sitting in the living room. The midnight staff told Ms. Thorman that Resident B needed to be put to bed. While Ms. Thorman was taking Resident B to her room, staff Tyiesha Houston yelled for Ms. Thorman to come to the bedrooms because Ms. Houston found Resident A laying on the floor. Ms. Thorman stated that she observed Resident A laying in the fetal position in the middle of the bedroom floor. Ms. Thorman stated that Resident A's face was bloody and very bruised. Resident A told Ms. Thorman that she was going to get her coat for church. Ms. Thorman then called EMS and Resident A's family. Ms. Thorman stated that the EMS worker told her that Resident A had been on the floor for a long time.

During the onsite investigation, I interviewed staff Chanice Gilbert. According to Ms. Gilbert, she was not working on the day of the incident, but she heard from other staff that Resident A fell on the floor and was found by morning staff.

During the onsite investigation, I interviewed Resident A. According to Resident A, she was not in any pain at the time. Resident A could not recall what led to her being on the floor the night of the incident. I observed Resident A's face to be very bruised around

According to Mr. Radyko, Resident A fell, and the facility followed the proper protocols. Mr. Radyko stated that a resident can fall at any time and the facility cannot be responsible to watch every resident every minute of the day. Mr. Radyko stated that some of the employees are brought in by a third party agency called Kare and the facility is not in possession of those staff files. Mr. Radyko stated that he would have to contact Kare to retrieve staff files. Mr. Radyko provided me with a copy of the Resident Registry and the Registry was inaccurate.

On 07/16/24, I received and reviewed staff files for Taylor Burnett, Shailynn Prince, Dahila Patterson, and Marlon Williams. These staff members are staff from a third party agency called Kare. According to the files staff Taylor Burnett, Shailynn Prince, Marlon Williams and Dahila Patterson were missing the following required AFC documents:

- Verification of experience, education, and training.
- Verification of reference checks.
- Beginning and ending dates of employment.
- Medical information, as required.
- Required verification of the receipt of personnel policies and job descriptions.
- Mr. Marlon William's file was also missing a completed background check.

On 08/06/24, I interviewed staff Taylor Burnett. According to Ms. Burnett, she did not work on 06/22/24 at the Sunnydale facility but worked at the Riverdale facility, despite the staff schedule indicating that she worked on 06/22/24 from 11pm to 7am at

Sunnydale. Ms. Burnett stated that the schedules are not accurate most of the time. Ms. Burnett stated that she has not had any resident falls or incidents on any of the shifts she worked at either facility.

On 08/28/24, I interviewed staff Tyeisha Houston. According to Ms. Houston, she worked the morning shift on 6/23/24. Ms. Houston stated that she was doing her morning rounds per usual, and she found Resident A laying on the floor. Ms. Houston yelled for Ms. Thorman to come to the bedrooms for assistance with tending to Resident A. Ms. Houston stated that she observed Resident A laying in the fetal position in the middle of the bedroom floor. Ms. Houston stated that Resident A's face was bloody and very bruised. Resident A told Ms. Houston that she was cold. Ms. Houston stated that Resident A was very confused and disoriented. Ms. Thorman then called EMS and Resident A's family.

On 08/28/24, I Interviewed Resident A's son. According to Resident A's son, he was unaware of his mother's fall in June. His sister is the contact person for his mother, so she was probably the one who was notified. Resident A's son stated that his mother passed away approximately two weeks ago.

On 08/28/24, I conducted an exit conference with licensee designee Rita Kumar to discuss the findings of this report. Ms. Kumar did not answer; therefore, a voicemail was left.

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 did not treat and care for Resident A with dignity and her personal needs, including protection and safety, have not been attended to at all times in accordance with the provisions of the act. According to staff Ms. Thorman and Ms. Houston, Resident A was found laying on her bedroom floor with a bruised and bloody face. It is unknown how long Resident A was left on the floor unattended. Also, it is unknown who worked the midnight shift prior to Ms. Thorman and Ms. Houston arrival on 6/23/24. The staff schedule provided by the facility during the onsite investigation, Ms. Taylor Burnett worked. However, Ms. Burnett denied working at the Sunnydale facility on 06/22/24, and instead worked at the Riverdale facility. The extent of Resident A's injuries led her to be sent to the hospital. The exact nature of Resident A's injuries are unknown

	because the facility failed to provide any medical documentation for Resident A's injuries.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2024A0617025 and CAP dated 08/23/24**

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain individuals providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; determination of existence of national criminal history; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.**
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall notemploy or independently contract with an individual who has direct access to residents until the adult fostercare facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a

	relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.
ANALYSIS:	On 07/16/24, I received and reviewed staff file for Marlon Williams. Mr. Marlon William's file was missing a completed background check.
CONCLUSION:	**VIOLATION 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 June 2024 to July 15th, 2024, the facility does not schedule med techs during the night shift. Also, there were no staff scheduled for the midnight shift on 6/7/24, 6/20/24, 6/24/24, 6/30/24, 7/1/24, 7/2/24, 7/8/24 and 7/15/24.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR # 2024A0617025 and CAP dated 08/23/24**

APPLICABLE RULE	
R 400.15201	**Qualifications of administrator, direct care staff, licensee, and members of household; provision of names of employee, volunteer, or member of household on parole or probation or convicted of felony; food service staff.**
	(9) A licensee and the administrator shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, social, and intellectual needs of each resident.**

ANALYSIS:	During the past months, the Sunnydale facility has had a renewal inspection and three special investigations which all concluded with severe violations. Ms. Kumar has failed to bring the facility into compliance with AFC rules and regulations. I have provided Ms. Kumar with technical assistance on numerous occasions however, she has remained hands off from the facility. Ms. Kumar has hired multiple people to run the day-to-day operations of the facility and has not taken responsibility to rectify the violations. The residents continue to suffer as a result. Ms. Kumar has failed to demonstrate that she is suitable to meet the physical, emotional, and intellectual needs of each resident.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**
ANALYSIS:	On 07/16/24, I received and reviewed staff files for Taylor Burnett, Shailynn Prince, Dahila Patterson, and Marlon Williams. These staff members are staff from a third party agency called Kare. According to the files, staff Taylor Burnett, Shailynn Prince, Marlon Williams and Dahila Patterson were missing all required AFC trainings.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15208	**Direct care staff and employee records.**
	(1) A licensee shall maintain a record for each employee. The record shall contain all of the following employee information: **(e) Verification of experience, education, and training.** **(f) Verification of reference checks.** **(g) Beginning and ending dates of employment.** **(h) Medical information, as required.** **(i) Required verification of the receipt of personnel policies and job descriptions.**
ANALYSIS:	On 07/16/24, I received and reviewed staff files for Taylor Burnett, Shailynn Prince, Dahila Patterson, and Marlon Williams. These staff members are staff from a third party agency called Kare. According to the files staff Taylor Burnett, Shailynn Prince, Marlon Williams and Dahila Patterson were missing the following required AFC documents: -Verification of experience, education, and training. -Verification of reference checks. -Beginning and ending dates of employment. -Medical information, as required. -Required verification of the receipt of personnel policies and job descriptions.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.** **(b) Job titles.** **(c) Hours or shifts worked.** **(d) Date of schedule.** **(e) Any scheduling changes.**

ANALYSIS:	According to Mr. Radyko, the staff are expected to initial next to their name on the schedule to indicate that they worked. However, there are times when staff forget to initial. I reviewed the staff schedule for June and July 2024 and the schedule was missing a multitude of initials, therefore making it impossible to verify who actually worked. On 08/06/24, I interviewed staff Taylor Burnett. According to Ms. Burnett, she did not work on 06/22/24 at Sunnydale but she worked at Riverdale during that time. The staff schedule Indicated that she worked on 06/22/24 from 11pm to 7am at Sunnydale. Ms. Burnett stated that the schedules are not accurate most of the time.
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 an accurate resident register.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR # 2024A0617025 and CAP dated 08/23/24**

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, Head nurse Ms. Patricia Conner came to the facility to assist with the investigation and stated that the resident files were located in her office because she pulled them to work on them and bring them into compliance. We went to her office to review the files and Resident A's and several other resident files were blank with no required AFC forms completed.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR # 2024A0617025 and CAP dated 08/23/24**

IV. RECOMMENDATION

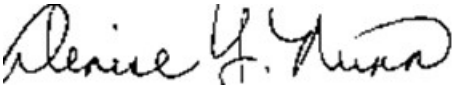
A provisional license was accepted and recommended in Special Investigation Reports #2024A0617016 and #2024A0617025, which remains in effect.

Contingent upon receipt of an acceptable corrective action plan I recommend continuance of the current 1st provisional license.

08/28/24

Eric Johnson Date
Licensing Consultant

Approved By:



09/20/2024

Denise Y. Nunn Date
Area Manager