GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 13, 2024

Lynn McKenzie
Brookdale Senior Living Communities, Inc.
Suite 2300
6737 West Washington St.
Milwaukee, WI 53214

RE: License #: AL730079392
Investigation #: 2024A0576053
Brookdale Saginaw MC

Dear Lynn McKenzie:

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.
- 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. Failure to submit an acceptable corrective action plan will result in disciplinary action.

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) 643-7960.

Sincerely,

Christina Garza, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 240-2478

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL730079392
Investigation #:	2024A0576053
Complaint Receipt Date:	08/05/2024
Investigation Initiation Date:	08/08/2024
Report Due Date:	10/04/2024
Licensee Name:	Brookdale Senior Living Communities, Inc.
Licensee Address:	Suite 2300 6737 West Washington St., Milwaukee, WI 53214
Licensee Telephone #:	(615) 221-2250
Administrator:	Lynn McKenzie
Licensee Designee:	Lynn McKenzie
Name of Facility:	Brookdale Saginaw MC
Facility Address:	2445 McCarty Road, Saginaw, MI 48603
Facility Telephone #:	(989) 249-7300
Original Issuance Date:	01/12/1998
License Status:	REGULAR
Effective Date:	12/21/2022
Expiration Date:	12/20/2024
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS, AGED

II. ALLEGATION(S)

	Violation Established?
Staff forcefully took Resident A's clothes off to shower her. Staff hit Resident A across the face causing redness.	Yes

III. METHODOLOGY

08/05/2024	Special Investigation Intake 2024A0576053
08/05/2024	APS Referral
08/08/2024	Special Investigation Initiated - On Site Interviewed Suenae Blankenship, Health and Wellness Director, and Resident A
09/05/2024	Contact - Telephone call made Interviewed Staff, Angela Burnside
09/05/2024	Contact - Telephone call made Left message for Relative A to return call
09/06/2024	Contact - Telephone call made Interviewed Katie Parker, Covenant Hospice Supervisor
09/06/2024	Contact - Telephone call made Interviewed Nicole Tracy, Covenant Certified Nursing Assistant (CNA)
09/13/2024	Contact - Telephone call made Interviewed Licensee Designee, Lynn McKenzie
09/13/2024	Exit Conference

ALLEGATION:

Staff forcefully took Resident A's clothes off to shower her. Staff hit Resident A across the face causing redness.

INVESTIGATION:

On August 8, 2024, I completed an unannounced on-site inspection at Brookdale Saginaw MC and interviewed Suenae Blankenship, Health and Wellness Director. Director Blankenship reported that the Licensee Designee, Lynn McKenzie received a call from Covenant Hospice personnel as they have staff that comes to the facility to provide Resident A showers. Licensee Designee McKenzie was told that Resident A did not want to shower, and the certified nursing assistant (CNA) from hospice, Nicole Tracy went to Staff, Angela Burnside for assistance. CNA Tracy witnessed Staff Burnside become aggressive with Resident A and witnessed Staff Burnside slap Resident A in the fact. Staff Burnside was immediately removed from providing care to the residents and an investigation was commenced. Staff Burnside was interviewed, and she reported that Resident A slapped her, and she denied slapping Resident A. Staff Burnside stated she grabbed Resident A's wrist in response to being slapped. Staff Burnside was removed from the schedule pending completion of the investigation and subsequently turned in her badge. Resident A was interviewed, and she was unable to verbalize what occurred. Resident A is verbal however what she says is not coherent. Resident A was examined immediately after the incident and petechiae was noted on her left cheek. Director Blankenship advised that Resident A has dementia.

On August 8, 2024, I interviewed Resident A in her room. Resident A was resting in her bed and appeared well. Resident A looked comfortable and did not appear to be under any duress. Resident A was asked how long she has lived at the home, and she stated, "all the time". Resident A was asked if she likes living at her home and she stated, "it depends". Resident A was asked if she felt safe at her home, and she stated "sometimes". Resident A was asked if she had any issues with staff and she stated, "not sure what". Resident A responded to other questions and made other statements however the statements were not coherent. The interview was concluded.

On August 8, 2024, I reviewed Resident A's Health Care Appraisal. Resident A is 82 years old and was noted to be "well groomed and pleasantly confused." Resident A has a diagnosis of Alzheimer's Disease. I reviewed Resident A's service plan which revealed AFC staff will assist with toileting and hospice will complete showers for Resident A.

On August 8, 2024, I reviewed an AFC Licensing Division Incident / Accident Report (IR). The IR was authored by Suenae Blankenship and dated for July 30, 2024. The IR documented that on July 30, 2024, the executive director was notified by Covenant Hospice manager that their aide reported witnessing a Brookdale care associate slap a resident across the face while assisting her with a shower. The associate was removed from resident care and suspended pending investigation. The resident was examined by Health and Wellness Director Suenae Blankenship. Corrective measures include retraining of staff regarding abuse/neglect and specific to memory care residents when reluctant to receive care.

On September 5, 2024, I interviewed Staff Angela Burnside regarding the allegations. Staff Burnside reported that Resident A has a shower aide that helps give her baths. Staff Burnside was helping the shower aide give Resident A a bath because the aide cannot do it by herself as Resident A is combative. Staff Burnside sat Resident A down on the toilet so she could use the restroom. Resident A slapped Staff Burnside in the face when she tried to take Resident A's pants off. Staff Burnside grabbed Resident A's hand, held it above her head, and told her not to hit her. Staff Burnside denied hitting Resident A as alleged. Staff Burnside left the bathroom and told the shower aide who was in the bathroom that she would have to shower Resident A on her own. Staff Burnside reported that after the incident with Resident A she told Suenae Blankenship what occurred.

On September 5, 2024, I left a message for Relative A to return call.

On September 6, 2024, I interviewed Katie Parker, Covenant Hospice Supervisor. Supervisor Parker reported that CNA Nicole Tracy called her to report that she had just witnessed Brookdale Saginaw MC Staff slap Resident A. Supervisor Parker called Licensee Designee, Lynn McKenzie to report the incident.

On September 6, 2024, I interviewed CNA Nicole Tracy. CNA Tracy explained that Resident A has dementia. When CAN Tracy A got to the facility to bathe Resident A, she was in bed. CNA Tracy asked Staff, Angela Burnside to help her get Resident A out of bed. Resident A became combative with the staff. Staff Burnside got Resident A to the bathroom and was forcefully taking Resident A's clothes off. Resident A was saying "no, no, no!" And Resident A did not want her clothes off. Resident A slapped Staff Burnside in the face and then Staff Burnside slapped Resident A in the face. Resident A did not respond after being hit. CNA Tracy did not know if Staff Burnside held Resident A's hand up at any time. Staff Burnside then left the area telling CNA Tracy she can deal with Resident A.

On September 13, 2024, I interviewed Licensee Designee, Lynn McKenzie regarding the allegations. Licensee Designee McKenzie stated she received a call that Staff, Angela Burnside slapped Resident A. An investigation was commenced immediately, and Staff Burnside was out of the facility within an hour of the incident. Staff Burnside has been terminated and is not re-hirable.

I conducted an exit conference with Licensee Designee, Lynn McKenzie and advised her I would be requesting a corrective action plan for the cited rule violation. Licensee Designee stated staff received training regarding this incident and she will provide me the documentation.

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:	It was alleged that staff was forceful with Resident A and slapped her in the face. Upon conclusion of investigative interviews, there is a preponderance of evidence to conclude a rule violation. Resident A was interviewed however many of her statements were incoherent. Nicole Tracy, Resident A's shower aide was interviewed and stated Staff, Angela Burnside was aggressive with Resident A and slapped her in response to being slapped by Resident A. According to Health and Wellness Director, Suenae Blankenship, Resident A was examined immediately after being hit and Resident A had petechiae on her face. There is a preponderance of evidence to conclude Resident A was not treated with dignity and her safety and protection was not adhered to at all times.
CONCLUSION:	**VIOLATION ESTABLISHED**

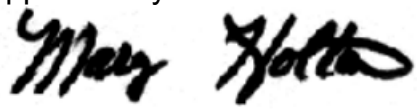
IV. RECOMMENDATION

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

9/13/2024

Christina Garza Date
Licensing Consultant

Approved By:



9/13/2024

Mary E. Holton Date
Area Manager