GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 29, 2025

Sonya Boulier
Sunrise Assisted Living of Troy
6870 Crooks Rd
Troy, MI 48098

RE: License #: AH630399616
Investigation #: 2025A0784039
Sunrise Assisted Living of Troy

Dear Sonya Boulier:

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 responsible party 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.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 335-5985.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630399616
Investigation #:	2025A0784039
Complaint Receipt Date:	03/19/2025
Investigation Initiation Date:	03/20/2025
Report Due Date:	05/19/2025
Licensee Name:	SZR Troy Assisted Living Opco, L.L.C.
Licensee Address:	Suite 200 500 N. Hurstbourne Pkwy Louisville, KY 40222-3301
Administrator/Authorized Representative:	Sonya Boulier
Name of Facility:	Sunrise Assisted Living of Troy
Facility Address:	6870 Crooks Rd Troy, MI 48098
Facility Telephone #:	(248) 293-1200
Original Issuance Date:	01/01/2020
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	80
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Inadequate resident protection	Yes
Additional Findings	No

III. METHODOLOGY

03/19/2025	Special Investigation Intake 2025A0784039
03/20/2025	Special Investigation Initiated - On Site
03/20/2025	Inspection Completed On-site
03/20/2025	Exit Conference Conducted with administrator/Authorized Representative

ALLEGATION:

Inadequate resident protection

INVESTIGATION:

On 3/19/2025, the department received this online complaint.

According to the complaint, on 3/12/2025, Resident A, who was wheelchair bound, was assaulted by another resident in the common area of the memory care (MC). Resident A was found, after screaming for help, on the floor with her wheelchair tipped over and the other resident standing over her. Resident A ended up with a bump on the back of her head, a bruise on her chin where she was struck, causing her teeth to go through her lip, and defensive bruises on her arms, wrists and hands. Resident A was taken by ambulance to Troy Beaumont Hospital and released back to the facility 12 hours later. On 3/14, Resident A was rushed back to the hospital. She ended up in hospice and passed away on 3/16.

On 3/20/2025, I interviewed staff 1 at the facility. Staff 1 stated she worked in the MC on the morning of the incident, 3/12/2025. Staff 1 stated that on that morning, Resident A started the day very agitated and vocal which she stated was not normal for Resident A during the morning hours. Staff 1 stated Resident A used a wheelchair and was very self-ambulatory in her chair. Staff 1 stated that on the morning of 3/12/2025, Resident A went into the dining area where Resident B was

sitting. Staff 1 stated Resident A approached Resident B and started saying over and over to him “you shouldn't take my car”. Staff 1 stated Resident A does not drive and appeared to be having a lapse in memory. Staff 1 stated she approached Resident B and asked if he would not mind going into his room where she stated he sometimes liked to be. Staff 1 stated she was concerned that Resident B might get upset. Staff 1 stated Resident B went to his room at first. Staff 1 stated Resident B came out of his room shortly after so she asked if he would sit in the common area where the tv was and he did. Staff 1 stated she also put a barrier of chairs between where Resident A was and where Resident B was sitting in the common area to deter Resident A from approaching him. Staff 1 stated she then went into another resident room across from the common area to assist that resident. Staff 1 stated while she was in that room, she could hear Resident A again asking Resident B about the car at which time she noticed Resident A’s voice suddenly stopped. Staff 1 stated that when Resident A’s voice stopped, she came out of the room she was in and saw Resident B standing in front of Resident A looking down at her while Resident A was looking up at him. Staff 1 stated that Resident B then punched Resident A twice, first with his right hand then his left, then grabbed her chair and flipped it back and to the side. Staff 1 stated she yelled for Resident B to stop and that he did and looked at her. Staff 1 stated she was scared as Resident B was “pretty big and strong”. Staff 1 stated she motioned for Resident B to go to his room. Staff 1 stated she did not say anything at that time and that Resident B kept saying “she is out of her mind”. Staff 1 stated she called 911 and that administration contacted Resident B’s daughter who came to the facility and stayed with him until he was transferred to the hospital. Staff 1 stated Resident A was taken to the hospital and brought back the same night after being evaluated. Staff 1 stated Resident A was diagnosed with a UTI which she stated explained why Resident A was not herself that morning. Staff 1 stated the next morning; she noticed Resident A was very quiet. Staff 1 stated this was not normal for Resident A and that she was normally very talkative and “bubbly”. Staff 1 stated Resident A was taken back to the hospital due to a high fever and low blood pressure. Staff 1 stated Resident A did not return to the facility after that. Staff 1 stated Resident B had moved to the MC from the assisted living (AL) side of the facility approximately 3 months earlier. Staff 1 stated she had heard that he had hit other residents in the AL prior to being moved to the MC. Staff 1 stated she had personally witnessed a time when Resident B was verbally threatening to another resident. Staff 1 stated the resident, who she stated was female, appeared to like Resident B and asked if she could touch his beard. Staff 1 stated Resident B appeared to become very irritated and responded “not if you want to keep your hand”. Staff 1 stated she had been concerned about Resident B since he was in MC as he displayed a very short and irritable temperament. Staff 1 stated she was concerned about the possibility of something happening between Resident B and another resident due to his temperament and that she reported this concern to a supervisor, staff 2. Staff 2 stated the concern was also due to the fact that Resident A was very strong and physically able to harm someone. Staff 1 stated Resident B regularly displayed irritation with other residents and even recently had an incident of aggression toward staff 3. Staff 1 stated Resident B has not returned to the facility.

On 3/20/2025, I interviewed staff 3 at the facility. Staff 3 provided statements similar to staff 1 regarding Resident B's noticeable temperament. Staff 3 stated that Resident B was moved to the MC approximately 2 to 3 months ago due to having behavior issues. Staff 3 stated Resident B was apparently forgetting where he was at and reportedly hitting staff and residents. Staff 3 stated that approximately one month ago, Resident B appeared to be upset and was verbalizing that he wanted to go home to his wife. Staff 3 stated Resident B then started yelling at another resident. Staff 3 stated she intervened and asked if Resident B would go to his room at which time she stated Resident B grabbed her and attempted to pick her up. Staff 3 stated she put her hands on Resident B's arms and sat him down. Staff 3 stated Resident B then attempted again to pick her up and that she sat him down once again. Staff 3 stated Resident B calmed down at that point. Staff 3 stated she was thankful that he calmed down as he was not normally redirectable. Staff 3 stated she reported this incident and concerns at that time to administrator Sonya Boulier that Resident B was not appropriate for the facility given that he was consistently easily irritable and capable of physically harming someone. Staff 3 stated administrator reportedly said she would talk to the family about it.

On 3/20/2025, I interviewed administrator/authorized representative Sonya Boulier and staff 4, a regional supervisor, at the facility. Administrator stated Resident B no longer lived at the facility. Administrator stated that according to facility records, Resident B was in AL from 12/07/2022 until 2/08/2025 and moved to MC on 2/09/2025. Administrator stated Resident B was moved due to a decline in cognition related to his ability to perform simple tasks and because he was urinating in inappropriate areas of the facility. Administrator stated she was aware of one situation in which Resident A was in an altercation with another resident approximately 9 months ago which was reported to her after she started working with the facility two months ago. Administrator stated it was reported to her that Resident B "playfully" hit another resident in his stomach. Administrator confirmed she was informed of the incident between staff 3 and Resident B. Administrator stated that to her knowledge, this was the first incident of aggression from Resident B. administrator stated that while staff can directly report concerns to her, staff normally report concerns to the resident care director, the wellness nurse and the resident care coordinator who in turn are supposed to report these concerns to her. Administrator stated that since the incident with Resident A and Resident B, she has been made aware that staff did have concerns that were apparently reported to the supervisory staff which she was not made aware of. Administrator stated she did not feel she was able to sufficiently address concerns about Resident B due to the lack of adequate communication from her administrative staff.

I reviewed Resident B's service plan, provided by staff 4. Each section of the plan includes a "revision" date, indicating the last date changes were made to the plan for that particular area of consideration. Under a section titled *Physically Aggressive,* with a revision date of 8/26/2024, the plan read, in part, "I have the potential to have physically aggressive behavioral expressions, to include showing and hitting, due to

Alzheimer's Disease and triggers specific to aggressive individuals who display acts of verbally or physically aggressive behavior. I become incompatible with confrontational individuals and become protective of others in my surroundings".

I reviewed facility Progress Notes for Resident A, provided by staff 4, dated between December 2024 and March 2025. Notes dated 1/29/2025 read "[Resident B] had another resident sit on his lap and refused to let her go. I had to pry his hand apart in order for him to let go of the other resident. [Resident B] tried to kiss resident before letting go". Notes dated 2/14/2025 read, in part, "Physically/verbally aggressive. Per CM [care manager], [Resident B] became verbally aggressive and then attempted to strike CM". Notes dated 2/21/2025 read, in part, "Resident punched another resident in the stomach while sitting on the sofa next to each other. He said the resident attacked him, but the other resident was sleeping". Notes dated 3/04/2025 read, in part, "Resident was aggressive with another resident. Staff shared it wasn't appropriate and not right to do so; he then decided to chase and follow staff saying: "I'm going to bash your face in".

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.**
For Reference: R 325.1901	**Definitions**
	(p) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	The complaint alleged Resident A was assaulted by Resident B due to inadequate supervision of Resident B. Documents reviewed and interviews with staff support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

4/23/2025

Aaron Clum — Date
Licensing Staff

Approved By:

04/29/2025

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