GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

Vera Gjolaj
Sunrise of Grosse Pointe Woods
21260 Mack Avenue
Grosse Pointe Woods, MI 48236

June 3, 2021

RE: License #: AH820391697
Investigation #: 2021A1011033
Sunrise of Grosse Pointe Woods

Dear Ms. Gjolaj:

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 licensee 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 (248) 975-5053.

Sincerely,

Andrea Krausmann, Licensing Staff
Bureau of Community and Health Systems
51111 Woodward Avenue 4th Floor, Suite 4B
Pontiac, MI 48342
(586) 256-1632

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820391697
Investigation #:	2021A1011033
Complaint Receipt Date:	06/01/2021
Investigation Initiation Date:	06/01/2021
Report Due Date:	08/01/2021
Licensee Name:	Welltower OpCo Group LLC
Licensee Address:	4500 Dorr Street Toledo, OH 43615
Licensee Telephone #:	(703) 854-0322
Authorized Representative/ Administrator:	Vera Gjolaj
Name of Facility:	Sunrise of Grosse Pointe Woods
Facility Address:	21260 Mack Avenue Grosse Pointe Woods, MI 48236
Facility Telephone #:	(313) 343-0600
Original Issuance Date:	12/23/2019
License Status:	REGULAR
Effective Date:	06/23/2020
Expiration Date:	06/22/2021
Capacity:	78
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The supervisor of shift did not take immediate action when Resident A had unexplained complaint of pain.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/01/2021	Special Investigation Intake 2021A1011033
06/01/2021	Special Investigation Initiated - Telephone Interviewed administrator Vera Gjolaj.
06/03/2021	Contact - Telephone call made Follow-up interview with Vera Gjolaj
06/03/2021	APS Referral – sent via email
06/03/2021	Contact – Document received APS Centralized intake worker Tasha Smith confirmed receipt.
06/03/2021	Exit Conference – Conducted with licensee authorized representative Vera Gjolaj via telephone.

ALLEGATION:

The supervisor of shift did not take immediate action when Resident A had unexplained complaint of pain.

INVESTIGATION:

On 5/27/21, the facility submitted an incident report to the department. On 5/28/21, I requested via email additional information from the facility's administrator Vera Gjolaj and she submitted a revised incident report containing more detailed information.

Due to the Covid pandemic, this investigation was conducted remotely.
On 6/3/21, I made a referral to adult protective services.

The incident report read that on 5/24/21 at 7:25 am the lead care manager Egypt Sharp went to assist Resident A with her morning routine. Ms. Sharp began to assist her with dressing, but Resident A placed both arms across her rib cage and grimaced with pain. Ms. Sharp asked if she was in pain and Resident A replied "yes". Ms. Sharp asked where it hurt and Resident A was unable to verbalize the site of her pain due to her diagnosis of dementia.

Ms. Sharp did not immediately notify Resident A's physician nor her authorized representative. Instead, Ms. Sharp telephoned facility's wellness nurse Marneah Davis to report her concerns. Ms. Sharp then completed Resident A's morning care and Resident A self-ambulated to the dining room using her walker and had breakfast.

Two hours later at 9:30 am Ms. Davis assessed Resident A. She observed no swelling or bruising to her arms or rib cage but observed Resident A was in pain. When questioned what happened and whether she had fallen, Resident A responded, "No, nothing's wrong with me, leave me alone".

At 10 am Nurse Practitioner Michelle Cruz was notified, and she ordered X-rays of Resident A's left humerus, forearm, chest and Tylenol to be administered every six hours. Once pain management orders were implemented, Resident A's pain was managed and did not interfere with daily activities, according to the incident report.

Resident A's authorized representative, Relative A1, was notified on 5/24/21 at 10:15 am.

X-rays were ordered and completed at 1 pm on 5/24 but results were not received until two days later on 5/26 at 3:30 pm. The results indicated Resident A had a small avulsion distal olecranon to her left elbow. Ms. Cruz was notified and recommended that Resident A be sent to the hospital for further evaluation. Relative A1 took Resident A to the hospital on 5/26 at 5:30 pm. In the emergency room, imagining was completed of her left elbow and ribs. The results showed the left elbow as normal osseous mineralization with no fracture or dislocation seen. However, imaging of the ribs showed minimally displaced fractures of the left seventh, eighth and nineth ribs.

On 6/1 and 6/3/21, I interviewed Ms. Gjolaj by telephone. Ms. Gjolaj affirmed that Egypt Sharp was the supervisor of resident care during the shift when Resident A complained of unexplained pain. Wellness nurse Marneah Davis was not on the premises when Ms. Sharp called and notified her. Ms. Gjolaj explained that Ms. Sharp did not immediately notify Resident A's physician of her pain, because that is not the facility's policy. Ms. Gjolaj said the supervisor is expected to notify the facility's nurse and the nurse will notify the resident's physician when deemed necessary.

Ms. Gjolaj said she did not believe any staff other than a nurse could obtain physician orders to send a resident to the hospital. I provided technical assistance and explained that home for the aged licensing rules do not require the facility to have a nurse. It is expected that the supervisor of resident care be responsible for the safety of residents, including immediate notification to the resident's physician and authorized representative of reportable incidents.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(4) The supervisor of resident care on each shift shall do all of the following: **(c) Be responsible for safety of residents in case of emergency.**
ANALYSIS:	The facility's policy of the supervisor of resident care on shift having to notify a facility Wellness nurse that is not on the premises, rather than being responsible for the safety of residents, does not meet compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Resident A complained of unexplained pain at 7:25 am on 5/24/21. Her physician and authorized representative were not notified of this reportable incident for more than two hours at 10 am and 10:15 am respectively. Consequently, pain management orders were not received until such time, and then her pain was managed.

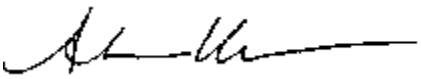
APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.
For reference R 325.1901	**Definitions.**

	(17) "Reportable incident/accident" means an intentional or unintentional event in which a resident suffers harm or is at risk of more than minimal harm, such as, but not limited to, abuse, neglect, exploitation, or unnatural death.
ANALYSIS:	The facility did not immediately report Resident A's 5/24/21 7:25 am unexplained pain to her physician and her authorized representative.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/3/21, I reviewed the findings of this report with licensee authorized representative Vera Gjolaj by telephone.

IV. RECOMMENDATION

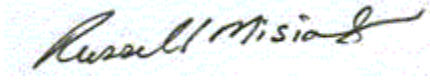
Contingent upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.



6/3/21

Andrea Krausmann Date
Licensing Staff

Approved By:



6/3/21

Russell B. Misiak Date
Area Manager