GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 20, 2021

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

RE: License #: AH630381578
Investigation #: 2021A1027054
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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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.

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 (517) 284-9727.

Sincerely,

Jessica Rogers

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

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

I. IDENTIFYING INFORMATION

License #:	AH630381578
Investigation #:	2021A1027054
Complaint Receipt Date:	09/07/2021
Investigation Initiation Date:	09/08/2021
Report Due Date:	11/07/2021
Licensee Name:	CA Senior Birmingham Operator, LLC
Licensee Address:	Suite 4900 161 N. Clark Chicago, IL 60601
Licensee Telephone #:	(312) 673-4387
Administrator:	Jordan Houston
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?
Resident A lacked protection.	No
Additional Findings	Yes

III. METHODOLOGY

09/07/2021	Special Investigation Intake 2021A1027054
09/08/2021	Complaint was forwarded to LARA from APS
09/08/2021	Special Investigation Initiated - Letter Email sent to administrator Jane Goulette requesting documentation pertaining to investigation
09/15/2021	Inspection Completed On-site
09/17/2021	Contact - Telephone call made Telephone interview conducted with Resident A's niece
09/21/2021	Inspection Completed-BCAL Sub Compliance
10/01/2021	Exit Conference Conducted with authorized representative Stephen Levy and administrator Jordan Houston by email

ALLEGATION:

Resident A lacked protection.

INVESTIGATION:

On 9/7/21, the department received a complaint which alleged Resident A was abused by a caregiver.

On 9/15/21, I conducted an on-site inspection at the facility. I interviewed Executive Director Jordan Houston. Mr. Houston stated the facility provides Resident A her medications, however private duty caregivers through agency Assist One and Residential Hospice staff assist her with activities of daily living. Mr. Houston stated facility staff will assist with care if requested by Resident A’s family, private

caregivers, or hospice staff. Mr. Houston stated Resident A has a diagnosis of dementia and a history of falls. Mr. Houston stated on 9/4, facility staff were notified by Resident A's private caregiver that she had fallen on 9/3 and was complaining of back pain. Mr. Houston stated facility staff notified him, as well as Resident A's family and hospice nurse. Mr. Houston stated on 9/5, Resident A's hospice nurse evaluated her and observed left ankle had bruising and swelling, as well as bruising under her left thigh. Mr. Houston stated the hospice nurse also observed circular shaped bruising that appeared to look like fingerprints on Resident A's left upper arm and a bruise on her left index finger. Mr. Houston stated Resident A's hospice nurse reviewed the Assist One caregiver notes regarding the fall which read she had slide out of her wheelchair. Mr. Houston stated Resident A's hospice nurse felt her observations of the bruising was not consistent with the type of fall. Mr. Houston stated Resident A's hospice nurse filed a report with Adult Protective Services (APS), as well as informed Resident A's family. Mr. Houston stated Resident A's hospice nurse obtained an order to x-ray her lumbar spine, coccyx, pelvis, and left ankle, which showed no injuries. Mr. Houston stated Resident A's family placed a surveillance camera in her room on 9/5. Mr. Houston stated Assist One caregiver Shauntel Sommerville was on duty the day Resident A's fell. Mr. Houston stated Resident A's family had requested with the Assist One agency that Ms. Sommerville no longer provide care for her. Mr. Houston stated he spoke with the director at Assist One to also request Ms. Sommerville not return to the facility while an investigation regarding Resident A's injuries was pending, however the director stated he did not have the authority since the caregivers were privately paid by Resident A's family. Additionally, Mr. Houston stated he requested that the Assist One caregivers communicate any incidents to the facility staff and Resident A's family in a timely manner. Mr. Houston stated Ms. Sommerville provided care for Resident A after the fall on 9/7, 9/8, 9/9, then no longer returned to the facility. Mr. Houston stated APS and the detective were on-site at the facility last week. While on-site, I interviewed Resident A's hospice nurse who was evaluating Resident A in her room. Resident A's hospice nurse's statements were consistent with Mr. Houston. Additionally, I observed Resident A's bruising on her left ankle which was consistent with statements from Mr. Houston. While on-site I reviewed the Assist One caregiver notes. The note from 9/3 by Ms. Sommerville read "Went down for after 9 A [sic], attended strength therapy socialized with peer until lunch @ 12:30 PM returned to apartment at @ 1P [sic]. Was being very combative and confused. Threw phone across the room, kept trying to get up out of wheelchair on her own and kept pulling away. She fell on her bottom next to her bed. Refused to go down for dinner, offered to order the food she stated that she wasn't hungry. She calmed down after 6 P [sic]."

On 9/17/21, I conducted a telephone interview with Resident A's niece. Resident A's niece stated Resident A had a history of falls, one which resulted in a broken pelvis with declines, as well as back pain, prior to receiving 24-hour caregivers and hospice. Resident A's niece stated Resident A had complained of back pain and she also observed the bruising on 9/5. Resident A's niece stated she spoke with Assist One to request Ms. Sommerville be removed from Resident A's care, however the

agency reported Ms. Sommerville was the scheduler for the agency. Resident A's niece stated she placed a camera in Resident A's room on 9/5. Resident A's niece stated she observed Ms. Sommerville on the camera for a few days following her request to be removed from her care but could not recall exact dates. Resident A's niece stated she observed Ms. Sommerville kept Resident A out of her room most of the day after the camera was installed, which was not normal routine for Resident A. Resident A's niece stated Ms. Sommerville had not returned to care for Resident A since that time frame. Resident A's niece stated, "no one really knows what happened" and "I do not blame the facility."

I reviewed Resident A's facesheet which read consistent with statements from Mr. Houston.

I reviewed Resident A's service plan which read consistent with statements from Mr. Houston.

I reviewed an email, provided by Mr. Houston, from the Residential Hospice nurse explaining the sequence of events on 9/5/21 which read consistent with statements from both their interviews.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
For Reference: R325.1901	**Definitions**

	(16) "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:	Interviews with the executive director, Resident A's hospice nurse and niece as well as review of facility documentation revealed it is uncertain how Resident A's fall or bruising occurred with the agency caregiver. Once staff were notified of the incident, facility policies were followed which led to further investigation from APS and the police.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 9/15/21, I conducted an on-site inspection at the facility. Mr. Houston introduced himself as the new administrator of the facility as of 9/10.

On 9/15/21, I interviewed licensing staff Brender Howard who stated she had not received notification of the change of administrator.

I reviewed the facility file which revealed an appointment of administrator form was not submitted to the department for Mr. Houston.

APPLICABLE RULE	
R 325.1913	**Licenses and permits; general provisions.**
	(2) The applicant or the authorized representative shall give written notice to the department within 5 business days of any changes in information as submitted in the application pursuant to which a license, provisional license, or temporary nonrenewable permit has been issued.

ANALYSIS:	Interviews with the administrator and review of the facility file revealed the department was not notified of the facility's change in administrator.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED. Reference Confirming Letter dated 5/17/21.**

INVESTIGATION:

On 9/15/21, I conducted an on-site inspection at the facility. Mr. Houston stated the previous administrator did not submit an incident report for Resident A's fall with bruising and allegation of abuse on 9/3.

I reviewed the facility filed which was consistent with statements from Mr. Houston.

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:	Interview with the administrator and review of the facility file revealed the department did not receive notification of Resident A's fall with injuries and allegation of abuse.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/01/2021, I shared the findings of this report with authorized representative Stephen Levy by email as requested by Mr. Levy.

IV. RECOMMENDATION

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

9/21/21

Jessica Rogers Date
Licensing Staff

Approved By:

9/23/21

Russell B. Misiak Date
Area Manager