GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 18, 2024

Hemant Shah
Cranberry Park West Bloomfield LLC
25500 Meadowbrook Rd, Suite 230
Novi, MI 48375

RE: License #: AH630402042
Investigation #: 2025A1027002
Cranberry Park 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.

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 877-458-2757.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630402042
Investigation #:	2025A1027002
Complaint Receipt Date:	10/03/2024
Investigation Initiation Date:	10/04/2024
Report Due Date:	12/02/2024
Licensee Name:	Cranberry Park West Bloomfield LLC
Licensee Address:	Suite 230 25500 Meadowbrook Rd Novi, MI 48375
Licensee Telephone #:	(248) 692-4355
Administrator:	Pamela Skatzka
Authorized Representative:	Hemant Shah
Name of Facility:	Cranberry Park of West Bloomfield
Facility Address:	2450 Haggerty Rd West Bloomfield, MI 48323
Facility Telephone #:	(248) 671-4204
Original Issuance Date:	03/10/2022
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	53
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was left in his wheelchair.	No
Morphine was given late.	Yes
Additional Findings	No

The complaint alleged one aide was working each hallway which was investigated in Special Investigation Report 2024A1027094.

III. METHODOLOGY

10/03/2024	Special Investigation Intake 2025A1027002
10/04/2024	Special Investigation Initiated - Letter Email sent to Pamela Skatzka and Hemant Shah requesting information pertaining to allegations
10/04/2024	Contact - Document Received Email received from Pamela Skatzka with requested information
10/10/2024	Inspection Completed On-site
10/11/2024	Contact - Document Sent Email sent to Ms. Skatzka requesting additional documentation
10/11/2024	Contact - Document Received Email received from Ms. Skatzk with requested documentation
10/11/2024	Inspection Completed-BCAL Sub. Compliance
10/17/2024	Exit Conference Conducted by email with Hemant Shah and Pamela Skatzka

ALLEGATION:

Resident A was left in his wheelchair.

INVESTIGATION:

On 10/3/2024, the Department received a complaint via the online system stating that Resident A (only the first name was provided) was left in a wheelchair for 24 hours. Due to the anonymous nature of the complaint, I was unable to obtain additional information from the complainant.

On 10/4/2024, email correspondence with Ms. Skatzka revealed that there were two residents with the first name mentioned in the complaint, both of whom used wheelchairs.

On 10/10/2024, I conducted an on-site inspection and interviewed staff.

Administrator Pamela Skatzka confirmed that both residents shared the same first name. She explained that Resident A resided in memory care and received hospice services and passed away on 10/3/2024. Ms. Skatzka noted that Resident A used a wheelchair for mobility, and his family visited frequently during his final days. She stated that after his passing, Resident A's family expressed their gratitude for the care provided and had no complaints.

Regarding Resident B, Ms. Skatzka indicated he lived in assisted living and had not raised any complaints about his care. She mentioned that Resident B preferred to wake up at 6:00 AM each day and sometimes went to bed late. While it may have seemed, he was in his wheelchair for an extended period, staff members conduct rounds every two hours to check on residents and would assist him into bed upon request. Additionally, all residents had call pendants to summon staff for assistance at any time.

Statements from Employees #1 and #2 were consistent with Ms. Skatzka's account.

Resident B indicated he had no concerns about his care and felt that some staff provided excellent service.

Resident A's service plan read consistent with staff statements.

Resident A's service plan aligned with staff statements, as did Resident B's, which noted that he occasionally refused to go to bed and would fall asleep in his wheelchair, making it challenging for staff to assist him.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**

ANALYSIS:	It could not be determined whether the allegations referred to Resident A or Resident B; however, staff and resident testimonies, along with a review of documentation, indicated that this allegation could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Morphine was given late.

INVESTIGATION:

On 10/3/2024, the Department received a complaint through the online system indicating that medications, specifically morphine, were administered two to three hours late.

On 10/10/2024, I conducted an on-site inspection and interviewed staff.

Administrator Pamela Skatzka and Employee #1 confirmed that Resident C was the only resident receiving morphine around the clock, while Resident B had also been prescribed morphine prior to passing away.

Employee #2's statements aligned with those of previous staff. She noted that Resident C's morphine was scheduled for administration every three hours. Employee #2 explained that medications could be given one hour before or after their prescribed time; however, she aimed to administer Resident C's morphine either on schedule or shortly afterward. Other residents may have morphine prescribed as needed, but they were not currently receiving it.

Resident C reported that staff were attentive to his medications and administered them on time, including morphine.

A review of Resident A’s medication administration records (MARs) for September and October 2024 indicated that one or more doses of morphine were left blank on 9/26/2024, 9/27/2024, and 10/1/2024. Similarly, Resident C’s MARs showed one or more doses of morphine were blank on 9/2/2024, 9/3/2024, 10/1/2024, and 10/4/2024. Review of Residents A and C’s Controlled Drug Receipt/Record/Disposition Forms revealed staff signed the Morphine as administered for those specific dates.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.
	(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following:
	(b) Complete an individual medication log that contains all of the following information: **(v) The initials of the individual who administered the prescribed medication.**
ANALYSIS:	While staff and resident accounts indicated that morphine was administered on time, the medication administration records did not consistently reflect that staff initialed the doses as given. Therefore, this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of this license remain unchanged.

Jessica Rogers 10/14/2024

Jessica Rogers Date
Licensing Staff

Approved By:

Andrea L. Moore 10/15/2024

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