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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 4, 2020

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

RE: License #: AL580080590
Investigation #: 2020A0116021
Brookdale Monroe AL (MI)

Dear Ms. Barrett:

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. 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 (313) 456-0380.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL580080590
Investigation #:	2020A0116021
Complaint Receipt Date:	05/12/2020
Investigation Initiation Date:	05/13/2020
Report Due Date:	07/11/2020
Licensee Name:	Brookdale Senior Living Communities, Inc.
Licensee Address:	Suite 2300 6737 West Washington St. Milwaukee, WI 53214
Licensee Telephone #:	(414) 918-5000
Administrator:	Tonya Barrett (Acting)

Licensee Designee:	Tonya Barrett (Acting)
Name of Facility:	Brookdale Monroe AL (MI)
Facility Address:	1605 Fredericks Drive Monroe, MI 48162
Facility Telephone #:	(734) 241-5700
Original Issuance Date:	04/28/1998
License Status:	REGULAR
Effective Date:	01/27/2019
Expiration Date:	01/26/2021
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED

II. ALLEGATION(S)

	Violation Established?
Resident A is a two person assist. Staff Laura Moore was verbally abusive to Resident A and would threaten to not give him snacks. On 5/4/20, she left Resident A in his wheelchair all night. She has since been terminated.	Yes

III. METHODOLOGY

05/12/2020	Special Investigation Intake 2020A0116021
05/12/2020	APS Referral APS complaint rejected for investigation
05/13/2020	Special Investigation Initiated - Telephone

	Interviewed licensee designee Robin Freysinger.
05/20/2020	Contact - Telephone call made Interviewed former staff Laura Moore.
05/20/2020	Contact - Telephone call made Interviewed staff Colleen Sheehan.
05/20/2020	Contact - Telephone call made Left a message on Resident A's cell phone requesting a return call.
05/20/2020	Contact - Telephone call made Left a message for staff Arielle Thiel.
05/21/2020	Contact - Telephone call received Interviewed Ms. Thiel.
05/21/2020	Contact - Telephone call received Interviewed Resident A.
05/21/2020	Inspection Completed-BCAL Sub. Compliance No onsite conducted due to Covid-19
06/01/2020	Exit Conference With Tonya Barrett (acting on behalf of the corporation).

ALLEGATION:

Resident A is a two person assist. Staff Laura Moore was verbally abusive to Resident A and would threaten to not give him snacks. On 5/4/20, she left Resident A in his wheelchair all night. She has since been terminated.

INVESTIGATION:

I interviewed licensee designee, Ms. Freysinger, via telephone on 05/13/20 and she reported that on the midnight shift (10:00 p.m.-6:00 a.m.) on 05/03/20 Ms. Moore worked along with Ms. Sheehan. Ms. Freysinger reported being informed by Ms. Thiel that Resident A had shared with her that Ms. Moore left him in his wheelchair all night and was “mean” in her dealings with him. Ms. Freysinger reported she interviewed Resident A and he was consistent in his account of what occurred on the night of 05/03/20 into the morning of 05/04/20. Ms. Freysinger reported that after completion of the internal investigation, Ms. Moore was terminated.

I interviewed Ms. Moore on 05/20/20 and she reported that the allegations are false. Ms. Moore reported that to date she is still uncertain as to why she was terminated. Ms. Moore reported that she was not and has not ever been verbally abusive or mean to any of the residents. Ms. Moore reported that she has worked at the facility for a year and a half with no issues.

Ms. Moore reported on the night of 05/03/20 she and Ms. Sheehan worked together and normally each staff is responsible for a hallway and on the night of 05/03/20 she was responsible for the hallway that Resident A’s room is in. Ms. Moore admitted that she denied Resident A additional snacks as she had already provided him with multiple snacks. She reported that Resident A continued to request snacks and she offered him some water or something to drink. Ms. Moore reported Resident A was upset about that but was eventually okay. Ms. Moore reported that Resident A is very heavy and weighs about 360lbs and is a two-person assist. Ms. Moore reported that at night staff use Resident A’s sliding board to assist in getting him in his bed. She reported that Resident A was in bed when she got to work at 10:00 p.m. when she did her rounds to check on everyone. Ms. Moore reported that at around 12:30 a.m. she went back to Resident A’s room and saw him attempting to get out of bed by himself, she assisted him back in bed and asked him why was he trying to get out of bed. Ms. Moore reported that Resident A wanted to smoke a cigarette, which is normally prohibited at that time of night/early morning. Ms. Moore reported that Resident A was adamant about going outside to smoke and was becoming more and more agitated when she told him that he would have to wait until morning. Ms. Moore reported that due to Resident A’s agitation and behavior she called the Resident Care Coordinator Katie LaRose who told her to allow him to go outside and smoke in hopes that this would calm him down and prevent any additional problems during the night/morning. Ms. Moore reported that she took Resident A outside to the smoking area in his wheelchair and she came back inside and sat in front of the window where she could see him and still hear/see call lights of the other residents in her hallway. Ms. Moore reported that Resident A stayed outside smoking and talking on his cell phone for about 1 hour to a 1 ½ hours before finally allowing her to bring him back inside. Ms. Moore reported that she brought Resident A back to his room and he wanted to stay in his wheelchair and watch television. Ms. Moore reported she went on her break around 2:00 a.m. after coming bringing Resident A back to his room. Ms. Moore reported that she and Ms. Sheehan checked on

Resident A throughout the night as he constantly pulled his call light, but never asked to be put back in bed. Ms. Moore reported that Ms. Sheehan was assisting her because she was attending to other residents during a few of the times when Resident A pulled his call light. Ms. Moore reported that during the additional times she checked in on Resident A throughout the night he was either watching television or dozing off in his wheelchair. I asked Ms. Moore did she ever ask Resident A if he was ready to get back in bed and she responded that she did not. Ms. Moore reported that she no longer works at the facility.

I interviewed Ms. Sheehan on 05/20/20 and she reported that on the night of 05/03/20 she worked the midnight shift (10:00 p.m.-6:00 a.m.) with co-worker Ms. Moore. Ms. Sheehan denied hearing or observing Ms. Moore be verbally abusive or mean to Resident A or any of the other residents. Ms. Sheehan also reported that prior to the start of the shift, the afternoon staff told her not to provide Resident A with any additional snacks because he had already been given four or five snacks during the afternoon shift. Ms. Sheehan reported that although she was not technically responsible for Resident A or the residents in his hallway, she helped Ms. Moore out as needed throughout the shift while she was attending to other residents. Ms. Sheehan admitted that she did not provide any snacks to Resident A but offered him water, which he denied. Ms. Sheehan reported that she and Ms. Moore were both checking in on Resident A as he was pulling his call light on and off all night. Ms. Moore reported when she went to check on him this one particular time, she observed him attempting to get out of bed independently because he was adamant about going outside to smoke. Ms. Sheehan reported this was around 12:30 a.m. She reported Ms. LaRose told Ms. Moore to let him go outside to smoke in efforts to calm him down. Ms. Sheehan reported that Resident A was outside for about an hour and Ms. Moore had to stay by him to ensure he was safe and did not attempt to leave. Ms. Sheehan reported during this time she would answer all call lights to ensure that if any residents needed anything, she could take care of them. Ms. Sheehan reported that during the time they were putting Resident A in his wheelchair he tried to hit her with his chair and was rude and disrespectful. Ms. Sheehan reported that once Ms. Moore brought him back inside, she took him to his room and reported to her that he was in his wheelchair watching television. Ms. Sheehan reported that while Ms. Moore was on break (around 2:00 a.m.) Resident A pulled his call light and she went in to see what he needed, she reported he said nothing and asked nothing of her. Ms. Sheehan reported that he pulled his call light again at 3:00 a.m. and again at 3:30 a.m. and when she went to check on him, he had a smirk on his face and said, “We can do this all night.” Ms. Sheehan reported that Resident A continually pulled his call light and she and/or Ms. Moore answered it. Ms. Sheehan reported that Resident A was in his wheelchair watching television and not once through the night did he ask to be put in his bed.

I interviewed staff Ms. Thiel on 05/21/20 and she reported that when she went to work on 05/04/20 at 2:00 p.m. Resident A told her that he slept in his wheelchair all night and that staff ignored his call lights all night, although he pulled it several times. Ms. Thiel reported that after speaking with Resident A she reported the information

to her supervisor Ms. LaRose who in turn informed the then licensee designee, Ms. Freysinger, of the matter. Ms. Thiel reported that Resident A is fairly new to the facility and reported she has had no issues with him, although several staff have complained that he is rude and difficult to handle.

I interviewed Resident A on 05/21/20 and he reported that his staff Laura left him in his wheelchair all night. Resident A reported that he pulled his call light about 15 times that night and reported that he was ignored. Resident A reported that Ms. Moore knows that he is unable to get in his bed independently and reported at no point did she offer to help get him in his bed after he finished smoking outside. Resident A reported that since he moved into the facility he has never had to sleep in his wheelchair. Resident A reported that this is the first time he has had any issue with Ms. Moore or any of the other staff. Resident A denied that Ms. Moore was verbally abusive to him and did not recall being denied snacks as reported.

I reviewed Resident A's assessment plan dated 03/31/20 and it documents that Resident A is a two person assist and staff are to use a stand-up lift and slide board for all transfers.

I conducted the exit conference with Operations Specialist, Tonya Barrett, on 06/01/20. The licensee designee, Ms. Freysinger resigned, and Ms. Barrett is acting on behalf of the corporation at the present. Ms. Barrett is in the process of being credentialed. Ms. Barrett was aware of the incident that occurred and was a part of the internal investigation. I informed her of the rule violation and the requirement of submitting a corrective action plan to address the violation. Ms. Barrett reported an understanding.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	Based on the findings of the investigation, which included interviews of Ms. Freysinger, Ms. Moore, Ms. Sheehan, Ms. Thiel and Resident A, I am able to corroborate the allegation specific to Resident A being left in his wheelchair all night. With regard to Ms. Moore being verbally abusive and withholding snacks from Resident A, there is insufficient evidence to corroborate those allegations. Although Ms. Moore and Ms. Sheehan deny that they failed to answer Resident A's call lights throughout the night and both reported that they visually checked on him every time he pulled his call light, he remained in his wheelchair all night and required staff assistance in transferring him from wheelchair to bed. Further, Ms. Moore admitted that she never asked Resident A if he was ready to or wanted to get back in bed and just assumed, he was satisfied sleeping in his wheelchair. Resident A reported that Ms. Moore did not answer his call light even after reportedly pulling it at least 15 times. Resident A reported that he was forced to sleep in his wheelchair and reported that this was the first time something like this has ever happened to him. Resident A reported that all of the other staff treat him good and he has nothing further to report. This violation is established as staff failed to provide supervision, protection and personal care as defined in the act and specified in the resident's written assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

06/01/2020

Pandrea Robinson
Licensing Consultant

Date

Approved By:

06/04/2020

Ardra Hunter
Area Manager

Date