GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 7, 2021

Stephen Levy
The Sheridan at Birmingham
2400 E. Lincoln Street
Birmingham, MI 48009

RE: License #: AH630381578
Investigation #: 2021A0585030
The Sheridan at Birmingham

Dear Mr. Levy:

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 (248) 975-5053.

Sincerely,

Brender L. Howard

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
4th Floor, Suite 4B, 51111 Woodward Avenue
Pontiac, MI 48342
(313) 268-1788
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630381578
Investigation #:	2021A0585030
Complaint Receipt Date:	04/19/2021
Investigation Initiation Date:	04/20/2021
Report Due Date:	06/19/2021
Licensee Name:	CA Senior Birmingham Operator, LLC
Licensee Address:	Suite 4900 161 N. Clark Chicago, IL 60601
Licensee Telephone #:	(312) 673-4387
Administrator:	Melissa Bell
Authorized Representative:	Stephen Levy
Name of Facility:	The Sheridan at Birmingham
Facility Address:	2400 E. Lincoln Street Birmingham, MI 48009
Facility Telephone #:	(248) 940-2050
Original Issuance Date:	03/29/2018
License Status:	REGULAR
Effective Date:	09/27/2019
Expiration Date:	09/26/2020
Capacity:	128
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
There is not enough staff to address the needs of the residents.	Yes
Additional Findings	No

III. METHODOLOGY

04/19/2021	Special Investigation Intake 2021A0585030
04/20/2021	APS Referral Referred allegations to Adult Protective Services (APS).
04/20/2021	Special Investigation Initiated - Telephone Contacted complainant #1 to discuss allegations.
05/04/2021	Inspection Completed On-site Completed with observation, interview, and record review.
06/09/2021	Exit Conference. Conducted with authorized representative Stephen Levy.

ALLEGATION:

There is not enough staff to address the needs of the residents.

INVESTIGATION:

On 4/19/21, the department received two complaint via BCHS online complaint. Two separate complaints were submitted to the department on 4/19/21 with both pertaining to the shortage of staffing at the facility.

I interviewed ombudsman Mary Katsarles on 4/20/21 and she stated that she filed the complaint on half of several residents' authorized representative. She stated that according to the residents' authorized representatives, there is not enough staff to feed, clean or change the residents. She stated that she is very concerned for all the residents that live at the home.

I interviewed the second complainant on 4/20/21. He stated that he is concerned about Resident L as well as other residents' safety due to the lack of staff. He stated

that on 4/19, there was no medication technician on the third floor. He stated that residents are left in bed and in their chairs all day. He stated that he has given Resident L showers multiple times due to the lack of staff. He stated that he has also had to do Resident L's laundry. He stated that breakfast was served late on 4/18 and it was served by one of the housekeepers.

This facility has a three-floor assisted living area and a separate 1st floor secured memory care unit. Ms. Bell affirmed that staff on one floor would not be able to see or hear residents on another floor. Also, staff in the assisted living area would not be able to see or hear the residents in the memory care unit.

The facility's staffing schedule indicates for every day, afternoon, and midnight shift there is to be two resident care manager and one medication technician on each of the three floors in the assisted living area. Also, there are to be two care managers and a medication manager on the memory care unit. This would be a total of 12 staff on each shift. However, review of a few staff schedules revealed this staffing level is not being fulfilled.

On 5/4/21, I conducted an onsite inspection. I interviewed administrator Melissa Bell. She stated that there is enough staff to care for the needs of the residents. She stated that the census was 72. She stated that there are 3 floors for assisted living and one floor for memory care. She stated that there are two care staff to each floor. She stated that they utilize staff agencies to fill vacancies when staff call in if they are available. She stated that sometimes it is hard to get agency staff and when that happens, she will come in herself to fill the vacancy. She stated that sometimes staff are scheduled to do split floor where they work two floors. Ms. Bell shared copies of staffing schedule/sign in sheets.

On 5/4/21, I interviewed medication technician Bernadette Green at the facility. She stated that she also assists with residents' care when she is not passing medication. She stated that they are short staffed, and she must do several floors. She stated that there is one CENA on the third floor which is the busiest floor. She stated that most of the residents are getting care but sometimes it is hard to do everything. She stated that some residents must wait longer for assistance.

On 5/4/21, I interviewed housekeeper Gigi Gaskins who stated that she was asked to help serve food to the residents because there was not enough care staff. She stated that breakfast was served around 9:00 a.m. that morning.

On 5/4/21, I interviewed resident care manager Alexis Thomas at the facility. She stated that she doesn't believe that it is enough staff. She stated that she was the only aide working that floor. She stated that the third floor consists of 19 residents. She stated that there are two person assists on that floor. She stated that if she need help with a two person assist, she calls help from another floor although there may be just one staff on that other floor.

On 5/4/21, I interviewed Relative K who is also a resident of the facility. He stated that Resident K was admitted to the facility as a two person assist. He stated that he has been transferring Resident K by himself because staff always take too long.

On 5/4/21, I interviewed Relative M by telephone. She stated that there is a lack of staff and there are constant turnovers. She stated that staff tell Resident M to press the pendant for help, but they take a long time and by that time, resident try to go by herself. She stated that although the staff supposed to do Resident M's laundry, she does it because they never have staff to do it. She stated that Resident M have been left in bed until 1/1:30 in the afternoon.

The service plan for Resident K read that she was total dependent on staff for mobility/ambulation, grooming, and toileting, two persons assist for bathing. Staff to completes all housekeeping tasks.

The service plan for Resident L read, history of falls, requires assistance with transfers, requires assistance with medication, bath requires one person assistance and staff is complete all housekeeping and laundry. Resident may have difficulty following instructions with using the telephone and other communication devices.

The service plan for Resident M read, requires hands on assistance by staff members, requires frequent hands-on assistance with transfers and mobility. The plan read, resident requires physical assistance with all tasks related to toileting. Resident is dependent on staff for all escort needs and requires the use of manual wheelchair.

The review of the staff schedule from January through March reveal that there was several days that did not show the number of staff that was consistent to Ms. Bell's statement.

On 5/6/21, I interviewed staff scheduler Antonia George by telephone. She stated that there are three shifts, 6 am – 2 pm, 2 pm – 10 pm and 10 pm -6 am. She stated that every floor has two caregivers.

In an email from Ms. Bell, she sent the following:

"The below chart shows the duration of time it took to clear the alerts. Please keep in mind that some staff claimed alerts on their phone and assisted the residents but forgot to clear the alert in the system. Since many staff did not immediately clear alerts, we have many that took longer than an hour to clear. "

Time to Clear:	Alerts:	
Less than a minute	85	5%
1-10 minutes	399	25%
10-20 minutes	216	14%
20-60 minutes	349	22%
1-2 hours	157	10%
2-9 hours	221	14%
10+ Hours	157	10%
Total:	**1,584**	**100%**

A random review of response time documentations revealed extended response times have occurred as follows:

Date	Alert	Response time
3/7	11:33:00 am	25 minutes 14 seconds
3/16	7:21:58 pm	1 hour 14 minutes 24 seconds
3/16	1:43:09 pm	31 minutes 16 seconds
3/16	3:05:55 pm	28 minutes 9 seconds
3/17	2:02:00 pm	34 minutes 47 seconds
3/17	2:12:04 pm	24 minutes 35 seconds
3/18	8:03:45 am	1 hour 6 minutes 21 seconds
3/18	9:27:02 am	33 minutes 1 second
3/18	10:10:34 am	1 hour 10 minutes 7 seconds
3/18	2:22:11 pm	1 hour 5 minutes 5 seconds
3/19	7:54:54 am	27 minutes 12 seconds
3/19	10:55:27 am	40 minutes 49 seconds
3/19	8:35:07 pm	28 minutes 37 seconds
3/22	1:09:52 am	38 minutes 8 seconds
3/22	6:25:00 pm	30 minutes 50 seconds
3/23	1:14:04 pm	31 minutes 11 seconds
3/24	1:03:59 am	23 minutes 3 seconds
3/24	7:29:36 pm	27 minutes 8 seconds
3/25	1:11:29 am	31 minutes 58 seconds
3/25	11:48:41 pm	23 minutes 54 second
3/26	11:31:33 am	38 minutes
3/27	5:00:45 am	42 minutes 2 seconds
3/27	5:20:58 am	21 minutes 35 seconds
3/27	8:11:41 am	33 minutes 37 seconds
3/28	12:03:08 am	1 hour 0 minutes 49 seconds

3/28	9:46:33 am	25 minutes 42 seconds
3/29	3:37:39 am	29 minutes 9 seconds
3/29	1:20:45 pm	1 hour 36 minutes 18 seconds
3/29	2:26:38 pm	31 minutes 3 seconds
3/30	7:27:18 pm	25 minutes 45 seconds
3/31	11:54:49 am	1 hour 14 minutes 55 seconds
3/31	12:34:59 pm	34 minutes 34 seconds

The call light pendant also revealed times that exceeded 2 to 10 hours that was charted as bedroom motion.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	The facility has 57 residents residing among three separate floors and two separate units. Resident needs vary from fairly independent only needing medication management to requiring "total assistance". Staff schedules are not filled as expected. In addition, there are excessive response times on all three shifts for residents in all areas of the home. There were response times that ranged from 21 minutes to one hour and 36 minutes. The facility did not demonstrate compliance with their own standards nor with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

At the time of the exit, Melissa Bell was no longer the administrator.

On 6/9/21, I reviewed the findings of this report with licensee authorized representative Stephen Levy via telephone.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remains unchanged.

6/9/21

Brender Howard — Date
Licensing Staff

Approved By:

6/7/21

Russell B. Misiak — Date
Area Manager